STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155381		A. BU	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  12/02/2024			ETED	
	PROVIDER OR SUPPLIE	R TH & LIVING COMMUNITY		1667 SI	ADDRESS, CITY, STATE, ZIP COD HERIDAN RD SVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000	conducted by the Ir accordance with 42 Survey Date: 12/0 Facility Number: 100 At this Emergency Manor Health & L substantial complia Preparedness Required Medicaid Participator CFR 483.73. The facility has 12 the survey, the cen	2/24  200551 155381 2267400  Preparedness survey, Harbour iving Community was found in ance with Emergency irements for Medicare and ting Providers and Suppliers, 42  9 certified beds. At the time of	E 00	000	Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliar Event ID: DR8Z21 Dear Mrs. Buroker: Please find enclosed the Plan Correction for the State Licens Survey conducted on December 2nd, 2024. This letter is to infect you that the plan of correction attached is to serve as Harboth Manor Health & Living Communication of the State Licens We allege substantial complian We allege substantial complian We allege substantial complian In December 16th, 2024. We requesting paper compliance of this plan of correction.  If you have any further question please do not hesitate to contain me at 317-770-3434  Sincerely,  Jacob Atkinson, HFA	of sure per corm ur unity nce. nce are for	

 $LABORATORY\ DIRECTOR'S\ OR\ PROVIDER/SUPPLIER\ REPRESENTATIVE'S\ SIGNATURE$ 

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: BR8Z21 Facility ID: 000551 If continuation sheet Page 1 of 16

PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155381	A. BUILDING B. WING	onstruction 	COMPLETED 12/02/2024
	ROVIDER OR SUPPLIER IR MANOR HEALTI	H & LIVING COMMUNITY	1667 S	ADDRESS, CITY, STATE, ZIP COD HERIDAN RD ESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Submission of this plan of correction in no way constitute an admission by Harbour Man Health and Living or its management company that the allegations contained in the sureport is a true and accurate portrayal of the provision of nucare or other services provide this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law.  This statement of deficiencies plan of correction will be revie at the Monthly Quality Assurance/Assessment Committee meeting.	es or e urvey ursing d in
E 0041 SS=C Bldg	Hospital CAH and	(e), 485.542(e), 485.62 LTC Emergency Power iew and interview, the facility	E 00/1	E044	12/16/2024
	failed to implement inspection, testing, a found in the Health	the emergency power system and maintenance requirements Care Facilities Code, NFPA  Code in accordance with 42	E 0041	I. The corrective actions to be accomplished for those residents found to have been	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BR8Z21

Facility ID: 000551

If continuation sheet

Page 2 of 16

PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155381	B. WI		<del></del>	COMPLI 12/02/2	
		100001	J	_	A DDDDGG CUTY OT ATE TID COD	12/02/	2021
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD HERIDAN RD		
HARBOU	IR MANOR HEALT	H & LIVING COMMUNITY			SVILLE, IN 46060		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION	
TAG	REGULATORY OR CFR 483.73(e)(2).	R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	CFK 465.75(e)(2).				affected by the deficient practice.		
	Findings include:				practice.		
	5				Facility failed to implement the		
	Based on review of	"Test Generator"			emergency power system		
		the Maintenance Director			inspection, testing and		
	_	w from 10:45 a.m. to 1:25 p.m.			maintenance requirement. Ful		
		nentation of weekly emergency			audit of emergency power sys	tem	
		ns for 12 weeks of the past 52			completed.		
		lable for review. Throughout were three weeks missing in			II. The facility will identify		
		weeks missing in October,			other residents that may		
	-	2024; one week each missing			potentially be affected by the	,	
		ist and May 2024. Based on			deficient practice.		
	interview at the tim	e of record review, the			•		
		tor stated he had been on the			All staff and residents have th	е	
		and stated that no additional			potential to be affected by this		
		veekly emergency generator			deficient practice.		
	was available for re	aforementioned time frames					
	was available for re	eview.			III. The facility will put into		
	This finding was re	viewed with the Maintenance			place the following systemat	ir	
	Director at the exit				changes to ensure that the		
					deficient practice does not		
					recur.		
					The Maintenance Comemics -	nd	
					The Maintenance Supervisor a staff have been provided educ		
					on the emergency power syste		
					inspection, testing, and	,,,,	
					maintenance requirements fro	m l	
					the life safety code.		
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
			1		Maintenance Director or desig	nee	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BR8Z21 Facility ID: 000551

If continuation sheet Page 3 of 16

PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

	ATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155381		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/02/2024
	ROVIDER OR SUPPLIER	H & LIVING COMMUNITY	1667 S	ADDRESS, CITY, STATE, ZIP COD HERIDAN RD ESVILLE, IN 46060	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	will audit weekly checks for the emergency power system. At 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 freviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by Quality Assurance Committee V. Plan of Correction completion date.  Plan of Completion date is December 16, 2024.	udits he e ity ation d t the
K 0000					
Bldg. 01	Licensure Survey w		K 0000	December 16th 2024  Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street	
	Provider Number: AIM Number: 1002	155381		Indianapolis, IN 46204	
	Health & Living Co	Code survey, Harbour Manor mmunity was found not in quirements for Participation in		Re: Allegation of Complian  Event ID: DR8Z21	nce

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BR8Z21

Facility ID: 000551

If continuation sheet

Page 4 of 16

PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155381	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/02/2024
	PROVIDER OR SUPPLIEF	H & LIVING COMMUNITY	1667 S	ADDRESS, CITY, STATE, ZIP COE SHERIDAN RD ESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	TION (X5)  JUD BE COMPLETION  ROPRIATE DATE
	Life Safety from Fi National Fire Prote Life Safety Code (I Health Care Occup  This one-story facil Type V (111) const The facility has a fi detection in the cor corridors, hard wire resident rooms in th capacity of 129 and time of this visit.  All areas where res were sprinklered ar services were sprin			Please find enclosed the Correction for the State L Survey conducted on De 2nd, 2024. This letter is you that the plan of correattached is to serve as H Manor Health & Living Corredible allegation of con We allege substantial con December 16th, 2024 requesting paper compliating plan of correction.  If you have any further queliase do not hesitate to me at 317-770-3434	cicensure cember to inform ection larbour ommunity inpliance. mpliance We are ance for uestions,
	Quanty Review con	npleted on 12/04/24		Sincerely,  Jacob Atkinson, HFA Executive Director Harbour Manor Health an  correction in no way cons an admission by Harbour Health and Living or its management company the allegations contained in teport is a true and accur	of stitutes Manor nat the the survey

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BR8Z21 Facility ID: 000551

If continuation sheet

Page 5 of 16

PRINTED: 12/17/2024 FORM APPROVED

JENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155381	A. BUILDING B. WING	<u>01</u>	COMPLETED 12/02/2024	
HARBOL	Г	H & LIVING COMMUNITY STATEMENT OF DEFICIENCIE	1667 S	ADDRESS, CITY, STATE, ZIP COD HERIDAN RD ESVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K 0293	NEDA 101			portrayal of the provision of nucare or other services provided this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law.  This statement of deficiencies plan of correction will be review at the Monthly Quality Assurance/Assessment Committee meeting.	d in and	
K 0293 SS=E Bldg. 01	failed to ensure 1 or conflicting exit sign affect 30 residents, use the north 100 hr.  Findings include:  Based on observation Director on 12/02/2 doors going into the 111, an "EXIT" signight. There was not the sign, just reside cause confusion durates and the Maintenance Dipointing two directions.	on with the Maintenance 4 at 2:19 p.m., before the barrier c corridor by resident room n pointed to the left and to the exit door to the right or left of nt rooms. This condition could ring an emergency evacuation. ew at the time of observation, rector agreed the sign was ons which led into resident	K 0293	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 af	fect	
	rooms and not exits This finding was re	. viewed with the Maintenance		30 residents, staff and visitors need to use the north 100 hall exit.	that	

FORM CMS-2567(02-99) Previous Versions Obsolete

Director during the exit conference.

Event ID:

BR8Z21

Facility ID: 000551

If continuation sheet

Page 6 of 16

PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155381		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/02/2024
	PROVIDER OR SUPPLIER  JR MANOR HEALTH & LIVING COMMUNITY	1667 S	ADDRESS, CITY, STATE, ZIP COD HERIDAN RD SVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.	ic
			The Maintenance Supervisor a staff have been provided eduction the exit signage in the facil Audit exit signs weekly for corsignage.	cation ity.
			IV The facility will monitor the corrective action by implementing the following measures.	
			Maintenance Director or design 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 Assura Committee meeting. Frequent and duration of reviews will be adjusted as needed if compliating is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee	ne ince cy e nce
			V. Plan of Correction completion date.  Plan of Completion date is December 16, 2024.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BR8Z21

Facility ID: 000551

If continuation sheet

Page 7 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155381		A. BUILDING <u>01</u> COMPLETED			X3) DATE SURVEY COMPLETED 12/02/2024	
	PROVIDER OR SUPPLIER JR MANOR HEALTI	H & LIVING COMMUNITY		1667 SHERIDAN RD NOBLESVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=C Bldg. 01	Based on record revinterview; the facility system inspections in NFPA 25 for 1 of 1 of the past 52 weeks pressure gauges. N Inspection, Testing, Water-Based Fire P Edition, Section 5.2 sprinkler systems shensure that normal abeing maintained. Since department contested, and maintain 13. Section 13.1.1.1 utilized for inspectivalized for inspectivalized, valve compostates records shall tests, and maintenar components and sha authority having jur deficient practice of and visitors in the faction of the facility's dry spread ocumented as being weeks of December the time of record	iew, observation, and ty failed to document sprinkler fully in accordance with dry sprinkler system during 3 is for the sprinkler system's FPA 25, Standard for the and Maintenance of rotection Systems, 2011 i.4.2 states gauges on dry pipe hall be inspected weekly to hir and water pressures are section 5.1.2 states valves and mections shall be inspected, and in accordance with Chapter 2 states Table 13.1.1.2 shall be bon, testing and maintenance of conents and trim. Section 4.3.1 be made for all inspections, and the system and its all be made available to the insidiction upon request. This hall be made available to the insidiction upon request. This hall affect all residents, staff, ancility.  The made for all inspections, and affect all residents, staff, ancility.	K 0	353	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  The facility's dry sprinkler systing gauges were not documented being inspected weekly for thr weeks of December 2023. Aucompleted 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 affected by the deficient practice could affected by the 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 a staff have been provided educe on the importance of weekly gauge audits as stated by the NFPA.	eem as eee dit  ffect  tic  and cation

PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155381	B. WING		12/02/2024	
	Г	H & LIVING COMMUNITY STATEMENT OF DEFICIENCIE	1667 S	ADDRESS, CITY, STATE, ZIP COD SHERIDAN RD ESVILLE, IN 46060	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
TAG		LSC IDENTIFYING INFORMATION	IAG		DATE	
	missing three weeks	vailable for review for the s in December 2023. viewed with the Maintenance exit conference.		IV The facility will monitor the corrective action by implementing the following measures.		
	3.1-19(b)			Maintenance Director or design will audit weekly the sprinkler gauge documentation. Audits occur weekly x 12 weeks, the monthly for 6 months. The resof these reviews will be discus at the monthly facility Quality Assurance Committee meetin Frequency and duration of rewill be adjusted as needed if compliance is below 100%. Ongoing frequency and durati will be determined by the Quant Assurance Committee  V. Plan of Correction completion date.  Plan of Completion date is December 16, 2024.	s will n sults ssed g. views	
K 0511 SS=D Bldg. 01	failed to ensure elector of 10 smoke compa Edition. Article 406 (Cover Plates), required installed so as to	en and interview, the facility etrical wiring was protected in 1 rtments. NFPA 70, 2011 a.6, Receptacle Faceplates tires receptacle faceplates shall completely cover the opening mounting surface. NFPA 70,	K 0511	K511- Utilities and Gas  I. The corrective actions to I accomplished for those residents found to have been affected by the deficient practice.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2011 Edition. Article 406.5 (F) Exposed Terminals,

BR8Z21

Facility ID: 000551

If continuation sheet

Page 9 of 16

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTIO		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155381	B. W	ING		12/02/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			HERIDAN RD		
HARROI	IR MANOR HEALT	H & LIVING COMMUNITY			SVILLE, IN 46060		
				INOBEL	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	DATE	
	•	e enclosed so that live wiring			Electrical wiring was covered	-	
		sposed to contact. This			cover plate. (Pictures Attached	d)	
	-	ould affect staff while in the					
	kitchen.				II. The facility will identify		
	Findings indude.				other residents that may		
	Findings include:				potentially be affected by the	•	
	Raced on observation	ons on 12/02/24 at 1:52 p.m.			deficient practice.		
		facility with the Maintenance			The deficient practice could at	ffect	
	-	a coverplate missing from an			all staff and residents.	IIGGE	
		oox on the ceiling in the kitchen			an stan and residents.		
		ires. Based on interview at the			III. The facility will put into		
	-	, the Maintenance Director			place the following systemat	tic	
		sed wires in the kitchen and			changes to ensure that the		
	-	as soon as possible.			deficient practice does not		
		•			recur.		
	This finding was re	viewed with the Maintenance					
	Director during the	exit conference.					
					The cover plate was added to	the	
	3.1-19(b)				junction box to cover the expo	sed	
					wires.		
					Maintenance Supervisor and		
					have been provided education	n on	
					the exposed wires.		
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
					Maintenance Director or desig	inee	
					will audit weekly the kitchen	JIICC	
					ceiling, so no wires are expos	ed	
					with proper cover plate. Audit		
					occur weekly x 12 weeks, ther		
					monthly for 6 months. The res	l l	
					of these reviews will be discus		
					at the monthly facility Quality		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BR8Z21 Facility ID: 000551

If continuation sheet Page 10 of 16

PRINTED: 12/17/2024

	OF HEALTH AND HUN						RM APPROVED
	MEDICARE & MEDIC		(VO) 1.5	III TINI E CO	ONG THE LOTTON		IB NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155381			<u>01</u>	COMPL	
		155361	B. W			12/02	/2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					HERIDAN RD		
HARBOL	IR MANOR HEALT	H & LIVING COMMUNITY	NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Assurance Committee meetin Frequency and duration of rev will be adjusted as needed if compliance is below 100%. Ongoing frequency and durati will be determined by the Qua Assurance Committee  V. Plan of Correction completion date.  Plan of Completion date is	on	
K 0712 SS=F Bldg. 01	facility failed to cor of 4 quarters. LSC 1 conducted quarterly conditions. This def and residents. Findings include: Based on record rev with the Maintenan 10:33 a.m., there was fourth quarter (Octo 2023 provided that with '12' handwrote	review and interview, the aduct quarterly fire drills for 1 19.7.1.6 requires drills to be a on each shift under varied ficient practice affects all staff riew of the facility's fire drills are Director on 12/02/24 at as a third shift fire drill for the ober, November, December) of was dated 01/28/24 at 2:00 a.m. next to the typed date. Based	K 0	712	K712- Fire Drills  I. The corrective actions to I 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 documenta (Attached)  II. The facility will identify	n	12/16/2024
	on interview at the	cime of record review, the or stated he has been on the			other residents that may potentially be affected by the	9	

FORM CMS-2567(02-99) Previous Versions Obsolete

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.

Event ID:

BR8Z21

Facility ID: 000551

deficient practice.

all staff and residents.

The deficient practice could affect

If continuation sheet

Page 11 of 16

PRINTED: 12/17/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155381	B. WING		12/02/2024
	Г	TH & LIVING COMMUNITY  STATEMENT OF DEFICIENCIE	1667 S	ADDRESS, CITY, STATE, ZIP COD SHERIDAN RD ESVILLE, IN 46060	(X5)
PREFIX				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG		DATE
	Director at the exi  2. Based on record facility failed to put documentation for	eviewed with the Maintenance t conference.  I review and interview, the rovide complete fire drill 1 of 12 fire drills performed month period. This deficient		III. The facility will put into place the following systema changes to ensure that the deficient practice does not recur.  Maintenance Supervisor and	
		ect all residents in the facility.		have been provided education	•
	practice could are	ect all residents in the facility.		•	n on
	Findings include:			the fire drill procedure with	
	Findings include:			documentation.	
	on 12/02/24 at 11: Director present, t performed on 01/0 first quarter) did n	of the facility's fire drill reports 32 a.m. with the Maintenance the documented fire drill report 18/24 at 8:00 a.m. (first shift of the ot include a sign in sheet of the Based on interview at the time		IV The facility will monitor the corrective action by implementing the following measures.	
	confirmed the lack previously mentio This finding was r	the Maintenance Director of a staff sign in sheets for the ned fire drill report.		Maintenance Director or design will audit monthly to ensure fir drills are completed with proper documentation. Audits will ocumentation. The remaining the complete companies of the companies o	re er ccur esults
	Director during the 3.1-19(b) 3.1-51(c)	e exit conference.		of these reviews will be discuss at the monthly facility Quality Assurance Committee meetin Frequency and duration of rewill be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee	ng. views ion
				V. Plan of Correction	
				completion date.	
				Plan of Completion date is December 16, 2024.	

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED		
155381		B. WI	B. WING 12/02/2			2024		
NAME OF PROVIDER OR SUPPLIER HARBOUR MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP COD 1667 SHERIDAN RD NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0753 SS=E Bldg. 01	Based on observation failed to ensure 2 of in accordance with 19.7.5.6 states comprohibited in any he one of the following (1) They are flame-rapproved fire-retard labeled for application applied.  (2) The decorations NFPA 701, Standar Flame Propagation (3) The decorations exceeding 100 kW NFPA 289, Standar Individual Fuel Pacignition source.  (4)*The decorations paintings, and other the walls, ceiling, an accordance with the (a) Decorations on interfere with the oplatching of the door limitations of 19.7.5 (b) Decorations do wall, ceiling, and despace of a smoke corprotected throughous sprinkler system in (c) Decorations do it wall, ceiling, and do	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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 abeled 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		753	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Combustible Items removed froom 216 and 32.  II. The facility will identify other residents that may potentially be affected by the deficient practice.  The deficient practice could affected 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 a staff have been provided eduction fire resistant decorations as stated by the NFPA.	oe  n  form  fect  and cation	12/16/2024	
		proved supervised automatic			measures			

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155381		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  12/02/2024	
	PROVIDER OR SUPPLIEF JR MANOR HEALT	H & LIVING COMMUNITY	1667 S	ADDRESS, CITY, STATE, ZIP COD SHERIDAN RD ESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0918	sprinkler system in (d) Decorations do wall, ceiling, and de sleeping rooms have four persons, in a suprotected throughout automatic sprinkler Section 9.7. This deficient pract residents, staff and compartments.  Findings include:  Based on observation Director during a toto 2:55 p.m. on 12/0 resident room 216 accovered over 90 per Based on interview observations, the Mire resistance rating available for review treated with fire retained the covered more than the covered more than the stage of the covered more than the stage of the stage of the covered more than the stage of the stage of the covered more than the stage of	accordance with Section 9.7. not exceed 50 percent of the por areas inside patient ing a capacity not exceeding moke compartment that is at by an approved, supervised system in accordance with ice could affect over 50 visitors in two smoke  ons with the Maintenance pur of the facility from 1:25 p.m. 102/24, the corridor door to and resident room 32 each were recent with holiday decorations, at the time of the faintenance Director stated the gof the decorations was not ardant material as far as he e surface of each door was 90 percent.		Maintenance Director or desig will audit 10 resident doors weekly. Audits will occur week 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at th monthly facility Quality Assura Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliant 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.	nee cly x e nce ccy nce
SS=C Bldg. 01	Based on record rev failed to ensure a w inspections for the	view and interview, the facility ritten record of weekly emergency generator set was	K 0918	K918- Electrical Systems and Essential Electric Systems.	12/16/2024
	maintained for all 5	2 weeks from October 2023		I. The corrective actions to b	ie e

through October 2024. This deficient practice

accomplished for those

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER				COMPLETED	
155381		B. WI	ING		12/02/	2024	
NAME OF PROVIDER OR SUPPLIER HARBOUR MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 1667 SHERIDAN RD NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)			DATE		
	could affect all residents, staff and visitors.  Findings include:				residents found to have beer	า	
					affected by the deficient practice.		
	Based on review of "Test Generator"				Facility failed to implement the	)	
	documentation with	the Maintenance Director			emergency power system		
	during record review	w from 10:45 a.m. to 1:25 p.m.			inspection, testing and		
	on 12/02/24, docum	nentation of weekly emergency			maintenance requirement. Ful	I	
	generator inspection	ns for 12 weeks of the past 52			audit of emergency power sys	tem	
		lable for review. Throughout			completed.		
		were three weeks missing in					
	1	weeks missing in October,			II. The facility will identify		
	I -	2024; one week each missing			other residents that may		
		ast and May 2024. Based on			potentially be affected by the	)	
	interview at the time of record review, the				deficient practice.		
	Maintenance Director stated he had been on the				l <u>.</u>		
	job since May 2024 stated that no additional				All staff and residents have th		
	documentation of weekly emergency generator				potential to be affected by this	i	
	inspections for the aforementioned time frames				deficient practice.		
	was available for review.						
	This finding was re Director at the exit 3.1-19(b)	viewed with the Maintenance conference.			III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.	iic	
					The Maintenance Supervisor a staff have been provided eduction the emergency power systems inspection, testing, and maintenance requirements from the life safety code.  IV The facility will monitor the corrective action by implementing the following measures.	eation em	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BR8Z21

Facility ID: 000551

If continuation sheet

Page 15 of 16

PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155381	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/02/2024		
NAME OF PROVIDER OR SUPPLIER HARBOUR MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 1667 SHERIDAN RD NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		(X5) COMPLETION DATE	
				Maintenance Director or design will audit weekly checks for the emergency power system. Aud 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 durat of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by Quality Assurance Committee  V. Plan of Correction completion date.  Plan of Completion date is December 16, 2024.	e dits ne e ty tion		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: BR8Z21 Facility ID: 000551 If continuation sheet Page 16 of 16