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	05/21/2026

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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect a residents' right to refuse some types of non-requested transfers within the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a relocation planning conference meeting was held with the resident's responsible party and the Executive Director prior to moving the resident onto a locked memory care unit and prior to moving the resident out of the locked memory care unit and back to the skilled unit for 1 of 1 resident reviewed for transfers. (Resident H)Findings include:During an interview, on 5/19/26 at 1:05 p.m., Resident H's resident representative indicated due to his profession, he was unable to visit Resident H often but the last time he went to the facility to visit, all Resident H's belongings were gone, and Resident H was not in his room. He asked a staff member where Resident H was and was told the dementia unit. Resident H's son explained he had not been to the dementia unit before and did not know where the unit was, so he asked the staff member how to get there. To get to the dementia unit, he had to go through two sets of locked doors. When he entered the men's dementia unit and found Resident H's room, there was a stop sign across the door frame. He was concerned because he thought Resident H's health had worsened since he had been moved to a dementia unit and a stop sign was blocking the entrance to his room. Resident H had been residing in the same room on the skilled unit since he was admitted to the facility. He had not been informed by the facility as to why Resident H was moved to the dementia unit.Resident H's son was also unaware Resident H had since been moved back to his previous room on the skilled unit until speaking with the surveyor.The clinical record for Resident H was reviewed on 5/19/26 at 9:50 a.m. The diagnoses included, but were not limited to, severe dementia with behavior disturbances, anxiety disorder, and psychotic disorder with delusions.Resident H was admitted to the facility on [DATE].The facility census history for Resident H indicated, on 4/22/26, an intra-facility transfer occurred in which the resident was moved to the locked memory care unit. On 4/28/26, a second intra-facility transfer occurred in which the resident was moved out of the locked memory care unit and back to the skilled unit. Resident H had previously remained in the same room since 2020.A care plan, initiated 5/19/23 and dated as last reviewed 5/17/26, indicated Resident H's son lived nearby, but he was not available to visit or receive resident's calls as much as the resident would like. Interventions included, but were not limited to, the resident was able to call his son after 6:00 p.m., or afterwards. There were no new interventions dated after 5/19/23.A physician's order, initiated on 4/21/26 and discontinued on 4/30/26, indicated Resident H could reside on a secure unit.An Intra-Facility Transfer Notice of Room Change document, dated 4/21/26 at 2:08 p.m., and completed by the Social Service Director, indicated Resident H was being moved from the skilled unit to the memory care unit. The transfer took place on 4/21/26. The reason for the transfer was to transition to the Cottage (men's memory care unit). The option to waive the right for 48-hour notice, the right for a relocation planning conference, the right to receive the notice in writing, and the acknowledgement the legal representative/responsible party had received notice were all check marked.The contact number for the legal representative and the date of notification were not marked. A progress note, dated 4/21/26 at 12:56 p.m., indicated the Executive Director (ED) notified Resident H's responsible party of the room move to the all-male dementia unit and the responsible party was agreeable to the move.The progress note documented by the ED did not include any information regarding why the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	move was occurring, whether the option to tour the unit was given, whether Resident H's responsible party was offered or refused the right to waive 48-hour notice, a relocation planning conference, or to receive the notice in writing.An Intra-Facility Transfer Notice of Room Change document, dated 4/28/26 at 1:41 p.m., and completed by the Social Service Director, indicated Resident H was being moved from the memory care unit to the skilled unit. The transfer took place on 4/28/26. The option to waive the right for 48-hour notice, the right for a relocation planning conference, and the right to receive the notice in writing were all check marked. The acknowledgement of legal representative or responsible party was marked N/A.Documentation of a progress note related to the notification to Resident H's responsible party for the room change was not located in the electronic health record.During an interview, on 5/20/26 at 1:16 p.m., the ED indicated she contacted Resident H's son by telephone for the first room change and left a voice message regarding the second room change. Resident H was moved to the locked memory care unit because the facility had noticed an increase in self-isolation by staying in his room and he was not participating in activities he normally would. Prior to an intra-facility transfer, the family would be notified why the room change was occurring, and a planning conference would be held with the resident and/or responsible party.During an interview, on 5/20/26 at 9:21 a.m., the Social Service Director indicated when room changes are considered, the resident and/or responsible party should be informed prior to and agree to the room change. After consent was obtained, the resident would be moved, and social services would follow up with the resident for several days to ensure the resident was transitioning well. Resident H had a low cognition and would be unable to consent or agree to a room change. Resident H's son was the resident's responsible party. The Social Service Director did not know the reason for Resident H's room change.During an interview, on 5/20/26 at 12:06 p.m., the Social Service Director indicated this morning, she and the Minimum Data Set (MDS) nurse conducted Resident H's quarterly care plan meeting via telephone. Resident H's son had asked about his father's dementia diagnosis and wanted to know why he was moved to the memory care unit. The process for non-emergent intra-facility transfers was to notify and explain the reason for the move to the responsible party, answer any questions, tour the unit and room with the responsible party, obtain consent prior to the transfer, observe the resident on the new unit, and document the process in the resident's record.During an interview, on 5/20/26 at 12:40 p.m., the Minimum Data Set (MDS) nurse indicated when the room change for Resident H was considered, the facility looked for roommate compatibility and area compatibility. Resident H's room change was not an emergent need.During an interview, on 5/20/26 at 2:03 p.m., Resident H's son indicated he attended a care plan meeting with the Social Service Director and the MDS nurse earlier today. He had asked about his father's diagnosis of dementia and room change. He was told by the MDS nurse the room change was due to a decrease in his activity and the facility wanted him to come out of his room more often, so the facility moved him to a different room. Again, he indicated he had not been contacted or informed about a room change prior to the visit to the facility in April when he found his father and belongings were not in the room on the skilled unit and the facility documents should not indicate he had been notified.During an interview, on 5/21/26 at 12:50 p.m., the ED indicated Resident H's son was difficult to contact and did not visit very often. She had called him and left a voicemail about the room change. She did not have documentation for the message.A current facility policy, titled Resident Rights,' dated as last revised 10/2023 and received from the Clinical Support Nurse on 5/21/26 at 9:40 a.m., indicated .The facility must protect and promote the rights of each resident.Receive written notice.before the resident's room.in the facility is changed.Refuse to transfer to another room in the facility; if the purpose of the transfer is solely for the convenience of staff.The resident and/or resident representative has the right to be notified of the following.a change in room.A current facility policy, titled Intra Facility Transfers/Roommate Notification Policy, dated as last revised 11/2017 and received from the Clinical Support Nurse on 5/21/26 at 9:40 a.m., indicated .Intra-facility transfers will be initiated if only one or more of the following exists.The move is necessary for medical reasons.the move is necessary for the welfare of (continued on next page)

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents or other residents.Notice will be given to the resident who is moving at least 48 hours prior to the move.An intra-facility transfer form will be completed prior to the room change. Information included in form are the following.Reason for the transfer.Name, address and telephone number of the local and state long term care ombudsman.Notification of the transfer will be made to the resident and/or representative and recorded on the intra facility form. The legal representative may be notified by phone prior to the transfer which shall be recorded on the intra facility transfer form. The resident/representative will receive the notice in writing unless they waive their right to do so.This citation relates to Intake 3002127.410 IAC (Indiana Administrative Code) 3.1-12(a)(18)410 IAC (Indiana Administrative Code) 3.1-12(a)(19)410 IAC (Indiana Administrative Code) 3.1-12(a)(20)410 IAC (Indiana Administrative Code) 3.1-12(a)(21)410 IAC (Indiana Administrative Code) 3.1-12(a)(22)410 IAC (Indiana Administrative Code) 3.1-12(a)(23)410 IAC (Indiana Administrative Code) 3.1-12(a)(24)

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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 - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with a diagnosis of dementia was provided effective person-centered dementia care and was not relocated to locked memory care unit without a documented reason which resulted in a resident-to-resident altercation for 2 of 2 residents reviewed for dementia care. (Resident H and G) This deficient practice resulted in an altercation between Resident H and G. Resident G received an intertrochanteric femur fracture (a broken hip around the upper thigh bone) which required surgical intervention.Findings include:An anonymous email, dated 5/3/25 at 4:52 p.m., indicated a resident-to-resident altercation occurred in which Resident G was pushed down by Resident H. Resident G complained of pain and required surgery. Facility management were not taking reports seriously, were hiding and sweeping concerns under the rug and were lying to families.A facility reported incident (FRI), dated 4/27/26 at 5:30 p.m., indicated Resident G walked by Resident H's room when the two residents made contact. Resident G fell to the floor. Resident G was sent to the emergency room for further evaluation due to right sided hip and leg pain. Resident G returned to the facility with a diagnosis of intertrochanteric femur fracture. After the facility investigation of the incident was completed, the fall was not witnessed. The root cause was determined to be Resident H was showing difficulty transitioning to a new environment (locked memory care unit). The report indicated both residents' families were aware of the incident.A facility document, dated 4/27/26, indicated the facility had failed to supervise a resident from intrusively wandering (Resident G), which had resulted in an injury after a resident-to-resident altercation.1. The clinical record for Resident H was reviewed on 5/19/26 at 9:50 a.m. The diagnoses included, but were not limited to, severe dementia with behavior disturbances, anxiety disorder, and psychotic disorder with delusions.Resident H was admitted to the facility on [DATE].The facility census history for Resident H indicated, on 4/22/26, an intra-facility transfer occurred in which the resident was moved to the locked memory care unit. On 4/28/26, a second intra-facility transfer occurred in which the resident was moved out of the locked memory care unit and back to the skilled unit. Resident H had previously remained in the same room since 2020.A care plan, initiated on 10/1/20 and dated as last reviewed 5/17/26, indicated Resident H had episodes of verbal and physical aggression towards staff and peers. Resident H was very particular about sticking to his own routine. Interventions included, but were not limited to, staff should approach Resident H in a calm manner, staff should not attempt to encourage the resident to make choices that he specified he did not want, such as food items, activity, or a change in his routine, and to allow Resident H to sit alone per the resident's preference. These interventions had been in place since May of 2023.A care plan, initiated on 10/26/20 and dated as last reviewed 5/17/26, indicated Resident H had experienced episodes of increased agitation due to not wanting to change his clothing or a change in his routine. Interventions included, but were not limited to, allow the resident to express his feelings and concerns and to approach the resident later. There were no new interventions dated after 10/26/20.A care plan, initiated 7/16/24 and dated as last reviewed 5/17/26, indicated Resident H could become aggressive when his trash was not emptied and his room was not cleaned a certain way. Interventions included, but were not limited to, empty resident's trash as needed and to encourage the resident to let staff know if his trash was full and needed emptied. There were no new interventions dated after 7/16/24.A care plan, initiated 7/17/24 and dated as last reviewed 5/17/26, indicated Resident H had episodes of agitation with staff during care, and at times could be very aggressive. Interventions included, but were not limited to, alternate staff as needed and to provide personal space as needed. There were no new interventions dated after 7/17/24.An annual Brief Interview for Mental Status (BIMS) assessment, dated 3/29/26, indicated Resident H had severely impaired cognition.A psychiatric progress note, dated 4/14/26, indicated per staff report, Resident H had remained at baseline. Staff had not reported (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	any new or worsening behaviors.Resident H's activity participation log, from 4/1/26 to 4/21/26, indicated Resident H had attended twenty-two (22) out of twenty-five (25) activities.A physician's order, initiated on 4/21/26 and discontinued on 4/30/26, indicated Resident H could reside on a secure unit.A physician's order, initiated on 4/22/26 and discontinued on 5/5/26, indicated Resident H could have a stop sign placed on his door.A behavior event document, dated 4/27/26 at 4:30 p.m., indicated Resident H was involved in a resident-to-resident altercation in which Resident H had pushed a wandering resident to keep the resident from entering his room. The psychosocial change/stressor identified for the behavior was Resident H's new admission to the memory care unit. The intervention was to move Resident H back to his previous unit (skilled unit).A psychiatric progress note, dated 4/28/26, indicated according to the staff report, Resident H had recently moved to the memory care unit. Staff had reported Resident H appeared to enjoy the unit at first but had begun to have issues with a resident who intrusively wandered (Resident G), which led to a resident-to-resident altercation.An Interdisciplinary Team (IDT) progress note, dated 4/29/26 at 10:44 a.m., indicated Resident H was standing at the doorway of his room when Resident G walked by and attempted to enter the room. Resident H pushed Resident G away in attempt to redirect Resident G from his room. The root cause was Resident H had a diagnosis of dementia and Resident G was invading Resident H's space.A monthly behavioral health report, dated 5/10/26, indicated in the month of April, the only documented new or worsening behavior for Resident H was a peer-to-peer interaction. The completion of IDT reviews for the event was marked N/A, completion of care plan updates with effective interventions was marked N/A, staff education of interventions was marked N/A.During an interview, on 5/19/26 at 12:42 p.m., RN (Registered Nurse) 2 indicated since returning from the memory care unit, Resident H had been demonstrating increased aggression with the staff. RN 2 was not aware of the reason why the resident had been moved to the memory care unit. He had not been experiencing any new or worsening behaviors prior to the room change. However, within a few days after his room change, he had an altercation with another resident.During an interview, on 5/20/26 at 9:21 a.m., the Social Service Director (SSD) indicated Resident H liked things a certain way; his own space, to be in his room, did not like when people would enter his room and did not do well with change. Resident H's room change was discussed in the IDT (interdisciplinary team) morning meeting. Resident H's facility care companion had disagreed with a room change due to the resident being particular about his own space and not doing well with changes in his routine. Despite the disapproval, he was moved to the memory care unit the next day. The Social Service Director did not know the reason for Resident H's room change.During an interview, on 5/20/26 at 9:46 a.m., the Activity Director indicated she was not sure why the facility had moved Resident H's room. The housekeeping supervisor was Resident H's facility care companion. She had disagreed with moving the resident to the memory care unit. The resident liked his own personal space and being alone in his room.During an interview, on 5/20/26 at 9:50 a.m., the Housekeeping Supervisor indicated she was present in the meeting and had voiced to the interdisciplinary team Resident H liked his own private space.During an interview, on 5/20/26 at 12:40 p.m., the Minimum Data Set nurse indicated the facility, as a team, thought the resident would benefit from the Cottage (men's memory care unit) experience and would get him out of his room since Resident H had shown an increase in isolation.During an interview, on 5/20/26 at 2:03 p.m., Resident H's son indicated the Minimum Data Set nurse told him today, the room change was due to a decrease in Resident H's activity. The facility wanted him to come out of his room more often, so the facility moved him to a different room. Resident H's representative indicated he was not aware Resident H was involved in any resident-to-resident altercation.2. The clinical record for Resident G was reviewed on 5/19/26 at 10:25 a.m. The diagnoses included, but were not limited to, displaced intertrochanteric fracture of the right femur, dementia, and Alzheimer's disease.A care plan, initiated 4/4/23 and dated as last reviewed 5/17/26, indicated Resident G was at risk of falls. Resident G would jog in the hallways or walk at a fast pace and had no spatial awareness, would approach others and get into their personal (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	spaces. The care plan for falls did not include an approach for safety monitoring or supervision prior to the incident with Resident H.A care plan, initiated on 5/11/23 and dated as last reviewed 5/17/26, indicated Resident G demonstrated mood distress and behavioral symptoms as evidenced by frequent pacing in the hallways, inability to remain seated, and restlessness, likely related to his underlying cognitive/psychiatric condition and his impaired ability to self-regulate. The goal was Resident G would demonstrate reduced restlessness and pacing, with improved ability to engage in structured or supervised activities and maintain safety with staff support and redirection. Interventions included, but were not limited to, educating staff on resident specific behaviors and appropriate responses, encouraging Resident G to become involved with physical activities and social interactions, and work with Resident G to identify effective coping mechanisms. These interventions had been in place since 2025 and prior to the incident with Resident H.A care plan, initiated on 7/1/25 and dated as last reviewed 5/17/26, indicated Resident G demonstrated behavioral disturbances which placed him at risk for falls, injury, and environmental hazards. Interventions included, but were not limited to, offer structured activities or purposeful tasks (folding towels, organizing safe items, walking with staff, a fidget apron) to meet the need for movement and provide reassurance of safety and wellbeing. These interventions had been in place since 2025 and prior to the incident with Resident H.A care plan, initiated 9/9/25 and dated as last reviewed 5/17/26, indicated at times, Resident G would intrusively wander related to advanced cognitive impairment, resulting in the inability to recognize personal space. The resident had poor spatial awareness. The goal indicated Resident G would be maintained in a safe environment with reduced incidents of intrusive wandering, collisions, or altercations related to poor spatial awareness and intrusive wandering. Interventions included, but were not limited to, increasing supervision, offer/assisting Resident G to sit down in a dining chair, and address any immediate needs such as hunger, thirst, pain, boredom, loneliness, tiredness. These interventions had been in place since 2025 and prior to the incident with Resident H.An elopement risk assessment, dated 3/4/26, indicated Resident G was able to move freely throughout the unit, was often observed wandering aimlessly and without purpose, and intrusively wandered.An annual BIMS assessment, dated 3/29/26, indicated Resident G had severely impaired cognition.A behavior event, dated 4/27/26 at 4:30 p.m., indicated Resident G attempted to enter Resident H's room without invite. Staff had observed Resident G attempting to enter the other resident's room. The other resident who was standing at his door at that time attempted to prevent Resident G from entering his room. During the interaction, the wandering resident and the other resident lost their balance resulting in both falling to the floor.A physician communication tool, dated 4/27/26, indicated Resident G was complaining of right hip pain with movement.A progress note, dated 4/27/26 at 5:45 p.m., indicated Resident G was complaining of right hip/leg pain after a fall. The resident was grimacing and guarding the affected side upon assessment and was unable to bear weight. Emergency services were called and Resident G was transported to the hospital for further evaluation.A hospital document, dated 4/27/26, indicated Resident G was sent to the emergency room following a fall in his memory care unit, was complaining of right hip pain, and was unable to ambulate (walk). After further evaluation, Resident G was found to have a right intertrochanteric femur fracture. Resident G was taken to surgery for the fracture repair.An IDT progress note, dated 4/29/26, indicated Resident G attempted to enter Resident H's room without invite. The root cause identified was Resident G had a diagnosis of dementia and a history of intrusive wandering.During an interview, on 5/19/26 at 11:09 a.m., Resident G's wife and daughter were in the memory care unit sitting at a dining table with Resident G who was sitting in a Broda chair. The daughter indicated prior to the fracture, her dad was always on the move and wandering around the unit. The wife indicated, on 4/27/26, the facility had called to inform her Resident G had fallen and was being transported to the hospital after complaining of right hip/leg pain. The facility had not mentioned the fall was due to a resident-to-resident altercation and they (the wife and daughter) had still not been made aware of the details related to the fall. They had requested, from the facility, Resident G's records.During an interview, on 5/20/26 at 1:32 p.m., the (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Clinical Support Nurse indicated Resident G's fall was not witnessed. She acknowledged all the documentation had stated the event was witnessed and was a result of a resident-to-resident altercation but indicated after the facility investigation, it had been determined Resident G's fall was not witnessed.During an interview, on 5/21/26 at 12:50 p.m., the Executive Director (ED) indicated during the facility investigation of the incident, the fall was found to have been unwitnessed and indicated Resident G and Resident H were not provided with the appropriate supervision/monitoring to prevent the incident.During an interview, on 5/21/26 at 11:45 a.m., the Clinical Support Nurse indicated the facility did not have a policy regarding resident-to-resident altercations.A current facility policy, titled Resident Rights, dated as last revised 10/2023 and received from the Clinical Support Nurse on 5/21/26 at 9:40 a.m., indicated .The facility must protect and promote the rights of each resident.Receive services in the facility with reasonable accommodation of resident needs.The resident has a right to care in an environment that promotes maintenance or enhancement of each resident's quality of life. The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.This citation relates to Intake 3002127.410 IAC (Indiana Administrative Code) 3.1-37(a)