STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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 a State Residential Licensure Survey. Survey dates: August 15 and 16, 2023 Facility number: 010890 Residential Census: 59 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/18/23.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to invite the local fire department to participate in scheduled fire drills at least every six months. This had the potential to affect all 59 residents residing in the facility. Finding includes: The fire drills were reviewed on 8/15/23. The monthly fire drills were completed as required, however there was no indication the local fire department was invited to attend any of the drills. Interview with the Maintenance Director, on 8/15/23 at 11:15 a.m., indicated the last time the fire department participated was 9/30/22. They had not been invited to attend again since.	R 0092	What Has Been Done to Correct? The new maintenance director was educated on the protocol and procedures for fire and disaster drills to include inviting the local fire department every 6 months. How Will Recurrence Be Prevented? Facility will invite the local fire department to participate in the fire and disaster drill via email, the email will be printed and kept in a binder with the record of all training and drills and documentation of names and signatures of personnel present. Next fire drill with invite for fire department to be held on 9/19/2023. Person Responsible: Maintenance Director, ED Due Date: 9/19/2023	09/19/2023
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed to ensure the Director of the Memory Care Unit had the required education and experience for the Director's position. This had the potential to affect 14 residents who resided on the Memory Care Unit. Finding includes: The employee licensures and certifications were reviewed on 8/15/23 at 2:00 p.m. The Memory Care Unit Director was hired on 8/1/22. She lacked documentation of an earned degree in health care, mental health or social service, one year of work experience with dementia or Alzheimer's residents, and 12 hours of dementia-specific training within three months of the initial employment as the Director of the Dementia special care unit. Interview with the Administrator on 8/16/23 at 11:30 a.m., indicated the Memory Care Unit	R 0095	What has been done to correct? The previous memory care director is now the Memory Care Coordinator. Current DON acting as memory care director. How Will Recurrence Be Prevented? The facility will ensure that the employee holding the position of Director of Memory care will have an earned degree from an educational institution in health care, mental health, or social service profession or be a licensed health facility administrator. This employee will also have a minimum of 1 year work experience with dementia or Alzheimer's residents within the past 5 years.	09/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	Director had completed 8 hours of dementia training. She was not a nurse or licensed health facility administrator and she had not completed any degree in health care, mental health, or social service. She was unaware of the required criteria for the Director position.		Person Responsible: ED or designee, HR Due date: 9/1/2023	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was at least one staff member with a current CPR and first aid certification in the facility for a four-hour period, on 8/13/23, of 12 shifts reviewed. This had the potential to affect all 59 residents residing in the	R 0117	What has been done to correct? The daily schedule will now include CPR credentials next to each staff member scheduled to ensure there is a minimum of 1 licensed staff member for each	10/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	facility. Finding includes: Facility staffing schedules for 8/13/23 through 8/16/23 were reviewed on 8/15/23 at 2:00 p.m. The schedules indicated there were no staff members scheduled on 8/13/23, from 6:00 p.m. to 10:00 p.m., certified in CPR and first aid. Interview with the Administrator and Business Office Manager on 8/16/23 at 10:50 a.m., indicated they had no additional staff CPR or first aid certifications to provide.		shift over a 24-hour period. How Will Recurrence Be Prevented? All clinical staff members will have a current CPR license before working in the facility, including agency staff. Licenses will be kept in a binder divided by months and staff will be notified at the beginning of each month when it is time to renew. PLC (Priority Life Care) will provide a corporate clinical nurse who is certified to train and renew all CPR licenses as needed. This will be completed and in place by 11/1/2023. Person Responsible: DON or designee, PLC corporate clinical nurse Due Date: 10/1/2023 During our annual survey we were not asked for agency staff CPR license's. We have proof that all days in question had sufficient staff with active CPR license.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure annual dementia training had been completed for 3 of 5 employees reviewed. (ADON, CNA 1 and Culinary Director) Findings include: The employee records and inservices were reviewed on 8/15/23 at 2:00 p.m. a. The ADON was hired on 9/30/22. She had only	R 0120	What has been done to correct? All employees will have completed at least 6 hours of Dementia training via Relias before working in the facility. Staff will complete the annual training before their due date or be taken off the schedule until it is completed, including disciplinary action. How Will Recurrence Be	09/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	completed 1.75 hours of dementia training within 6 months of hire. b. CNA 1 was hired on 9/1/22. She had not completed any dementia training within 6 months of hire. c. The Culinary Director was hired on 2/22/22. He had not completed any dementia training in 2022. Interview with the Administrator on 8/16/23 at 11:25 a.m., indicated the dementia training had not been completed.		Prevented? The business office manager will keep all Relias dementia training records in a separate binder and notify employees and managers when each employee is due to complete initial and or annual training. Training will be completed as listed above. This binder will be in place by 9/1/2023. Person Responsible: ED or designee, Business office manager, DON Due Date: 9/1/2023	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure each resident had a semi-annual evaluation completed for 3 of 7 residents reviewed. (Residents 2, 8 and 6) Findings include:	R 0216	What has been done to correct? Point click care is set up to remind nursing managers when each LOC assessment is due. The nursing manager will complete or delegate the assessment prior	10/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	1. The record for Resident 2 was reviewed on 8/15/23 at 12:00 p.m. The resident was admitted on 12/30/18. The last Level of Care Assessment was completed on 3/1/23. There was no documentation a Level of Care Assessment had been completed in the six months prior. 2. The closed record for Resident 8 was reviewed on 8/15/23 at 2:50 p.m. The resident was admitted on 7/13/21. The last Level of Care Assessment was completed on 5/23/23. There was no documentation a Level of Care Assessment had been completed in the six months prior. 3. Record review for Resident 6 was completed on 8/15/23 at 2:09 p.m. Diagnoses included, but were not limited to, dementia. The resident was admitted to the facility on 6/16/19. A Level of Care Assessment for Resident 6 was completed on 3/20/23. There was no documentation to indicate a Level of Care Assessment had been completed 6 months prior. Interview with the Director of Nursing on 8/15/23 at 2:45 p.m., indicated the Level of Care Assessments were what they completed for the residents' semi-annual evaluations. The facility changed the electronic health record system to a different system in May 2023. They were unable to retrieve any documentation from the old system. Interview with the Dementia Care Coordinator on 8/16/23 at 10:46 a.m., indicated she was unable to provide any documentation semi-annual evaluations had been completed prior to 3/20/23.		to the due date. How Will Recurrence Be Prevented? Every resident will have an assessment done every 6 months. Each assessment will also be printed, signed by appropriate parties, and placed in the resident's hard chart. This will be updated and in effect by 11/1/2023. Person Responsible: DON or designee Due Date: 10/1/2023	
R 0269	410 IAC 16.2-5-5.1(b) Food and Nutritional Services -			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
Bldg. 00	Noncompliance (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician. Based on observation, record review, and interview, the facility failed to serve meals from a menu approved by a Registered Dietician. This had the potential to affect all 59 residents residing in the facility. Finding includes: On 8/15/23 at 12:01 p.m., Cook 1 was observed taking the lunch food temperatures. The lunch meal was spaghetti with meat sauce, a tossed salad, and garlic bread. On 8/16/23 at 8:40 a.m., residents were observed eating breakfast in Main Dining Room. The breakfast meal was pancakes with strawberries and bacon. The weekly menu, approved by the Registered Dietician (RD) and provided by the Administrator, indicated the lunch meal for 8/15/23 was honey dijon pork cutlet, orzo florentine, roasted fresh beets, bread or roll, and fruity oat bar. The breakfast meal for 8/16/23 was cheddar egg potato bake, toast, seasonal fruit, and hot or cold cereal. A weekly menu, provided by the Administrator upon entrance conference, indicated the lunch meal for 8/15/23 was spaghetti and meat sauce, garlic bread, tossed salad, and applesauce. The breakfast meal for 8/16/23 was pancakes with fresh berries and bacon. Interview with the Administrator on 8/16/23 at 10:50 a.m., indicated the weekly menu she had provided at entrance conference was created by	R 0269	What has been done to correct? Training for staff on the new dining services (Dining RD) to be done on 8/29/23 and 8/30/23. Certifications will be kept in the POC binder and HR file. How Will Recurrence Be Prevented? New dietician onboard. Facility will follow the dietician's menu daily. All dietary staff will be educated via in-service by 9/1/2023. Menu's are reviewed daily with the culinary director during morning meeting. ED will confirm daily menu items served match our approved dieticians menu for all meals served. Person Responsible: ED, Culinary Director Due Date 9/1/2023	09/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	the Culinary Director. She was not aware it was different from the menu approved by the RD and that the RD approved menu was not being followed. The Culinary Director was not available for interview.			
R 0350 Bldg. 00	410 IAC 16.2-5-8.1(b)(1-2) Clinical Records - Noncomformance (b) Clinical records must be retained after discharge: (1) for a minimum period of one (1) year in the facility and five (5) years total; or (2) for a minor, until twenty-one (21) years of age. Based on record review and interview, the facility failed to maintain resident records for a period of five years for 5 of 6 residents who resided in the facility prior to 5/1/23. (Residents 2, 4, 6, 8 and 9) Findings include: 1. Resident 2's record was reviewed on 8/15/23 at 12:00 p.m. The resident was admitted on 12/30/18. There were no clinical records except a year of Nursing Notes prior to 5/1/23 available for review. 2. Resident 4's record was reviewed on 8/15/23 at 10:00 a.m. The resident was admitted on 5/20/22. There were no clinical records except a year of Nursing Notes prior to 5/1/23 available for review. 3. Resident 6's record was reviewed on 8/15/23 at 2:09 p.m. The resident was admitted on 6/16/23. There were no clinical records except a year of Nursing Notes prior to 5/1/23 available for review. 4. Resident 8's record was reviewed on 8/15/23 at 2:50 p.m. The resident was admitted on 7/13/21. There were no clinical records except a year of Nursing Notes prior to 5/1/23 available for review.	R 0350	What has been done to correct? All medical records will be retained for at least 5 years with the process listed below. How will Recurrence Be Prevented? The facility nursing department scheduler will print all progress notes and assessments at the beginning of each month for the previous month and file them in the resident's hard chart. This will be completed by the 5th day of each month indefinitely starting in September. DON or designee will audit records monthly to ensure compliance. Person Responsible: DON or designee Due Date: 9/5/2023	09/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	5. Resident 9's record was reviewed on 8/16/23 at 9:02 a.m. The resident was admitted on 7/9/20. There were no clinical records except a year of Nursing Notes prior to 5/1/23 available for review. Interview with the Director of Nursing (DON), on 3/15/23 at 3:05 p.m., indicated a new management company had taken over effective 5/1/23 and implemented a new electronic heath record (EHR) program. Prior to the transition, they had printed out a year of Progress Notes for each resident. The facility no longer had access to any records from the previous EHR, including, but not limited to, vital signs, medication administration records and service plans.			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to complete a discharge summary and transfer form for 1 of 2 closed records reviewed. (Resident 9)	R 0354	What has been done to correct? Staff will be in-serviced on using the transfer/discharge report in point click care which includes all	10/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	Finding includes: The closed record for Resident 9 was reviewed on 8/16/23 at 11:10 a.m. The resident was discharged and transferred to another facility on 6/4/23. There were no transfer or discharge forms completed in the record. Interview with the Director of Nursing (DON) on 8/16/23 at 11:35 a.m., indicated there should be a progress note documenting the details of the resident's discharge.		required information. How will Recurrence Be prevented? Staff will print and send with all residents discharging for any reason the transfer/discharge form in point click care. Staff will fill in pertinent information on the bottom of the form and attach a bed hold policy and current med list. This will be done indefinitely starting 10/1/2023. DON or designee will audit all discharges daily to ensure compliance. Person Responsible? DON or designee Due Date: 10/1/2023	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 3 of 5 residents reviewed. (Residents 4, 5 and 6) Findings include: The resident Emergency Binder was reviewed on 8/15/23. The following information was missing: a. Resident 4 - missing hospital preference. b. Resident 5 - missing hospital preference. c. Resident 6 - missing hospital preference and emergency contact phone number. Interview with the Memory Care Director, on 8/15/23 at 2:55 p.m., indicated the items were missing and she would get the records for those residents updated.	R 0356	What has been done to correct? Emergency Binder audit completed and or updated. All required information was added. A new transfer/discharge summary was added for each resident. How will Recurrence Be prevented? Monthly audits of emergency binder will be completed by the 5th day of each month. All missing and or updated information will be added. This will be done indefinitely starting 9/5/2023. Person Responsible? DON or designee Due Date: 9/5/2023	09/05/2023
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure each resident record included an annual health statement for 4 of 7 resident records reviewed. (Residents 2, 5, 6 and 4) Findings include:	R 0409	What was done to correct? Audit of all charts will be completed. Health assessment forms will be sent to all doctors for residents then placed in hard charts once completed.	10/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	1. Resident 2's record was reviewed on 8/15/23 at 12:00 p.m. The resident had been admitted on 12/30/18. Diagnoses included, but were not limited to, diabetes mellitus and hypertension. The record lacked any documentation an Annual Health Statement had been completed. 2. Record review for Resident 5 was completed on 8/15/23 at 11:12 a.m. Diagnoses included, but were not limited to, dementia and diabetes mellitus. The resident was admitted to the facility on 6/10/23. The record lacked any documentation an Annual Health Statement had been completed. 3. Record review for Resident 6 was completed on 8/15/23 at 2:09 p.m. Diagnoses included, but were not limited to, dementia. The resident was admitted to the facility on 6/16/19. The record lacked any documentation an Annual Health Statement had been completed. Interview with the Dementia Care Coordinator on 8/16/23 at 10:46 a.m., indicated she was unable to provide any documentation an Annual Health Statement had been completed for Residents 5 and 6. 4. Resident 4's record was reviewed on 8/15/23 at 10:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and hypertension. A Physician Assessment, dated 5/19/22, indicated the TB and infectious disease section had not been completed and was left blank. There was lack of any Health Statement to indicate the resident was free of communicable		How will Recurrence Be prevented? All resident health assessment forms with due dates will be placed in a binder divided by the month they are due. Assessments will be sent to the assigned doctor for completion by the 10th of each month. Once returned to the facility, the completed assessments will be placed in the hard chart and the binder. This process will be done indefinitely. Any changes will be updated in LOC or service plan as appropriate and communicated with the resident and family. This audit will be completed by 10/10/2023 with all assessments updated by the assigned doctors. DON or designee will audit residents health assessments monthly to ensure compliance. Person Responsible? DON or designee Due Date: 10/10/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	diseases. Interview with Director of Nursing (DON) on 8/15/23 at 3:15 p.m., indicated they had a new company take over the facility in May and they had not required any health statement orders.			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure residents received annual and admission tuberculosis (TB) tests or screenings for 7 of 7 residents reviewed for annual and/or admission TB test or screenings. (2, 8, 3, 6, 4, 5 and 3) Findings include:	R 0410	What was done to correct? TB binder made to include completed yearly TB screening form for all residents dated for August 2023. How will Recurrence Be prevented? Upon admission, all residents will receive a 2-step TB skin test when applicable. TB	09/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	1. The record for Resident 2 was reviewed on 8/15/23 at 12:00 p.m. . The resident was admitted on 12/30/18. There was no documentation the resident had received an annual TB test or screening in the past 12 months. 2. The closed record for Resident 8 was reviewed on 8/15/23 at 2:50 p.m. . The resident was admitted on 7/13/21. There was no documentation the resident had received an annual TB test or screening in the past 12 months. Interview with the Director of Nursing on 8/15/23 at 3:15 p.m., indicated they were behind on TB tests, and were going initiate annual TB test/ screenings every August going forward. 3. Record review for Resident 5 was completed on 8/15/23 at 11:12 a.m. Diagnoses included, but were not limited to, dementia and diabetes mellitus. The resident was admitted to the facility on 6/10/23. The resident had a chest x-ray completed on 3/17/23. The record lacked any documentation a tuberculin test on or prior to admission was completed. There was no documentation to indicate a risk assessment for tuberculosis had been completed. 4. Record review for Resident 6 was completed on 8/15/23 at 2:09 p.m. Diagnoses included, but were not limited to, dementia. The resident was admitted to the facility on 6/16/19. The record lacked any documentation an annual tuberculin test or risk assessment for tuberculosis had been completed. Interview with the Dementia Care Coordinator on		screening forms will be completed yearly in August for all residents and placed in the binder. This will be done indefinitely. This audit will be completed by 9/1/2023. Person Responsible? DON or designee Due Date: 9/1/202	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	8/16/23 at 10:46 a.m., indicated she was unable to provide any documentation for the tuberculin testing or risk assessments had been completed for Residents 5 and 6. 5. Resident 4's record was reviewed on 8/15/23 at 10:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and hypertension. The resident had a TB (tuberculosis) test completed in April 2022 and a TB Risk Assessment completed in June 2022. Interview with Director of Nursing (DON) on 8/15/23 at 3:15 p.m., indicated she had not yet completed a new annual TB Risk Assessment. 6. Record review for Resident 3 was completed on 8/16/23 at 10:12 a.m. Diagnoses included, but were not limited to, hypothyroidism, hyperlipidemia, hypertension and major depressive disorder. The resident was admitted to the facility on 8/26/22. There was a lack of documentation to indicate the resident had received any annual TB testing. 7. Record review for Resident 9 was completed on 8/16/23 at 11:00 a.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, osteoporosis and varicose veins of lower extremities. The resident was admitted to the facility on 7/9/20. There was a lack of documentation to indicate the resident had received any annual TB testing or screening. Interview with the Director of Nursing (DON) on 8/16/23 at 11:06 a.m., indicated she was unable to provide documentation any TB tests or screening			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	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
	had been completed on the resident. The prior company did not require this testing, just an chest x-ray.			