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	04/16/2025

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 the Investigation of Complaints IN00452160 & IN00455467. Complaint IN00452160 - State deficiency related to the allegations is cited at R300. Complaint IN00455467 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: April 15 and 16, 2025 Facility number: 010890 Residential Census: 95 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/21/25.	R 0000	**R 000** 410 IAC 16.2-5-1.2(v)(1-6) ___ Yes ___ No What Has Been Done to Correct? This plan of correction is not to be construed as an admission of, or agreement with the findings and conclusions in the statement of deficiencies. This Plan of Correction is being submitted as required by regulation. How Will Recurrence Be Prevented? Person Responsible: Due Date: 05/03/2025	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency Based on observation, record review, and interview, the facility failed to label two aspirin bottles with the resident's full name, physician's name, and dosage instructions for 1 of 2 medication carts reviewed. (Resident G) Finding includes: On 4/25/25 at 9:15 a.m., the following was observed on the 200 hall medication cart located in the nurses' office with QMA 1:	R 0300	**R 300** 410 IAC 16.2-5-6 (C) (4) Pharmaceutical Services-Deficiency ___ Yes _X_ No What Has Been Done to Correct? DON and ADON conducted an audit of all medication rooms and carts for all over the counter medications, prescription medications, and biologicals. Any	05/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Smith	DON	05/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	There were two boxes of Aspirin 81 milligrams (mg) marked with the first name of Resident G on each box. There was no last name, physician name, or dosage instructions listed on the box. During an interview at the time, QMA 1 indicated the bottles belonged to Resident G and she would immediately label them correctly. During an interview on 4/15/25 at 3:46 p.m., the Director of Nursing (DON) indicated the medication should have been labeled appropriately. This citation relates to Complaint IN00452160.		medications observed during this audit that were not properly labeled were properly destroyed or labeled correctly. Written counseling was provided to the QMA responsible for the occurrence and an Inservice was conducted with all nurses and QMAs regarding labeling all medications including over the counter medications upon receipt. How Will Recurrence Be Prevented? DON or designee to complete bi-weekly cart audits for 3 months, then weekly audits indefinitely to ensure compliance. Person Responsible: DON Due Date: 05/03/2025	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to maintain clinical records that were accurately documented per policy related to documentation after an unwitnessed fall for 1 of 3 resident records reviewed. (Resident B) Finding includes: Resident B's record was reviewed on 4/15/25 at 11:12 a.m. The diagnoses included, but were not limited to, high blood pressure, depression, dementia, and high cholesterol. The Service Plan assessment, dated 8/7/23 and	R 0349	**R 349** 410 IAC 16.2-5-8.1 (a) (1-4) Clinical Records Noncompliance ___ Yes _X_ No What Has Been Done to Correct? DON and ADON completed an audit of all falls within the last 60 days to ensure that all residents were properly assessed, and all interventions were in place. All assessments including HTT assessments and vitals were documented according to state	05/23/2025

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	last reviewed on 2/13/25, indicated the resident demonstrates inappropriate judgement related to safety. Resident B had moderate dementia with short term memory loss and possible long term memory loss. Toileting required moderate assistance, grooming and transferring required assistance. A Nurses' Note, dated 4/1/25 at 2:52 p.m., indicated the resident was observed sitting on her buttocks with her feet directly out in front of her wheelchair. A bump was observed to the back of the resident's head. Vitals were immediately obtained, all parties were notified, 72 hour charting was started, and safety checks were initiated. During an interview on 4/16/25 at 9:04 a.m. The Director of Nursing (DON) indicated RN 1 obtained vitals but did not complete a head-to-toe assessment after Resident B's unwitnessed fall on 4/1/25. She understood the facility policy and had no additional information to provide. The current facility policy, titled, "Fall Prevention and Fall Management Procedure" was provided by the DON on 4/15/25 at 2:35 p.m. The policy indicated immediately after a fall the following should occur, "...complete a head to toe body assessment..."		guidelines. DON updated fall audit form to include nursing assessment. How Will Recurrence Be Prevented? DON or designee will audit completion of Head-to-toe assessments after each fall, weekly for 6 months to ensure compliance. Person Responsible: DON Due Date: 05/03/2025	