STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155381	A. BUILDING -- B. WING	12/02/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/02/24 Facility Number: 000551 Provider Number: 155381 AIM Number: 100267400 At this Emergency Preparedness survey, Harbour Manor Health & Living Community was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 129 certified beds. At the time of the survey, the census was 121. Quality Review completed on 12/04/24	E 0000	December 16th 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: **DR8Z21** Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on December 2nd, 2024. This letter is to inform you that the plan of correction attached is to serve as Harbour Manor Health & Living Community credible allegation of compliance. We allege substantial compliance on December 16th, 2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-770-3434 Sincerely, Jacob Atkinson, HFA	

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

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			Executive Director Harbour Manor Health and Living 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 statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42	E 0041	**E041** **I. The corrective actions to be accomplished for those residents found to have been**	12/16/2024

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	CFR 483.73(e)(2). Findings include: Based on review of "Test Generator" documentation with the Maintenance Director during record review from 10:45 a.m. to 1:25 p.m. on 12/02/24, documentation of weekly emergency generator inspections for 12 weeks of the past 52 weeks was not available for review. Throughout the 52 weeks, there were three weeks missing in February 2024, two weeks missing in October, March and January 2024; one week each missing in September, August and May 2024. Based on interview at the time of record review, the Maintenance Director stated he had been on the job since May 2024 and stated that no additional documentation of weekly emergency generator inspections for the aforementioned time frames was available for review. This finding was reviewed with the Maintenance Director at the exit conference.		**affected by the deficient practice.** Facility failed to implement the emergency power system inspection, testing and maintenance requirement. Full audit of emergency power system completed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor and staff have been provided education on the emergency power system inspection, testing, and maintenance requirements from the life safety code. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director or designee	

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			will audit weekly checks for the emergency power system. 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 **V. Plan of Correction completion date.** Plan of Completion date is December 16, 2024.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/02/24 Facility Number: 000551 Provider Number: 155381 AIM Number: 100267400 At this Life Safety Code survey, Harbour Manor Health & Living Community was found not in compliance with Requirements for Participation in	K 0000	December 16th 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: **DR8Z21**	

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, hard wired smoke detectors in all resident rooms in the building. The facility has a capacity of 129 and had a census of 121 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/04/24		Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on December 2nd, 2024. This letter is to inform you that the plan of correction attached is to serve as Harbour Manor Health & Living Community credible allegation of compliance. We allege substantial compliance on December 16th, 2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-770-3434 Sincerely, Jacob Atkinson, HFA Executive Director Harbour Manor Health and Living 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	

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			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 statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 1 exit paths did not have conflicting exit signs. This deficient practice could affect 30 residents, staff and visitors that need to use the north 100 hall exit. Findings include: Based on observation with the Maintenance Director on 12/02/24 at 2:19 p.m., before the barrier doors going into the corridor by resident room 111, an "EXIT" sign pointed to the left and to the right. There was no exit door to the right or left of the sign, just resident rooms. This condition could cause confusion during an emergency evacuation. Based on an interview at the time of observation, the Maintenance Director agreed the sign was pointing two directions which led into resident rooms and not exits. This finding was reviewed with the Maintenance Director during the exit conference.	K 0293	**K923- Exit Signage** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Arrows changed on exit sign to point into correct locations. (Picture Attached) **II. The facility will identify other residents that may potentially be affected by the deficient practice.** This deficient practice could affect 30 residents, staff and visitors that need to use the north 100 hall exit.	12/16/2024

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	3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor and staff have been provided education on the exit signage in the facility. Audit exit signs weekly for correct signage. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director or designee will audit weekly the emergency signs to display correct exits. 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 **V. Plan of Correction completion date.** Plan of Completion date is December 16, 2024.	

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K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and interview; the facility failed to document sprinkler system inspections fully in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 3 of the past 52 weeks for the sprinkler system's pressure gauges. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 12/02/24 between 10:45 a.m. and 1:25 p.m. with the Maintenance Director, the facility's dry sprinkler system gauges were not documented as being inspected weekly for three weeks of December 2023. Based on interview at the time of record review, the Maintenance Director stated he has been on the job since May of 2024, had gathered all the documentation he could locate and that there were no other weekly	K 0353	**K353- Sprinkler System** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility's dry sprinkler system gauges were not documented as being inspected weekly for three weeks of December 2023. Audit completed for all dry sprinkler system gauges. (Attached) **II. The facility will identify other residents that may potentially be affected by the deficient practice.** The deficient practice could affect all staff and residents. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor and staff have been provided education on the importance of weekly gauge audits as stated by the NFPA.	12/16/2024

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	gauge inspections available for review for the missing three weeks in December 2023. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director or designee will audit weekly the sprinkler gauge documentation. 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 **V. Plan of Correction completion date.** Plan of Completion date is December 16, 2024.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure electrical wiring was protected in 1 of 10 smoke compartments. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals,	K 0511	**K511- Utilities and Gas** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	12/16/2024

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	Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect staff while in the kitchen. Findings include: Based on observations on 12/02/24 at 1:52 p.m. during a tour of the facility with the Maintenance Director, there was a coverplate missing from an electrical junction box on the ceiling in the kitchen that had exposed wires. Based on interview at the time of observation, the Maintenance Director confirmed the exposed wires in the kitchen and said he would fix it as soon as possible. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		Electrical wiring was covered by a cover plate. (Pictures Attached) **II. The facility will identify other residents that may potentially be affected by the deficient practice.** The deficient practice could affect all staff and residents. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The cover plate was added to the junction box to cover the exposed wires. Maintenance Supervisor and staff have been provided education on the exposed wires. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director or designee will audit weekly the kitchen ceiling, so no wires are exposed with proper cover plate. 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	

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			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 **V. Plan of Correction completion date.** Plan of Completion date is December 16, 2024.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the facility's fire drills with the Maintenance Director on 12/02/24 at 10:33 a.m., there was a third shift fire drill for the fourth quarter (October, November, December) of 2023 provided that was dated 01/28/24 at 2:00 a.m. with '12' handwrote next to the typed date. Based on interview at the time of record review, the Maintenance Director stated he has been on the job since May 2024, had gathered all the fire drill documentation he could locate and that there are not any additional fire drills available for review at the time of this survey to show a third shift drill had been conducted in the fourth quarter of 2023.	K 0712	**K712- Fire Drills** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility failed to conduct quarterly fire drills for 1 of 4 quarters. Previous fire drills audited for proper documentations. (Attached) **II. The facility will identify other residents that may potentially be affected by the deficient practice.** The deficient practice could affect all staff and residents.	12/16/2024

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	This finding was reviewed with the Maintenance Director at the exit conference. 2. Based on record review and interview, the facility failed to provide complete fire drill documentation for 1 of 12 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 12/02/24 at 11:32 a.m. with the Maintenance Director present, the documented fire drill report performed on 01/08/24 at 8:00 a.m. (first shift of the first quarter) did not include a sign in sheet of the participating staff. Based on interview at the time of record review, the Maintenance Director confirmed the lack of a staff sign in sheets for the previously mentioned fire drill report. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Maintenance Supervisor and staff have been provided education on the fire drill procedure with documentation. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director or designee will audit monthly to ensure fire drills are completed with proper documentation. Audits will occur 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 **V. Plan of Correction completion date.** Plan of Completion date is December 16, 2024.	

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K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 2 of over 50 rooms was maintained in accordance with Section 19.7.5.6. Section 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic	K 0753	**K753- Combustible Decorations** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Combustible Items removed from room 216 and 32. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** The deficient practice could affect all staff and residents. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor and staff have been provided education on fire resistant decorations as stated by the NFPA. **IV The facility will monitor the corrective action by implementing the following measures.**	12/16/2024

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HARBOUR MANOR HEALTH & LIVING COMMUNITY	1667 SHERIDAN RD NOBLESVILLE, IN 46060

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	sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect over 50 residents, staff and visitors in two smoke compartments. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:25 p.m. to 2:55 p.m. on 12/02/24, the corridor door to resident room 216 and resident room 32 each were covered over 90 percent with holiday decorations. Based on interview at the time of the observations, the Maintenance Director stated the fire resistance rating of the decorations was not available for review, the decorations were not treated with fire retardant material as far as he knew and agreed the surface of each door was covered more than 90 percent. This finding was reviewed with the Maintenance Director the exit conference. 3.1-19(b)		Maintenance Director or designee will audit 10 resident doors weekly. 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 **V. Plan of Correction completion date.** Plan of Completion date is December 16, 2024.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for all 52 weeks from October 2023 through October 2024. This deficient practice	K 0918	**K918- Electrical Systems and Essential Electric Systems.** **I. The corrective actions to be accomplished for those**	12/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155381	A. BUILDING 01 B. WING	12/02/2024

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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	could affect all residents, staff and visitors. Findings include: Based on review of "Test Generator" documentation with the Maintenance Director during record review from 10:45 a.m. to 1:25 p.m. on 12/02/24, documentation of weekly emergency generator inspections for 12 weeks of the past 52 weeks was not available for review. Throughout the 52 weeks, there were three weeks missing in February 2024, two weeks missing in October, March and January 2024; one week each missing in September, August and May 2024. Based on interview at the time of record review, the Maintenance Director stated he had been on the job since May 2024 stated that no additional documentation of weekly emergency generator inspections for the aforementioned time frames was available for review. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice.** Facility failed to implement the emergency power system inspection, testing and maintenance requirement. Full audit of emergency power system completed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor and staff have been provided education on the emergency power system inspection, testing, and maintenance requirements from the life safety code. **IV The facility will monitor the corrective action by implementing the following measures.**	

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			Maintenance Director or designee will audit weekly checks for the emergency power system. 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 **V. Plan of Correction completion date.** Plan of Completion date is December 16, 2024.	