STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155149		05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00198223 and IN00200002. Complaint IN00198223-Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F312 and F514. Complaint IN00200002-Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F312 and F323. Survey date: May 24 and 25, 2016 Facility number: 000070 Provider number: 155149 AIM number: 100266190 Census bed type: SNF: 7 SNF/NF: 66 Total: 73 Census by payor source: Medicare: 3 Medicaid: 64 Other: 6 Total: 73	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155149		05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	Sample: 20 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on May 31, 2016.			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow doctors orders for a Nebulizer treatment and a post fall intervention for 2 of 20 records being reviewed for following doctors orders (Residents B and D). Findings include: 1. The record review for Resident B was completed on 5/25/16 at 6:30 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic ischemic heart disease and atrial fibrillation. The resident had an Electronic Medication Administration Record dated	F 0282	This Plan of Correction constitutes my written allegation ofcompliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that deficiency exists or that one was citedcorrectly. This Plan of Correction is submitted to meet requirements by stateand federal law. **F282:Services by Qualified Persons/Per Care Plan** It is the practice of this provider toprovide or arrange services by a qualified person in accordance with eachresident's written plan of care. **Whatcorrective action will be accomplished for those residents found to have beenaffected?** Resident B's physician was notified that nebulizer treatment wasnot given as ordered and was	06/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	May 2016, which included, but was not limited to, the following order: 2/20/16--Albuterol Sulfate (a breathing treatment medication) 2.5 mg (milligrams)/ 3 ml (milliliters) by inhalation every six hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. The resident had a Care Plan dated 12/29/14, which addressed the problem he had a potential for impaired gas exchange related to a diagnosis of COPD. Approaches included, "...12/29/15--Administer Nebulizer treatments as ordered...." At 1:15 p.m., Resident B was brought back from lunch and left sitting in the hallway at LPN #2's medication cart. LPN #2 indicated she was ready at that time, to perform his Nebulizer treatment and she transported him to his room in his broda chair. At 1:17 p.m., LPN #2 was observed to begin his Nebulizer treatment. At 1:38 p.m., LPN #2 was observed to remove the Nebulizer mask indicating the resident's Nebulizer treatment was completed. During an interview on 5/25/16 at 3:30 p.m., the Executive Director (ED)		administered late. No physician changes were made at that time. **How other residents will be identified and what correction actiontaken?**All residents with orders for routine nebulizer treatments have thepotential to be affected by the alleged deficient practice. Physician ordersfor all residents that require nebulizer treatments have been reviewed byDNS/Designee for accuracy and potential for missed or late administration.Physician orders have been changed and updated where indicated. **What systemic changes will be made toensure the deficient practice does not recur?** Education/disciplinary action provided to LPN #2. Licensed nurses will be in serviced byDNS/Designee on the policy of following physician orders, plan of care andmedication pass procedure. DNS/Designee willcomplete medication passprocedure skills validation check offs for licensed nursing staff on or beforeJune 07, 2016. **Howthe corrective action will be monitored?**DNS/Designee willconduct random medication pass procedure skills validations check-offs onvarying shifts and varying nursing staff members to assure that compliance ismet weekly x 4, bi-weekly x 3 and then monthly x 3 months. **Bywhat date the systemic changewill be completed** June07, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155149		05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	indicated the Nebulizer treatment was not given on time because it was due at 12:00 p.m., and it was after 1:00 p.m., when the resident received his treatment. A current policy titled "Medication Pass Procedure" dated 2/2010 with a revised date of 03/2013, provided by the ED on 5/25/16 at 3:30 p.m., indicated "Procedure Steps: 1. Medications administered within 60 minutes before and/or after time ordered... 17. Medication administration will be recorded on the MAR [Medication Administration Record] or TAR [Treatment Administration Record] after given...."2. The record for Resident D was reviewed on 5/25/16 at 12:40 p.m. Diagnoses included, but were not limited to, chronic pain, insomnia, diabetes, anorexia, anemia, anxiety, renal dialysis, and depression. Nursing notes, dated 4/16/16, indicated Resident D had an unwitnessed fall, she was found sitting next to her bed after she rolled out of the bed while attempting to vomit. An IDT (Interdisciplinary Team) fall review note, dated 4/18/16, indicated Resident D had a low blood pressure at the time of her fall.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	A Physician's order, dated 4/18/16, indicated to monitor Resident D's orthostatic blood pressure readings every shift for 3 days. During an interview, with the Director of Nursing Services, on 5/25/16 at 4:05 p.m., she indicated she could not locate any completed orthostatic blood pressure readings for Resident D. This Federal tag relates to Complaints IN00198223 and IN00200002. 3.1-35(g)(2)			
F 0312 SS=E Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure feet and nail care were provided for 13 of 21 residents observed for ADL (Activities of Daily Living) care	F 0312	**F312: ADL Care Provided For DependentResidents** It is the practice of this provider toprovide or arrange services by a qualified person in accordance with eachresident's written plan of care. **Whatcorrective action will be**	06/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155149		05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	(Residents M, N, O, Q , R, V, L, P, D, E, T, S and U). Findings include: 1. During the initial tour on 5/24/16 at 10:00 a.m., with LPN #3 in attendance the following observations were made: a. Resident M was observed to have dry skin to both feet with a brown colored debris dried between her toes, which was crumbly and some of the debris fell off onto the bed sheet around her feet when her toes were separated by LPN #3. A foul odor was noted when the resident's toes were separated. Resident M's record review was completed on 5/25/16 at 4:25 p.m. The resident's Quarterly MDS (Minimum Data Set) assessment dated 2/17/16, indicated the resident's BIMS (Brief Interview for Mental Status) was 5, which indicated the resident's mental status was severely impaired. She was an extensive assist with a one person assist for personal hygiene and total dependence with two person assist for bathing. The resident had a Care Plan dated, 8/22/13, which addressed the problem of self care deficit related to dementia and		**accomplished for those residents found to have beenaffected?** All residents were observed for the need of foot care andtoenail/ fingernail care was provided as indicated. **How other residents will be identified and what correctionaction taken?** All residents have the potential to be affected bythis alleged deficient practice. IDT completed an all facility sweep to checkall resident's fingernails and toenails to determine any resident in need ofnail care on 5/27/2016. Nail care was provided at this time for each residentas indicated. All residents unable to receive complete nail/foot care fromfacility staff was added to the list for podiatry follow up. Podiatry contacted and scheduled to visit onJune 06, 2016. **Whatsystemic changes will be made to ensure the deficient practice does not recur?** Nursing staff will be educated onproviding nail care for all appropriate residents during am and pm care and as needed;trimming nails on shower days when indicated; and observing resident's feetprior to getting up, during showers, and prior to going to bed and notifyingcharge nurse of any abnormalitiesby June 07, 2016. IDTwill implement weekly skin sweeps, including observation of fingernails andtoenails weekly x 4 weeks, then bi-weekly x 3 months, and then monthly toidentify any resident nail care needs. **How the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	rheumatoid arthritis. The goal indicated, "Resident will have all ADL needs met as evidenced by clean, neat, dry and dressed appropriately through next review." b. Resident N was observed to have dry skin to both his feet and his feet were cracked on the bottom. He had dried brown colored debris between his toes when LPN #3 separated his toes. When his toes were separated on both feet by LPN #3, some of the brown colored debris crumbled into balls falling onto his bed sheet around his feet. A foul odor was observed when LPN #3 separated his toes. Resident N's record review was completed 5/25/16 at 4:30 p.m. The resident's Quarterly MDS assessment dated 5/7/16, indicated the resident's BIMS was 7, which indicated the resident's mental status was severely impaired. He was an extensive assist with one person assist for personal hygiene and total dependence with two person assist for bathing. The resident had a Care Plan, dated 2/26/16, which addressed the problem the resident required assistance and/or monitoring for ADL care. The goal dated 6/1/16, indicated "Resident will have ADL needs met."		**corrective actionwill be monitored?** To ensurecompliance, the DNS/ designee will complete the Skin Management Program CQItool weekly x 4 weeks, monthly x 6 months and then quarterly until continuedcompliance is maintained for two consecutive quarters. The results of theseaudits will be reviewed by the CQI committee overseen by the ED. If the thresholdof 95% is not achieved an action plan will be developed to ensurecompliance. Deficiency inthis practice will result in disciplinary action up to and includingtermination of the responsible employee. **By what date the systemic changewill be completed?** June 07, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	The resident had a Care Plan dated 2/26/16, which addressed the problem of self care deficit related to weakness and inadequate vision. The goal indicated, "Resident will have all ADL needs met as evidence by resident will be clean, dry and odor free through next review." c. Resident O was observed to have dry and scaly skin to both her feet with yellowish/light brown patches on the top and bottom of her feet. She had brownish/yellow debris between her toes. The resident's tip of her third toe on her right foot and including that nail was black and hard. At that time, LPN #3 indicated she would have to look at the resident's record because she did not know the length of time this area had been there. Resident O's record review was completed on 5/25/16 at 3:20 p.m. The resident's Significant change MDS assessment dated 2/12/16, indicated the resident's BIMS was 15, which indicated she was cognitively intact. She was an extensive assist with one person assist for personal hygiene and total dependence and two person assist for bathing. The resident had a Care Plan, dated 1/21/15, which addressed the problem of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	self care deficit related to COPD (chronic obstructive pulmonary disease), arthritis, multiple sclerosis and fibromyalgia. d. Resident Q was observed to have dry and scaly skin to both her feet. When LPN #3 separated the resident's toes she had yellow colored debris between her toes with a foul odor. Resident Q's record review was completed on 5/25/16 at 4:46 p.m. The Quarterly MDS assessment, dated 3/22/16, indicated her BIMS was 12, which indicated the resident's metal status was moderately impaired. She was extensive assist with a one person assist for personal hygiene and total dependence with a two person assist for bathing. The resident had a Care Plan, dated 4/22/15, which addressed the problem the resident required assistance and/or monitoring for ADL care. The goal indicated, "Resident will have ADL needs met." The resident had a Care Plan, dated 2/24/16, which addressed the problem of self care deficit related to diagnosis of dementia and decreased mobility. The goal indicated, "Resident will have all ADL's needs met AEB [As Evidenced			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	By] resident will be clean, dry and odor free through the next review." e. Resident R was observed to have dry and scaly skin to both her feet. Her right foot had brown colored debris between her toes with a foul odor when LPN #3 separated her toes. When LPN #3 removed her socks, her skin was observed falling off her feet onto the comforter as if it was snowing. Resident R's record was reviewed on 5/25/16 at 4:55 p.m. The Quarterly MDS assessment, dated 5/6/16, indicated her BIMS was 8, which indicated the resident's mental status was moderately impaired. She was an extensive assist with one person assist for personal hygiene and total dependence with a two person assist for bathing. The resident had a Care Plan, dated 4/28/16, which addressed the problem she required assistance and/or monitoring for ADL care. The goal indicated, "Resident will have ADL needs met." The resident had a Care Plan, dated 1/23/15, which addressed the problem of self care deficit related to decreased mobility. The goal indicated, "Resident will have all ADL needs met as evidence by resident will be clean, dry and odor			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	free through next review." f. Resident V was observed to have very dry and scaly skin to both her feet. LPN #3 was unable to separate her toes due to pain related to her hammertoes to her bilateral feet. Resident V's record was reviewed on 5/25/16 at 5:03 p.m. The Quarterly MDS assessment, dated 3/12/16, indicated her BIMS was 13, which indicated her mental status was cognitively intact. She was an extensive assist with one person assist for personal hygiene and total dependence with two person assist for bathing. The resident had a Care Plan, dated 4/22/15, which addressed the problem she required assistance and/or monitoring for ADL care. The goal indicated, "Resident will have ADL needs met." The resident had a Care Plan, dated 12/17/13, which addressed the problem of self care deficit related to diagnosis of dementia and muscle weakness. The goal indicated, "Resident will have all ADL needs met as evience [sic] by resident will be clean, dry and odor free through next review." g. On 5/24/16 at 11:10 a.m., Resident L			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	was observed to have long nails on both her hands and the left hand and right thumb had black debris under those nails. Resident L's record was reviewed on 5/25/16 at 4:18 p.m. The Annual MDS assessment, dated 4/15/16, indicated her BIMS was 0, which indicated her mental status was severely impaired. She was an extensive assist with one person assist for personal hygiene and total dependence with two person assist for bathing. The resident had a Care Plan, dated 7/11/12, which addressed the problem of self care deficit related to dementia and osteoarthritis. h. On 5/24/16 at 11:13 a.m., Resident P was observed to have black debris under his fingernails on both hands. At that time, CNA #1 indicated there was debris under the resident's nails and his nails needed cleaned. Resident P's record was reviewed on 5/25/16 at 4:30 p.m. The Quarterly MDS assessment, dated 5/7/16, indicated his BIMS was 7, which indicated his mental status was severely impaired. He was an extensive assist with a one person assist for personal hygiene and a total dependence with a two person assist for bathing.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	The resident had a Care Plan, dated 1/20/14, which addressed the problem of self care deficit related to decreased mobility. During an interview on 5/24/16 at 11:30 a.m., LPN #3 indicated she smelled an odor coming from a couple of the residents' feet while doing the initial resident tour, but she couldn't remember off hand who they were. She indicated she did not know what the debris was between the residents' toes who was observed with debris between their toes. LPN #3 indicated she had already discussed the foot problem with the Director of Nursing Services and the CNA's needed educated about giving the residents proper foot care. 2. During the initial tour, on 5/24/16 at 10:00 a.m., with the Director of Nursing Services in attendance, the following were observed: a. Resident D was observed to have white flaky dry skin on both feet and long fingernails with black debris noted underneath. During a record review, completed on 5/25/16 at 12:40 p.m., the MDS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	(Minimum Data Set) quarterly assessment, dated 5/10/16, indicated Resident D was an extensive assist for hygiene needs and a total dependence for bathing. The resident had a Care Plan, dated 7/25/13, which addressed her self care deficit related to: hypertension, depression, end stage renal disease, chronic pain, and neuropathy. The goal indicated "Resident will have all ADL needs met as evidenced by clean, neat, dry, and dressed appropriately through next review." During an interview with Resident D, on 5/24/16 at 10:30 a.m., she indicated her fingernails were only cleaned and cut on the scheduled activity manicure days and staff did not attend to her nails when they gave her showers. Resident D had a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact. b. Resident E was observed to have white flaky dry skin on both feet and her fingernails had black debris observed underneath them. During record review, completed on 5/25/16 at 1:10 p.m., the MDS annual assessment, dated 5/23/16, indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	Resident E was an extensive assist for hygiene needs and a total dependence for bathing. The resident had a Care Plan, dated 7/11/11, which addressed her self care deficit related to: Cerebral Palsy, hypertension, anemia, and chronic obstructive pulmonary disease. The resident's participation with ADL's may fluctuate due to her disease processes. During an interview with Resident E, on 5/24/16 at 11:30 a.m., she indicated her preferred method of bathing was a bed bath. She indicated staff did not lotion her feet or clean/cut her fingernails during her bed baths. She indicated the only nail care she received was from her daughter during her visits to the facility. Resident E had a BIMS score of 10, which indicated the resident's mental status was moderately impaired. c. Resident T was observed to have white flaky dry skin along with dark dried scabs on the top of both feet. During record review, completed on 5/25/16 at 3:40 p.m., the MDS quarterly assessment, dated 2/24/16, indicated Resident T was an extensive assist for hygiene needs and a total dependence for bathing. Resident T had a BIMS score of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	5, which indicated her mental status was severely impaired. The resident had a Care Plan, dated 4/28/15, which addressed the need for assistance and/or monitoring for ADL care. The goal indicated "Resident will have ADL needs met." d. Resident S was observed to have long fingernails with black and brown debris observed underneath them. During record review, completed on 5/25/16 at 11:00 a.m., the MDS quarterly assessment, dated 4/12/16, indicated Resident S was an extensive assist for hygiene needs and a total dependence for bathing. Resident S had a BIMS score of 6, which indicated her mental status was severely impaired. The resident had a Care Plan, dated 4/22/15, which addressed the need for assistance and/or monitoring for ADL care. The goal indicated "Resident will have ADL needs met." e. Resident U was observed to have long fingernails with black debris observed underneath them. During record review, completed on 5/25/16 at 3:20 p.m., the MDS annual			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155149		05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	assessment, dated 3/9/16, indicated Resident U was an extensive assist for hygiene needs and a total dependence for bathing. Resident U's mental status was severely impaired according to the Cognitive Skills for Daily Decision Making score. The resident had a Care Plan, dated 6/25/13, which addressed the problem of self care deficit related to decreased mobility, diagnoses of Alzheimer's dementia, and hemiplegia. The goal indicated "Resident will have all ADL needs met as evidence by resident will be clean, dry, and odor free through the next review." During an interview on 5/24/16 at 11:15 a.m., the Activities Director indicated Resident L had "food" underneath her nails, Resident S had "food and dirt" underneath her nails, and Resident U had "dirt" underneath her nails. She indicated all 3 residents needed their fingernails cut and cleaned. During an interview on 5/25/16 at 3:30 p.m., the Director of Nursing Services indicated she could not locate a facility policy regarding nail care; however it was expected that staff perform nail care as needed during a.m. and p.m. care.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	This Federal tag relates to Complaints IN00198223 and IN00200002. 3.1-38(a)(3)(A) 3.1-38(a)(3)(E)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure fall interventions were followed to prevent further falls and failed to follow through with post fall interventions to prevent another potential fall for 2 of 3 residents reviewed for accidents (Resident C and D). Findings include: 1. The record for Resident C was reviewed on 5/25/16 at 10:15 a.m. Diagnoses included, but were not limited to, glaucoma, myopia, anemia, insomnia, anxiety, dementia, hypertension, depression and chronic kidney disease.	F 0323	**F 323: Free of Accidents/ Hazards/Supervision/Devices** It is the practice of this provider toprovide or arrange services by a qualified person in accordance with eachresident's written plan of care. **Whatcorrective action will be accomplished for those residents found to have beenaffected?** Resident C no longerresides in facility. Resident D had physician notification completed that orderhad not been followed. No new orders or changes were made at that time. IDT reviewedresidents current plan of care for falls with changes made where indicated. **How other residents will be identified**	06/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	Nursing notes, dated 1/31/16 at 8:30 a.m., indicated Resident C had a witnessed fall in the dining room with no injuries. An Interdisciplinary Team (IDT) fall review note, dated 2/1/16 at 11:15 a.m., indicated the new intervention was to bring the resident to the dining room after completion and placement of the resident's food tray. Nursing notes, dated 4/4/16 at 6:46 a.m., indicated Resident C had an unwitnessed fall and was found sitting up next to her bed. No injuries were noted. Nursing notes, dated 4/4/16 at 8:39 a.m., indicated Resident C had an unwitnessed fall and was found lying on her right side on the floor in her room. A 5 cm (centimeter) x 3 cm hematoma was noted to the right side of the resident's forehead. An IDT fall review note, dated 4/5/16 at 12:21 p.m., indicated the new interventions included a mattress with bolsters and a re-evaluation from the Physical Therapy department. A fall event, dated 4/30/16 at 8:37 a.m., indicated Resident C had an unwitnessed fall in the dining room. No injuries were noted.		**andwhat correction action taken?** Allresidentswho have falls have the potential to be affected by the alleged deficientpractice. Residents who have fallen over the past 30 days have had their planof care reviewed to ensure that all interventions are in place. No othersresidents identified to be affected by alleged deficient practice. **What systemic changes will be made toensure the deficient practice does not recur?** Staff will be in serviced on fallprevention, compliance of fall interventions and use of resident profile.All physicians' orders will bereviewed by the Unit Manager/ designee on the next business day to ensure ordershas been entered into Electronic Medical Record accurately. All physician orders will have an additionalcheck completed by DNS/ Designee Monday-Friday. IDT willimplement weekly fall intervention sweeps, including ensuring that allinterventions listed on plan of care and resident profile are in place weekly x4 weeks, then bi-weekly x 3 months, and then monthly to identify any potentialdeficient practice needs. Fall intervention communication binder will beimplemented on each unit to facilitate communication of all new interventions.Staff will review binder shift to shift and initial verifying notification andknowledge of all new interventions put in place and remain appropriate. **How the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	An IDT fall review note, dated 5/2/16 at 9:54 a.m., indicated "Resident had an unwitnessed fall on 4/30/16 at 7:10 a.m., ...Resident was sitting in her wheelchair in the main dining room waiting for breakfast. Resident fell from wheelchair trying to get up on her own...CNA needs education for the interventions...Resident is not to be placed in the dining room until food is sitting in front of her at the table...A 1:1 inservice initiated for the CNA on the resident's intervention of not being in the dining room alone and without food in front of her...." The plan of care, dated 6/23/14, indicated the resident was at risk for falls. Interventions included, but were not limited to, physical therapy evaluation, roho mattress with bolsters, and do not bring the resident to the dining room until her tray is ready to be served. During an interview on 5/25/16 at 3:30 p.m., the Director of Nursing Services indicated Resident C had an unwitnessed fall in the dining room and the CNA was inserviced on following the resident's plan of care. 2. The record for Resident D was reviewed on 5/25/16 at 12:40 p.m. Diagnoses included, but were not limited		**corrective actionwill be monitored?** To ensurecompliance, the DNS/ designee will complete the Fall Management tool weekly x 4weeks, then bi weekly x 3 months, and then monthly x 3 months to identify anypotential deficient practice. The results of these audits will be reviewed bythe CQI committee overseen by the ED. If the threshold of 95% is not achievedan action plan will be developed to ensure compliance. Deficiency in thispractice will result in disciplinary action up to and including termination ofthe responsible employee. **By what date the systemic change will becompleted?** June 3, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	to, chronic pain, insomnia, diabetes, anorexia, anemia, anxiety, renal dialysis, and depression. A Nursing note, dated 4/16/16, indicated Resident D had an unwitnessed fall, was found sitting next to her bed after she rolled out of bed while attempting to vomit. An IDT fall review note, dated 4/18/16, indicated the resident was vomiting and had a low blood pressure at the time of the fall. A new intervention and physician order was placed to monitor Resident D's orthostatic blood pressure every shift for three days. The plan of care, dated 7/25/13, indicated the resident was at risk for falls. A new intervention, updated 4/18/16, was to monitor orthostatic blood pressures times 3 days and then re-evaluate. During an interview on 5/25/16 at 4:05 p.m., the Director of Nursing Services indicated she could not locate any completed orthostatic blood pressure readings for Resident D. A current facility policy, titled "Fall Management Program", dated 2/2015, received from the Executive Director, on 5/25/16 at 3:30 p.m., indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	"...Procedure: Fall risk...4. The resident specific care requirements will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet...." This Federal tag relates to Complaint IN00200002. 3.1-45(a)(2)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review, the facility failed to ensure the documentation for a nebulizer treatment was accurate for 1 of 20 resident records reviewed for accurate documentation (Resident B). Finding includes:	F 0514	**F 514: Record-Complete/Accurate/Accessible** It is the practice of this provider to provide or arrangeservices by a qualified person in accordance with each resident's written planof care.	06/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	The record review for Resident B was completed on 5/25/16 at 6:30 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic ischemic heart disease and atrial fibrillation. The resident had an Electronic Medication Administration Record dated May 2016, which included, but was not limited to, the following order: 2/20/16--Albuterol Sulfate (a breathing treatment medication) 2.5 mg (milligrams)/ 3 ml (milliliters) by inhalation every six hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. The resident had a Care Plan, dated 12/29/14, which addressed the problem he had a potential for impaired for gas exchange related to a diagnosis of COPD. Approaches included, "...12/29/15--Administer Nebulizer treatments as ordered...." On 5/25/16 from 11:00 a.m. to 12:15 p.m., and 1:15 p.m. to 1:38 p.m., Resident B was continuously observed and the following observations were made: At 11:00 a.m., Resident B was observed sitting in his room in his broda chair		**What corrective action will beaccomplished for those residents found to have been affected?** Resident B's documentation was correctedto accurately reflect the administration time of the nebulizer treatment. ResidentB's physician was notified that nebulizer treatment was not given as orderedand was administered late. No physicianchanges were made at that time. **Howother residents will be identified and what correction action taken?** Allresidents with orders for routine Nebulizer Treatments have the potential to beaffected by this alleged deficient practice. DNS reviewed documentation for allresidents who receive routine nebulizer treatments to ensure documentation isaccurate. No other residents were found to be affected by this deficientpractice. **What systemic changes will bemade to ensure the deficient practice does not recur?** One on one education/ disciplinaryaction was provided to charge nurse regarding inaccurate documentation.Licensednurses will be in serviced by DNS/Designee on the policy of timely and accuratedocumentation, and medication pass procedure. DNS/Designee will complete medication pass procedure skills validation check offs for licensed nursing staff onor before June 07, 2016. **Howthe corrective action will be**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	watching T.V. with his oxygen on at two liters per nasal cannula. At 11:25 a.m., the resident was observed sitting in his room in his broda chair with his eyes closed and his T.V. was playing. His oxygen was on at two liters per nasal cannula. At 11:49 a.m., the resident was sitting in his room in his broda chair watching T.V. with his oxygen on at two liters per nasal cannula. At 12:15 p.m., Resident B was taken to the dining room for lunch by CNA #1. Resident B was not observed to have received his nebulizer treatment prior to going to lunch. At 12:55 p.m., Resident B's 12:00 p.m., Nebulizer treatment Medication Administration Record was observed and the treatment was documented by LPN #2 as given. During an interview at that time, LPN #2 indicated she had given the resident his Nebulizer treatment at 12:00 p.m., prior to him going to lunch. When LPN #2 was asked about the documentation of his Nebulizer treatment and the Nebulizer treatment not being observed given prior to lunch, LPN #2 indicated she had given the treatment to Resident O instead of Resident B. LPN		**monitored?** DNS/Designee will conduct random medication pass procedure skillsvalidations check-offs on varying shifts and varying nursing staff members toassure that compliance is met weekly x 4, bi-weekly x 3and then monthly x 3 months. **By what date the systemic change will becompleted?** June 07, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	#2 indicated she needed to look at Resident B's EMAR (Electronic Medication Administration Record). After looking at the EMAR, LPN #2 indicated she had not given the Nebulizer treatment to Resident B, but had documented that she had and she would give him his Nebulizer treatment as soon as he was finished with his lunch. Resident O's EMAR dated May 2016, was observed for her Nebulizer treatment, which indicated her treatments were PRN and there was no documentation that indicated she had been given a Nebulizer treatment for that day. Resident B's EMAR dated May 2016, indicated the box designated for 12:00 p.m., for the ordered Albuterol Sulfate 2.5 mg/3 ml for inhalation every 6 hours at 12:00 a.m., 6 a.m., 12:00 p.m. and 6:00 p.m., had LPN #2's initials documented in the box at that time. At 1:15 p.m., Resident B was brought back from lunch and left sitting in the hallway at LPN #2's medication cart. LPN #2 indicated she was ready, at that time to perform his Nebulizer treatment and she transported him to his room in his broda chair. At 1:17 p.m., LPN #2 was observed to begin his Nebulizer treatment.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	At 1:38 p.m., LPN #2 was observed to remove the Nebulizer mask indicating the resident's Nebulizer treatment was completed. During an interview on 5/25/16 at 3:30 p.m., the Executive Director indicated the nurse should have documented the medication on the computer as soon as the medication was given, not before the medication was given. The Administrator acknowledged the Nebulizer treatment was not given on time because it was due at 12:00 p.m., and it was after 1:00 p.m., when the resident received his treatment. During that same time the Director of Nursing Services Specialist indicated in order for the nurses to get their medication passed "on time" they would pass the medications, then go back later to the computer after all their medications have been passed and the medication orders have went from "green to red" and finalize the medication pass. She indicated when the medications go from "green to red" the "red" color indicated the medications were being administered late. She indicated by the nurses giving their medications first and "documenting or pushing the finalization button" to indicate the medications were given allowed the nurses to get their medications to the residents on time, but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/25/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260	

(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
	made the medication administration look like it was late, when in actuality the documentation was late, not the medication administration. A current policy titled "Medication Pass Procedure" dated 2/2010 with a revised date of 03/2013, provided by the Executive Director on 5/25/16 at 3:30 p.m., indicated "Procedure Steps: 1. Medications administered within 60 minutes before and/or after tie ordered... 17. Medication administration will be recorded on the MAR [Medication Administration Record] or TAR [Treatment Administration Record] after given...." This Federal tag relates to Complaint IN00198223. 3.1-50(a)(2)			