STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155381	A. BUILDING 00 B. WING	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOUR MANOR HEALTH & LIVING COMMUNITY	1667 SHERIDAN RD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00392401, IN00391287 and IN00392875. Complaint IN00392401 - Unsubstantiated due to lack of evidence. Complaint IN00391287 - Unsubstantiated due to lack of evidence. Complaint IN00392875 - Substantiated. Federal/State deficiencies related to the allegations are cited at F606. Survey dates: October 21, 25, and 26, 2022 Facility number: 000551 Provider number: 155381 AIM number: 100267400 Census Bed Type: SNF/NF: 111 SNF: 12 Total: 123 Census Payor Type: Medicare: 12 Medicaid: 86 Other: 25 Total: 123 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 27, 2022	F 0000	**Submission of this plan of correction in no way constitutes an admission by Harbour Manor Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law.** **This plan of correction is also Harbour Manor Health & Living Community's credible allegation of compliance.We allege substantial compliance on November 18th, 2022.We are respectfully request paper compliance for this survey.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacob Atkinson	Executive Director	11/16/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0606 SS=D Bldg. 00	483.12(a)(3)(4) Not Employ/Engage Staff w/ Adverse Actions §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. Based on record review and interview the facility failed to ensure a criminal background check was completed for 1 of 5 employee records sampled. (Registered Nurse (RN) 2) Finding includes: Employee records were reviewed on 10/25/22 at 10:16 a.m. Records for RN 2 lacked a criminal background check. During an interview, on 10/25/22 at 1:39 p.m., the	F 0606	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Background check for agency RN completed on 10/25/22 **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	11/18/2022

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	administrator indicated they had a "My Case" background check for RN 2 but did not have a criminal background check from the contracted agency. He indicated the agency had hired the nurse in 2009, and this was considered sufficient at that time. He indicated the agency was responsible for the background checks since it was a contracted employee. He provided a background check performed on 10/25/22 for RN 2. A current facility policy, titled "Associate Screening Policy" with a revision date of 3/1/22, provided by the Assistant Director of Nursing on 10/26/22 at 12:50 p.m., indicated "...background checks are completed on all associates, where required by law...A criminal background check, including any Sex Offender or Violent Offender Registries, will be completed prior to any employment or engagement under an interim or professional services contract and upon reasonable suspicion during employment to confirm that no individual has been convicted of an offense that would preclude them from providing care or services to residents...Temporary employment agencies will be required by contract to ensure that temporary staff have undergone all of the employee screening described in this policy and the staff is not precluded from employment..." This Federal tag relates to complaint IN00392875. 3.1-28(b)(1)		**action(s) will be taken.** All residents have the potential to be affected by the deficient practice. Audit of Hoosier staffing will be completed by 11/18/22 **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Human Resources will be educated on the associate screening policy. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** HR or designee will audit 5 agency staff to make sure background checks have been completed. Audits will occur weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee	

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