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	09/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure a resident was treated with respect and dignity for 1 of 3 residents reviewed for resident rights. (Resident B)Findings include:A facility reported incident, dated 9/22/25, indicated a staff member had a concern regarding a female resident who was treated roughly by a QMA (Qualified Medication Aide) during care on 9/15/25 at 8:01 p.m. The clinical record for Resident B was reviewed on 9/23/25 at 1:45 p.m. The diagnoses included, but were not limited to, dementia with other behavioral disturbances, Alzheimer's disease, generalized anxiety disorder, pain, difficulty in walking, and cognitive communication deficit.A care plan, dated 10/19/23, indicated Resident B refused medications and ancillary services. The interventions included, but were not limited to, offer other staff as needed, provide Resident B with safety and redirect the resident as needed.A care plan, dated 10/19/23, indicated Resident B had a hearing loss. The interventions included, but were not limited to, facing the resident when speaking, obtain the resident's attention before speaking, speak clearly, and adjust tone as needed. A facility document, titled Employee Communication Form, dated 9/19/25, indicated QMA 1 was terminated from the facility for a violation of resident rights related to disregarding resident safety.During an interview, on 9/22/25 at 4:03 p.m., LPN 6 indicated QMA 1 had taken Resident B to the shower room and gave her a shower on 9/15/25. QMA 1 brought the resident back to her room with the resident sitting on the seat of her rollator walker and pushing the resident from the shower room to her bed. LPN 6 heard QMA 1 talk loudly at Resident B to get up, get up, get up. When LPN 6 arrived at the doorway of Resident B's room, she observed QMA 1 attempting to put the resident to bed. LPN 6 felt QMA 1 was being rough with Resident B. LPN 6 told QMA 1 there was a better way to assist the resident to bed, to step out of the room, and she would finish placing Resident B in the bed.During an interview, on 9/22/25 at 7:29 p.m., QMA 1 indicated she had taken Resident B to the shower room and pushed her back to her room with the resident sitting on the seat part of her rollator walker. QMA 1 asked Resident B to stand up, so she could place her in bed, but the resident refused. QMA 1 lifted her up with both her arms under the resident's armpits and placed her on the bed. LPN 6 was standing in the doorway watching her place the resident to bed and told QMA 1 she had been rough with the resident, to step out of the room, and LPN 6 finished placing Resident B in the bed. During an interview, on 9/23/25 at 11:30 a.m., the Clinical Support nurse indicated QMA 1 was terminated because she did not understand Resident B should not have been placed in bed when she did not get up off her walker. The facility did not find QMA 1 abusive to the resident, but she did violate her resident rights. A current facility policy, titled Resident [NAME] of Rights, dated 12/17 and provided by the Director of Nursing on 9/22/25 at 1:50 p.m., indicated .The resident has the right to be treated with consideration, respect and recognition of their dignity and individuality .The resident will have the right to the following.Refuse any treatment or service, including medication This citation relates to Intake 2621869.3.1-3(t)

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 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. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure Activity of Daily Living (ADL) care was provided in a safe and comfortable manner for 2 of 3 residents reviewed for ADL care. (Resident B and C)Findings include:A facility reported incident, dated 9/22/25, indicated a staff member had a concern regarding a resident who was treated roughly by a QMA (Qualified Medication Aide).1. The clinical record for Resident B was reviewed on 9/23/25 at 1:45 p.m. The diagnoses included, but were not limited to, dementia with other behavioral disturbances, Alzheimer's disease, generalized anxiety disorder, pain, difficulty in walking, and cognitive communication deficit.A care plan, dated 11/8/22, indicated Resident B required assistance with ADLs including bed mobility and transfers. The interventions included, but were not limited to, assist with bed mobility, transfers, and locomotion/ambulation as needed.A facility document, titled Employee Communication Form, dated 9/19/25, indicated QMA 1 was terminated from the facility for a violation of resident rights related to disregarding resident safety.During an interview, on 9/22/25 at 4:03 p.m. , LPN 6 indicated QMA 1 had taken Resident B to the shower room and gave her a shower on 9/15/25. QMA 1 brought the resident back to her room with the resident sitting on the seat of her rollator walker and pushing the resident from the shower room to her bed. LPN 6 heard QMA 1 talk loudly at Resident B to get up, get up, get up. When LPN 6 arrived at the doorway of Resident B's room, she observed QMA 1 attempting to put the resident to bed. LPN 6 felt QMA 1 was being rough with Resident B. LPN 6 told QMA 1 there was a better way to assist the resident to bed, to step out of the room, and she would finish placing Resident B in the bed.During an interview, on 9/22/25 at 7:29 p.m., QMA 1 indicated she had taken Resident B to the shower room and pushed her back to her room with the resident sitting on the seat part of her rollator walker. QMA 1 asked Resident B to stand up, so she could place her in bed, but the resident refused. QMA 1 lifted her up with both her arms under the resident's armpits and placed her on the bed. LPN 6 was standing in the doorway watching her place the resident to bed and told QMA 1 she had been rough with the resident, to step out of the room, and LPN 6 finished placing Resident B in the bed. QMA 1 indicated she did not use a gait belt to transfer the resident onto the bed. During an interview, on 9/23/25 at 11:30 a.m., the Clinical Support nurse indicated QMA 1 did not use a gait belt to transfer the resident from the walker to the bed, and she did not follow the facility policy and procedure.2. The clinical record for Resident C was reviewed on 9/23/25 at 2:15 p.m. The diagnoses included, but were not limited to, Parkinson's disease, vascular dementia, osteoporosis with current pathological fracture, and pathological fracture of the right ankle.A care plan, dated 11/19/20, indicated Resident C had impaired mobility related to the diagnosis of Parkinson's disease and required assistance with ADLs. The interventions included, but were not limited to, assist with incontinence care and observe for signs of pain.A care plan, dated 7/12/23, indicated Resident C was at risk of pain. The interventions included, but were not limited to, leg brace with open knee per order and observe for nonverbal signs of pain: changes in breathing, vocalizations, crying, teeth clenched, changes in posture and sad/worried face.During an interview, on 9/22/25 at 1:50 p.m., the Executive Director indicated QMA 7 was suspended pending investigation related to Resident C's care and had returned to work. Since Resident C fractured her ankle, she required two people to assist with bed mobility and transfers. During an interview, on 9/22/25 at 2:09 p.m., CNA 4 indicated she heard Resident C crying while QMA 7 was providing care. Resident C was being held over toward the wall with QMA 7's hand against her back while she provided incontinence care. Resident C had previously rolled out of bed and broke her ankle and had been more difficult to care for. Resident C needed two caregivers when turning her in the bed because she yelled and cried out in pain whenever she was touched. CNA 4 stopped QMA 7 and immediately told the nurse. During an interview, on 9/22/25 at 4:30 p.m., QMA 7 indicated she was trying to change Resident C's brief. Resident C yelled out while QMA 7 was changing her. She stopped providing care and was going to go tell the nurse Resident C was in pain when CNA 4 walked into the room and told her to stop the care. CNA 4 went and reported her to the nurse, and she was suspended. She was able to come back to work. A current facility policy, titled Ambulation with walker, dated 2/2010 and provided by the Director of Nursing on 9/23/25 at 2:29 p.m., indicated Place the gait belt around the resident's waist. 8. Place walker in front of resident as close to the bed as possible. 9. Have the resident grasp both arms of the walker. 10. Brace the leg of the walker with your foot and place your hand on top of the walker. 11. Assist the resident to stand on count of three.Walk slightly behind and to the affected side of the resident holding onto the gait belt.Remove the gait belt.A current facility policy, titled Resident [NAME] of Rights, dated 12/17 and provided by the Director of