STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harcourt Terrace Nursing and Rehabilitation	8181 Harcourt Rd Indianapolis, IN 46260

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32842 Based on interview and record review, the facility failed to ensure effective person-centered dementia care was provided to a resident with known physically aggressive behaviors for 2 of 5 residents reviewed for dementia care. (Residents H and J) This deficient practice resulted in an altercation between Resident H and J. Resident J received a fractured left wrist and a laceration above his right eye. The deficient practice was corrected on 7/10/24, prior to the start of the survey, and was therefore past noncompliance. Findings include: A facility document, titled Indiana State Department of Health Survey Report System, indicated on 7/2/24 at 9:30 p.m., Resident J complained of arm pain after an interaction with Resident H. Resident J received a fractured ulna (left wrist bone) during the altercation with Resident H. Resident H was sent to a psychiatric hospital for evaluation and treatment. A facility document, titled Event Report, dated 7/1/24 at 7:00 p.m., indicated Resident H was in the dining room hitting other residents in the face. He was removed from the dining room and redirected to his room. He was given medication, then he calmed down. There were other residents affected by his behavior. The other residents were redirected to their rooms to ensure safety. The interventions put into place to prevent another behavior were to administer medications as ordered, redirect to his room, and 15-minute checks for increased surveillance. The facility's investigation indicated an altercation between Residents H and J occurred, on 7/1/24 at approximately 7:00 p.m., on the men's memory care cottage. Staff on the unit were interviewed and no one witnessed the altercation. CNA 2 heard a noise down the hall, went to determine what it was, and observed Residents H and J in the hallway talking to one another. Resident J was asking Resident H to get away from him and indicated Resident H had hit him causing the laceration to his face. On 7/2/24, Resident J complained of left arm pain and the nurse observed his arm to be swollen. X-ray results indicated he had a fractured left wrist. 1. The clinical record for Resident H was reviewed on 7/23/24 at 10:29 a.m. The diagnoses included, but were not limited to, neurocognitive disorder with Lewy bodies, psychotic disorder with delusions due to known physiological conditions, schizophrenia, generalized anxiety disorder, major depressive disorder, sleep disorders, and other symptoms and signs involving cognitive functions and awareness. (continued on next page)

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

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A care plan addressed the resident enjoyed dancing, riding motorcycles, boating, camping and hunting. The approaches included, but were not limited to, 10/23/23, staff would provide the resident with opportunities to utilize strengths, staff would provide the resident with the needed materials to practice his strengths. A care plan addressed the resident enjoyed the following types of activities. He enjoyed reading magazines, loved dogs and listening to music such as classic rock, country and 80's music. He enjoyed watching the local news and westerns on TV. He enjoyed outside activities but had a history of eloping during outside activities. He enjoyed reminiscing on his past experiences. He was in the Army. The approaches included, but were not limited to, 10/23/23, give verbal reminders to resident to remind him of activities of his interest, provide assistance to activities as needed, provide independent supplies for room as needed. A nursing progress note, dated 10/23/23 at 12:40 a.m., indicated Resident H was being very combative. The nurse attempted to redirect the resident, but he went into the TV room, attempted to open the window, and became very combative. He went to the unit's back door and started pushing on it and was redirected to his room. The resident came from his room and as the nurse was walking the resident hit the nurse with a punch. The nurse asked the resident kindly to go get some rest, but the resident went to the nurse's cart and began removing medication cups from the cart and throwing them on the floor. The nurse redirected him to his room, then he came out of his room with a foot pedal in his hand, hiding it at his back, and began swinging it at the nurse, while she was washing her hands in the dinner area sink. The nurse hurriedly came behind the resident, took the foot pedal from him, and redirected him to his room. A nursing progress note, dated 10/27/23 at 12:50 a.m., indicated the resident was going into other residents' rooms. He was redirected by staff to go back to his room. The resident came out of his room walked down the hallway, grabbed the pill crusher off the nurses' cart and attempted to hit staff with it. Staff were unable to get the pill crusher from the resident, so 911 was called. The resident went back to his room. A care plan addressed the problem of the resident exhibited cognitive impairment as evidenced by the resident was severely impaired. The approaches included, but were not limited to, 10/27/23, encourage participation in daily activities particularly regarding orientation, socialization and stimulation, encourage social interaction, give the resident choices throughout the day regarding decisions as able to do so, provide simple instructions and repeat as needed. A nursing progress note, dated 10/30/23 at 8:13 a.m., indicated the resident continued to wander into other residents' rooms. A nursing progress note, dated 10/31/23 at 1:26 p.m., indicated the resident was observed removing the mop from the housekeeping cart. The staff member asked the resident for the mop back and grabbed the handle of the mop, then the resident grabbed the staff member's hand in an aggressive manner and squeezed. The nurse asked the resident calmly to show the staff member how to use the mop and he demonstrated how to use it, then she asked if she was able to use it and he provided the nurse with the mop and walked away. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note, dated 11/7/23 at 7:03 a.m., indicated the resident continued to be combative toward peers and staff. The resident attempted to physically hit staff and was involved in several verbal altercations with peers. The resident had to be redirected by staff several times, refused care/hygiene attempts, and was being closely supervised by staff. A nursing progress note, dated 11/7/23 at 2:09 p.m., indicated the resident continued to wander around the unit, going in and out of other residents' room at times and continued to be combative with staff. The resident was given personal space when he became aggressive. A care plan addressed the problem the resident would engage in verbal and/or physical aggression towards staff and/or other residents. He may throw furniture, break items, and try to fight staff members. The approaches included, but were not limited to, 11/7/23, staff members would offer the resident an appropriate activity of the resident's preference, staff members would offer the resident personal space to help the resident calm down, staff members would redirect the resident as needed. A care plan addressed the problem the resident had episodes of intrusive wandering and aggressive episodes toward staff members when providing redirection from other residents' room. The approaches included, but were not limited to, 11/07/23, door identifier to reorient the resident to his room. 11/8/23, staff will offer the resident an activity of their choice. A care plan addressed the problem the resident had signs and symptoms of mood distress. He had a diagnosis of Lewy body dementia and received an antipsychotic medication. Approaches included, but were not limited to, 11/10/23, administer medications and monitor and record effectiveness, encourage the resident to become involved with physical activities and social interactions, obtain a psych consult or psychosocial therapy. A nursing progress note, dated 11/11/23 at 7:30 p.m., indicated the resident spent part of the shift in his room asleep and later came out just before midnight and began pushing and banging on the unit exit door, and depressing the door latch. Any attempt to redirect the resident, he would ball his fist up and attempted to drive his knee into anyone who tried to redirect him. He did this on several occasions and had to be re-redirected. The resident did not take re-direction well and any attempt to further assess the resident failed. A nursing progress note, dated 11/18/23 at 8:41 a.m., indicated Resident H was observed walking the halls and carrying a foot pedal for a wheelchair. He struck another resident with the foot pedal then another resident in a different room began to insert himself into the situation causing Resident H to become even more agitated. He swung the foot pedal even more, refused redirection, continued to carry the foot pedal around and banged it on the walls. The other resident moved away from the initial conflict and allowed Resident H to wander around giving him space to vent. The intervention was somewhat effective. A care plan addressed the problem the resident would engage in verbal and/or physical aggression towards staff and/or other residents. He may throw furniture, break items, and try to fight staff members. The approaches included, but were not limited to, 11/20/23, staff members would monitor the resident closely to prevent any unsafe episodes. 11/20/23, staff members would offer a snack/beverage of his interest. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A social service progress note, dated 11/22/23 at 9:16 a.m., indicated the Social Worker met with the resident to check his psychosocial status. Resident H indicated he missed his twin brother who has passed away. His daughter was called to ask her to bring pictures of his brother in and the psychiatric physician was asked to evaluate and treat the resident. A nursing progress note, dated 11/24/23 at 2:08 p.m., indicated the resident was transported for a psychiatric evaluation by ambulance. A care plan addressed the problem the resident had difficulty making himself understood. Approaches included, but were not limited to, the following: 11/28/23, allow the resident time to speak and avoid interruption, provide a quiet, non-hurried environment, free of background noises and distractions, remind the resident to speak slowly and clearly, repeat what the resident said to validate. A psychiatric hospital note indicated Resident H was admitted on [DATE] and discharged on [DATE], for aggression and paranoia. His coping strategies were walking around, singing and dancing, having a snack, sitting with staff and peers, and he liked helping others or being social. A nursing progress note, dated 12/13/23 at 9:39 p.m., indicated Resident H returned to the facility from a psychiatric hospital stay. He was confused and required extra time and guidance with directions. A psychiatric progress note, dated 12/19/23, indicated Resident H was being seen for his initial visit with the psychiatric physician services to assess his current psychiatric status. He had multiple psychiatric hospitalization s with the most recent one on 11/24/23. He was admitted to the facility on [DATE]. He was referred to the psychiatric physician services for management of dementia with behaviors. He was cognitively impaired, speech and thought processes were disorganized and nonsensical. The nursing staff reported the resident had been agitated and physically aggressive towards other residents. Prior to the hospitalization , he threatened to use a foot pedal and pill crusher towards another resident. A nursing progress note, dated 12/30/23 at 11:51 a.m., indicated the nurse was in the common area of the unit when she heard a noise like glass breaking. A CNA called her to the man cave area of the memory care-secured unit where Resident H had picked up a chair and used it to break out a window, then he threw a cup of lemonade on the nurse. The physician was called, and a new order was given for Haldol (an antipsychotic medication) 5 mg (milligrams) for one dose. A psychiatric progress note, dated 1/2/24, indicated Resident H was being seen for a routine follow-up visit to assess his current psychiatric status. The nursing staff reported he had been intrusively wandering and was easily agitated. He had physical aggression and threw a chair through a window on his memory care-secured unit. He was confused at his baseline and his speech was disorganized. Past psychiatric hospitalization s included, but were not limited to, 8/4/23 to 10/16/23 and 11/24/23 to 12/13/23. A nursing progress note, dated 1/9/24 at 3:23 p.m., indicated the resident threw water from the mop on other residents, but he was able to be redirected to his room. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A psychiatric progress note, dated 2/5/24, indicated Resident H was being seen for mood and behavioral issues. He was minimally cooperative with the mental status examination. He was positive for visual hallucinations. His insight and judgement were severely impaired. A social service progress note, dated 2/15/24 at 12:21 p.m., indicated the resident was seen by the psychiatric physician. The resident demonstrated confusion with agitation and aggressive behavior, which had been disruptive to the residents on the male memory care-secured unit. A psychiatric progress note, dated 2/20/24, indicated Resident H was being seen to assess his current psychiatric status. His speech was disorganized. He had a history of inpatient psychiatric admissions for psychosis. A nursing progress note, dated 2/26/24 at 4:55 a.m., indicated the resident was found sitting on his roommate's legs. They were fully clothed. The incident appeared to be both the residents' ideas because both residents were observed attempting to get up from a sitting position. They both appeared confused and Resident H was taken to another room. A nursing progress note, dated 2/26/24 at 1:38 p.m., indicated the resident took a mop from the housekeeping staff and hit the staff in the head with the mop. He attempted to hit other residents with the mop but was redirected by staff. A psychiatric general note, dated 2/26/24, indicated Resident H was being physically aggressive towards staff and another resident. His behavior was disruptive and non-pharmacological interventions attempted three times but were ineffective. A telephone order for Haldol 5 mg now for one dose. A nursing progress note, dated 2/27/24 at 9:35 p.m., indicated Resident H was intrusively wandering into another resident's room, while the resident was lying down. The resident got up and began to make contact with the resident. Both residents were scuffling with each other. The residents were separated, and Resident H was redirected and was administered a PRN (as needed) medication. A psychiatric progress note, dated 2/28/24, indicated Resident H was being seen to assess his current psychiatric status. The nursing staff indicated the resident continued to exhibit physical aggression. He was restless and intrusive. The Haldol given on 2/26/24, was effective. A nursing progress note, dated 3/1/24 at 2:16 p.m., indicated the staff was attempting to provide care to the resident and the resident refused. As staff was walking away to allow a cool-off period, the resident made contact with the staff's shoulder. The staff redirected the resident and allowed him personal space to cool-off. A psychiatric general note, dated 3/1/24, indicated Resident H was delusional, hitting staff and barricading himself in his room. He pushed the medication cart into the nurse. A Haldol dose was given and was effective. Haldol was scheduled to be given for three days. He may benefit from a psychiatric stay for further evaluation if the current medication regimen was ineffective. A social service progress note, dated 3/1/24 at 2:18 p.m., indicated the Social Worker notified Resident H's daughter regarding the resident being admitted for an inpatient psychiatric stay. The resident's daughter agreed. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note, dated 3/1/24 at 6:49 p.m., indicated the resident was sent to the psychiatric hospital for evaluation and treatment. A psychiatric hospital note indicated Resident H was admitted on [DATE] and discharged on [DATE], for agitation with physical aggression. While hospitalized , the hospital staff reported he displayed behaviors of increased intrusive wandering and physical aggression with staff. He had delusions and believed staff members were trying to harm or kill him. He refused his medications on occasion and became combative depending on the staff member's approach. He was in others' space at times. The staff members had tried to redirect the resident using redirection and reassurance, without success in improving his behaviors. An Interdisciplinary Team (IDT) progress note, dated 3/19/24 at 9:22 a.m., indicated the resident entered another resident's room and started pushing chairs around, then he tried to throw a chair. Staff redirected him several times to get him out of the resident's room. A care plan addressed the problem the resident would engage in verbal and/or physical aggression towards staff and/or other residents. He may throw furniture, break items, and try to fight staff members. The approaches included, but were not limited to, 3/19/24, the resident would continue to be seen by psychiatric services. 3/20/24, weighted blanket as needed for anxiety. A psychiatric progress note, dated 3/21/24, indicated the resident was being seen for mood and behavioral issues. The staff reported the resident demonstrated irritability and aggressive behavior toward staff. During the session, he presented himself as depressed, minimally cooperative, and when asked if he was getting along with others, he shook his head no and pointed to a staff member in the room. An IDT progress note, dated 3/29/24 at 10:02 a.m., indicated Resident H entered another resident's room and put on that resident's shoes. That resident told Resident H to take off his shoes, then Resident H hit the other resident and he fell on the floor during the altercation. Staff redirected the two residents and escorted Resident H to his own room. A nursing progress note, dated 4/4/24 at 12:19 a.m., indicated the resident was walking up and down the unit hallway and opening some of the residents' doors and waking them up. The residents were complaining about his intrusiveness, and he was repeatedly redirected, but he would not comply with any attempts to redirect him. He balled his fist up to hit whoever tried to redirect him. He would not comply with any attempts at redirection. He was offered snacks and juices to drink, which he ate it all up, then started walking again and intruded into things and other residents' rooms. He got on the floor twice and got himself up out of anger. As he continued to walk up and down the hallway, he attempted to pull the side rails from the walls. He went to the man cave sat for a while, then got a wheelchair and started rolling it. He ran the wheelchair into the nurses' station door and ran the wheelchair into a CNA. He was redirected. A PRN order for Haldol was ordered, but not given because the resident went to his room as he was redirected to do so and fell asleep. Any attempts to get his vitals, he balled his fist up as if he was going to hit the staff members. A psychiatric progress note, dated 4/4/24, indicated the resident was being seen for mood and behavioral issues. The resident was being seen due to staff request. The staff reported Resident H had pushed a wheelchair into staff and had been wandering into other residents' rooms. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note, dated 4/6/24 at 2:00 p.m., indicated the resident wandered up and down the hallway after lunch and was found in another resident's room. He had taken some of that resident's candy. When the nurse asked the resident to come out of the resident's room, he threw the candy down on the floor and walked out of the room. He would not allow the CNAs to help change him. A nursing progress note, dated 4/8/24 at 1:44 p.m., indicated Resident H went into another resident's room and slept in his bed. He would not come out. He refused to allow the nurse to take his vitals for his weekly skin assessment. He eventually went to his room and laid down. A psychiatric progress note, dated 4/9/24, indicated the resident was being seen to assess his current psychiatric status. Staff reported he was physically aggressive at times. A psychiatric progress note, dated 4/18/24, indicated the resident was being seen for mood and behavioral issues. The staff reported Resident H had been pulling railings off the walls. The resident had a maladaptive communication and comprehension issue, which negatively impacted his treatment. A nursing progress note, dated 5/8/24 at 10:02 a.m., indicated the resident came out of his room for breakfast and while staff was passing out trays he made contact with the staff member's face twice. He then went into another resident's room and made contact with the resident. When redirected he went into the hallway and made contact with a different resident's stomach. A nursing progress note, dated 6/2/24 at 1:34 p.m., indicated the resident was walking around, being aggressive, trying to fight staff and a resident. The physician was called, and an order was given for Zyprexa (an atypical antipsychotic medication) 2.5 mg. The medication was given, and the resident appeared to be a little calmer. A nursing progress note, dated 6/5/24 at 2:30 p.m., indicated the resident was intrusively wandering, then became combative with another resident when staff attempted to redirect him out of the resident's room. He was also combative with staff members and became physically violent with staff members while using current interventions to remove him from the resident's room. The staff were unable to redirect the resident safely. He was allowed to remain inside the resident's room with the door closed. A nursing progress note, dated 6/5/24 at 3:45 p.m., indicated the resident was given as needed (PRN) medication ordered by the psychiatric physician. The resident became aggressive while staff were checking on him for safety and he proceeded to punch the staff member in the face. For safety measures pending an evaluation by a psychiatric hospital, the resident was placed on one-on-one supervision. The resident continued to barricade himself in his room and refused to come out of room. A psychiatric progress note, dated 6/6/24, indicated Resident H was being seen for mood and behavioral issues. The staff reported the resident recently engaged in physical aggression with two other residents. The staff reported nothing appeared to trigger the aggressive behavior. A psychiatric hospital note indicated Resident H was admitted on [DATE] and discharged on [DATE], for confusion and aggression. His coping strategies were socializing and interacting with staff and participating in activities he was able to follow. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A care plan addressed the problem the resident would engage in verbal and/or physical aggression towards staff and/or other residents. He may throw furniture, break items, and try to fight staff members. The approaches included, but were not limited to, 6/6/24, offer cool down period as needed for behaviors. 6/6/24, PRN medication as ordered. A nursing progress note, dated 6/19/24 at 1:48 p.m., indicated Resident H returned from a psychiatric hospital stay. The resident was pleasant. A psychiatric progress note, dated 6/20/24, indicated the resident was being seen for mood and behavioral issues. The staff reported Resident H just returned from a week psychiatric stay due to his combative behaviors. A nursing progress note, dated 6/22/24 at 1:31 p.m., indicated the resident was wandering into another resident's room. A Qualified Medication Aide (QMA) attempted to redirect the resident to his room when he balled his fist up and made contact with the QMA's face. The nurse heard the QMA's scream for help and assisted the QMA with the redirection of the resident to his room. While assisting the resident to his room, he showed signs of aggravation. A nursing progress note, dated 6/22/24 at 10:29 p.m., indicated a staff member attempted to get a urinalysis on the resident, but he showed signs of agitation, and he refused his medication in the evening. A psychiatric progress note, dated 6/25/24, indicated the resident was being seen to assess his current psychiatric status. He had multiple hospitalization s. He recently returned from a psychiatric hospital stay where he was admitted for agitation and physical aggression towards staff and other residents. A care plan addressed the problem the resident had episodes of intrusive wandering and aggressive episodes toward staff members when providing redirection from other residents' room. The approaches included, but were not limited to, 6/25/24, allow the resident space and validate his frustrations. 6/25/24, approach the resident calmly when assisting him away from other residents' rooms. 6/25/24, offer assistance to resident to his room/bathroom and dining room when he was wandering aimlessly in the hallway. A significant change Minimum Data Set (MDS) assessment, dated 6/26/24, indicated Resident H had physical behavioral symptoms which placed others at a significant risk for physical injury. The resident wandered and significantly intruded on the privacy or activities of others. A nursing progress note, dated 7/2/24 at 7:26 a.m., indicated the resident continued his intrusive wandering into other residents' rooms. When attempting to redirect the resident, he would become aggressive, and ball up his fist up to strike. He was presently calm, snacks were provided, and he was walking throughout the unit dinner area and hallway with no issues at that time. A nursing progress note, dated 7/2/24 at 8:47 a.m., indicated the resident was being combative and attempting to hit staff members and other residents. A one-time order for Haldol 5 mg was given. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note, dated 7/2/24 at 9:38 a.m., indicated the resident was observed sitting in the man cave and was observed grabbing another resident's walker by the activities area. The staff member went to tell the nurse and heard a loud noise. The nurse observed Resident H lying on his back near the couch and lift. The resident got himself off the ground and into a chair. He had complaints of back pain, and a knot was observed on the back of his head. His blood pressure (BP) was 69/46 and a manual BP was 78/48. He became less alert and non-reactive to the sternum rub. The resident was sent out by 911 to the hospital. A nursing progress note, dated 7/2/24 at 9:40 p.m., indicated the resident returned from the hospital and was placed on one-on-one supervision until he was able to be evaluated by psychiatric services or transferred out to a psychiatric hospital. An Interdisciplinary Team progress note, dated 7/2/24 at 8:00 a.m., indicated Resident H was being combative with peers. The immediate interventions were redirection, separation and assist to assigned room. The root cause of his behavioral expression was he was unable to voice his wants and needs effectively, had a diagnosis of dementia, psychotic disorder, schizophrenia, and over stimulation. The resident did not believe his peers belonged in his home. The preventative interventions related to the above root cause was determined to be redirecting the resident to his room and belongings, redirecting the resident to activities going on at that time, assess the resident for unmet needs, order obtained for Risperidone (an antipsychotic medication) and Haldol, the resident was to be checked by the behavioral and medication review, and continue 15-minute checks for increased surveillance. A nursing progress note, dated 7/3/24 at 5:07 p.m., indicated Resident H was transferred to a psychiatric hospital. A care plan addressed the problem the resident had episodes of intrusive wandering and aggressive episodes toward staff members when providing redirection from other residents' room. The approaches included, but were not limited to, 7/2/24, assist the resident to a less stimulating environment (he enjoyed being outside or in his room) and offer one on one conversation (he enjoyed talking about his old motorcycles). 7/3/24, the resident was to have a private room. A care plan addressed the problem the resident would engage in verbal and/or physical aggression towards staff and/or other residents. He may throw furniture, break items, and try to fight staff members. The approaches included, but were not limited to, 7/2/24, dim lights and/or assist resident to less stimulating location such as outdoor patio or his room and validate his frustrations. 7/3/24, 15-minute checks. 2. The clinical record for Resident J was reviewed on 7/23/24 at 2:05 p.m. The diagnoses included, but were not limited to, dementia with agitation, fracture of the lower end of the left ulna, secondary malignant neoplasm of the brain, malignant neoplasm of part of the bronchus or lung, and weakness. An admission MDS assessment, dated 6/10/24, indicated the resident did not display any physical or verbal type of behavior toward other residents or staff. He did display wandering type behavior which significantly intruded on the privacy and activities of others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harcourt Terrace Nursing and Rehabilitation	8181 Harcourt Rd Indianapolis, IN 46260

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Actual harm Residents Affected - Few	A physician's progress note, dated 7/2/24, indicated Resident J was seen for left lower arm pain. The resident reported getting in an altercation with another resident. He had pain and swelling to his left forearm and the area was tender to touch. A surgical consult, dated 7/10/24, indicated Resident J presented in the physician's office for a wrist injury, which he injured approximately two and a half weeks ago. He experienced pain and limited use of his left wrist. X-rays indicated he had a fractured left wrist. He was placed in a splint for the next four weeks. During an interview, on 7/19/24 at 2:38 p.m., Resident J indicated Resident H and two other men were in his room and Resident H was sitting on his bed. He told the men to get out of his room. The next thing he knew Resident H and him was wrestling on the bed in his room. When he got up, he had pain in his left wrist. During an interview, on 7/23/24 at 2:41 p.m., Employee 3 indicated there were no activities after 5:00 p.m. The facility was low on activity staff, and they tried to fill in with CNAs who had a day off when they were able to. Some days when there were no activity staff available, the CNAs on the memory care unit were responsible for completing the activities for the day. Resident H responded better when he was doing one-on-one activities. During an interview, on 7/23/24 at 3:31 p.m., CNA 4 indicated Resident H wandered into other residents' rooms. He hit staff and resisted care at times. He did not take redirection well. She was scared of him because he would use his balled-up fist and hit the staff during care. He fought with almost all the residents on the memory care unit. Staff did not do any activities after 5:00 p.m. He was very hard to care for because of his combativeness. During an interview, on 7/23/24 at 3:45 p.m., RN 5 indicated Resident H did wander intrusively into other residents' room. He was combative with the staff. He was strong and quick with his fists. The deficient practice was corrected by 7/10/24, after the facility implemented a systemic plan that included the following actions: Resident H was admitted to an inpatient psychiatric unit for treatment, all residents' safety was ensured, residents were interviewed for abuse, skin assessments were completed on residents, staff were in-serviced on abuse prevention and behavior management and interventions, 1:1 observations collected daily and reviewed by the IDT team for any concerns or changes needed to the plan of care. This citation relates to Complaint IN00437935. 3.1-37(a)