STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 00 B. WING	01/28/2025

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

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00446914, IN00448863 and IN00449209. Complaint IN00446914 - No deficiencies related to the allegations are cited. Complaint IN00448863 - No deficiencies related to the allegations are cited. Complaint IN00449209 - No deficiencies related to the allegations are cited. Survey dates: January 22, 23, 24, 27 and 28, 2025. Facility number: 000070 Provider number: 155149 AIM number: 100266190 Census Bed Type: SNF: 5 SNF/NF: 68 Total: 73 Census Payor Type: Medicare: 2 Medicaid: 58 Other: 13 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 5, 2025.	F 0000		
F 0583 SS=D	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Bergman	RDCS-RN	02/17/2025

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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Bldg. 00	Based on observation, interview and record review, the facility failed to ensure a resident's right to privacy was provided during personal care for 1 of 3 residents reviewed for resident rights. (Resident 376) Findings include: During an observation, on 1/27/25 at 10:54 a.m., LPN 5 entered Resident 376's room to administer a gastrostomy tube (a feeding tube inserted into the abdomen directly into the stomach) bolus (a method of administering liquid food directly into the stomach) of Jevity 1.5 (a nutrition supplement). The resident's door was left open. LPN 5 pulled the resident's cover back and lifted his gown exposing his abdomen. The privacy curtain in the resident's room was not closed and three people walked by the resident's room. The clinical record for Resident 376 was reviewed on 1/23/25 at 3:42 p.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia (low levels of oxygen in your body tissue), convulsions, congestive heart failure, dysphagia (difficulty swallowing), and atrial fibrillation. During an interview, on 1/27/25 at 11:35 a.m., the Assistant Director of Nursing (ADON) indicated while providing care to a resident, the resident's door should be closed for privacy and the door was not closed. During an interview, on 1/28/25 at 3:22 p.m., the Director of Nursing (DON) indicated the facility did not have a policy on providing privacy for a resident.	F 0583	**F 583 – We respectfully request desk review in this matter. Thank you for your consideration.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 376 had no negative effects and is at baseline for resident. LPN 5 received 1:1 education per DNS by 2/17/25 on residents right to privacy. (see Attachment F) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All the residents receiving enteral feeding have the potential to be affected. No other residents were found to be affected. All staff in-serviced on resident rights, specific to privacy per DNS/Designee by 2/17/25. (see Attachment F) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff in-serviced on resident rights, specific to privacy per DNS/Designee by 2/17/25. (see Attachment F) Enteral feeding skills validation completed with LPN 5.	02/17/2025

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	A current facility policy, titled "Resident Rights," dated 11/2011 and received from the DON on 1/22/25 at 11:30 a.m., indicated "...The Resident has a right to a dignified existence, self-determination and communication with, and access to, persons and services inside and outside the Facility...." 3.1-3(p)(4)		(see Attachment F) All new nurses will complete enteral feeding skills validation upon hire. DNS/designee will complete weekly enteral feeding observations to ensure privacy to the resident is being maintained and policy compliance. (see Attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as Attachment A will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. Date of Completion: 2/17/25	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, interview and record review, the facility failed to ensure a	F 0657	**F 657 – We respectfully request desk review in this matter.**	02/17/2025

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	comprehensive care plan was developed for a resident with a hand splint for 1 of 4 residents reviewed for care plans. (Resident 33) Findings include: During an observation, on 1/22/25 at 12:10 p.m., Resident 33 was sitting in the dining room. Unit Manager 4 entered the dining room and placed a blue hand splint on the resident's right hand. During an observation, on 1/23/25 at 11:00 a.m., the resident was sitting in the activity room, and a hand splint was on her right hand. During an observation, on 1/27/25 at 10:27 a.m., the resident was sitting in the activity room, and a hand splint was on her right hand. The clinical record for Resident 33 was reviewed on 1/23/25 at 3:19 p.m. The diagnoses included, but were not limited to, transient ischemic attack (temporary disruption in the blood supply to a part of the brain), hypertension, anxiety disorder, and major depressive disorder. The electronic medical record did not include a physician's order or a care plan for a right-hand splint. During an interview, on 1/28/25 at 2:29 p.m., the Director of Nursing (DON) indicated the resident did not have a care plan for the hand splint prior to 1/27/25. During an interview, on 1/28/26 at 2:34 p.m., the DON indicated the facility did not have any additional care plan policies. A current facility policy, titled "IDT		**Thank you for your consideration.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident 33 is wearing right hand splint with plan of care in place. Resident 33 had no negative effects and is at baseline for resident. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents with a splint have the potential to be affected. Audit completed per MDS to identify any residents with splint to ensure a plan of care is in place as indicated. (see Attachment B) MDS has been educated on implementing plan of care for residents with splints per DNS. (see Attachment F) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. IDT will review all residents with a splint and obtain orders as indicated, implement plan of care, and add to residents' profile. IDT will review all new admissions to ensure care plans are implemented as indicated. Care plan reviews will be completed upon admission, readmission, quarterly and with	

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	Comprehensive Care Plan policy," dated as revised 8/2023 and received from the Clinical Support Nurse on 1/28/25 at 11:50 a.m., indicated "...Care plan review will be interdisciplinary and should include...nursing...therapy...MDS...." 3.1-35(a) 3.1-35(b)(1)		any significant change. MDS has been educated on implementing plan of care for residents with splints per DNS. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as Attachment B will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. Date of Completion: 2/17/25	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to ensure pharmaceutical services were obtained timely to support a resident's healthcare needs for 1 of 1 resident reviewed for pharmacy services. (Resident 376) Findings include:	F 0755	**F 755 – We respectfully request desk review in this matter. Thank you for your consideration.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	02/17/2025

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	The clinical record for Resident 376 was reviewed on 1/23/25 at 3:42 p.m. The diagnoses included, but were not limited to, convulsions, congestive heart failure, emphysema, and encephalopathy (a change in your brain function due to injury or disease). A care plan, dated 3/8/24, indicated the resident was at risk for injury related to seizure activity. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 1/9/25, indicated to give Lacosamide (an anticonvulsant medication) 10 milligrams (mg)/ 1 milliliter (ml) solution twice a day. The physician's order for Lacosamide 10 mg/1 ml solution was ordered on 1/9/25 and was not available until 1/22/25. The resident received his first dose on 1/22/25 at 11:05 a.m. The resident missed 26 doses of the medication. During an interview, on 1/27/25 at 9:53 a.m., Registered Nurse (RN) 6 indicated if the resident was out of medication, she would check the Pyxis (a medication dispensing system), call the pharmacy, and would notify the Executive Director (ED) and Director of Nursing (DON). The resident was prescribed the medication for seizures and missing the medication for so long could cause the resident to have a seizure. During an interview, on 1/28/25 at 10:40 a.m., the DON indicated if a medication was not available for a resident, she would reach out to pharmacy and notify the physician. She would check with the physician to ask if an alternate medication could be given until the ordered medication was delivered. The facility would monitor seizure		Resident 376 had no negative outcomes. Resident 376 has all ordered medications available. - aAudit of medications completed by DNS/designee to ensure medication orders are available per MD order. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving medications from pharmacy have the potential to be affected. All nurses in-serviced by DNS/Designee on procedure when resident does not have a medication available, check Omnicell EDK, notify pharmacy, notify MD/NP, Notify DNS and Documentation. (see Attachment F). -Inservice provided to the Medical Records nurse on EMAR compliance per DNS by 2/17/25. (see Attachment F). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All nurses in-serviced by DNS/Designee by 2/17/25 on procedure if a resident does not have a medication available, check Omnicell EDK, notify pharmacy, notify MD/NP, Notify DNS and	

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	activity and wait on medication. During an interview, on 1/28/25 at 2:00 p.m., the DON indicated the medication should not have been unavailable for days. A current facility skill competency checklist (provided as the medication administration policy), titled "Medication Administration," dated as last revised 7/2023 and received from the Executive Director on 1/28/25 at 3:40 p.m., did not address missing multiple doses of a scheduled medication. 3.1-25(a) 3.1-25(g)(1) 3.1-25(g)(2) 3.1-25(g)(3)		Documentation. IDT will run EMAR compliance report daily and review in clinical meeting and follow up on any omissions per policy. DNS/designee to complete daily audit to ensure EMAR compliance. (see Attachment G). -- Inservice provided to the Medical Records nurse on EMAR compliance per DNS by 2/17/25. (see Attachment F). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as Attachment C will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. Date of Completion: 2/17/25	

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review, the facility failed to ensure residents were assessed for side effects of antipsychotic medications with the Abnormal Involuntary Movement Scale (AIMS) according to the policy and procedure for 2 of 5 residents reviewed for unnecessary medications. (Resident 37 and 45) Findings include: 1. The clinical record for Resident 37 was reviewed on 1/27/25 at 10:44 a.m. The diagnoses included, but were not limited to, Alzheimer's disease with early onset, type 2 diabetes mellitus with diabetic polyneuropathy, dementia with other behavioral disturbance and agitation, bipolar disorder, mood disorder, generalized anxiety disorder, and moderate recurrent major depressive disorder. A care plan, dated 10/10/23, indicated the resident was at risk for adverse side effects related to the use of psychotropic medication, antipsychotic, antidepressant and antianxiety medication. A physician's order, dated 1/1/24, indicated to give risperidone (an atypical antipsychotic medication) 0.5 milligrams (mg) twice a day. A physician's order, dated 5/2/24, indicated to give sertraline (a depression medication) 100 mg once a day. A physician's order, dated 6/4/24, indicated to give buspirone (an anxiety medication) 5 mg twice a day. An AIMS assessment, dated 1/2/24 at 10:50 a.m.,	F 0758	**F 758 – We respectfully request desk review in this matter. Thank you for your consideration.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 37 and 45 have a completed AIMs assessment. Residents 37 and 45 had no negative effects and are at baseline. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving antipsychotic medications have the potential to be affected. Audit completed on all residents receiving antipsychotics to ensure AIMs assessment has been completed per policy. (see Attachment H). IDT in-serviced per Senior ED/DNS on completing AIMs assessment per policy. (see Attachment F). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; IDT will track AIMs on clinical white board and review daily in	02/17/2025

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	indicated an involuntary movement score of 3. An AIMS assessment, dated 8/27/24 at 3:28 p.m., indicated an involuntary movement score of 0. During an interview, on 1/24/25 at 3:15 p.m., the Director of Nursing (DON) indicated she did not find an AIMS assessment completed between January and August. She indicated an AIMS assessment should have been completed every six months. 2. The clinical record for Resident 45 was reviewed on 1/27/25 at 8:43 a.m. The diagnoses included, but were not limited to, vascular dementia with other behavioral disturbance, type 2 diabetes mellitus with complications, depressive episodes, anxiety disorder, psychotic disorder with delusions due to known physiological condition, recurrent moderate major depressive disorder, and violent behavior. A care plan, dated 3/8/24, indicated the resident was at risk for adverse side effects related to the use of psychotropic medication, antidepressant, and antipsychotic medications. A physician's order, dated 3/8/24, indicated to give divalproex (a seizure medication also used for mood) 250 mg twice a day. A physician's order, dated 3/8/24, indicated to give risperidone (an atypical antipsychotic medication) 1 mg every 6 hours as needed. A physician's order, dated 3/9/24, indicated to give sertraline (a depression medication) 75 mg once a day. An AIMS assessment, dated 7/8/24 at 10:51 a.m.,		clinical meeting. MDS will open AIMs assessments observation per MDS schedule, IDT will ensure completion of assessment. -IDT in-serviced per Senior ED/DNS on completing AIMs assessment per policy. (see Attachment F). -DNS/designee to complete weekly audit to ensure completion of AIMs assessments. (see Attachment D). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as Attachment D will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. Date of Completion: 2/17/25	

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	indicated an involuntary movement score of 0. During an interview, on 1/27/25 at 11:57 a.m., the Clinical Support Nurse indicated she could not find an admission AIMS assessment and one should have been completed when the resident was admitted in March. A current facility policy, titled "Documentation Guidelines for Nursing," dated as revised 7/2024 and received from the Clinical Support Nurse on 1/28/25 at 2:12 p.m., indicated "...AIMs-every 6 months for residents receiving antipsychotics...Also complete with new order...." 3.1-48(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure documentation was complete and accurately reflected the care provided for 2 of 2 residents reviewed for accurate documentation. (Resident 55 and 18) Findings include: 1. The clinical record for Resident 55 was reviewed on 1/27/24 2:52 p.m. The diagnoses included, but were not limited to, diabetes mellitus, dementia, and hypertension. A care plan, dated 7/25/23, indicated the resident was at risk for altered nutritional status related to dementia, hypertension, and schizophrenia. Interventions included, but were not limited to, offer bedtime snacks. A physician's order, dated 11/7/23, indicated to	F 0842	**F 842 – We respectfully request desk review in this matter. Thank you for your consideration.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Residents 55 and 18 were not effected and both are at baseline. - Documentation was corrected for	02/17/2025

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	administer a bedtime snack to the resident. The January 2025 Medication/Treatment record indicated snacks were not administered because they were not available on January 6th, 13th, 15th and 20th. The documentation indicated that the resident was given 0 (zero) bedtime snacks on those days. 2. The clinical record for Resident 18 was reviewed on 1/28/25 at 3:03 p.m. The diagnoses included, but were not limited to, hypertension, chronic kidney disease, and Alzheimer's dementia. A physician's order, dated 8/14/24, indicated to administer a bedtime snack to the resident. The January 2025 Medication/Treatment record indicated snacks were not administered because they were not available on January 6th, 13th, and 15th. The documentation indicated that the resident was given 0 (zero) bedtime snacks on those days. During an interview, on 1/28/25 at 8:53 a.m., the Corporate Support Nurse indicated bedtime snacks were available on the unit. She spoke with the nurse who had documented they were not available and was told they did not have snacks in the unit. The nurse indicated "she just found something to give the residents". A facility skills competency checklist, titled "Medication Administration," dated as last revised 7/2023 and received from the Executive Director on 1/28/25 at 3:40 p.m., indicated "...administration will be documented on the MAR...TAR (Medication and Treatment Administration Record) after given...." The checklist did not address documentation of		residents 55 and 18 to accurately reflect the care provided. - Residents 55 and 18 are being provided a bedtime snack per order. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All residents have the potential to be affected. - No other residents were found to be affected. - All nursing staff in-serviced on accurate and complete documentation including bedtime snacks per DNS/designee by 2/17/25. (see Attachment F). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	

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HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	accurate information on the MAR/TAR. 3.1-50(a)(2)		- All nursing staff in-serviced on accurate and complete documentation including bedtime snacks per DNS/designee by 2/17/25. (see Attachment F). - IDT to review daily x 5 days per week via the facility activity report to ensure compliance. - DNS/designee to audit daily for accurate and complete documentation to ensure compliance. (see Attachment E). - ED/DNS will ensure snacks are available in the evening by 8:00 p.m. - QIS questions with residents will be completed to ensure residents are receiving evening snacks per order. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as Attachment E will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 00 B. WING	01/28/2025

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			If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. Date of Completion: 2/17/25	