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	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	2002 ANDREW AVE LA PORTE, IN 46350

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00432156. Complaint IN00432156 - State deficiencies related to the allegations are cited at R039 and R270. Survey date: April 18, 2024 Facility number: 010890 Residential Census: 103 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/25/24.	R 0000		
R 0039 Bldg. 00	410 IAC 16.2-5-1.2(n) Residents' Rights- Deficiency (n) Residents may, throughout the period of their stay, voice grievances to the facility staff or to an outside representative of their choice, recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference. Based on record review and interview, the facility failed to ensure a grievance was completed and investigated related to a family member's concern regarding dietary services, for 1 of 3 residents reviewed for dietary services. (Resident C) Finding includes: During a telephone interview on 4/18/24 at 10:25 a.m., a family member of Resident C indicated that Employee 1 had served orange juice to her mother	R 0039	What Has Been Done to Correct? DON and ED performed an Inservice to all staff educating them on how to complete a grievance including reporting every grievance to DON and ED. All grievance reports will be investigated immediately. How Will Recurrence Be Prevented? During morning meetings all	05/10/2024

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

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	on 4/14/24. Her mother had an allergy to oranges, and had been served oranges previously on 4/5/24. She reported the incident to the Lead Server and the Dietary Manager (DM). Resident C's record was reviewed on 4/18/24 at 9:04 a.m. Diagnoses included, but were not limited to, hypertension, Diabetes Mellitus and dementia. The resident was allergic to Vitamin C, oranges and orange juice. An Incident Note, dated 4/5/24, indicated the resident had eaten oranges, she was unable to report who had served them to her. The Nurse Practitioner was present in the facility and assessed the resident. She was given 12.5 milligrams of Benedryl. The family member was notified and wanted the resident sent to the hospital for evaluation. The resident was admitted to the hospital for abnormal labs and returned to the facility on 4/10/24. The 4/5/24 incident had been reported to the State Agency. There were no additional reportables related to the resident. The Grievance Log was reviewed on 4/18/24. There was nothing related to resident being served orange juice on 4/14/24. During an interview on 4/18/24 at 11:00 a.m., the DM indicated the family member had notified her on 4/14/24 that she found orange juice in her mother's room that had been served, but the resident did not drink it. The DM indicated it had been an accident. She wrote up Employee 1 for the incident and was planning an all dietary staff inservice the following day. During an interview on 4/18/24 at 11:58 a.m., the		grievances will be discussed and followed up with on a daily basis until resolved indefinitely. All grievances will also be reviewed monthly during QA to ensure completion. Once completed all grievances will be kept in a grievance binder. Person Responsible: DON or Designee	

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	Executive Director indicated she was not aware the resident had been served orange juice recently and it should have been investigated. During an interview on 4/18/24 at 12:15 p.m., the Director of Nursing indicated she had heard through the grapevine the resident had been served orange juice, but that an aide had found it, so she did not think that had to be investigated as a grievance. There had been no follow up with the family. This citation relates to Complaint IN00432156.			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, record review, and interview, the facility failed to ensure dietary requirements were met related to a resident being served food to which she was allergic on two occasions, for 1 of 3 residents reviewed for dietary services. (Resident C) Finding includes: On 4/18/24 at 11:00 a.m., the kitchen was observed with the Dietary Manager (DM). There was a white board on the wall with the names and allergens of five residents. There were Dietary Huddle sheets taped to the shelf above the serving area that had the day's menu being served and a list of five residents and their allergens for comparison. Resident C was on the white board	R 0270	What Has Been Done to Correct? A dietary form has been created that includes all residents with food allergies that must be filled out and signed by a dietary aide and nursing staff before going out to residents. All room trays must also be signed off by dietary and nursing staff before going out. How Will Recurrence Be Prevented? The dietary manager will pull these forms and audit them three times a week for 60 days starting on 4/18/24. Audits will then decrease to once weekly for 4 months, then once monthly indefinitely.	05/06/2024

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	and Dietary Huddle sheets as being allergic to oranges. Resident C's record was reviewed on 4/18/24 at 9:04 a.m. Diagnoses included, but were not limited to, hypertension, Diabetes Mellitus and dementia. The resident was allergic to Vitamin C, oranges and orange juice. An Incident Note, dated 4/5/24, indicated the resident had eaten oranges, she was unable to report who had served them to her. The Nurse Practitioner was present in the facility and assessed the resident. She was given 12.5 milligrams of Benedryl. The family member was notified and wanted the resident sent to the hospital for evaluation. The resident was admitted to the hospital for abnormal labs and returned to the facility on 4/10/24. During a telephone interview, on 4/18/24 at 10:25 a.m., a family member of Resident C indicated that Employee 1 had served orange juice to her mother on 4/14/24. The family member had reported the incident to the Lead Server and the Dietary Manager (DM). Her mother had an allergy to oranges, and had also been served oranges previously on 4/5/24. During an interview on 4/18/24 at 11:00 a.m., the DM indicated after the incident on 4/5/24, they initiated the Dietary Huddle sheets as an extra step to check for allergies before food was served and the three staff members who served residents that day received write ups. She indicated the family member had notified her on 4/14/24 that she found orange juice in her mother's room that had been served, but the resident did not drink it. The DM indicated it had been an accident. She wrote up Employee 1 for the incident and was planning		Person Responsible: Dietary Manager	

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	an all dietary staff inservice the following day. This citation relates to Complaint IN00432156.			