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	10/24/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 38872 Based on observation, interview and record review, the facility failed to ensure a resident had been assessed to self-administer medications for 1 of 1 resident reviewed for medication administration. (Resident B) Finding includes: During an interview and observation, on 10/23/24 at 9:16 a.m., Resident B was up in her room. A clear plastic cup was noted on the table with approximately eight pills in the cup. Resident B indicated the nurse brought the medications to her when she was bathing or dressing and she was to take the medications when she ate, so the nurse left the pills in the room. The resident's breakfast tray was noted to be on the table and untouched. The clinical record for Resident B was reviewed on 10/23/24 at 10:27 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, end stage renal disease, and chronic systolic heart failure. There was no physician's order, care plan or assessment to indicate the resident was able to self-administer medications found in the record. During an interview, on 10/23/24 at 9:45 a.m., RN 1 indicated she went to administer medications to Resident B this morning and was called out of the room. She indicated she was going to return to the room, and she should not have left the medications in the room. The resident did not have an order, an assessment, or a care plan for self-administration of medications. During an interview, on 10/23/24 at 11:08 a.m., the Director of Nursing indicated Resident B did not have a physician's order, care plan or self-administration assessment. A current facility policy, titled Self Administration of Medications, dated as last reviewed 1/2015 and received from the Director of Nursing on 10/23/24 at 1:32 p.m., indicated .If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the Self-Administration of Medication Assessment observation .A physician order will be obtained specifying the resident's ability to self-administer medications .The resident's care plan will be updated to include self administration 3.1-11(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38872 Based on observation, interview and record review, the facility failed to ensure cups were free of film/build up from hard water prior to using the cups to serve drinks to residents for 1 of 1 dishwasher reviewed. Finding includes: During an observation of the kitchen, on 10/23/24 at 8:59 a.m., clean cups were found to be stored in the dishwasher room. They were stored bottom up in large plastic dishwasher crates in a shallow square container with wheels that set up off the floor approximately six inches. There were 18 of 29 cups found to have a white film in the bottom, inside of the cups. The film could be scrapped off the bottom of the cup. There were also an additional 9 of 9 cups with handles, found stored in a separate dishwasher crate, also containing a film at the bottom. During an interview, on 10/23/24 at 9:01 a.m., Dietary Staff 2 indicated the cups were used to serve fluids. The Kitchen Manager supplied the salt, and they were out of salt. All the cups had been washed. During a random observation, on 10/23/24 at 9:09 a.m., Resident B was observed to move his bedside table with his breakfast tray on top of the table, into the hall, by his door. One of the two cups on the tray was found to have a white film on the inside bottom of the cup. During an interview, on 10/23/24 at 9:06 a.m., the Executive Director indicated the facility did use the cups for serving fluids. During an observation, on 10/23/24 at 9:12 a.m., Resident C was found to have two empty cups on his tray. Both cups were found to have a white film on the inside bottom of the cups. During an interview, on 10/23/24 at 9:16 a.m., Resident D indicated the facility was using dirty cups. During an interview, on 10/23/24 at 9:33 a.m., the Executive Director indicated salt was needed to soften the water. The staff could wash/scrub the film out of the cups by hand when there was no salt. During an interview, on 10/23/24 at 10:51 a.m., the Executive Director indicated the facility had hard water, once the staff soaked the cups the film would come out. During an observation, of the mid-day meal on the Memory Care Unit, on 10/23/24 at 1:27 p.m., Resident E was observed to have a cup of water. A white film was observed, inside the cup, at the bottom. During an observation, of the mid-day meal on the Memory Care Unit, on 10/23/24 at 1:28 p.m. Resident F was observed to have a cup of water with a noted white film, inside the cup, at the bottom. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the exit conference, on 10/24/24 beginning at 10:51 a.m., the Executive Director indicated the facility had hard water and the film was the sanitizer. A current facility policy, titled Cleaning Dishes, dated as last revised in 4/2024 and received from the Director of Nursing on 10/23/24 at 1:44 p.m., indicated .Scrape, rinse or soak items before washing .Check each rack for soiled items as it comes out of the machine .Run dirty items through again until they are clean This citation relates to Complaint IN00445242. 3.1-21(i)(3)