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	10/30/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00420307. This visit included a State Residential Licensure Survey. Complaint IN00420307 - No deficiencies related to the allegations are cited. Survey dates: October 23, 24, 25, 26, 27 and October 30, 2023. Facility number: 000551 Provider number: 155381 AIM number: 100267400 Census Bed Type: SNF/NF: 105 SNF: 9 Residential: 49 Total: 163 Census Payor Type: Medicare: 9 Medicaid: 85 Other: 20 Total: 114 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 1, 2023.	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 November9th 2023.** **We are respectfully requesting paper compliance for this survey.**	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and			

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

Jacob Atkinson | Executive Director | 11/07/2023

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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	bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to ensure a resident was scheduled with urology (a specialist), as ordered by the primary care provider, for 1 of 3 residents reviewed for urinary tract infections/catheter care. (Resident 98) Findings include:	F 0690	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident 98 has since discharged from the facility.	11/10/2023

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	During an observation and interview on 10/25/23 at 10:43 a.m., Resident 98's catheter tubing and bag were observed to contain large amounts of sediment and amber colored urine. The resident indicated the appearance of the urine in the tubing was typical of what he would see at any given time. During an observation and interview on 10/26/23 at 11:14 a.m., the urinary catheter tubing continued to have sediment present. The resident indicated there was always "junk" in the tubing. Resident 98's clinical record was reviewed on 10/26/23 at 9:32 a.m. His diagnoses included neurogenic bladder. Current physician orders, dated 10/4/23, indicated urinary catheter care to be provided twice a day, once upon rising and again at night, and the urinary catheter and drainage bag should be changed as needed for occlusion or dislodgement. The order included any change of the bag, catheter, or tubing, should be documented in the resident's progress notes. A progress note, dated 6/8/23, indicated he had difficulty urinating. A bladder scan revealed a large amount of urine, an in-and-out catheterization was performed, and 800 mL (milliliters) of urine was drained. At that time, a urinary catheter was anchored and he was to be closely monitored over the next several days for urine output. A Nurse Practitioner progress note, dated 6/9/23, indicated the urinary catheter should be continued and, if necessary, he should be referred to urology.		**how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Residents with orders for urology specialists have the potential to be affected by this alleged deficient practice and have been audited to ensure urology appointments are scheduled per the MD order. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Licensed nurses will be educated to schedule urology appointments per MD orders. **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** DON or designee will audit 5 residents with catheters ensure MD urology appointments are scheduled. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee	

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	A Nurse Practitioner progress note, dated 6/12/23, indicated a referral to urology. A Nurse Practitioner progress note, dated 6/15/23, indicated he was started on ciprofloxacin (an antibiotic) for a urinary tract infection. The clinical record lacked indication the referral to urology was completed. A progress note, dated 7/26/23, indicated blood was found in his urine. A progress note, dated 8/9/23, indicated results from the urinalysis was brown, cloudy urine with sediment. It was positive for leukocytes (white blood cells indicative of infection) and protein. A progress note, dated 8/10/23, indicated the resident was experiencing increased confusion. A progress note, dated 8/14/23, indicated the urinary catheter remained and trimethoprim-sulfamethoxazole (an antibiotic) was ordered for seven days. A physician progress note, dated 8/14/23, indicated an appointment should be set-up with urology to assess whether or not the catheter could be removed. The clinical record lacked indication the referral to urology was completed. A physician's progress note, dated 10/23/23, indicated the urinary catheter was still in place. A physician's progress note, dated 10/25/23, indicated an appointment with urology should		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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	set-up for evaluation and assessment to determine if the catheter could be removed. The clinical record lacked indication the referral to urology was completed. During an interview with the Unit Manager on 10/27/23 at 2:15 p.m., she indicated any notes given by the nurse practitioner or physician would be found in the resident's electronic chart. Whenever the physician or nurse practitioner indicated an appointment should be scheduled, she would be the one to put in the order. During an interview with the ADON, on 10/30/23 at 11:56 a.m., she indicated there was no formal procedure or policy for referrals, but the facility's Unit Manager would initiate the process after it was indicated by the physician or nurse practitioner. 3.1-41(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to			

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	meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure narcotics were reconciled per facility policy for 2 of 4 medication carts reviewed for medication storage. (East 1 cart and East 2 cart) Findings include: 1. During a medication storage observation of the East 1 cart, accompanied by LPN 3 on 10/30/23 at 9:30 a.m., the "Nurse Narcotic Sign In/Out Sheet" record was reviewed and the following dates lacked shift to shift reconciliation of controlled medications: In October 2023- 10/3, 10/4, and 10/5 on night shift, 10/6 on all three shifts, 10/7 and 10/8 on day and evening shifts, 10/9 on all three shifts,	F 0755	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Narcotic count sheets to be signed off on moving forward. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. Narcotic count sheets will be signed off an each shift to ensure count is correct. **what measures will be put into**	11/10/2023

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	10/10 on day and evening shifts, 10/11 on evening shift, 10/12, 10/13, 10/14, and 10/15 on both day and evening shifts, 10/16 on all three shifts, 10/17 and 10/18 on both day and evening shifts, 10/19 on all three shifts, 10/20 and 10/21 on both day and evening shifts, 10/22 on all three shifts, 10/23 and 10/24 on both day and evening shifts, 10/27 on both day and evening shifts, and 10/29 on both day and evening shifts. In November 2023- 11/19 and 11/20 on both day and evening shifts, 11/21 on all three shifts, 11/22 on both day and evening shifts, 11/23 and 11/24 on both night and day shifts, 11/25 on all three shifts, 11/26, 11/27, 11/28, and 11/29 on both day and evening shifts, and 11/30 on both night and day shifts. 2. During a medication cart observation with QMA 4, on 10/30/23 at 9:45 a.m., of the East 2 cart, the "Nurse Narcotic Sign In/Out Sheet" record, was reviewed and the following dates lacked shift to shift reconciliation of controlled medications: In September 2023- 9/18 on both night and evening shifts, 9/20, 9/21, and 9/22 on night shift, 9/23 on all three shifts, 9/24 on night shift, 9/25 on day shift, 9/28 on both day and evening shifts, 9/29 on night shift, and 9/30 on all three shifts.		**place and what systemic changes will be made to ensure that the deficient practice does not recur.** LPN/RN will be educated on the importance of counts sheets. Audits will be completed to ensure the deficient practice does not recur. **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** DON or designee will audit East cart to ensure count sheets are done each shift . Audits will occur daily x 30 days, 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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	In October 2023- 10/1 on both night and day shifts, 10/2 on both day and evening shifts, 10/3, 10/4, 10/5, 10/6, and 10/7 on all three shifts, 10/8 on both day and evening shifts, 10/9 on night shift, 10/10 on evening shift, 10/11, 10/12, and 10/13 on day and evening shifts, 10/14 through 10/23 on all shifts, 10/24 and 10/25 on night shift, 10/26 on both day and evening shifts, and 10/27 through 10/30 on all three shifts. During an interview on 10/30/23 at 10:00 a.m., the Infection Preventionist indicated East cart 1 contained medications for 24 residents and East cart 2 contained medications for 23 residents. During an interview on 10/30/23 at 10:06 a.m., the ADON indicated the expectation for staff was every shift completed a count of narcotics at the beginning and end of their shift. Both employees signed the narcotics book to verify the count was correct and the responsibility of the medication cart had been transferred. An undated, current facility policy titled "Controlled Substance Reconciliation," provided by the DON on 10/30/23 at 11:12 a.m., indicated the following: "...1. Each facility should verify the quantity of controlled substance(s) on hand as well as the number of accompanying "count sheets" at the end of each nursing shift....4. Quality assurance checks of the centralized log sheet are the responsibility of the nursing department, but may also be done periodically by the consulting pharmacist(s)...."			

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	3.1-25(b)(3)			
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of			

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	care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of			

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	the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:			

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	(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping			

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	requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. Based on interview and record review, the facility failed to ensure timely communication was maintained between the facility and the hospice provider for 1 of 2 residents reviewed for hospice services. (Resident 31) Findings include: Resident 31's clinical record was reviewed on 10/26/23 at 2:05 p.m. Diagnoses included chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, and vascular dementia. The resident was admitted to hospice services on 7/20/23 with a diagnoses of COPD. A current care plan, initiated 7/20/23, indicated the resident received hospice services. Interventions included coordinate plan of care with hospice to promote comfort with care. During a review of the hospice communication binder on 10/26/23 at 2:38 p.m. with LPN 5, the record lacked a completed plan of care document, CNA visit notes, social worker visit notes, and chaplain visit notes. The binder lacked a visiting schedule for staff to expect services to be provided and the hospice interdisciplinary (IDT) notes section was blank. The nursing notes	F 0849	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident 31 hospice binder has been updated with plan of care, CNA visit notes, social worker visit notes, and chaplain visit notes. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Residents with hospice services have the potential to be affected by the alleged deficient practice and have been audited to ensure documentation is up to date. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**	11/10/2023

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	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	section contained minimal handwritten information for the following dates: 7/19/23, 8/8/23, 8/11/23, 8/18/23, 8/22/23, 8/24/23, 8/29/23, 9/6/23, 9/20/23. LPN 5 indicated the hospice nurse spoke to staff following her visits. LPN 5 was unsure the last time a nurse or CNA had visited the resident. During an interview on 10/30/23 at 11:29 a.m., the ADON indicated the hospice binder was not updated or current. The plan of care schedule for the provider was not included in the binder. There was no plan of care information, CNA, social services, or chaplain visit notes, and complete nursing notes. The IDT notes section was blank. She had reached out to the provider on 9/18/23, 9/28/23, and 10/11/23, regarding the lack of visit documentation, but had not received a response. A review of a current facility policy, updated July 2020 and titled, "Nursing Facility and Hospice Services Agreement," and provided by the DON on 10/30/23 at 11:15 a.m., indicated the following: "...3.1 Coordination of Responsibilities....Hospice and Facility shall develop a process by which to exchange information between Hospice IDG and Facility staff regarding development and updating of the Coordinated POC and evaluation of care outcomes to insure each Hospice Patient receives necessary and appropriate care and services...."		Social services associates will be educated on importance of hospice documentation. Hospice binders will be audited to ensure timely communication and documentation in binder. **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** SS or designee will audit 5 hospice resident binders 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	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00420307. Complaint IN00420307 - No deficiencies related to	R 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**	

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	the allegations are cited. Survey dates: October 23, 24, 25, 26, 27 & 30, 2023. Facility number: 000551 Residential Census: 49 Harbour Manor Health and Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed November 1, 2023.		**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 November9th 2023.** **We are respectfully requesting paper compliance for this survey.**	