

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Andrew Ave LA Porte, IN 46350	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>32582</p> <p>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)</p> <p>Finding includes:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 were not limited to, a defined perimeter mattress and a low bed with mat.</p> <p>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.</p> <p>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.</p> <p>This citation relates to Complaint IN00429142.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Andrew Ave LA Porte, IN 46350	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-45(a)