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	10/26/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00419181, IN00418060, IN00416470, IN00415987 and IN00415217. Complaint IN00419181 - Federal/state deficiencies related to the allegations are cited at F600. Complaint IN00418060 - Federal/state deficiencies related to the allegations are cited at F584. Complaint IN00416470 - No deficiencies related to the allegations are cited. Complaint IN00415987 - No deficiencies related to the allegations are cited. Complaint IN00415217 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: October 23, 24, 25 and 26, 2023 Facility number: 000070 Provider number: 155149 AIM number: 100266190 Census Bed Type: SNF/NF: 77 SNF: 3 Total: 80 Census Payor Type: Medicare: 5 Medicaid: 66 Other: 9 Total: 80	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any concusion set forth in the statement of deficiencies or of any violation of the regulation. This provider**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Piotrowicz	Executive Director	11/20/2023

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 2, 2023.		**request that the 2567 plan of correction be considered the letter of credible allegation and request desk review (paper compliance) on or after 11/16/23**	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.			

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	(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview and record review, the facility failed to provide an environment free of odors on the south hall and around the nursing station on the skilled unit for 1 of 3 units reviewed for environment. (Willow Bend Unit) Findings include: During a walk through of the facility, on 10/23/23	F 0584	**F584** **Environment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Room will be cleaned daily for	11/15/2023

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	at 9:27 a.m., a very strong smell of urine was noted in the south hall of the skilled care unit (Willow Bend Unit). The smell was strongest between rooms 15-18. During an interview, on 10/23/23 at 9:32 a.m., RN 5 indicated staff was changing residents at the time and then walked down the hall. She returned at 9:33 a.m., and indicated she would call housekeeping and locate the source of the urine smell and have it cleaned if needed. She then walked down the hall towards the end to a room on the left and knocked on the door, and again returned and indicated the smell was coming from that room, the resident refused care and was care planned for refusing care. During a random walk through of the Willow Bend Unit, on 10/24/23 at 8:33 a.m., a smell of urine was noted at the nursing station and in the south hall of the unit. During a walk through of the facility, on 10/25/23, the Willow Bend Unit had an odor of urine around the nursing station and down the south hall. During an interview, on 10/25/23 at 8:13 a.m., RN 5 indicated the odor was from Resident D. Staff could not get the resident cleaned up until she let them. RN 5 went down the hall to the resident's room. Resident D told RN 5 to get out of her room, she was sleeping. On 10/25/23 at 1:26 p.m., the smell of urine was noted while walking toward the Willow Bend Unit from the Moving forward unit. The odor was detected at rooms 9-10 and continued around the corner and down the south hall. During an interview, on 10/25/23 at 2:05 p.m.,		the resident with oder and she will be approached daily for cnecessary care needed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice ED/Designee will conduct an Environmental staff in-service related to Environment including proper cleaning of room **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/Designee will conduct an Environmental staff in-service related to Environment including proper work order procedure The ED will make weekly rounds with the Environmental Director through randum rooms throughout facility to ensure the deficient practice does not recur. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality	

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	Resident E indicated he felt his room was kept clean, but occasionally there was an odor in the hall, it may be urine. During an interview, on 10/25/23 at 2:13 p.m., Resident F indicated he felt the facility did keep his room clean. There was an odor when staff took him out of his room. During an interview, on 10/25/23 at 2:29 p.m., Resident G indicated there was a strong urine odor in the hall where his room was located. During an interview, on 10/26/23 at 3:56 p.m., the Executive Director was made aware of the odor in the hall of the Willow Bend Unit. He indicated the odor was due to Resident D and her refusal of care. During an interview, on 10/26/23 at 8:53 a.m., Resident D indicated she did receive bed baths 1-2 times a week. She did refuse care. She indicated housekeeping came in daily and cleaned her room. They sweep and mop. Housekeeping had already been in her room that morning. The room had a slight odor of urine. There was an empty soda bottle under the bed, straws in packaging on the floor under the bedside table, straw packaging (no straws) were also found on the floor, a mustard packet which was unopened was also found on the floor. During an interview, on 10/26/23 at 9:04 a.m., Housekeeping Staff 9 indicated she had not cleaned Resident D's room yet. She had only removed the trash from the room. A current policy, titled "CONTROLLING ODORS IN YOUR COMMUNITY," undated and received from the Corporate Support Nurse on 10/26/23 at		Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	12:14 p.m., indicated "...Odors should always be treated and removed at the source where they are generated...." This Federal Tag relates to Complaint IN00418060. 3.1-19(f)(5)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review, the facility failed to protect a resident from abuse when the resident was reported to have been hit in the back of the head/neck by a staff member for 1 of 3 residents reviewed for abuse. The deficient practice was corrected on 10/13/23, prior to the start of the survey, and was therefore past noncompliance. Finding includes: An Incident Report to the Indiana Department of Health, dated 10/8/23, indicated the Executive Director was notified by staff another resident	F 0600	Past noncompliance: No POC required.	11/07/2023

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	made contact with a resident in the TV room. They type of injury was redness to the back of the neck. The action taken by facility included ensuring resident safety, the Executive Director was notified, the employee was immediately suspended pending an investigation. The investigation was to include staff and resident interviews and skin assessments for residents who were unable to be interviewed. During an observation, on 10/23/23 at 3:49 p.m., Resident B was up in a recliner in the television room (also referred to as Man Cave and Theater Room) on the men's memory care unit. The resident had a dedicated CNA at his side. The resident was clean and dry, wearing nonskid socks. The television was on, but the resident appeared to be restless in his seat. The resident was alert with confusion and did not make sense when conversation was attempted. The record for Resident B was reviewed on 10/24/23 at 9:00 a.m. Diagnoses included, but were not limited to, unspecified dementia with other behavioral disturbance, generalized anxiety disorder, and nontraumatic subdural hemorrhage. The resident had a score of 01 on the Basic Interview for Mental Status (BIMS-an assessment of a resident's cognitive functioning) completed on 8/25/23. A score of 01 indicated the resident was severely cognitively impaired. A nursing note, documented by the Memory Care Support Specialist (MCSS) on 10/8/23 at 5:40 p.m., indicated Resident B's Power of Attorney (POA) was notified of an allegation her spouse had been hit in the back of the head. The POA notified the MCSS of Resident B's history of "brain bleeds" and requested the physician be notified of the			

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	history. The Nurse Practitioner was notified, and staff was to continue to monitor the resident and send him out for further care if a change in condition was observed. A facility statement indicated Activity Assistant 6 was interviewed about the incident on 10/8/23. Activity Assistant 6 indicated he was trying to get Resident B into the Man Cave (theater area/tv room) due to the resident going around the dining room and attempting to grab other residents' food and drinks. He did grab him by the arm to direct him into the Man Cave to set him in his chair. He indicated he did not strike the resident on his head or any part of his body and was only directing him into the room and the chair. The statement was dated 10/10/23 at 1:30 p.m. and was signed by the Executive Director. A facility statement indicated Activity Aid 6 was witnessed, at the end of the lunch period, to have slapped Resident B in the back of the neck to make him sit down in the theater room chair by the window. The observation was reported to the Director of Nursing, Executive Director, and the Activities Manager. The statement was signed by Therapy Aid 7 on 10/8/23. A facility document, titled "Skin Sweep Tool," dated 10/8/23, indicated the only skin issue found on Resident B was a bruise on his inner right elbow area. There was no time noted of the form to indicated how long after the reported incident the skin check had been completed. A document, titled "Resident Abuse Questionnaire," was part of the investigation of Activity Aid 6. The answer to question four (4) "...Made you feel uncomfortable (touched you inappropriately) ..." was answered "...Yes, he			

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	speaks aggressively. He has not touched him inappropriately...." The answer to question five (5) "...Have you seen or heard of any resident being treated in any of these ways...." was answered "...He speaks to other residents in a mean manner...." The document was for the interview of Resident C on 10/8/23 and the interviewer's printed name on the form belonged to the MCSS. A document, titled "Resident Abuse Questionnaire," was part of the investigation of Activity Aid 6. The answer to question five (5) "...Have you seen or heard of any resident being treated in any of these ways...." was answered "...physically aggressive...grab and force other residents in their seats...." The answer to question six (6) "...Did you tell anyone about what happened...What was their response...." was answered "Staff, they do not listen and tells him to be quiet...." The document was for the interview of Resident D on 10/8/23 and the interviewer's printed name on the form belonged to the MCSS. A facility document, titled "Employee Communication Form," indicated on 10/8/23 at 12:30 p.m., Activity Aid 6 had violated the policy with inappropriate behavior toward a resident. The details of the incident were "...Staff member was seen by another staff member smacking resident on head/neck in man cave. Upon investigation other residents stated he had aggressive language and behavior toward other resident...." The employee was suspended on 10/8/23 and terminated from employment on 10/13/23. The document was signed by the Executive Director and the MCSS on 10/13/23. A facility document, titled "Employee Communication Form," dated 5/18/23 indicated			

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	Activity Aid 6 had previously been suspended for violation of the abuse policy. He was suspended pending an investigation of alleged resident abuse. After the investigation, it was determined there was no abuse. There was no further action required. The form was signed by the Executive Director and Activity Aid 6 on 5/26/23. During an interview, on 10/23/23 at 9:50 a.m., the Executive Director indicated the incident should not have been reported as a resident-to-resident event. It was a staff member who made contact with the resident. The staff member was no longer employed with the facility. The facility was unable to substantiate the abuse allegation but during the investigation other things did come up. The resident did have a red mark on his neck, but it dissipated. The Executive Director indicated it was the Activity Assistant's word against another employee's word and no other abuse issues were reported on the activity assistant. The staff member was terminated from employment for other issues, on 10/13/23, when the investigation was completed. The staff member was immediately removed from the building, after the incident, and did not return. During an interview, on 10/24/23 at 2:19 p.m., Therapy Assistant 7 indicated during the lunch period she looked up and in the line of her vision toward the theater she observed Activity Assistant 6 hit Resident B in the back of the neck to get him to sit down. Activity Assistant 6 was telling the resident to sit down and to stop. This was when he hit him in the back of the neck. Resident B did sit down. Resident B was up about 15 minutes later and when he passed by, she noticed how red he was on the back of his neck. She indicated she was not able to leave the unit as she was the only CNA on the unit. She did call			

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	and report it to the Director of Nursing. She was told she needed to report the incident to the Executive Director and the Director of Nursing would give her the number. It took about an hour, and she had not heard back from the Director of Nursing, so she called the Memory Care Support Specialist (MCSS) and reported the incident to her. The MCSS asked her to write up a statement. She did write up a statement and clocked out to go home when the MCSS contacted her and let her know the Executive Director was on his way to the facility and to stay so he could talk to her. She did remain and did speak with the Executive Director. During a telephone interview, on 10/25/23 at 10:08 a.m., the spouse of Resident B indicated she had never had concerns of abuse in the facility until she was made aware a staff member was involved in an incident with her spouse. Her spouse had been hit by a staff member. She had not witnessed any abuse during visits, but it was concerning. During an interview, on 10/25/23 at 1:11 p.m., the Director of Nursing indicated, in regard to the incident, anyone could accuse/say something about another person, and she would agree with the Executive Director the situation was one person's word against another person's word. During an interview, on 10/26/23 at 8:18 a.m., the MCSS indicated she received a call on Sunday, 10/8/23, around 2:30 p.m. Therapy Assistant 7 told her what she had witnessed. The MCSS contacted the Director of Nursing, and she informed the Activity Aid to clock out, explained the situation to him, and informed him an investigation was to be started. She arrived at the facility around 3:00-3:30 p.m. She indicated she had also informed the Executive Director of the situation. She did			

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	look at the resident and did not observe any marks, the back of his neck was a little red and by the time she left the facility, at about 6:00 p.m., the area had returned to normal color. The MCSS indicated the employee had an allegation prior. He had said something, but no one witnessed it. It was reported to her the day after it happened, and she had reported it to the Director of Nursing and Executive Director. There was no friction between the Activity Assistant and the Therapy Assistant. She described the Therapy Assistant/CNA as work driven, she cared about her residents, was personable and built relationships with the families she had contact with. During an interview, on 10/26/23 at 8:42 a.m., LPN 4 indicated Activity Assistant 6 and Therapy Assistant 7, to her knowledge, got along, but she did not observe them interacting together much. During an interview, on 10/26/23 at 8:47 a.m., QMA 8 indicated Activity Assistant 6 and Therapy Assistant/CNA 7 worked in different departments, they seemed friendly when she did see them. A current policy, titled "Abuse Prohibition, Reporting, and Investigation," dated as last revised June 2023 and received from the Director of Nursing on 10/26/23 at 10:59 a.m., indicated "...It is the policy of American Senior Communities to provide each resident with an environment that is free from abuse...this includes but is not limited to verbal abuses...physical abuse, mental abuse...Physical Abuse-A willful act against a resident...Examples may include...slapping, punching...." The deficient practice was corrected by 10/13/23, after the facility implemented a systemic plan that			

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	included the following actions: The facility investigated the incident involving Resident B and Activity Aid 6, educated the staff on abuse prohibition and reporting, provided Resident B with a dedicated staff member to care for him and assist him, assessed Resident B for injury, assessed Resident B post incident for psychosocial effects related to the incident and terminated Activity Aid 6 from employment on 10/13/23. This Federal Tag relates to Complaint IN00419181. 3.1-27(a)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse,			

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	10/26/2023

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
	except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications were stored safely in the original containers until the time of administration for 12 of 17 residents on the Auguste Cottage Memory Care Unit. (Residents 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13) Finding includes: During an observation, on 10/25/23 at 8:42 a.m., QMA 3 was observed to remove a clear plastic medication cup of medications from the top drawer of the medication cart. She was not observed to set up the medications individually using the computer or medication cards to prep the medications. The drawer of the medication cart contained multiple cups of medications with names written on each cup. QMA 3 indicated there were 10 cups of medications in the drawer. Before the QMA could answer any questions, LPN 4, who had been standing approximately three feet behind the QMA approached the medication cart and indicated to the QMA medications could not be set up in cups, they needed to be prepped one at a time. The QMA indicated "oh". The drawer contained 12 cups of medications, each with a resident's name written on the cups. The policy for medication administration and a list of medications in each cup was requested of LPN 4. During an interview, on 10/25/23 at 1:11 p.m., the Director of Nursing indicated the facility did not have a policy which addressed setting up more than one medication at a time.	F 0761	F761 (D) med storage **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·="" li="">Preset meds were immediately destroyed by nurse manager and meds were given individual to each resident. ·="" li="">all Nurses and and QMA's were in-serviced on proper medication pass. **QMA's were inserviced How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice ·DNS/Designee will conduct an in-service with all Licensed nurses and QMAs on medication storage policy **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/Designee will conduct an in-service with all Licensed nurses and QMAs on medication	11/15/2023

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	During an interview, on 10/25/23 at 2:40 p.m., the Director of Nursing indicated the facility staff was not able to identify the medications found in the cups, only a pharmacist could. She indicated the medications had not been administered, they had been discarded. A facility document, titled "Medication Pass Procedure," dated as last reviewed 12/2016 and provided by the Director of Nursing on 10/26/23 at 10:59 a.m., did not address setting up medications. 3.1-25(b)(4) 3.1-25(b)(5)		storage policy A 5 day a week rounding tool including medication storage to be utilized by nurse managers to ensure medications are appropriately dispensed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	