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 04/01/2026
NAME OF PROVIDER OR SUPPLIER Harcourt Terrace Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect a resident's right to be free from verbal abuse and intimidation (Resident B) by another resident (Resident C) for 1 of 4 residents reviewed for abuse.Findings include:During an observation and interview, on 3/30/26 at 11:04 a.m., Resident B was lying in bed, covered with a sheet and had a back scratcher resting on the right side of the bed next to him. Resident B indicated he had no complaints regarding the staff, but Resident C cussed at him last evening (3/29/26) while a nurse was providing tracheostomy care for him. Resident C was his old roommate and now lived in the room across the hall from him. Resident C yelled and cussed at him for no reason.During an observation and interview, on 3/31/26 at 12:18 p.m., Resident B was lying in bed, covered with a sheet and had a back scratcher resting on the right side of the bed next to him. His right hand was resting on the back scratcher. Resident B indicated it bothered him when Resident C talked s**t and threatened him because the attacks were always unprovoked. Resident B indicated he did not get out of bed and Resident C always came into the doorway of his room. If the staff questioned Resident C about the altercation, Resident C claimed to the staff he was stopping by to see Resident B's roommate. Resident B indicated, on 3/29/26, Resident C threatened to come into his room and kick his a**. Resident B indicated since Resident C lived across the hall; Resident C had to pass his room every time Resident C left his own room. Resident B indicated he had been having trouble staying asleep at night because Resident C was allowed to come and go from the facility at all hours of the night, would return to the facility drunk, and Resident C could bring a weapon back with him or enter his (Resident B) room while he was sleeping and bonk him on the head with something, and there would be nothing he (Resident B) could do about it.During an interview, on 3/31/26 at 12:18 p.m., Anonymous Staff Member 7 indicated Resident C would yell and cuss at a lot of staff and residents, but the behavior was particularly bad towards Resident B. Anonymous Staff Member 7 did not know why Resident C did not like Resident B.During an interview, on 3/31/26 at 2:21 p.m., Resident B's daughter indicated Resident B called her in the evening, on 3/30/26, and told her Resident C had come to his room yelling and cussing at him. This was the third incident she had been made aware of. Resident B told her Resident C had threatened to beat him up. Resident B's daughter indicated the facility allowed Resident C to come and go from the facility whenever he would like and she was concerned about her dad's safety since there were now threats of physical harm. Her dad was bed bound and was unable to protect himself. She and Resident B were concerned about Resident C bringing a weapon into the facility and indicated the facility would have no way of knowing until it was too late. Resident C was a danger to not only her dad but other residents as well. Staff had no control over Resident C. Her dad had mentioned to her he was worried about what Resident C could do to him, so her dad kept a back scratcher next to him for protection.During an interview, on 3/30/26 at 2:31 p.m., the Executive Director (ED) indicated when Resident B arrived three months ago, he and Resident C were roommates for a very short time. Resident C did not want a roommate and there were problems between the two residents from the beginning. Resident C did not qualify to be in the facility because he was independent and did not (continued on next page)

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

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 04/01/2026
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	require any assistance for activity of daily living but refused to look for another living situation because he did not want to pay to live anywhere. There were suspicions Resident C had returned to the facility intoxicated. The police had to be called because Resident C returned to the facility, staff reported Resident C smelled of alcohol, was yelling, being verbally aggressive to staff and yelling at other residents. The ED indicated the facility had lost staff due to Resident C's behaviors and Resident C did whatever he wanted and everyone knew it.During an interview, on 3/31/26 at 3:39 p.m., the Social Service Director indicated Resident C had a history of becoming disruptive and aggressive about having a roommate. When Resident B returned from the hospital, on 1/30/26, he was placed in a room with Resident C. Resident C was not happy about having a roommate and having to move his belongings to one side of the room. Resident C was then moved into a room across the hall and had become angry when his T.V. wasn't working properly after he moved rooms. Since the issue with Resident C's T.V., every time Resident C passed Resident B's room there was an altercation. A couple of days ago (3/29/26), Resident C was yelling at Resident B from the doorway of Resident B's room. Resident B reported Resident C threatened to beat his a**. Early Monday morning (3/30/26), Resident C heard the nurse in the room with Resident B talking about getting cleaned up and started yelling at Resident B calling him a fat a** and continued to make threats. There were other residents who did get along with Resident C who could possibly move rooms to allow Resident B to move further away from Resident C. She had mentioned the idea of room changes three different times during the morning IDT (interdisciplinary team) meetings, but the idea was always rejected. The first time she suggested this was after following up with Resident B after the first altercation on 2/3/26. She believed the suggestion was turned down because the facility was trying to make Resident C uncomfortable so the resident would want to live somewhere else but believed everyone else (residents) were uncomfortable due to the disruptions Resident C caused.During an interview, on 3/31/26 at 3:55 p.m., the ED indicated Resident B complained to his daughter about Resident C and claimed he was threatened. Resident B's daughter called the facility, reported the incident, and stated Resident C was verbally aggressive to her father. The ED informed the daughter her father had an [NAME] and was claiming he denied being bothered by the altercation when the ED spoke with Resident B about what had happened. The ED believed Resident B was an aggressor too. The ED indicated the nurse was attempting to suction Resident B's tracheostomy when Resident B was being verbally aggressive with the nurse. Resident C had overheard the conversation and entered the doorway to Resident B's room and started yelling at Resident B saying, you take up all the nurse's time and no one else can get help. The ED indicated Resident C was sticking up for the staff member. Resident B and the daughter had been offered to move rooms several times, but they both refused. The ED indicated she believed moving rooms would not make a difference because of the way the building was set up. Resident C wanted to stop in Resident B's room to say hi to Resident B's roommate and the roommate had the right to be visited by other residents. Resident B had never been bothered by Resident C yelling, cussing, and name calling in the past, but now, for the first time, it bothered him. The ED indicated that a resident must have physical or psychosocial distress from an interaction to qualify as a resident-to-resident event. She would expect staff to separate the residents and document the incident. The event would be documented in the aggressor's record and social services would complete resident follow-ups regardless of admitted distress.During an interview, on 4/1/26 at 9:46 a.m., Resident B's daughter voiced safety concerns for all the residents in the facility. Resident B's daughter indicated after the second altercation between Resident B and Resident C, she requested a room change but indicated no one wanted to move her father's room. The ED had asked her about changing rooms yesterday during the telephone call but claimed none of the other residents wanted to move closer to Resident C. Resident B's daughter indicated this was the first time the facility was considering a room change but also claimed there would always be opportunities for Resident C to be around Resident B. At first, Resident B was okay with Resident C entering his room to see his roommate, but when the verbal aggression was a constant problem, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident B started telling Resident C to stop coming in. Resident C was verbally aggressive to Resident B all the time, even when staff were present and providing care for her father. Resident B was too proud of a man to admit being bothered by another man's behaviors and threats.During an interview, on 4/1/26 at 12:28 p.m., the Director of Nursing (DON) indicated Resident B had never admitted to being bothered by Resident C until now and believed it was Resident B's daughter who was bothered by the altercation and not actually Resident B. Until now, there have never been reports of threats from Resident C. The DON indicated per the federal regulations, Resident C yelling, cussing and calling Resident B names was not considered abuse because Resident B was not admitting psychosocial distress.During an interview, on 4/1/26 at 1:27 p.m., Resident B indicated the ED had asked if he wanted to move to another room when she spoke with him yesterday (3/31/26). Resident B felt since Resident C caused the issues, Resident C should be the one to move and because of that, he told the ED he did not want to move rooms. Resident B also wanted to let people know if something happened to him, he was not the aggressor.1. The clinical record for Resident B was reviewed on 3/30/26 at 1:16 p.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, anxiety, depression, and morbid obesity.A care plan, dated 1/30/26, indicated Resident B displayed signs and symptoms of mood distress as evidenced by finding little interest or pleasure in doing things, decrease in sleep, increase in fatigue, and trouble concentrating and to encourage Resident B to verbalize feelings, concerns, fears, and to clarify misconceptions.A care plan, dated 2/27/26, indicated Resident B was at risk of depression and to allow Resident B to express feelings and frustration and for staff to offer validation and support.A progress note, dated 2/4/26, indicated the Social Service Director was following up with Resident B. Resident B indicated he had an issue with his last roommate (Resident C) coming in and out of his room after Resident C moved out of the room they had shared. Resident B indicated he was happy in the facility before his hospital stay but since returning from the hospital, he has been unhappy. During the follow-up interview with Resident B, Resident C started yelling, cursing and calling the resident names from the hallway. Resident B became upset and shouted back at Resident C. The Social Service Director closed the door and was able to talk to Resident B until he became calm.A psychiatric visit note, dated 3/19/26, indicated Resident B had a history of anxiety. Resident B described experiencing low mood, trouble sleeping, worry, irritability, and nervousness.A psychiatric visit note, dated 3/23/26, indicated Resident B would like to go home and reported he had been dealing with depression and anger.2. The clinical record for Resident C was reviewed on 3/30/26 at 1:48 p.m. The diagnoses included, but were not limited to, alcohol abuse, anxiety, and insomnia.A behavior event, dated 1/15/26, indicated Resident C was informed he would be getting a new roommate. Resident C indicated he did not want a roommate and anyone they placed in his room, he would make it very uncomfortable for them. Staff educated Resident C about proper notification of receiving a new roommate and he was asked to try and get along with the new roommate. Resident C indicated he did not care about the facility policy or reason for the facility to place a new roommate in his room and stated he would not tolerate another roommate. Resident C's current roommate was removed from the room and taken to another location in the facility.A progress note, dated 1/27/26, indicated Resident C was very irritated and appeared to be under the influence. Resident C was going in and out of other resident's rooms being disrespectful and using vulgar language.A progress note, dated 2/25/26, indicated Resident C was standing outside of a resident's room encouraging the resident to cuss out a different resident.A wellness visit note, dated 3/11/26, the Nurse Practitioner indicated per nursing staff reports, Resident C had been returning to the facility intoxicated.A behavior event, dated 3/13/26, indicated Resident C had returned to the facility, appeared to be intoxicated, was yelling at the staff so what if I'm drunk. As Resident C was propelling himself to his room, he stopped in the doorway of Resident B's room and started yelling at Resident B saying, his big a** lays in the bed all f***ing day not doing s**t, talking on the phone about me all the time. Staff made several attempts to redirect Resident C before the verbal altercation stopped. The document indicated this behavior (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	affected other residents.A progress note, dated 3/27/26, indicated the DON, ED, SSD, unit manager, and Medical Director spoke with Resident C regarding returning to the facility intoxicated, as evidence by, Resident C voiced being drunk and his behaviors. Resident C was provided with a policy for education on the matter. Resident C became upset and said, leave me alone about this b******t.Documentation by the nurse regarding the witnessed verbal altercation, on 3/29/26, was not located in Resident B and/or Resident C's clinical record.Documentation of what had occurred requiring police involvement was not located in Resident B and/or Resident C's clinical record.There was no behavior contracts located in Resident C's clinical record. A plan which ensured Resident B's safety had not been put into place by the facility.A current facility policy, titled Abuse Prohibition, Reporting, and Investigation, dated as last revised 3/2026 and received from the ED on 3/30/26 at 10:26 a.m., indicated .to provide each resident with an environment that is free from abuse.This includes but is not limited to verbal abuse, physical abuse, mental abuse.will not permit residents to be subjected to abuse by anyone, including employees, home office staff, other residents.Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Verbal abuse-The use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents.within their hearing distance.This includes.verbal threats of harm by resident to resident.Mental abuse-verbal or nonverbal infliction of anguish, pain, or distress that results in psychological or emotional suffering.This includes.resident to resident if it appears to be willfully directed to a specific resident.Examples of mental abuse include but are not limited to.harassing a resident, mocking, insulting, ridiculing .yelling.with the intent to intimidate.threatening resident.Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect.These symptoms include but are not limited to.Aggressive and/or catastrophic reactions of residents.outbursts or yelling out.difficulty in adjusting to new routines.Abuse includes.Resident to resident abuse of any type.Types of abuse.Verbal abuse.Mental abuse.Resident to Resident Abuse.Any individual who witnesses resident-to-resident abuse will immediately separate and protect the residents involved.Staff member(s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained.The individual who witness the abuse will report the situation immediately to his/her supervisor and Executive Director. In the event a behavior management plan is unsuccessful, or if the team feels that the inappropriate behavior poses a risk to other residents, the facility reserves the right to transfer/discharge the resident following the transfer/discharge policy .Based on the root cause, ED/Designee will determine how care provision will be changed.All residents will be protected from physical and psychological harm during and after the allegation and investigation. This will include.Responding immediately to protect the alleged victim and protect the integrity of the investigation.Provide increased supervision of the alleged victim and other residents.Implement room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator.Provide emotional support and counseling to the resident during and after the investigation if needed .In cases where an altercation has occurred but does not meet the criteria for reporting, the facility must meet the following requirement.Providing care and services according to acceptable standards of practice to prevent harm as a result of resident-to-resident altercations .It is the responsibility of every employee.to report abuse situations, but also suspicion of abuse and unusual observations and circumstances to his/her immediate supervisor and to the Executive Director A current facility policy, titled Resident Rights, dated as last revised 2/2019 and received from the ED on 3/30/26 at 10:26 a.m., indicated .This facility recognizes that each resident has the right to a dignified existence.This facility will protect and promote the rights of each resident.410 IAC (Indiana Administrative Code)3.1-27(a)(1)410 IAC (Indiana Administrative Code)3.1-27(b)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident?s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on interview and record review, the facility failed to ensure medications were administered, labs were obtained, and admission orders were transcribed according to the physician's orders for 2 of 3 residents reviewed for quality of care. (Resident J and E)Findings include: 1. During an interview, on 3/30/26 at 11:00 a.m., Resident J indicated on the morning of 2/7/26, the facility staff did not give him his insulin medication.

The clinical record for Resident J was reviewed on 3/30/26 at 11:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes, anemia, and hypertension

A physician's order, dated 12/2/25, indicated to administer 16 units of lispro insulin three (3) times a day with meals.

The Medication Administration Record (MAR) indicated, on 2/7/26, the 7:30 a.m. dose was not administered.

During an interview, on 3/31/26 at 11:55 a.m., Unit Manager (4) indicated due to the resident's preference, Resident J did not want her to administer his insulin the morning of 2/7/26. She passed the medication administration responsibility onto another nurse.

During an interview, on 3/31/26 at 12:31 p.m., Licensed Practical Nurse (LPN) 3 indicated she was not informed she was supposed to take care of Resident J until it was too late. He did not refuse his insulin for her. The dose was not administered because she was told too late and he did not get his 7:30 a.m. dose.

During an interview, on 4/1/26 at 1:10 p.m., the Director of Nursing (DON) indicated the facility did not have a medication administration policy. They had a skills validation checkoff.

A facility skills competency document, titled Medication Administration, dated April 2025 and received from the DON on 4/1/26, indicated .Medications administered within 60 minutes before and/or after time ordered or within the 4 hour time range (if on time ranges).The 5 rights of medication performed: Right Resident, Right Medication, Right Dose, Right Route, Right Time.

2. The clinical record for Resident E was reviewed on 3/30/26 at 11:05 a.m. The diagnoses included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis affecting the right dominant side, dysphagia (difficulty swallowing), aphasia (inability to produce speech), and dysarthria (motor speech disorder which impairs control of the muscles used for speech).

a. The rehab hospital Discharge summary, dated [DATE], indicated Resident E had been assessed for hypercalcemia (high level of calcium in the blood), hyponatremia (low level of sodium in the blood), and hyperammonemia (high level of ammonia in the blood) and to continue to monitor labs levels.

Resident E was admitted , on 1/14/26 at 11:08 a.m., from a rehabilitation (rehab) hospital.

A lab report, dated 1/16/26, indicated the resident's sodium was 132 (low) and calcium was 12.5 (high).
(continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's progress note, dated 1/19/26, indicated the resident was seen for hypercalcemia, hyponatremia, and elevated ammonia levels. The plan was to repeat a comprehensive metabolic panel lab test in one (1) week. A physician's order, dated 1/19/26, indicated to repeat an ammonia and comprehensive metabolic panel lab test on 1/26/26. A lab report, dated 1/30/26, indicated the quantity of blood was insufficient to obtain lipid or thyroid test results. The report did not indicate a comprehensive metabolic panel or ammonia level was ordered or obtained. The clinical record did not contain results for a repeat comprehensive metabolic panel or ammonia level after the initial results on 1/16/26. An emergency room note, dated 2/7/26 at 9:51 a.m., indicated Resident E was admitted to the hospital for diagnoses of acute respiratory failure with hypoxia, hypercalcemia, acute renal insufficiency, and hypernatremia. A hospital history and physical, dated 2/7/26 at 12:26 p.m., indicated the Resident E's abnormal lab values included, but were not limited to sodium, potassium, and calcium. b. The rehab hospital Discharge summary, dated [DATE], indicated speech-language pathology evaluated the patient for dysphagia and communication deficits. The patient was found to have mild oral phase deficits, characterized by right anterior loss and pocketing, intermittent cough with thin liquids and solids, and impulsivity during feeding. The patient was continued on a dysphagia diet with 1:1 supervision for all meals due to an aspiration risk. Discharge to a skilled nursing facility (SNF) was set for 1/14/26. A dysphagia diet was ordered and included 1:1 or close supervision, alternate sips/liquids and SMALL bites, medications crushed in puree, and no straws. Resident E was admitted , on 1/14/26 at 11:08 a.m., from a rehabilitation (rehab) hospital. A physician's order, dated 1/14/26, indicated may crush appropriate medications and mix with applesauce or other food sources as needed. The electronic medical record did not include orders for 1:1 or close supervision for meals, alternating sips of liquids with small bites, medications needed to be crushed in puree, or no straws. During an interview, on 3/30/26 at 12:30 p.m., Resident E's daughter indicated her father had swallowing difficulties from a stroke which had gotten worse. He was in a rehabilitation hospital in December and then admitted to the facility on [DATE] for continued therapy. She had filed a grievance with the facility, on 1/20/26, related to RN 5 placed an uncrushed pill in her father's mouth and not in applesauce. Her father required his medications to be crushed in applesauce. During an interview, on 3/31/26 at 11:00 a.m., Unit Manager 4 indicated a physician's order indicating the nurse may crush medications was not the same as an order to always crush the medications. She did not believe the resident received his medications crushed. A current facility policy, titled Nursing Admission/Return admission Policy and Procedure, dated 12/25 and provided by the Executive Director on 3/31/26 at 3:54 p.m., indicated .The admitting nurse (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	must review the pre-admission assessment, history and physical, hospital discharge summary.and physician orders.Transcribe the admission orders from the original orders. This citation relates to Intake 2738953 and 2742060. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure the same size tracheostomy canula was kept at bedside as ordered for 1 of 1 resident reviewed for respiratory care. (Resident B)Findings include:During an observation, on 4/1/26 at 11:21 a.m., Resident B had a tracheostomy.The clinical record for Resident B was reviewed on 4/1/26 at 12:00 p.m. The diagnoses included, but were not limited to, chronic respiratory failure and sleep apnea.A physician's order, dated 2/2/26, indicated the tracheostomy type and size was a Bivona tracheostomy XL 7 (a silicone, wire-reinforced, extra-length tracheostomy tube deigned for adult patients who require deeper airway access).A physician's order, dated 2/2/26, indicated to keep a small tracheostomy canula and the same size tracheostomy canula at bedside.During an interview, on 4/1/26 at 11:25 a.m., RN 2 indicated the tracheostomy canula stored at the bedside was a size 6. She would have to check to see if the facility stored the same size canula at bedside.During an interview, on 4/1/26 at 11:30 a.m., the Minimum Data Set (MDS) Coordinator indicated Resident B had a size 6 canula at bedside and she would have to check if the facility stored the same size canula at bedside.During an interview, on 4/1/26 at 1:10 p.m., the Director of Nursing (DON) indicated the same size canula just needed to be stored in the facility but not stored at the bedside. She observed the physician's order which indicated the same size canula should be stored at the bedside. She indicated the facility did not have a policy for tracheostomies.410 IAC (Indiana Administrative Code) 3.1-47(a)(4)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were disposed of in a secure and safe method to prevent diversion and/or accidental exposure for 1 of 3 residents reviewed for pharmacy services. (Resident E)Findings include:The clinical record for Resident E was reviewed on 3/30/26 at 11:05 a.m. The diagnoses included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis affecting the right dominant side, dysphagia (difficulty swallowing), aphasia (inability to produce speech), and dysarthria (motor speech disorder which impairs control of the muscles used for speech).Resident E was admitted , on 1/14/26 at 11:08 a.m., from a rehabilitation (rehab) hospitalThe rehab hospital Discharge summary, dated [DATE], indicated speech-language pathology evaluated the patient for dysphagia and communication deficits. The patient was found to have mild oral phase deficits, characterized by right anterior loss and pocketing, intermittent cough with thin liquids and solids. Medications were to be crushed in puree form.A Medication Administration Record, dated 2/7/26 at 7:27 a.m., indicated the following medications were marked as not administered due to the resident's condition:a. aspirin (a non-steroidal anti-inflammatory medication)b. vitamin D3 (a vitamin supplement)c. lactulose (a liquid laxative used to reduce blood ammonia levels)d. methylphenidate (a scheduled II controlled substance)e. sennosides-docusate sodium (a laxative)f. rifaximin (an antibiotic medication)g. polyethylene glycol (a laxative)A controlled substance record indicated one (1) tablet of rifaximin was signed out on 2/7/26 at 8:00 a.m., by RN 5.The controlled substance record did not indicate the tablet was disposed of or wasted with a second nurse.During an interview, on 3/31/26 at 11:00 a.m., Unit Manager 4 indicated RN 5 had informed her Resident E did not receive his medications on 2/7/26 due to his condition and RN 5 had thrown all the medications in the trash in his room. Unit Manager 4 indicated medications were not supposed to be thrown in the trash in resident's room. Unit Manager 4 had taken a second staff member into the room and verified two (2) pills were found in the trash can. There were only 2 pills found in the trash out of the 6 pills ordered for that morning. There was no liquid medications found in the trash can. The controlled substance had not been destroyed with a second nurse.During an interview, on 4/1/26 at 2:00 p.m., RN 5 indicated she did not administer any medications to the resident that morning.An employee communication form, dated 2/8/26, indicated RN 5 received a written warning for inaccurately signing out medications as given and not destroying medications per policy.A skills competency nursing checklist, titled Medication Administration (Medication Pass Procedure), revised 4/2025 and provided by the Director of Nursing (DON) on 4/1/26 at 2:35 p.m., indicated .Wasted, dropped or discarded medications disposed of in Drug Buster disposal system.Administration and inventory of controlled substances were documented according to facility policy.A current facility policy, titled Controlled Substances: Storage, Documentation, Inventory and Destruction (Includes Fentanyl Patch Removal and Destruction), dated 10/25 and provided by the DON on 4/1/26 at 11:49 a.m., indicated .all unused medication will be destroyed by.a witnessing licensed nurse.destruction will be documented on the resident's Controlled Substance Record.This citation relates to Intake 2738953.410 IAC (Indiana Administrative Code) 16.2-3.1-25(e)(2)410 IAC (Indiana Administrative Code) 16.2-3.1-25(o)

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 04/01/2026
NAME OF PROVIDER OR SUPPLIER Harcourt Terrace Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a provided diet was comparable and compatible to the diet ordered from a rehabilitation hospital on admission for 1 of 3 residents reviewed for therapeutic diets. (Resident E)Findings include:The clinical record for Resident E was reviewed on 3/30/26 at 11:05 a.m. The diagnoses included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis affecting the right dominant side, dysphagia (difficulty swallowing), aphasia (inability to produce speech), and dysarthria (motor speech disorder which impairs control of the muscles used for speech).Resident E was admitted , on 1/14/26 at 11:08 a.m., from a rehabilitation (rehab) hospitalThe rehab hospital Discharge summary, dated [DATE], indicated speech-language pathology evaluated the patient for dysphagia and communication deficits. The patient was found to have mild oral phase deficits, characterized by right anterior loss and pocketing, intermittent cough with thin liquids and solids, and impulsivity during feeding. The patient was continued on a dysphagia diet with 1:1 supervision for all meals due to an aspiration risk. The speech therapist recommended ongoing monitoring for signs of aspiration or pulmonary compromise. A team conference was held on 1/7/26 and indicated the modified barium swallow study remained unchanged and the diet was a minced/moist diet. Discharge to a skilled nursing facility (SNF) was set for 1/14/26. A dysphagia diet was ordered as IDDSI (International Dysphagia Diet Standardization Initiative which is a global standard for classifying texture-modified foods and thickened liquids for individuals with swallowing difficulties) thin/IDDSI 0 (IDDSI Level 0, termed Thin, refers to liquids that flow freely like water, milk, or juice), 1:1 or close supervision, alternate sips/liquids and SMALL bites, no straws, minced and moist/IDDSI 5 (IDDSI Level 5, termed minced and moist, refers to food which is soft and moist but with no liquid leaking or dripping from the food. Food which has been mashed or minced before serving and biting was not required). Resident E's discharge self-care functional abilities for eating were supervision or touching assistance.A facility admission observation, dated 1/14/26 at 12:26 p.m., indicated Resident E's current health problems included swallowing difficulties.A physician's order, dated 1/14/26 at 11:30 a.m. and discontinued 1/14/26, indicated a regular diet.A physician's order, dated 1/14/26 at 8:33 p.m. and discontinued 1/27/26, indicated a soft bite-sized diet.A document, titled Complete IDDSI Framework Detailed definitions 2.0, dated 2019, indicated a minced and moist diet included small lumps equal to or less than 4 millimeters (mm) wide by 15 mm long and required minimal chewing while a soft and bite-sized diet included 15 mm by 15 mm pieces and required regular chewing and tongue control. A soft and bite-sized diet according to IDDSI would be an IDDSI Level 6.A care plan, dated 1/15/26, indicated the resident required assistance with eating related to dysphagia and dysarthria.An admission Minimum Data Set (MDS) assessment, dated 1/21/26, indicated the resident required partial to moderate assistance with eating.A progress note, dated 1/23/26 at 12:57 p.m., indicated the nurse was called to the dining room due to the resident coughing and vomiting. Resident E continued to eat and cough. A progress note, dated 1/26/26 at 12:10 p.m., indicated the resident was eating lunch and had thick secretions, coughing, and emesis. A physician's order, dated 1/27/26 at 11:10 a.m., indicated pureed diet. During an interview, on 3/30/26 at 12:30 p.m., Resident E's daughter indicated her father had swallowing difficulties from a stroke which had gotten worse. He was in a rehabilitation hospital in December and then admitted to the facility on [DATE] for continued therapy. She had filed a grievance with the facility, on 1/20/26, related to the facility leaving her father unattended while eating. Her father required close supervision for all meals.During an interview, on 3/31/26 at 11:55 a.m., Speech Therapist 6 indicated the facility did not offer a minced and moist diet. Speech would determine a diet substitution for a diet not offered. A soft and bite-sized diet would be considered an upgraded diet from minced and moist.A current facility policy, titled Nursing Admission/Return admission Policy and (continued on next page)

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	155149	A. Building B. Wing	04/01/2026

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure, dated 12/25 and provided by the ED (Executive Director) on 3/31/26 at 3:54 p.m., indicated .Transcribe the admission orders from the original orders.Diet-transcribe the diet using the correct terminology.A current facility policy, titled Diet Orders, dated 8/25 and provided by the ED on 3/31/26 at 3:54 p.m., indicated . Available Diets: Regular, Puree.Ground Meat.Soft & Bite Sized.If the physician orders a diet not consistent with the diets offered by the facility (above), nursing can utilize the diet terminology in the chart below.Order-Mechanical Soft* Interpretation-Soft & Bite Sized, Order-Minced and Moist* Interpretation-Puree .If a resident admits with orders for either a Mechanical Soft or Minced and Moist diet, please complete a nursing to therapy referral for Speech Therapy to review to ensure most appropriate diet is provided.This citation relates to Intake 2738953.410 IAC (Indiana Administrative Code) 16.2-3.1-21(a)(3)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure speech therapy was initiated and provided to a resident who admitted to the facility with a diagnosis of dysphagia (swallowing disorder) and on a therapeutic diet for 1 of 3 residents reviewed for therapy services. (Resident E)Findings include: The clinical record for Resident E was reviewed on 3/30/26 at 11:05 a.m. The diagnoses included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis affecting the right dominant side, dysphagia (difficulty swallowing), aphasia (inability to produce speech), and dysarthria (motor speech disorder which impairs control of the muscles used for speech).Resident E was admitted , on 1/14/26 at 11:08 a.m., from a rehabilitation (rehab) hospitalThe rehab hospital Discharge summary, dated [DATE], indicated speech-language pathology evaluated the patient for dysphagia and communication deficits. The patient was found to have mild oral phase deficits, characterized by right anterior loss and pocketing, intermittent cough with thin liquids and solids, and impulsivity during feeding. The patient was continued on a dysphagia diet with 1:1 supervision for all meals due to an aspiration risk. The speech therapist recommended ongoing monitoring for signs of aspiration or pulmonary compromise. A team conference was held on 1/7/26 and indicated the modified barium swallow study remained unchanged and the diet was a minced/moist diet. Discharge to a skilled nursing facility (SNF) was set for 1/14/26. A dysphagia diet was ordered as IDDSI (International Dysphagia Diet Standardization Initiative which is a global standard for classifying texture-modified foods and thickened liquids for individuals with swallowing difficulties) thin/IDDSI 0 (IDDSI Level 0, termed Thin, refers to liquids that flow freely like water, milk, or juice), 1:1 or close supervision, alternate sips/liquids and SMALL bites, no straws, minced and moist/IDDSI 5 (IDDSI Level 5, termed minced and moist, refers to food which is soft and moist but with no liquid leaking or dripping from the food. Food which has been mashed or minced before serving and biting was not required). Resident E's discharge self-care functional abilities for eating were supervision or touching assistance.A facility admission observation, dated 1/14/26 at 12:26 p.m., indicated Resident E's current health problems included swallowing difficulties.A physician's order, dated 1/14/26 at 11:30 a.m. and discontinued 1/14/26, indicated a regular diet.A physician's order, dated 1/14/26 at 8:33 p.m. and discontinued 1/27/26, indicated a soft bite-sized diet.A care plan, dated 1/15/26, indicated the resident required assistance with eating related to dysphagia and dysarthria.An admission Minimum Data Set (MDS) assessment, dated 1/21/26, indicated the resident required partial to moderate assistance with eating.A progress note, dated 1/23/26 at 12:57 p.m., indicated the nurse was called to the dining room due to the resident coughing and vomiting. Resident E continued to eat and cough. A therapy evaluation was triggered.A progress note, dated 1/26/26 at 12:10 p.m., indicated the resident was eating lunch and had thick secretions, coughing, and emesis. Speech therapy was to evaluate Resident E due to an event on 1/23/26.A physician's order, dated 1/27/26, indicated speech therapy to evaluate and treat.A physician's order, dated 1/27/26, indicated speech therapy to treat five (5) times a week for ten (10) weeks for swallowing dysfunction and oral functions for feeding.A physician's order, dated 1/27/26 at 11:10 a.m., indicated pureed diet. During an interview, on 3/31/26 at 2:45 p.m., the Director of Nursing (DON) indicated speech therapy was usually ordered for residents upon admission for worsening dysphagia or modified diets. She indicated she believed the resident's dysphagia had been stable or improving.During an interview, on 3/31/26 at 11:55 a.m., Speech Therapist 6 indicated when a resident was admitted with dysphagia and on a modified diet, speech therapy should be notified to evaluate. The facility had not ordered speech therapy when Resident E was admitted . The facility did not offer a minced and moist diet. Normally, speech therapy would determine the diet substitution for a diet which was not offered. A soft and bite-sized diet would be considered an upgraded diet status from minced and moist and should not be made without a speech therapy evaluation.During an interview, on 3/30/26 at 12:30 p.m., Resident E's daughter indicated her (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	father had swallowing difficulties from a stroke which had gotten worse. He was in a rehabilitation hospital in December and then admitted to the facility on [DATE] for continued therapy. She had filed a grievance with the facility, on 1/20/26, related to the facility leaving her father unattended while eating. Her father required close supervision for all meals.A current facility policy, titled Diet Orders, dated 8/25 and provided by the Executive Director (ED) on 3/31/26 at 3:54 p.m., indicated .If a resident admits with orders for either a Mechanical Soft or Minced and Moist diet, please complete a nursing to therapy referral for Speech Therapy to review to ensure most appropriate diet is provided.This citation relates to Intake 2738953.410 IAC (Indiana Administrative Code) 16.2-3.1-23(a)(1)