PRINTED: 02/28/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> CC			survey leted /2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2002 ANDREW AVE LA PORTE, IN 46350					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
R 0000								
Bldg. 00	This visit was for the Investigation of Complaint IN00416996.		R 00	000				
	Complaint IN00416 the allegations is cit	996 - State deficiency related to ed at R0245.						
	Unrelated deficiency is cited.							
	Survey date: Januar	y 18, 2024						
	Facility number: 01							
	Residential Census:	98						
	These State Resident accordance with 410	tial Findings are cited in) IAC 16.2-5.						
	Quality review com	pleted on 1/22/24.						
R 0243	410 IAC 16.2-5-4(
Bldg. 00	Health Services - I (3) The individual	-						
	medication shall d	ocument the administration						
	in the individual 's records that indica	medication and treatment						
	(A) time;	ito trio.						
	, ,	eation or treatment;						
	(C) dosage (if app (D) name or initials	•						
	administering the							
		iew and interview, the facility	R 02	243	CORRECTION: All nurses and		04/21/2024	
	of 3 residents review	llin was given as ordered for 1			QMA's (insulin certified) were educated on reading the MAR			
	administration. (Res				orders thoroughly, verifying or			
	Finding includes:				checking BS prior to insulin administration, ensuring the B within parameters for insulin			
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURI	3	TITLE		(X6) DATE	
Searfeeair Sutherland LPN, DON 02						02/22/2024		

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	G <u>00</u>	COMPLETED
			B. WING		01/18/2024
			STRE	EET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER				2 ANDREW AVE	
BRENTV	VOOD AT LAPORT	E		PORTE, IN 46350	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)	BE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		was reviewed on 1/18/24 at		administration, and notifying	
	_	ses included, but were not		MD of abnormal BS reading	S.
		iabetes mellitus, high blood		DDEVENTION DON	:
	pressure, and edema	a.		PREVENTION: DON or des	•
	The Level of Co	Assessment data 1/6/24		will audit all insulin MAR's t	wice
		Assessment, dated 1/6/24,		weekly to ensure insulin is	MD
		nt was oriented to self only.		administered as ordered by	IVIU
	_	ance with medications due to		including education and	atad for
	_	required daily supervision of		disciplinary action as warra	ited for
		equired staff assistance with nt including finger sticks.		6 months.	
	diabetic manageme	in menualing imger sucks.		DESDONSIDI E DEDSONI.	DON
	The Service Plan, dated 8/8/23, indicated the			RESPONSIBLE PERSON:	DON
				or designee	
	resident had diabetes mellitus. Interventions included, but were not limited to, administer			DUE DATE: 4/24/2024	
		ered, blood sugar checks as		DUE DATE: 4/21/2024	
		or for signs or symptoms of			
	low or high blood s				
	I low of fingil blood s	ugai.			
	A Physician's Order	r, dated 8/6/23, indicated			
	-	njection flexpen, inject 3 units			
		ce daily, hold for a blood			
	sugar less than 150.				
	A Physician's Order	r, dated 11/10/23, indicated			
	insulin glargine inje	ection 100 units, inject 25 units			
	subcutaneously every morning and inject 22 units				
	subcutaneously every evening, hold the				
	medication if blood sugar is less than 150.				
	The November 2023 Medication Administration				
	Record (MAR), indicated the Novolog was				
	administered when the blood sugar was less than				
	150 on the following dates and times:				
	- 11/3/23 at 7:00 a.m., blood sugar 143				
	- 11/7/23 at 7:00 a.r				
	- 11/8/23 at 7:00 a.i	_			
		.m., blood sugar 136			
		_			
	- 11/15/23 at 7:00 a.m., blood sugar 134 - 11/15/23 at 4:00 p.m., blood sugar 140				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/18/2024			
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE				STREET ADDRESS, CITY, STATE, ZIP COD 2002 ANDREW AVE LA PORTE, IN 46350					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATION OF THE APPROPRI		ATE	COMPLETION		
TAG				TAG	DEFICIENCY)		DATE		
		a.m., blood sugar 122							
		a.m., blood sugar 144							
		a.m., blood sugar 140							
		a.m., blood sugar 93							
	- 11/30/23 at 4:00 p.m., blood sugar 126								
	The November 202	23 MAR, indicated the insulin							
	glargine was admir	nistered when the blood sugar							
	was less than 150 on the following dates and								
	times:								
		a.m., blood sugar 123							
	- 11/12/23 at 8:00 a.m., blood sugar 85								
	- 11/13/23 at 8:00 a.m., blood sugar 105								
	- 11/13/23 at 5:00 p.m., blood sugar 123								
	- 11/14/23 at 8:00 a.m., blood sugar 129								
	- 11/15/23 at 8:00 a.m., blood sugar 134								
	- 11/15/23 at 5:00 p.m., blood sugar 140								
	- 11/16/23 at 5:00 p.m., blood sugar 109								
		a.m., blood sugar 144							
		a.m., blood sugar 140							
		a.m., blood sugar 93							
	- 11/30/23 at 8:00 a.m., blood sugar 148								
	- 11/30/23 at 5:00 p.m., blood sugar 126								
	The December 2023 MAR indicated the insulin glargine and Novolog were administered when the								
	blood sugar was less than 150 on the following dates and times:								
	- 12/5/23 at 6:00 a.m., blood sugar 102								
	- 12/8/23 at 6:00 a.	m., blood sugar 115							
	- 12/9/23 at 6:00 a.	m., blood sugar 125							
	During an interview	w on 1/18/23 at 12:40 p.m., the							
	Director of Nursing	g indicated the nurse should							
	have held the medi-	cation as ordered.							
R 0245	410 IAC 16.2-5-4	(e)(5)							
	Health Services -	Offense							
Bldg. 00	(5) Injectable med	dications shall be given only							
	by licensed perso								

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PRINTED: 02/28/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		B. WING 01/18/2024			/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					NDREW AVE		
BRENTWOOD AT LAPORTE					RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		view and interview, the facility	R 0	R 0245 CORRECTION: All QMA's v			04/21/2024
	-	ectable medications were given			educated on their scope of		
		nurse and/or a QMA (Qualified			practice including not		
	· ·	who had received specialized			administering injectable		
	_	administration for 2 of 3			medications if they are not		
		for insulin administration.			certified for administration. Th	е	
	(Residents C and D))			QMA noted by state		
					representative practicing outside of		
	Findings include:				· ·	scope was educated and	
					disciplined accordingly. All nu	-	
		ord was reviewed on 1/18/24 at			staff were educated to only sig	-	
		ses included, but were not			the MAR for medications that	they	
		mellitus, heart failure, and major			administered.		
	depressive disorder.						
	TI C ' DI 1 1 111/4/22 ' 1' (1/1				PREVENTION: A note was		
	The Service Plan, dated 11/4/23, indicated the				attached to all insulin MAR's for	or	
	resident had mild to moderate disorientation or				license or insulin certification		
	difficulty recalling/retaining information. She had diabetes mellitus and required assistance with				verification. DON or designee		
	medication adminis				verify certification/licensure du	_	
	medication adminis	stration.			twice weekly audit for 6 month	IS.	
	A Physician's Orde	r, dated 8/4/23, indicated			RESPONSIBLE PERSON: DO	NC	
Lantus injection (in		nsulin medication), inject 50			or designee		
	units subcutaneous	y twice daily.					
	The December 2023 Medication Administration Record (MAR) indicated QMA 1 signed out the				DUE DATE: 4/21/2024		
Lantus injection as administered on 12/24/23		administered on 12/24/23 at					
	5:00 p.m.						
	During an interview on 1/18/24 at 1:32 p.m., the						
	Director of Nursing indicated QMA 1 was not						
	certified to give insulin.						
	2. Resident D's record was reviewed on 1/18/24 at 12:53 p.m. Diagnoses included, but were not						
limited to, type 2 diabet							
		d high blood pressure.					
		6 F W					
	The Service Plan d	lated 9/13/23 indicated the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/18/2024			
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE				STREET ADDRESS, CITY, STATE, ZIP COD 2002 ANDREW AVE LA PORTE, IN 46350					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	resident was oriented and able to recall or retain information. She had diabetes mellitus and required assistance with medication administration. A Physician's Order, dated 9/15/23, indicated Novolog injection flexpen (insulin medication), 9 units subcutaneously three times daily with meals. The December 2023 Medication Administration Record (MAR) indicated QMA 1 signed out the Novolog injection as administered on 12/24/23 at 4:00 p.m. During an interview on 1/18/24 at 1:32 p.m., the Director of Nursing indicated QMA 1 was not certified to give insulin. This citation relates to Complaint IN00416996.								

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