| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. Building<br>B. Wing | 06/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harrison Terrace | 1924 Wellesley Blvd<br>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) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by Resident F hitting Resident G in the eye for 2 of 5 residents reviewed for abuse. (Resident F and Resident G). The deficient practice was correct on 5/7/26 prior to the start of the survey, and therefore past noncompliance. Findings include: 1. The clinical record for Resident F was reviewed on 6/03/26 at 9:30 a.m. The diagnosis included but was not limited to: dementia (decline in mental ability) and delusional disorder (beliefs that are not reality).A quarterly Minimum Data Set (MDS) Assessment, dated 4/30/26, indicated Resident F was cognitively impaired. The resident had no upper or lower extremity impairments. She independently ambulated with walker. 2. The clinical record for Resident G was reviewed on 6/03/26 at 10:00 a.m. The diagnosis included but was not limited to: dementia (decline in mental ability).An admission MDS Assessment, dated 2/12/26, indicated Resident G was cognitively impaired.A nursing note for Resident F, dated 5/6/26 at 12:00 p.m., indicated Registered Nurse (RN) 5 was at the medication cart putting away medications when Resident F approached the medication cart and asked RN 5 what did she do with her clothing. During that time, Resident F had scratched RN 5 on the side of her neck. RN 5 responded to resident that her clothing was in her room or in the laundry. Resident F returned to her room.A behavioral event for Resident F, dated 5/6/26 indicated the resident was exhibiting physical aggressive behavior toward RN 5. The resident accused RN 5 of taking her clothes, and scratched RN 5 on the side of her neck. The interventions that were provided at the time of incident were redirection and reported to resident her clothes were in her room.A nursing note for Resident F, dated 5/6/26 at 1:26 p.m., indicated Resident F was in the dining room eating her lunch meal. She approached Resident G accusing her of stealing her dress. During the altercation, Resident F punched Resident G in her left eye. A behavioral event for Resident F, dated 5/6/26, indicated Resident F had a behavior of physical assault. Resident F had approached Resident G accusing her of stealing her clothing. Resident F punched Resident G with closed fist in her left eye. Resident F was placed on 1:1 [one on one] staff supervision.A reportable incident to the Indiana Department of Health, dated 5/6/26, indicated Resident F had made physical contact with Resident G. The follow up: Resident G was moved to another unit.The investigation for the reportable incident between Resident F and Resident G was provided by the Director of Nursing on 6/3/26 at 9:00 a.m. The investigation included but was not limited to the following:A written statement by Certified Nursing Assistant (CNA) 2, dated 5/7/26 indicated, I was passing out chips to the resident's in the dining room. I started to hear yelling and heard ?I'll hit you dead in your mouth!' So I turned around and saw [Resident F] in [Resident G]'s face standing over [Resident G]. So as I was about to get in between Resident F quickly hit [Resident G] twice in her face. It happened so fast. I then got in between and broke it up. I told [Resident F] to go into her room and I got [Resident G] a cold rag and ice for her eye and then checked on [Resident F] in her room.An interview was conducted with Social Services Director on 6/3/26 at 10:46 a.m., indicated Resident F and Resident G had been roommates a few months ago. Resident F at times would get confused about the clothing in the closet. She had false belief the clothing was all hers. It was hard for her to recognize the barrier in between the closet to separate<br>(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 |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | her clothing from Resident G's clothing. Resident F had requested to be moved to another room to be closer to the dining room.An observation was made of Resident F sitting in the dining room on 6/3/26 at 10:52 a.m. The resident was speaking with another resident. Resident F stood up and ambulated independently with her walker and left the dining room. An observation was made of Resident G on 6/3/26 at 11:42 a.m. The resident was observed in her room sitting in her wheelchair. During that time, Resident G indicated A girl hit me with her hand in my eye. I had her blouse on and didn't know it.An interview was conducted with CNA 2 on 6/3/26 at 11:50 a.m. She indicated she was passing ice chips to the residents in the dining room. She heard arguing between Resident F and Resident G. Resident F was upset and stated Resident G had taken her dress. CNA 2 went to intervene and Resident F hit Resident G in her face. The incident happened fast.An interview was conducted with the Director of Nursing on 6/3/26 at 11:56 a.m. She indicated after the incident on 5/6/26 between Resident F and Resident G. Resident G was moved to a new unit and an action plan was put in place. An abuse policy was provided by the Director of Nursing on 6/3/26 at 12:09 p.m. It indicated, .Policy: It is the policy of American Senior Communities to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and involuntary seclusion.American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, home office staff, other residents, consultants, volunteers, staff, or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals.Definitions/Examples of Abuse: Willful, used in the definition of abuse, means the individual must have acted deliberately, not that the individual intended to inflict injury or harm. Physical Abuse - A willful act against a resident by another resident, staff member, or other individual (s). Examples may include but not be limited to hitting, slapping, punching, and choking.This deficient practice was corrected on 5/7/26 after the facility implemented a systemic plan that included the following actions: assessment of all residents with abusive behaviors; care plans audited, reviewed and updated, all staff in-serviced on abuse and how to respond to abusive behaviors, observation rounds of dining rooms during meals to be completed daily on alternating shifts to monitor for adequate staff supervision, Quality Assurance and Performance Improvement (QAPI) behavior management tool will be completed weekly times 4 weeks and monthly for 6 months to ensure system compliance.This citation is related to Intake 3020842.410 IAC (Indiana Administrative Code) 3.1-27(a)(1) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observation, interview, and record review, the facility failed to ensure the implementation of a care in pairs intervention that were put in place for behavior management for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: The clinical record for Resident B was reviewed on 6/2/26 at 1:30 p.m. The diagnoses included, but were not limited to, dementia (decline in mental ability) and psychotic and mood disturbance (emotional disturbances combined with detachment of reality).An admission Minimum Data Set (MDS) Assessment, dated 4/16/26, indicated Resident B was cognitively impaired. A behavior care plan, dated 4/13/26, indicated Resident B would become aggressive with staff, hitting them, yell and/or curse, become combative with redirection and may make threatening statements towards his peers.and staff. At times will turn on his call light, when staff arrive to help, he responds with insults, inappropriate, foul language, and delusional thinking. Resident would state that he owns the facility and that people are using his name to purchase things. Resident will also yell out and believe that he is a part of a conversation when he hears others engaging with each other. The interventions included but were not limited to: care in pairs (more than one staff member was to provide care to Resident B).A behavior care plan for Resident B, dated 4/21/26, indicated the resident will request for kisses by female staff members. The following interventions included, but were not limited to, care in pairs (more than one staff member was to provide care to Resident B).An observation was made of Resident B sitting in his wheelchair in the hallway by a supply room at 6/2/26 at 2:33 p.m. Certified Nursing Assistant (CNA) 1 was observed leaving the supply room with a trash bag and pushed Resident B to his room. She then closed the resident's door. CNA 1 was the only staff member observed in the resident's room.An interview was conducted with CNA 1 on 6/2/26 at 2:40 p.m. She indicated she had taken Resident B to his room, so he could use the restroom. She did not ask for assistance from another staff member. She was suppose to provide care in pairs, but Resident B was always good with her. She had not experienced any of his behaviors that at times he exhibits.The care plan policy was provided by the Director of Nursing (DON) on 6/3/26 at 8:29 a.m. It indicated .Policy: It is the policy of this facility that each resident would have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental and psychosocial well-being. This citation is related to Intake 3020842 410 IAC (Indiana Administrative Code) 3.1-35(b)(1) |