STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE - TERRACE CARE CENTER	**1900 ANDREW AVE LA PORTE, IN 46350**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00442947. Complaint IN00442947 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: October 24 and 25, 2024 Facility number: 000061 Provider number: 155136 AIM number: 100288620 Census Bed Type: SNF/NF: 130 Total: 130 Census Payor Type: Medicare: 7 Medicaid: 101 Private: 15 Other: 7 Total: 130 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/28/24.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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

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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident's safety after an exit alarm sounded for 1 of 1 resident reviewed for accidents. (Resident C) The deficient practice was corrected on 10/4/24, prior to the start of the survey, and was therefore past noncompliance. The facility completed an investigation and inserviced staff and families regarding elopement and alarm procedures. Finding includes: The record for Resident C was reviewed on 10/24/24 at 11:23 a.m. Diagnoses included, but were not limited to, sleep disorder, weakness, fall, dementia with anxiety, major depressive disorder, and fracture of the neck of the left femur. The 7/15/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. She had no behaviors and no episodes of wandering. The resident utilized a walker for ambulation. The Elopement Risk Evaluation, dated 7/14/24, indicated the resident was not at risk to elope at the time, placement on the elopement risk protocol was not indicated. The resident had no Care Plan related to wandering based on the Quarterly MDS and elopement risk assessment.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

An Indiana Department of Health (IDOH) reported incident, dated 10/3/24 at 11:15 p.m., indicated "Resident exited the building by entering door code to release door and exiting building. Resident noted to have an unwitnessed fall off property. 911 notified and resident transferred to ER for evaluation and treatment. Resident returned to facility." The resident sustained abrasions to the left side of her face and to her finger.

A Nurse's Note, dated 10/4/24 at 1:14 a.m., indicated the resident returned to the facility from the hospital accompanied by her daughter. The resident was alert and oriented to self, place, and situation. The resident was noted with an abrasion to the left side of her face. The resident was able to transfer herself and ambulate with the use of a rolling walker.

The Interdisciplinary Team (IDT) Note, dated 10/4/24 at 1:24 p.m., indicated the team met to review last night's event in which the resident was noted to have exited the facility. The IDT found in the late evening, the resident entered the code to exit the facility using the ambulance bay exit door. The resident had her shoes and coat on, her laundry basket, and money for her hair cut that upcoming weekend with her. Upon her return, the resident appeared calm, and she indicated that she used the code and was wanting to walk to her daughter's home. The resident's daughter indicated she had the resident exit the facility using the ambulance bay on the weekends using the code. The daughter stated the code out loud in front of the resident. The resident nodded her head in agreement.

A Social Service Progress Note, dated 10/4/24 at

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F 689	Continued From page 3	F 689		

2:24 p.m., indicated a meeting was held with the resident's daughter. The resident's daughter reported that her mother often waited for her by the door to take her out on pass. The daughter indicated her mother knew how to enter the code and exit the door. The resident's daughter reported she was not sure why her mother would have left the facility unattended. She indicated her mother did call her earlier on Wednesday afternoon asking her to come and get her. The resident's daughter reported her mother was frustrated that her mother-in-law was living at home with her. The daughter was educated on the sign in and out procedures when taking her mother out on pass. The daughter was escorted to the nurses' station and shown the procedure and expressed understanding.

Review of the facility investigation, initiated on 10/4/24, indicated the resident was seen by CNA 1 at approximately 10:00 p.m. - 10:15 p.m. The resident was provided a brief and assisted to the toilet as that was her routine. The resident had her shoes and clothing on but that was normal for the resident. Nothing seemed unusual with her.

RN 1's statement indicated, between 10:45 p.m. and 11:00 p.m., he responded to the ambulance bay door alarm. Earlier in the shift, he believed that an ambulance had come into the facility. A CNA responded to the door alarm around 8:00-9:00 p.m. and the ambulance staff reported they were there for a resident on the Gardens Unit. He believed the door was being used by the ambulance staff again to return a resident and he did not have a reason to believe that a resident had exited, as he looked out into the bay area and did not see anyone in the yard.

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During an interview on 10/24/24 at 2:15 p.m., the Interim Director of Nursing (DON) indicated the resident, upon her return, had indicated she was going to her daughter's house.

Follow up interview with the Interim DON at 2:34 p.m., indicated the last time somebody laid eyes on the resident was between 10:00 p.m. and 10:15 p.m. A late hospital return arrived at the facility and staff thought the alarm was possibly related to that. Only the ambulance bay area was checked, and no residents were observed. The Interim DON indicated staff responded to the alarm, but a resident head count was not completed, and it should have been. Multiple inservices had been held and changes were being implemented with the exit doors. Families were informed residents would need to be signed out for leave and the door codes were not to be shared.

The current facility policy titled, "Elopements and Wandering Residents" indicated the facility was equipped with door locks/alarms to help avoid elopements, alarms were not a replacement for necessary supervision and staff were to be vigilant in responding to alarms in a timely manner, and the facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk evaluation and analysis of hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.

3.1-45(a)(2)