STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Terrace	1924 Wellesley Blvd Indianapolis, IN 46219

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident had his face washed and shaved for 1 of 3 residents reviewed for activities of daily living (ADL) care. (Resident K) Findings include: The clinical record for Resident K was reviewed on 9/2/25 at 10:55 a.m. The diagnoses included, but were not limited to, dementia and acute osteomyelitis. A care plan, last reviewed/revised on 8/21/25 and obtained from the electronic health record on 9/4/25 at 9:19 a.m., indicated Resident K needed assistance with ADL care. The goal was for him to maintain his current functional status. The interventions included, but were not limited to, assisting with bathing as needed, assisting with dressing, grooming and hygiene as needed, and encouraging him to do as much for himself as possible. A care plan, last reviewed/revised on 8/21/25 and obtained from the electronic health record on 9/4/25 at 9:19 a.m., indicated Resident has a DX [Diagnosis] of Vascular Dementia. Resident has impaired daily decision-making skills and poor insight into care. Resident will refuse medications or allow staff to get him out of bed at times. Resident will not allow staff to turn or reposition. Per the family resident has always been very cautious of taking medications and believed that taking vitamins was the way to maintain good health. Resident will also refuse showers at times. resident is continuously putting on his call light stating that his TV is messed up despite staff turning TV back to preferred channel each time. Resident will not have any negative side effects due to medication refusals. On 9/2/25 at 10:55 a.m., Resident K was observed lying in bed. He had a heavy growth of beard on his face with dry flakey skin in his beard. On 9/3/25 at 10:01 a.m., Resident K was observed lying in his bed. He was unshaved and had dry, flakey skin in his beard and food on his face. During an interview on 9/4/25 at 11:28 a.m., Certified Nurse Aide (CNA) 16 indicated she sometimes provided care for Resident K. He required extensive assistance with ADL care. He would sometimes refuse care, but she had not known him to refuse to wash his face or shave. He would refuse to use deodorant. Residents were usually shaved on their shower days. On 9/4/25 at 3:00 p.m., Resident K was observed lying in bed. He was unshaved and had dry skin and food stuck in his beard and on the corners of his mouth. He indicated he used to get shaved. During an interview on 9/4/25 at 3:06 p.m., Registered Nurse 18 indicated Resident K's shower days were on Wednesday and Saturday on evening shift. On 9/5/25 at 11:20 a.m., Resident K was observed sitting in his wheelchair wearing a black t-shirt. He was unshaved and had dry skin in his beard. There were dried skin flakes present by the collar of his shirt, under his chin. The corners of his mouth were red. During an interview on 9/5/25 at 11:26 a.m., Licensed Practical Nurse (LPN) 14 indicated there was dried skin in Resident K's beard and probably flakes of potato chips that he liked to eat. Resident K was picky about things. He had previously lived off the grid. During an observation on 9/5/25 at 2:24 p.m., the Director of Nursing Services (DNS) obtained a warm washcloth and gently washed Resident K's face. This citation relates to Intake 1576791.3.1-38(a)(3)(A)3.1-38(a)(3)(D)

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely develop and implement an individualized plan of care for a resident with dementia who displayed a new behavior of making physical contact with peers for 2 of 3 residents reviewed for abuse (Resident B and Resident C). Findings include: 1a. The clinical record for Resident C was reviewed on 9/2/25 at 11:37 a.m. The diagnoses included, but were not limited to, dementia, anxiety, and insomnia. He was admitted to the facility on [DATE]. 1b. The clinical record for Resident B was reviewed on 9/3/25 at 8:55 a.m. The diagnoses included, but were not limited to, dementia with psychotic disturbances and psychotic disorder with delusions. The resident was admitted to the facility on [DATE]. Resident C had room changes on the following dates: 5/27/25, 7/1/25, 7/16/25, 7/24/25, and 7/25/25.A Social Service Progress Note, dated 7/24/25 at 12:11 p.m., indicated Resident C's daughter gave approval for him to move rooms. A Social Service Progress Note, dated 7/25/25 at 2:57 p.m., indicated Resident C was moved to room [ROOM NUMBER] due to him not being compatible with his peer. A New/Worsening/High Risk Behavior Event, dated 7/28/25 at 3:15 p.m., indicated Resident C was in the dining area. Another resident was banging a toy on the table. Resident C grabbed the other resident by the wrists to get the toy out of their hands. The residents were separated, and Resident C was able to go to his room, away from stimulation. The intervention put into place to prevent another behavior was for Resident C to have his medications evaluated. An Interdisciplinary Team (IDT) note, dated 7/29/25 at 9:46 a.m., indicated Resident C was in the dining area when another resident grabbed an item and banged the item on the table. In an effort to stop the other resident from banging, Resident C made contact with the other resident's wrist. Both residents were immediately separated and placed in their rooms in a less stimulating environment. The assessment of potential correlation to the root cause was overstimulation in the common area. Resident C was to have labs completed and to be seen by the physician and the psychiatric provider. Resident C has had multiple room moves due to incompatible roommate. The root cause of behavioral expression was Resident C has diagnoses of dementia, cognitive impairment, and insomnia. Resident C was still adjusting to community, peers and new environment. Resident C may have been experiencing overstimulation in the dining room. Resident space invaded and peer banging on table. The preventative intervention relating to above root cause was Resident C being redirected to room to decrease overstimulation. Resident C will undergo a medication review and labs. He was added to the physician and psychiatric provider list. Resident C will have increased supervision when the other resident was present. A New/ Worsening/ High Risk Behavior Event, dated 7/29/25 at 6:46 p.m., indicated Resident C was in the dining area when another resident entered Resident C's personal space. The environment was quiet and calm. The event occurred in the common area. Resident C asked the other resident to get out of his personal space. The other resident did not respond and got closer. Resident C then grabbed the other resident in an attempt to move the other resident out of his way. The two residents were separated. The physician and family of Resident C were notified. The intervention put into place to prevent another behavior was for Resident C to be evaluated by the Psychiatric Nurse Practitioner. The clinical record did not contain a care plan addressing Resident C's new behavior of grabbing another resident. A Quarterly Minimum Data Set (MDS) assessment, completed 7/31/25, indicated he was severely cognitively impaired. He had displayed physical behaviors, such as hitting, kicking, pushing, or grabbing others, one to three days during the seven day look back period. He was able to independently perform a sit to stand transfer and independently able to walk 150 feet in the corridor. A Psychiatric Provider Progress Note, dated 7/31/25 at 7:07 a.m., indicated the visit was a New Patient Visit. Nursing staff reported ongoing anxiety and aggression since admission, including incidents of grabbing peers. Resident C has required six room changes due to behavioral disruptions and was currently awaiting a room move into a private room. Staff report no signs of depression, sleep disturbances, appetite changes, or hallucinations. Resident C will be started on lorazepam (anti-anxiety medication) 0.5 milligrams (mg) twice daily to target anxiety and reduce agitation. The clinical record did not contain a care plan addressing Resident C receiving lorazepam. The clinical record did not contain a care plan addressing anxiety and agitation. On 7/31/25, Resident C was moved to a different room without a roommate. A Physician's Progress Note, dated 8/1/25 at 9:35 a.m., indicated the reason for the visit was for medication review, increased agitation, and anxiety. The facility requested Resident C to be seen for medicine review. Resident C had labs received 7/30/25. He was noted with increased agitation and

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the facility was free of odor, clean and in good repair with linens and walls for 4 of 4 residents reviewed for physical environment. (Residents' D, F, G, and H) Findings include: A. During the initial tour of the facility on 9/2/25 at 9:55 a.m., the main entry smelled strongly of urine. Upon entering the Meridian Hills Unit, the floor in the hallway was sticky, especially around rooms [ROOM NUMBERS]. The floor between the entrance door and the nurse's station had an approximate six-inch black spot. There was a wet floor sign in the dining room beside the spot. During an observation on 9/2/25 at 2:28 p.m., the floor on the Meridian Hills Unit, between the entrance door and the nurse's station, had an approximate six-inch black spot. During a Confidential Interview 20, they indicated the Meridian Unit does have a urine odor. B. Upon entering the Mapleton Unit on 9/2/25 at 9:57 a.m., a strong urine odor was noted. An observation was conducted of the Mapleton Unit on 9/2/25 at 10:59 a.m. The unit smelled strong of urine odor. Upon entering the Mapleton Unit on 9/4/25 at 2:26 p.m., a strong urine odor was noted. C. An observation was conducted of Resident G's room on 9/5/25 at 1:11 p.m. The door frame to the bathroom was observed with chips and scratches. The bed linen had a small hole in the top right corner. During a Confidential Interview 21, they indicated the Meridian Unit recently had a urine odor when you walk in the unit. The floors were dirty, linens were worn with holes, the rooms are not kept tidy with throwing of used gloves, dirty briefs and clothing on the floor. An environmental tour was conducted, on 9/8/25 at 11:00 a.m., with the Maintenance Supervisor (MS) and the Administrator. An observation was made of Resident G's room. The bathroom door frame was observed with chips and scratches on it. A used glove was lying on the floor below the bathroom sink. During that time, the resident's linen on his bed was observed. A small hole was in the linen on the top right corner. The MS reported the top of the door frame was chipped by the door closing and the bottom half was from wheelchairs hitting it. The dirty glove on the floor at that time was removed and discarded. Next, Resident D's room was observed. The chair rail along the wall had scrapes and chips and missing a piece of the chair rail by the bed. After, Resident H's room was observed. The walls were observed with two scrapes and paint missing. An interview was conducted with the Administrator and the MS on 9/8/25 at 11:15 a.m. The Administrator indicated she had been working with the housekeeping department to replace the older linen. She recently had the floors cleaned. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the MS on 9/8/25 at 11:59 a.m. He indicated the repairs were completed in the resident's room on an as needed basis. The residents' families and the staff fill out work orders that were located at the nurse's station if they observe rooms that need to be repaired. The facility does not have a policy for homelike environment. This citation relates to Intake 1576791. 3.1-19(f)(5)