STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TERRACE CARE CENTER	1900 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00428341 and IN00429142. Complaint IN00428341 - No deficiencies related to the allegations are cited. Complaint IN00429142 - Federal/state deficiencies related to the allegations are cited at F689. Survey dates: February 27 and 28, 2024 Facility number: 000061 Provider number: 155136 AIM number: 100288620 Census Bed Type: SNF/NF: 128 Total: 128 Census Payor Type: Medicare: 8 Medicaid: 96 Other: 24 Total: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/29/24.	F 0000	**Brickyard Terrace Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** Terrace Care Center respectfully requests consideration for a desk review.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

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

Tiffany A. Shepperd | Executive Director | 03/12/2024

Any defiencystatement 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 disclo days 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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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure fall interventions were in place as care planned for a resident with a history of falls, for 1 of 3 residents reviewed for falls. (Resident B) Finding includes: On 2/27/24 at 11:45 a.m., Resident B was observed seated in a wheelchair near the nurses' station. Her room was observed to have a standard mattress on the bed and there was no floor mat visible. On 2/27/24 at 3:00 p.m., with the Director of Nursing (DON) present, the resident was observed in her bed with her eyes closed. She was on a standard mattress and there was not a mat on the floor next to the bed. The resident's record was reviewed on 2/27/24 at 1:56 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, osteoporosis and a history of fall. The resident resided on the memory care unit. The Quarterly Minimum Data Set assessment, dated 2/13/24, indicated the resident had severe cognitive deficits and required extensive assistance of two staff for bed mobility, toileting and transfers. The current Fall Care Plan indicated the resident was at risk for falls, related a history of falls and a new environment. Interventions included, but	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident B floor mat placed, and proper mattress put in her room. No ill effect from alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents that are fall risks have the potential to be affected by this alleged deficient practice. All residents that require fall interventions have the potential to be affected by this alleged deficient practice. · A full house audit completed to ensure that all current residents that are fall risks have fall interventions in place. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All staff educated on the need for fall interventions to be in place. ·Director of nursing/designee will audit 5 residents 5x weekly x6	03/12/2024

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	were not limited to, a defined perimeter mattress and a low bed with mat. A Post Fall Evaluation, dated 1/30/24, indicated the resident had fallen in her room next to her bed while attempting to self transfer. She sustained a small skin tear to her right thumb and a bruise to her nose. During an interview with the DON on 2/27/24 at 3:00 p.m., she indicated a defined perimeter mattress was either a concave or a bolstered mattress. The resident had a standard mattress on her bed and there was no mat on the floor. There was no additional information provided. This citation relates to Complaint IN00429142. 3.1-45(a)		months to ensure fall interventions are in place. ·All audits will include all shifts and units and weekends. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Director of nursing/designee will complete audit tool to reflect proper fall interventions are in place using attached audit sheet. ·The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	