PRINTED: 05/21/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 04/18/2024			ETED			
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 R 0000	SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE PI REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
Bldg. 00								
ычд. 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.		R 0000					
	Quality review completed on 4/25	5/24.						
R 0039	410 IAC 16.2-5-1.2(n) Residents' Rights- Deficiency							
Bldg. 00	(n) Residents may, throughout their stay, voice grievances to or to an outside representative recommend changes in policy and receive reasonable respor requests without fear of reprise interference.	the facility staff of their choice, and procedure, ses to their						
	Based on record review and interval failed to ensure a grievance was convestigated related to a family m regarding dietary services, for 1 or reviewed for dietary services. (Re	ompleted and ember's concern f 3 residents	R 00	39	What Has Been Done to Corre DON and ED performed an Inservice to all staff educating them on how to complete a grievance including reporting e grievance to DON and ED. All	every	05/10/2024	
	During a telephone interview on 4 a.m., a family member of Resider Employee 1 had served orange justice.	t C indicated that			grievance reports will be investigated immediately. How Will Recurrence Be Prevented? During morning meetings all			

 $LABORATORY\ DIRECTOR'S\ OR\ PROVIDER/SUPPLIER\ REPRESENTATIVE'S\ SIGNATURE$

TITLE

(X6) DATE

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.

State Form Event ID: YGYG11 Facility ID: 010890 If continuation sheet Page 1 of 5

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

PRINTED: 05/21/2024 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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. STREET ADDRESS, CITY, STATE, ZIP COD 2002 ANDREW AVE LA PORTE, IN 46350 (X5 COMPLE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE LA PORTE IN ACTION SHOULD BE CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION (AS COMPLE LA PORTE IN ACTION SHOULD BE CORSCETED TO THE APPROPRIATE DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CORSCETED TO THE APPROPRIATE DEFICENCY COMPLE LA PORTE IN ACTION SHOULD BE CORSCETED TO THE APPROPRIATE DEFICENCY COMPLE LA PORTE IN ACTION SHOULD BE CORSCETED TO THE APPROPRIATE DEFICENCY COMPLE LA PORTE IN ACTION SHOULD BE CORSCETED TO THE APPROPRIATE DEFICENCY COMPLE LA PORTE IN ACTION SHOULD BE COMPLETED TO THE ACTION SHO	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> COM		COMPLETED 04/18/2024			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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 TAG PREFIX TAG				2002 ANDREW AVE				
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 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:	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
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	IAG	on 4/14/24. Her mo and had been served 4/5/24. She reported Server and the Dieta Resident C's record 9:04 a.m. Diagnoses to, hypertension, Di The resident was all and orange juice. An Incident Note, does resident had eaten of report who had served Practitioner was present assessed the resident milligrams of Benerotified and wanted hospital for evaluation to the hospital for all the facility on 4/10/2. The 4/5/24 incident Agency. There were related to the resident The Grievance Log There was nothing a served orange juice. During an interview DM indicated the facility on 4/14/24 that she mother's room that a resident did not drir been an accident. Stincident and was plainservice the follow	ther had an allergy to oranges, doranges previously on the incident to the Lead ary Manager (DM). was reviewed on 4/18/24 at a sincluded, but were not limited abetes Mellitus and dementia. Idergic to Vitamin C, oranges ated 4/5/24, indicated the granges, she was unable to get them to her. The Nurse issent in the facility and att. She was given 12.5 dryl. The family member was the resident sent to the item. The resident was admitted broomal labs and returned to 24. The had been reported to the State is no additional reportables int. was reviewed on 4/18/24. The lated to resident being on 4/14/24. The on 4/18/24 at 11:00 a.m., the item of the control orange juice in her found orange juice in her had been served, but the lak it. The DM indicated it had no wrote up Employee 1 for the anning an all dietary staffing day.	IAG	grievances will be discussed a followed up with on a daily bas until resolved indefinitely. All grievances will also be review monthly during QA to ensure completion. Once completed a grievances will be kept in a grievance binder. Person Responsible:	and sis ed		

State Form Event ID: YGYG11 Facility ID: 010890 If continuation sheet Page 2 of 5

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> C		COMPLETED
		B. WING 04/18/2024			
			CTREE	T ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	8		ANDREW AVE	
BRENTWOOD AT LAPORTE				ORTE, IN 46350	
DKENIW	OOD AT LAPORTI	=	LAP	JRTE, IN 40330	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		indicated she was not aware			
		en served orange juice recently			
	and it should have b	been investigated.			
	_	on 4/18/24 at 12:15 p.m., the			
	_	indicated she had heard			
		ne the resident had been			
		, but that an aide had found it,			
		that had to be investigated as			
		had been no follow up with the			
	family.				
	This citation relates	to Complaint IN00432156.			
R 0270	440 140 40 0 5 5	4/-)/4 0)			
K 02/0	410 IAC 16.2-5-5.				
Bldg. 00		nal Services - Deficiency			
Blug. 00	(c) The facility mus				
	with consideration	equirements and requests,			
		igious, ethnic, and personal			
	preferences; and	igious, etililic, and personal			
	(3) the temporary need for meals delivered to the resident 's room. Based on observation, record review, and				
			R 0270	What Has Been Done to Corre	ect? 05/06/2024
		ty failed to ensure dietary	K 0270	A dietary form has been creat	
		met related to a resident being		that includes all residents with	
	-	th she was allergic on two		food allergies that must be filled	
		3 residents reviewed for dietary		out and signed by a dietary ai	
	services. (Resident			and nursing staff before going	
		,		to residents. All room trays me	
	Finding includes:			also be signed off by dietary a	
	_			nursing staff before going out.	
	On 4/18/24 at 11:00	a.m., the kitchen was observed		How Will Recurrence Be	
	with the Dietary Ma	anager (DM). There was a		Prevented?	
	white board on the	wall with the names and		The dietary manager will pull	these
	allergens of five res	idents. There were Dietary		forms and audit them three tir	
	Huddle sheets taped	to the shelf above the		a week for 60 days starting or	ı
	serving area that ha	d the day's menu being served		4/18/24. Audits will then decre	ease
	and a list of five res	idents and their allergens for		to once weekly for 4 months,	then
	comparison. Reside	ent C was on the white board		once monthly indefinitely.	

State Form Event ID: YGYG11 Facility ID: 010890 If continuation sheet Page 3 of 5

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		B. W	B. WING			04/18/2024	
				CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
BRENTWOOD AT LAPORTE							
DKENIV	VOOD AT LAPORT	E		LAPUR	RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and Dietary Huddle	sheets as being allergic to			Person Responsible:		
	oranges.				Dietary Manager		
		was reviewed on 4/18/24 at					
	_	s included, but were not limited					
		iabetes Mellitus and dementia.					
		lergic to Vitamin C, oranges					
	and orange juice.						
	•	lated 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.						
	D						
	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	y on 4/18/24 at 11:00 a.m. the					
	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					
	1	in her mother's room that had					
		e resident did not drink it. The					
		d been an accident. She wrote					
		the incident and was planning					
	up Employee 1 for the meldent and was planning						I

State Form Event ID: YGYG11 Facility ID: 010890 If continuation sheet Page 4 of 5

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

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STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
			B. WING			04/18/2024	
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	PREFIX (EACH CORRECTIVE ACTION SHOULD B		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)				DATE
		nservice the following day.					
	This citation relates	to Complaint IN00432156.					

State Form Event ID: YGYG11 Facility ID: 010890 If continuation sheet Page 5 of 5