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	01/28/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 44598 Based on observation, interview and record review, the facility failed to ensure a resident's right to privacy was provided during personal care for 1 of 3 residents reviewed for resident rights. (Resident 376) Findings include: During an observation, on 1/27/25 at 10:54 a.m., LPN 5 entered Resident 376's room to administer a gastrostomy tube (a feeding tube inserted into the abdomen directly into the stomach) bolus (a method of administering liquid food directly into the stomach) of Jevity 1.5 (a nutrition supplement). The resident's door was left open. LPN 5 pulled the resident's cover back and lifted his gown exposing his abdomen. The privacy curtain in the resident's room was not closed and three people walked by the resident's room. The clinical record for Resident 376 was reviewed on 1/23/25 at 3:42 p.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia (low levels of oxygen in your body tissue), convulsions, congestive heart failure, dysphagia (difficulty swallowing), and atrial fibrillation. During an interview, on 1/27/25 at 11:35 a.m., the Assistant Director of Nursing (ADON) indicated while providing care to a resident, the resident's door should be closed for privacy and the door was not closed. During an interview, on 1/28/25 at 3:22 p.m., the Director of Nursing (DON) indicated the facility did not have a policy on providing privacy for a resident. A current facility policy, titled Resident Rights, dated 11/2011 and received from the DON on 1/22/25 at 11:30 a.m., indicated .The Resident has a right to a dignified existence, self-determination and communication with, and access to, persons and services inside and outside the Facility 3.1-3(p)(4)

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44598 Based on observation, interview and record review, the facility failed to ensure a comprehensive care plan was developed for a resident with a hand splint for 1 of 4 residents reviewed for care plans. (Resident 33) Findings include: During an observation, on 1/22/25 at 12:10 p.m., Resident 33 was sitting in the dining room. Unit Manager 4 entered the dining room and placed a blue hand splint on the resident's right hand. During an observation, on 1/23/25 at 11:00 a.m., the resident was sitting in the activity room, and a hand splint was on her right hand. During an observation, on 1/27/25 at 10:27 a.m., the resident was sitting in the activity room, and a hand splint was on her right hand. The clinical record for Resident 33 was reviewed on 1/23/25 at 3:19 p.m. The diagnoses included, but were not limited to, transient ischemic attack (temporary disruption in the blood supply to a part of the brain), hypertension, anxiety disorder, and major depressive disorder. The electronic medical record did not include a physician's order or a care plan for a right-hand splint. During an interview, on 1/28/25 at 2:29 p.m., the Director of Nursing (DON) indicated the resident did not have a care plan for the hand splint prior to 1/27/25. During an interview, on 1/28/26 at 2:34 p.m., the DON indicated the facility did not have any additional care plan policies. A current facility policy, titled IDT Comprehensive Care Plan policy, dated as revised 8/2023 and received from the Clinical Support Nurse on 1/28/25 at 11:50 a.m., indicated .Care plan review will be interdisciplinary and should include .nursing .therapy .MDS 3.1-35(a) 3.1-35(b)(1)

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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. 52091 Based on interview and record review, the facility failed to ensure pharmaceutical services were obtained timely to support a resident's healthcare needs for 1 of 1 resident reviewed for pharmacy services. (Resident 376) Findings include: The clinical record for Resident 376 was reviewed on 1/23/25 at 3:42 p.m. The diagnoses included, but were not limited to, convulsions, congestive heart failure, emphysema, and encephalopathy (a change in your brain function due to injury or disease). A care plan, dated 3/8/24, indicated the resident was at risk for injury related to seizure activity. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 1/9/25, indicated to give Lacosamide (an anticonvulsant medication) 10 milligrams (mg)/ 1 milliliter (ml) solution twice a day. The physician's order for Lacosamide 10 mg/1 ml solution was ordered on 1/9/25 and was not available until 1/22/25. The resident received his first dose on 1/22/25 at 11:05 a.m. The resident missed 26 doses of the medication. During an interview, on 1/27/25 at 9:53 a.m., Registered Nurse (RN) 6 indicated if the resident was out of medication, she would check the Pyxis (a medication dispensing system), call the pharmacy, and would notify the Executive Director (ED) and Director of Nursing (DON). The resident was prescribed the medication for seizures and missing the medication for so long could cause the resident to have a seizure. During an interview, on 1/28/25 at 10:40 a.m., the DON indicated if a medication was not available for a resident, she would reach out to pharmacy and notify the physician. She would check with the physician to ask if an alternate medication could be given until the ordered medication was delivered. The facility would monitor seizure activity and wait on medication. During an interview, on 1/28/25 at 2:00 p.m., the DON indicated the medication should not have been unavailable for days. A current facility skill competency checklist (provided as the medication administration policy), titled Medication Administration, dated as last revised 7/2023 and received from the Executive Director on 1/28/25 at 3:40 p.m., did not address missing multiple doses of a scheduled medication. 3.1-25(a) 3.1-25(g)(1) 3.1-25(g)(2) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-25(g)(3)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49891 Based on interview and record review, the facility failed to ensure residents were assessed for side effects of antipsychotic medications with the Abnormal Involuntary Movement Scale (AIMS) according to the policy and procedure for 2 of 5 residents reviewed for unnecessary medications. (Resident 37 and 45) Findings include: 1. The clinical record for Resident 37 was reviewed on 1/27/25 at 10:44 a.m. The diagnoses included, but were not limited to, Alzheimer's disease with early onset, type 2 diabetes mellitus with diabetic polyneuropathy, dementia with other behavioral disturbance and agitation, bipolar disorder, mood disorder, generalized anxiety disorder, and moderate recurrent major depressive disorder. A care plan, dated 10/10/23, indicated the resident was at risk for adverse side effects related to the use of psychotropic medication, antipsychotic, antidepressant and antianxiety medication. A physician's order, dated 1/1/24, indicated to give risperidone (an atypical antipsychotic medication) 0.5 milligrams (mg) twice a day. A physician's order, dated 5/2/24, indicated to give sertraline (a depression medication) 100 mg once a day. A physician's order, dated 6/4/24, indicated to give buspirone (an anxiety medication) 5 mg twice a day. An AIMS assessment, dated 1/2/24 at 10:50 a.m., indicated an involuntary movement score of 3. An AIMS assessment, dated 8/27/24 at 3:28 p.m., indicated an involuntary movement score of 0. During an interview, on 1/24/25 at 3:15 p.m., the Director of Nursing (DON) indicated she did not find an AIMS assessment completed between January and August. She indicated an AIMS assessment should have been completed every six months. 2. The clinical record for Resident 45 was reviewed on 1/27/25 at 8:43 a.m. The diagnoses included, but were not limited to, vascular dementia with other behavioral disturbance, type 2 diabetes mellitus with complications, depressive episodes, anxiety disorder, psychotic disorder with delusions due to known physiological condition, recurrent moderate major depressive disorder, and violent behavior. A care plan, dated 3/8/24, indicated the resident was at risk for adverse side effects related to the use of psychotropic medication, antidepressant, and antipsychotic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 3/8/24, indicated to give divalproex (a seizure medication also used for mood) 250 mg twice a day. A physician's order, dated 3/8/24, indicated to give risperidone (an atypical antipsychotic medication) 1 mg every 6 hours as needed. A physician's order, dated 3/9/24, indicated to give sertraline (a depression medication) 75 mg once a day. An AIMS assessment, dated 7/8/24 at 10:51 a.m., indicated an involuntary movement score of 0. During an interview, on 1/27/25 at 11:57 a.m., the Clinical Support Nurse indicated she could not find an admission AIMS assessment and one should have been completed when the resident was admitted in March. A current facility policy, titled Documentation Guidelines for Nursing, dated as revised 7/2024 and received from the Clinical Support Nurse on 1/28/25 at 2:12 p.m., indicated .AIMs-every 6 months for residents receiving antipsychotics .Also complete with new order 3.1-48(3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38872 Based on interview and record review, the facility failed to ensure documentation was complete and accurately reflected the care provided for 2 of 2 residents reviewed for accurate documentation. (Resident 55 and 18) Findings include: 1. The clinical record for Resident 55 was reviewed on 1/27/24 2:52 p.m. The diagnoses included, but were not limited to, diabetes mellitus, dementia, and hypertension. A care plan, dated 7/25/23, indicated the resident was at risk for altered nutritional status related to dementia, hypertension, and schizophrenia. Interventions included, but were not limited to, offer bedtime snacks. A physician's order, dated 11/7/23, indicated to administer a bedtime snack to the resident. The January 2025 Medication/Treatment record indicated snacks were not administered because they were not available on January 6th, 13th, 15th and 20th. The documentation indicated that the resident was given 0 (zero) bedtime snacks on those days. 2. The clinical record for Resident 18 was reviewed on 1/28/25 at 3:03 p.m. The diagnoses included, but were not limited to, hypertension, chronic kidney disease, and Alzheimer's dementia. A physician's order, dated 8/14/24, indicated to administer a bedtime snack to the resident. The January 2025 Medication/Treatment record indicated snacks were not administered because they were not available on January 6th, 13th, and 15th. The documentation indicated that the resident was given 0 (zero) bedtime snacks on those days. During an interview, on 1/28/25 at 8:53 a.m., the Corporate Support Nurse indicated bedtime snacks were available on the unit. She spoke with the nurse who had documented they were not available and was told they did not have snacks in the unit. The nurse indicated she just found something to give the residents. A facility skills competency checklist, titled Medication Administration, dated as last revised 7/2023 and received from the Executive Director on 1/28/25 at 3:40 p.m., indicated .administration will be documented on the MAR .TAR (Medication and Treatment Administration Record) after given The checklist did not address documentation of accurate information on the MAR/TAR. 3.1-50(a)(2)