PRINTED: 02/19/2025

DEPARTMENT OF HEALTH AND HUN	FORM APPROVED				
CENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED		
	155149	B. WING	01/28/2025		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD			
NAME OF FROVIDER OR SUFFLIER		8181 HARCOURT RD	8181 HARCOURT RD		

	PROVIDER OR SUPPLIER URT TERRACE NURSING AND REHABILITATION	8181 H	STREET ADDRESS, CITY, STATE, ZIP COD 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			
0000							
Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00446914, IN00448863 and IN00449209.	F 0000					
	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 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NX6911 Facility ID: 000070 If continuation sheet Page 1 of 13

PRINTED: 02/19/2025

	T OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	ľ	JILDING	00	COMPI	
THIS TELL	or condition.	155149	B. W			01/28	
		100110	D	_		0 1/20	
NAME OF E	PROVIDER OR SUPPLIER	3		1	ADDRESS, CITY, STATE, ZIP COD		
				1	IARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	NAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00							
	Based on observation	on, interview and record	F 0:	583	F 583 – We respectfully requ	ıest	02/17/2025
	review, the facility	failed to ensure a resident's			desk review in this matter.		
	· ·	s provided during personal			Thank you for your		
		lents reviewed for resident			consideration.		
	rights. (Resident 37				What corrective action(s) will	be	
	8				accomplished for those reside		
	Findings include:				found to have been affected by		
	8				deficient practice;	.,	
	During an observati	ion, on 1/27/25 at 10:54 a.m.,			Resident 376 had no neg	ative	
	_	dent 376's room to administer a			effects and is at baseline for	,au vo	
	_	feeding tube inserted into the			resident.		
		nto the stomach) bolus (a			LPN 5 received 1:1 education		
	1	ering liquid food directly into	per DNS by 2/17/25 on residents				
	the stomach) of Jev				right to privacy. (see Attachm		
		esident's door was left open.			F)	ICIT	
		esident's cover back and lifted			How other residents having the	20	
		his abdomen. The privacy			potential to be affected by the		
		ent's room was not closed and			same deficient practice will be		
		d by the resident's room.			identified and what corrective		
	unce people warket	Toy the resident's room.			action(s) will be taken;		
	The clinical record	for Resident 376 was reviewed			All the residents receiving	a	
		o.m. The diagnoses included,			enteral feeding have the pote	-	
	_	d to, acute respiratory failure			to be affected.	IIIIai	
		evels of oxygen in your body			No other residents were	found	
		s, congestive heart failure,			to be affected.	Journa	
	1	y swallowing), and atrial			All staff in-serviced on		
	fibrillation.	y swanowing), and autai			resident rights, specific to priv	/acv	
	mormanon.				per DNS/Designee by 2/17/25	•	
	During an interview	y, on 1/27/25 at 11:35 a.m., the			(see Attachment F)	J.	
		of Nursing (ADON) indicated			What measures will be put in	to	
		re to a resident, the resident's			place or what systemic chang		
		ed for privacy and the door			will be made to ensure that th	•	
	was not closed.	ed for privacy and the door					
	was not closed.				deficient practice does not red All staff in-serviced on	Jul,	
	During an interview	y, on 1/28/25 at 3:22 p.m., the			resident rights, specific to priv	/acv	
	1	g (DON) indicated the facility				-	
	Director of Marshing	(DON) mulcated the facility			per DNS/Designee by 2/17/25	J.	

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resident.

did not have a policy on providing privacy for a

Event ID:

NX6911

Facility ID: 000070

(see Attachment F)

Enteral feeding skills validation completed with LPN 5.

If continuation sheet

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION		X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155149	A. BU.	ILDING NG	00	01/28		
		133149	D. WII			01/20/		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ARCOURT RD			
HARCOL	JRT TERRACE NU	IRSING AND REHABILITATION			APOLIS, IN 46260			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION policy, titled "Resident Rights,"		TAG	(see Attachment F)		DATE	
		received from the DON on			All new nurses will comple	ete		
		m., indicated "The Resident			enteral feeding skills validation			
	has a right to a dig				upon hire.			
		and communication with, and			DNS/designee will comple	ete		
	_	and services inside and			weekly enteral feeding			
	outside the Facility	/ "			observations to ensure privace the resident is being maintained			
	3.1-3(p)(4)				and policy compliance. (see	s u		
	(4)(1)				Attachment A)			
					How the corrective action(s) w	ill bo		
					monitored to ensure the defici			
					practice will not recur, what qu			
					assurance program will be put	into		
					place;			
					Ongoing compliance with			
					corrective action will be monito			
					via facility QAPI program, with meetings being held bi-month			
					and is overseen by the Execu	-		
					Director.			
					CQI tool identified as			
					Attachment A will be complete			
					weekly x 4 weeks, monthly tim			
					6 months, and quarterly therea until compliance is achieved.	allei		
					If threshold of 100% is no	t		
					met, an action plan will be			
					developed to ensure complian	ice.		
					December data the constructions			
					By what date the systemic changes will be completed.			
					Date of Completion: 2/17/	25		
					,			
F 0657	483.21(b)(2)(i)-(ii	•						
SS=D	Care Plan Timing	g and Revision						
Bldg. 00	Rased on observat	ion, interview and record	F 06	57	F 657 – We respectfully requ	ast	02/17/2025	
	review, the facility		1,00	51	desk review in this matter.	og i	02/1//2023	

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	r í	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 01/28 /	ETED
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD IAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	comprehensive care resident with a hand reviewed for care piles of the	ion, on 1/22/25 at 12:10 p.m., ting in the dining room. Unit the dining room and placed a the resident's right hand. ion, on 1/23/25 at 11:00 a.m., ing in the activity room, and a ther right hand. ion, on 1/27/25 at 10:27 a.m., ing in the activity room, and a ther right hand. ion, on 1/27/25 at 10:27 a.m., ing in the activity room, and a ther right hand. for Resident 33 was reviewed to m. The diagnoses included, it to, transient ischemic attack to in the blood supply to a supertension, anxiety disorder, we disorder. ical record did not include a a care plan for a right-hand iv, on 1/28/25 at 2:29 p.m., the (DON) indicated the resident plan for the hand splint prior iv, on 1/28/26 at 2:34 p.m., the facility did not have any policies.		TAG	Thank you for your consideration. What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice. Resident 33 is wearing righand splint with plan of care in place. Resident 33 had no negative effects and is at base 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 identify any residents with splint ensure a plan of care is in place as indicated. (see Attachment MDS has been educated implementing plan of care for residents with splints per DNS (see Attachment F) What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recompliant in the place of the place of the place of care indicated, implement plan of care indicated, implement plan of care indicated, implement plan of care plan review all new admissions to ensure care plan are implemented as indicated. Care plan reviews will be completed upon admission, readmission, quarterly and with the complete in the place of the	e ed. ed. to nt to ce B) on cesee cur. ts. are,	DATE
		-			, , ,		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2025 FORM APPROVED OMB NO. 0938-039

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 01/28/2025
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181	FADDRESS, CITY, STATE, ZIP COD HARCOURT RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	revised 8/2023 and Support Nurse on 1. "Care plan review	received from the Clinical /28/25 at 11:50 a.m., indicated will be interdisciplinary and rsingtherapyMDS"		any significant change. MDS been educated on implementiplan of care for residents with splints per DNS. How the corrective action(s) was monitored to ensure the defice practice will not recur, what quassurance program will be puplace; Ongoing compliance with corrective action will be monitiva facility QAPI program, with meetings being held bi-month and is overseen by the Execut Director. CQI tool identified as Attachment B will be complete weekly x 4 weeks, monthly tin 6 months, and quarterly there until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliant By what date the systemic changes will be completed. Date of Completion: 2/17	vill be ient uality t into this cored in ally, stive ed ines after ot ince.
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3 Pharmacy Srvcs/Procedures) /Pharmacist/Records			
	failed to ensure pha obtained timely to s	and record review, the facility rmaceutical services were support a resident's healthcare ident reviewed for pharmacy (376)	F 0755	F 755 – We respectfully requidesk review in this matter. Thank you for your consideration. What corrective action(s) will accomplished for those reside found to have been affected by deficient practice;	be ents

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NX6911

Facility ID: 000070

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	BUILDING <u>00</u>		COMPLETED	
		155149	B. W	ING		01/28	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ARCOURT RD		
HARCOL	JRT TERRACE NU	IRSING AND REHABILITATION		INDIANAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		for Resident 376 was reviewed			Resident 376 had no neg	jative	
		p.m. The diagnoses included,			outcomes.		
		d to, convulsions, congestive			Resident 376 has all orde	ered	
	-	ysema, and encephalopathy (a			medications		
		in function due to injury or			available.		
	disease).						
		2/0/24 : 1: 4 1.4			- aAudit of medications comp	leted	
	*	3/8/24, indicated the resident			by DNS/designee to ensure		
	-	ry related to seizure activity.			medication orders are availab	le per	
		ded, but were not limited to,			MD order.		
	administer medicat	tions as ordered.			l., ., .,		
		1 . 11/0/05 . 1 1.			How other residents having the		
	* *	r, dated 1/9/25, indicated to			potential to be affected by the		
	,	an anticonvulsant medication)			same deficient practice will be		
)/ 1 milliliter (ml) solution twice a			identified and what corrective		
	day.				action(s) will be taken;		
	TEL 1 '' I	1 C T 110 /1 1			All residents receiving		
		der for Lacosamide 10 mg/1 ml			medications from pharmacy h	iave	
		ed on 1/9/25 and was not			the potential to be affected.		
		2/25. The resident received his			All nurses in-serviced by		
		25 at 11:05 a.m. The resident			DNS/Designee on procedure	wnen	
	missed 26 doses of	the medication.			resident does not have a		
	ъ	1/27/25 + 0.52			medication available, check		
	-	w, on 1/27/25 at 9:53 a.m.,			Omnicell EDK, notify pharma	•	
		RN) 6 indicated if the resident			notify MD/NP, Notify DNS and		
		ion, she would check the Pyxis			Documentation. (see Attachm		
	_	ensing system), call the			F)Inservice provide		
		ald notify the Executive			the Medical Records nurse or		
		Director of Nursing (DON). The			EMAR compliance per DNS b	ру	
	-	ribed the medication for			2/17/25. (see Attachment F).		
		ng the medication for so long ident to have a seizure.			What measures will be put in		
	could cause the res	ident to have a seizure.			place or what systemic chang		
	During on inter-i	y on 1/28/25 at 10:40 a m tha			will be made to ensure that the		
	_	w, on 1/28/25 at 10:40 a.m., the medication was not available			deficient practice does not re	Jur;	
					All nurses in-serviced by		
		would reach out to pharmacy			DNS/Designee by 2/17/25 on		
		sician. She would check with			procedure if a resident does r		
		k if an alternate medication			have a medication available,		
	-	il the ordered medication was			Omnicell EDK, notify pharma	-	
	delivered. The faci	lity would monitor seizure	1		notify MD/NP, Notify DNS and	d	

02/19/2025 PRINTED: OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/28/2025 155149 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8181 HARCOURT RD HARCOURT TERRACE NURSING AND REHABILITATION INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE activity and wait on medication. Documentation. IDT will run EMAR During an interview, on 1/28/25 at 2:00 p.m., the compliance report daily and review DON indicated the medication should not have in clinical meeting and follow up been unavailable for days. on any omissions per policy. DNS/designee to complete A current facility skill competency checklist daily audit to ensure EMAR (provided as the medication administration compliance. (see Attachment policy), titled "Medication Administration," dated G). as last revised 7/2023 and received from the Executive Director on 1/28/25 at 3:40 p.m., did not -- Inservice address missing multiple doses of a scheduled provided to the Medical Records medication. nurse on EMAR compliance per DNS by 2/17/25. (see Attachment 3.1-25(a) 3.1-25(g)(1)How the corrective action(s) will be 3.1-25(g)(2)monitored to ensure the deficient 3.1-25(g)(3)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.

Event ID: NX6911 Facility ID: 000070 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

If threshold of 100% is not

Date of Completion: 2/17/25

met, an action plan will be developed to ensure compliance.

By what date the systemic changes will be completed.

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 COMPLETE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00		COMPLETED 01/28/2025	
		155149	B. WI	NG		U1/28/	2025	
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD			
					ARCOURT RD			
HARCOU	IRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0758	483.45(c)(3)(e)(1)	• •						
SS=D		Psychotropic Meds/PRN						
Bldg. 00	Use							
		and record review, the facility	F 07	758	F 758 – We respectfully		02/17/2025	
		dents were assessed for side			request desk review in this			
		otic medications with the			matter. Thank you for your			
		ary Movement Scale (AIMS)			consideration.			
		licy and procedure for 2 of 5						
		for unnecessary medications.			What corrective action(s) will be	oe		
	(Resident 37 and 45	5)			accomplished for those reside			
					found to have been affected b	y the		
	Findings include:				deficient practice;			
					Residents 37 and 45 have	e a		
		rd for Resident 37 was reviewed			completed AIMs assessment.			
		a.m. The diagnoses included,			Residents 37 and 45 had no			
		d to, Alzheimer's disease with			negative effects and are at			
		diabetes mellitus with diabetic			baseline.			
		mentia with other behavioral			How other residents having th	е		
	_	tation, bipolar disorder, mood			potential to be affected by the			
	_	ed anxiety disorder, and			same deficient practice will be			
	moderate recurrent	major depressive disorder.			identified and what corrective			
					action(s) will be taken;			
	_	10/10/23, indicated the resident			All residents receiving			
		rse side effects related to the			antipsychotic medications hav	е		
		medication, antipsychotic,			the potential to be affected.			
	antidepressant and a	antianxiety medication.			Audit completed on all			
					residents receiving antipsycho	otics		
		, dated 1/1/24, indicated to			to ensure AIMs assessment h	as		
		atypical antipsychotic			been completed per policy. (se	ee		
	medication) 0.5 mil	ligrams (mg) twice a day.			Attachment H).			
					IDT in-serviced per Senio	r		
		, dated 5/2/24, indicated to			ED/DNS on completing AIMs			
	give sertraline (a de	epression medication) 100 mg			assessment per policy. (see			
	once a day.				Attachment F).			
					What measures will be put into)		
		, dated 6/4/24, indicated to			place or what systemic change	es		
	give buspirone (an a	anxiety medication) 5 mg twice			will be made to ensure that the	Э		
	a day.				deficient practice does not rec	ur;		
					IDT will track AIMs on clin	ical		
	An AIMS accessme	ent_dated 1/2/24 at 10:50 a m	1		white hoard and review daily in	2		

PRINTED: 02/19/2025

	T OF HEALTH AND HU! R MEDICARE & MEDIC					ORM APPROVED AB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	_	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	ì í	LETED
		155149	B. WING			3/2025
			STREET	Γ ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	8		HARCOURT RD		
HARCO	URT TERRACE NUI	RSING AND REHABILITATION		NAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	indicated an involu	ntary movement score of 3.		clinical meeting.		
				MDS will open AIMs		
		ent, dated 8/27/24 at 3:28 p.m.,		assessments observation pe		
	indicated an involu	ntary movement score of 0.		MDS schedule, IDT will ensu	ıre	
	l			completion of		
	_	y, on 1/24/25 at 3:15 p.m., the		assessment.		
		g (DON) indicated she did not				
		sment completed between		-IDT in-serviced p		
		t. She indicated an AIMS		Senior ED/DNS on completion	-	
assessment should have been completed every six			AlMs assessment per policy	. (see		
	months.			Attachment F).		
	2 The clinical reco	rd for Resident 45 was reviewed				
		a.m. The diagnoses included,		-DNS/designee to comple	to	
		d to, vascular dementia with		weekly audit to ensure comp		
		sturbance, type 2 diabetes		of AIMs assessments. (see	i Cuon	
		lications, depressive episodes,		Attachment D).		
		sychotic disorder with		How the corrective action(s)	will be	
		own physiological condition,		monitored to ensure the defi		
		major depressive disorder, and		practice will not recur, what		
	violent behavior.	3 1		assurance program will be p		
				place;		
	A care plan, dated 3	3/8/24, indicated the resident		Ongoing compliance wit	h this	
	was at risk for adve	rse side effects related to the		corrective action will be mon	itored	
	use of psychotropic	medication, antidepressant,		via facility QAPI program, wi	th	
	and antipsychotic m	nedications.		meetings being held bi-mont	hly,	
				and is overseen by the Exec	utive	
		, dated 3/8/24, indicated to		Director.		
		seizure medication also used for		CQI tool identified as		
	mood) 250 mg twic	e a day.		Attachment D will be comple		
				weekly x 4 weeks, monthly to		
		, dated 3/8/24, indicated to		6 months, and quarterly ther		
		atypical antipsychotic		until compliance is achieved		
	medication) 1 mg e	very 6 hours as needed.		If threshold of 100% is r	ot	
		1 . 10/0/04 1 . 1:		met, an action plan will be		
		, dated 3/9/24, indicated to		developed to ensure complia	ance.	
	give sertraline (a de	epression medication) 75 mg		1		1

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once a day.

An AIMS assessment, dated 7/8/24 at 10:51 a.m.,

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By what date the systemic

changes will be completed.

Date of Completion: 2/17/25

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155149	B. W	ING		01/28	/2025
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	K		8181 H	ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION		INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	indicated an involu	ntary movement score of 0.					
	During an interview	v, on 1/27/25 at 11:57 a.m., the					
	_	urse indicated she could not					
		AIMS assessment and one					
		ompleted when the resident					
	was admitted in Ma	•					
	A current facility p	olicy, 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	n., indicated "AIMs-every 6					
	months for resident	ts receiving					
	antipsychoticsAls	so complete with new order"					
	3.1-48(3)						
	3.1 10(3)						
F 0842	483.20(f)(5), 483.	70(i)(1)-(5)					
SS=D	Resident Records	s - Identifiable Information					
Bldg. 00	Dagad on intervious	and record review, the facility	FO	242	E 942 We respectfully resu		02/17/2025
		cumentation was complete and	F 08	542	F 842 – We respectfully required desk review in this matter.	est	02/17/2025
		the care provided for 2 of 2			Thank you for your		
		for accurate documentation.			consideration.		
	(Resident 55 and 1				Consideration.		
	(Resident 33 and 1)	0)			What corrective action(s) will	he	
	Findings include:				accomplished for those reside		
					found to have been affected b	y the	
		ord for Resident 55 was reviewed			deficient		
		n. The diagnoses included, but			practice;		
		, diabetes mellitus, dementia,					
	and hypertension.						
	A care plan dated	7/25/23, indicated the resident					
		red nutritional status related to					
		sion, and schizophrenia.					
		ded, but were not limited to,			- Residents 55	5	
	offer bedtime snacl				and 18 were not effected and		

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A physician's order, dated 11/7/23, indicated to

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are at baseline.

Documentation was corrected for

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND I LAN	or condition	155149	B. WING	00	01/28/2025	
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION	INDIAN	IAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE	
	administer a bedtim	ne snack to the resident.		residents 55 and 18 to accura	rtely	
	indicated snacks we they were not available and 20th. The docu resident was given those days. 2. The clinical reco on 1/28/25 at 3:03 plut were not limited	Medication/Treatment record ere not administered because able on January 6th, 13th, 15th mentation indicated that the 0 (zero) bedtime snacks on rd for Resident 18 was reviewed p.m. The diagnoses included, d to, hypertension, chronic l Alzheimer's dementia.		reflect the care provided. - Residents 55 and 18 are bei provided a bedtime snack per order.	-	
		, dated 8/14/24, indicated to ne snack to the resident.		How other residents having the	ne	
	indicated snacks we they were not availa 15th. The documen	Medication/Treatment record ere not administered because able on January 6th, 13th, and tation indicated that the 0 (zero) bedtime snacks on		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All	e	
	During an interview Corporate Support snacks were availab the nurse who had a available and was to the unit. The nurse something to give to			residents have the potential to affected. No other residents were four be affected. All nursing staff in-serviced of accurate and complete documentation including bedt snacks per DNS/designee by 2/17/25. (see Attachment F).	nd to on ime	
	"Medication Admir revised 7/2023 and Director on 1/28/25 "administration w MARTAR (Medi Administration Rec	npetency checklist, titled nistration," dated as last received from the Executive at 3:40 p.m., indicated will be documented on the cation and Treatment eard) after given" The		What measures will be put int place or what systemic chang will be made to ensure that th deficient practice does not recur;	es	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/28/2025		
	PROVIDER OR SUPPLIE	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 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 accurate information on the MAR/TAR. 3.1-50(a)(2)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) - 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.		(X5) COMPLETION DATE	
					- DNS/designee to audit daily for accurate and complete documentation to encompliance. (see Attachment E) ED/DNS will ensure snar 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.	sure cks		
					How the corrective action(s) we monitored to ensure the deficipractice will not recur, what quassurance program will be put place; Ongoing compliance with corrective action will be monitovia facility QAPI program, with meetings being held bi-monthly and is overseen by the Execut Director. CQI tool identified as Attachment E will be completed weekly x 4 weeks, monthly tim 6 months, and quarterly thereas until compliance is achieved.	ent uality into this pred ly, tive		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/28/2025	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTIO			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
					If threshold of 100% is not met, an action plan will be developed to ensure complian By what date the systemic changes will be completed. Date of Completion: 2/17/2	ce.	

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