STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155381		A. BU	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  SOMPLETED  09/01/2022			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 APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
E 0000 Bldg	An Emergency Preconducted by the I accordance with 42.  Survey Date: 09/0  Facility Number: Provider Number: AIM Number: 100  At this Emergency Manor Health & L substantial compliants Preparedness Required Medicaid Participator CFR 483.73.  The facility has 12 the survey, the centered the survey of the survey	eparedness Survey was Indiana Department of Health in 2 CFR 483.73.  101/22  1000551 155381 10267400  Preparedness survey, Harbour iving Community was found in ance with Emergency irements for Medicare and atting Providers and Suppliers, 42  9 certified beds. At the time of	E 00		Submission of this plan of correction in no way constitutes an admission by Harbour Manor Health and Living or its management company that the allegation contained in the survey repis a true and accurate portro of the provision of nursing or other services provided ithis facility. The Plan of Correction is prepared and executed solely because it is required by Federal and Stataw.  This plan of correction is all Harbour Manor Health & Liv Community's credible allegation of compliance.  We allege substantial compliance on September 9 2022.  We are respectfully request paper compliance for this survey.	ort ayal care n is so ving	
E 0029 SS=C Bldg	441.184(c), 482.484.102(c), 485.5485.727(c), 485.5491.12(c), 494.62	54(c), 418.113(c), 15(c), 483.475(c), 483.73(c), 625(c), 485.68(c), 920(c), 486.360(c), 2(c) Communication Plan 6.54(c), §418.113(c),					

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

(X6) DATE

TITLE

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 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPLETED
		155381	B. W	ING		09/01/2022
	PROVIDER OR SUPPLIEF	H & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 1667 SHERIDAN RD NOBLESVILLE, IN 46060			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
TAG	§441.184(c), §460 §483.73(c), §483. §485.68(c), §485. §485.920(c), §486 §494.62(c).  (c) The [facility] m an emergency prepared local laws and must least every 2 years failed to develop an emergency prepared complies with Federaccordance with 42 practice could affect Findings include:  Based on records remarked accordance with 42 practice could affect Findings include:  Based on records remarked accordance with 42 practice could affect Findings include:  Based on records remarked accordance with 42 practice could affect Findings include:  Based on records remarked accordance with 42 practice could affect Findings include:  Based on records remarked accordance with the Director of between 9:30 a.m. and EPP manuals did not names and phone in emergency from the Station contained on numbers which were review process. The stated that the contained on the stated that the contained on the stated that the contained of numbers which were review process. The stated that the contained of numbers which were review process. The stated that the contained of numbers which were review process. The stated that the contained of numbers which were review process. The stated that the contained of numbers which were review process. The stated that the contained of numbers which were review process. The stated that the contained of numbers which were review process. The stated that the contained of numbers which were review process.	0.84(c), §482.15(c), 475(c), §484.102(c), 625(c), §485.727(c), 6.360(c), §491.12(c),  ust develop and maintain eparedness communication is with Federal, State and its be reviewed and updated ears [annually for LTC]  view and interview, the facility and maintain an complete in dness communication plan that earl, State, and local laws in CFR 483.73(c). This deficient is all occupants.  Eview of the facility's endness Manual and interview if Maintenance on 09/01/22 and 12:15 p.m., the two provided in match. The contact list with numbers to contact in an in EPP kept at the Nurses in the end updated during the incomplete inc	E 0		what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  Contact sheet in Emerge Preparedness Binder have be updated  how other residents having to 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 be affected by the deficient practice. Contact sheet update and reviewed (Attachment A).  what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.	n 09/09/2022 n n cthe le coe le la to led
	Director present at	3:00 p.m.				
					Administrator and Maintenanc	e

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155381	A. BU	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  09/01/2022	
	PROVIDER OR SUPPLIE	R TH & LIVING COMMUNITY	•	1667 S	ADDRESS, CITY, STATE, ZIP COD HERIDAN RD ESVILLE, 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)  team educated on contact she		(X5) COMPLETION DATE
					for Emergency Preparedness Manual. (Attachment 2)		
					how the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; and	the	
					Administrator or designee will audit emergency preparednes binder. Audits will occur Wee x 4 weeks, Monthly x 6 month (Attachment 1). The results of these reviews will be discussed the monthly facility Quality. Assurance Committee meeting Frequency and duration of rewill be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quarantee Committee Date of Compliance: Septem 9, 2022.	ess ekly as of ed at ag. views ion ality	
K 0000 Bldg. 01							
Bidg. 01	Licensure Survey		K 0	000	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 reports a true and accurate portra	s ort	

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155381		ILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/01/2022	
	PROVIDER OR SUPPLIER	H & LIVING COMMUNITY		1667 SI	ADDRESS, CITY, STATE, ZIP COD HERIDAN RD SVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION 155381	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  of the provision of nursing c		(X5) COMPLETION DATE
	AIM Number: 1000 At this Life Safety Or Health & Living Compliance with Research Medicare/Medicaid Life Safety from Fire National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code (Life Safety Code) This one story facility one to the facility has a fire detection in the correct corridors, hard wire resident rooms in the capacity of 129 and time of this visit.  All areas where resident services were sprinklered an services were sprinklered an services were sprinklered.	Code survey, Harbour Manor ommunity was found not in equirements for Participation in a 42 CFR Subpart 483.90(a), are and the 2012 edition of the etion Association (NFPA) 101, asC), Chapter 19, Existing ancies and 410 IAC 16.2.  At was determined to be of ruction and fully sprinklered, are alarm system with smoke etidors, spaces open to the d smoke detectors in all the building. The facility has a had a census of 117 at the dents have customary access d all areas providing facility clered except for one detached ance office which were not			or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and Stat Law.  This plan of correction is als Harbour Manor Health & Livi Community's credible allegation of compliance.  We allege substantial compliance on September 96 2022.  We are respectfully request paper compliance for this survey.	n se so ng	
K 0321 SS=E Bldg. 01	barrier having 1-he (with 3/4 hour fire automatic fire exti accordance with 8 approved automat	- Enclosure are protected by a fire our fire resistance rating					

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from other spaces by smoke resisting

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155381	B. WING		09/01/2022	
			<u> </u>	_	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
				SHERIDAN RD		
HARBO	JR MANOR HEALT	H & LIVING COMMUNITY	NOBL	ESVILLE, IN 46060		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	` `	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1110	+	ors in accordance with 8.4.	1.1.0		2.112	
	Doors shall be se					
		_				
	_	and permitted to have				
		applied protective plates that				
		inches from the bottom of				
	the door.					
		and zone locations of				
		that are deficient in				
	REMARKS.					
	19.3.2.1, 19.3.5.9	1				
	Area	Automatic Sprinkler				
	Separation	N/A				
	a. Boiler and Fue	I-Fired Heater Rooms				
	b. Laundries (larg	er than 100 square feet)				
	c. Repair, Mainte	nance, and Paint Shops				
	d. Soiled Linen R	ooms (exceeding 64				
	gallons)					
	e. Trash Collection	n Rooms				
	(exceeding 64 ga	llons)				
	1 '	orage Rooms/Spaces				
	(over 50 square for	-				
		classified as Severe				
	Hazard - see K32					
		on and interview, the facility	K 0321	what corrective action(s) wil	09/09/2022	
		f over 10 hazardous area doors,	10321	be accomplished for those	05/05/2022	
		ms, were provided with		residents found to have been	n	
		elf-closing devices. This		affected by the deficient	'	
		ould affect more than 3 staff		practice.		
	and visitors in the l			practice.		
	and visitors in the i	Business Office.		Boxes located in the		
	Findings include:			business office have been		
	Findings include.					
	Događana facility	torm and intermitary with the		removed.		
		tour and interview with the				
		nance and Executive Director		how other residents having t		
		en 12:15 p.m. and 2:30 p.m., the		potential to be affected by the		
		Room greater than 50 square		same deficient practice will I		
		mber of combustible items,		identified and what correctiv	е	
	such as, paper, plas	stic, and 10-12 large cardboard		action(s) will be taken.		

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boxes containing paper. The corridor door to this

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155381	B. WING		09/01/2022
NAME OF D	PROVIDER OR SUPPLIEI		STREET.	ADDRESS, CITY, STATE, ZIP COD	
			1667 S	HERIDAN RD	
HARBOL	JR MANOR HEALT	H & LIVING COMMUNITY	NOBLE	ESVILLE, IN 46060	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	office did not self-o	close and latch into the door		3 staff and visitors could be	
	frame when tested.			affected by the deficient practi	ce.
				Boxes removed from office	
	1	cknowledged by the Director of		(Attachment B).	
		time of observation and			
		n at the exit conference with		what measures will be put in	to
		intenance and Executive		place and what systemic	
	Director present at	3:00 p.m.		changes will be made to	
				ensure that the deficient	
	3.1-19(b)			practice does not recur.	
				Administrator Maintanana ta	
				Administrator, Maintenance te	am
				and business office manager	
				educated on self-closing doors related to combustible items	
				(Attachment 2) .	
				how the corrective action(s)	
				will be monitored to ensure t	:he
				deficient practice will not	
				recur, i.e., what quality	
				assurance program will be p	ut
				into place; and	
				Administrator or designee will	
				audit 5 hazardous areas. Aud	lits
				will occur Weekly x 4 weeks,	, [
				Monthly x 6 months (Attachme	
				1). The results of these review	
				will be discussed at the month	lly
				facility Quality Assurance	
				Committee meeting. Frequen	·
				and duration of reviews will be	
				adjusted as needed if complia	nce
				is below 100%. Ongoing	
				frequency and duration will be	
				determined by the Quality	
				Assurance Committee	
				Date of Compliance: Septem	ber

9, 2022.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155381		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVE         A. BUILDING       01       COMPLETED         B. WING       09/01/2022			ETED		
	ROVIDER OR SUPPLIER	H & LIVING COMMUNITY		1667 SI	ADDRESS, CITY, STATE, ZIP COD HERIDAN RD SVILLE, 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)	TE	(X5) COMPLETION DATE
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAF coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to maintain the throughout the facil and gases around the sprinkler to operate NFPA 13, 2010 edit distance between the ceiling above shall to of sprinkler and the deficient practice constant.  Findings include:  Based on a facility to Director of Mainten	supply source  RKS information on non-required or partial or system.  and NFPA 25 on and interview, the facility he ceiling construction ity. The ceiling traps hot air e sprinkler and cause the at a specified temperature. Ition, 8.5.4.1.1 states the e sprinkler deflector and the be selected based on the type type of construction. This bould affect 4 residents and 3	K 0:	353	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  Sprinkler Head gap has beclosed.  how other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.  3 staff and 4 residents could be	n peen he e pe e	09/09/2022
	on 09/01/22 betwee	n 12:15 p.m. and 2:30 p.m., in	l		affected by the deficient practi	ce	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155381	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  09/01/2022	
	PROVIDER OR SUPPLIEF	H & LIVING COMMUNITY	1667 S	ADDRESS, CITY, STATE, ZIP COD SHERIDAN RD ESVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF the (1) Medical Roc and (2) Resident Ro dropped approxima tile and created a ga which would allow	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION  Om at the Rehab Nurses Station  oom 111, sprinkler heads had  tely 1-2 inches from the ceiling  ap around the sprinkler head  smoke and or heat to escape.  intenance stated that this part	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  Sprinkler head gap has been closed (Attachment B).  what measures will be put in place and what systemic changes will be made to		
	of the building is of when the air compr pipes causing the sp sag.  This finding was ac Maintenance at the discovery and again	the dry sprinkler system and essor engages it shakes the brinkler heads to sometimes eknowledged by the Director of time of observation and at the exit conference with intenance and Executive		1 ·	ce ead  the  tits  ent  ews hly  ncy e ance	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155381	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D1  B. WING			(X3) DATE SURVEY  COMPLETED  09/01/2022	
	PROVIDER OR SUPPLIEF	H & LIVING COMMUNITY	•	1667 SH	DDRESS, CITY, STATE, ZIP COD HERIDAN RD SVILLE, IN 46060	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE	DATE
K 0363	NFPA 101	KEEC IDENTIFICATION OR MITTER		1710			DATE
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
Diag. 01		corridor openings in other					
		losures of vertical openings,					
	-	is areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
	capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke						
	compartments are only required to resist the						
	passage of smoke. Corridor doors and doors						
		to rooms containing flammable or					
	combustible materials have positive latching						
		-					
		atches are prohibited by					
		These requirements do not					
		spaces that do not contain					
	flammable or com						
		en bottom of door and floor					
	_	ceeding 1 inch. Powered					
		with 7.2.1.9 are permissible					
	1 -	device capable of keeping					
		then a force of 5 lbf is					
		no impediment to the					
	_	rs. Hold open devices that					
		door is pushed or pulled are					
		ed protective plates of					
		re permitted. Dutch doors					
	I -	6 are permitted. Door					
		beled and made of steel or					
		compliance with 8.3,					
	unless the smoke						
	1 7	I fire window assemblies are					
	•	n sprinklered compartments					
		ictions in area or fire					
	1	s or frames in window					
	assemblies.						
	19.3.6.3, 42 CFR 483, and 485	Parts 403, 418, 460, 482,					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155381	B. W	ING		09/01/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			HERIDAN RD		
H∆RROI	IR MANOR HEALT	H & LIVING COMMUNITY			SVILLE, IN 46060		
11/11/1000		TI Q EIVING COMMONITI		NOBEL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		KS details of doors such as					
		ngs, automatics closing					
	devices, etc.						
		on and interview, the facility	K 0	363	what corrective action(s) will		09/09/2022
		f over 30 resident room corridor			be accomplished for those		
	_	d with a means suitable for			residents found to have beer	1	
		osed, had no impediment to			affected by the deficient		
		nd would resist the passage of			practice.		
		ent practice could affect 2					
	residents.				Resident room 11 door w	as as	
	F. 1				fixed prior to exit of survey.		
	Findings include:				l	_	
	D 1 0 111				how other residents having t		
		tour and interview with the			potential to be affected by th		
		nance and Executive Director			same deficient practice will be		
		en 12:15 p.m. and 2:30 p.m., the			identified and what correctiv	е	
		sident room 11 did not latch			action(s) will be taken.		
		n tested. Based on interview at					
		tion, the Director of			2 residents could be affected by	-	
		the corridor door would latch			the deficient practice. Residen	ΙŢ	
		because the door was not and he was surprised because			room door was fixed.		
		ently checked. The condition			what magazines will be not in	4-	
	was corrected durir	•		what measures will be pu		w	
	was corrected duffi	ig the survey.		place and what systemic changes will be made to			
	This finding was a	cknowledged by the Director of			ensure that the deficient		
		time of observation and			practice does not recur.		
		n at the exit conference with			practice accenticated.		
		intenance and Executive			Administrator and Maintenanc	e	
	Director present at				team resident door latching	J	
	Birector present at	2.00 p.m.			properly. (Attachment 2)		
	3.1-19(b)				p. 550.13. (/		
					how the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not	-	
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place; and	- <del>-</del>	
					Administrator or designee will		

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	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01  155381 B. WING			(X3) DATE SURVEY  COMPLETED  09/01/2022			
	PROVIDER OR SUPPLIE JR MANOR HEALT	R H & LIVING COMMUNITY		1667 SI	ADDRESS, CITY, STATE, ZIP COD HERIDAN RD SVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)  audit 5 resident doors to make sure they are latching properly Audits will occur Weekly x 4	e	(X5) COMPLETION DATE
IV 0070	NEDA				weeks, Monthly x 6 months (Attachment 1). The results o these reviews will be discusse the monthly facility Quality 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 Date of Compliance: Septem 9, 2022.	ed at g. /iews on lity	
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bu Barrier Construct 2012 EXISTING Smoke barriers s 1/2-hour fire resis barriers shall be p atrium wall. Smok in duct penetratio systems where an is installed for sm to the smoke barr 19.3.7.3, 8.6.7.1( Describe any men system in REMAK	nall be constructed to a tance rating per 8.5. Smoke permitted to terminate at an ace dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent rier.  1) Chanical smoke control					
	failed to ensure the passage of wire and walls were protected resistance of each s	on and interview, the facility penetrations caused by the d/or conduit through barriers d to maintain the smoke smoke barrier. LSC Section moke barriers to be constructed	K 03	372	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.		09/09/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/01/2022 155381 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1667 SHERIDAN RD HARBOUR MANOR HEALTH & LIVING COMMUNITY NOBLESVILLE, IN 46060 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE in accordance with LSC Section 8.5 and shall have Smoke barrier in wall above a minimum ½ hour fire resistive rating. LSC drop ceiling has been properly Section 8.5.2.1 requires smoke barriers to be sealed with fire caulk continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier how other residents having the to a smoke barrier, or by use of a combination potential to be affected by the thereof. 8.5.6.2 requires penetrations for cables, same deficient practice will be cable trays, conduits, pipes, tubes, vents, wires, identified and what corrective and similar items to accommodate electrical, action(s) will be taken. mechanical, plumbing, and communications systems that pass through a wall, floor, or 16 residents and staff could be floor/ceiling assembly constructed as a smoke affected by the deficient practice. barrier, or through the ceiling membrane of the Smoke barrier filled with fire caulk. roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of what measures will be put into restricting the movement of smoke. This deficient place and what systemic practice could affect staff and at least 16 residents changes will be made to and staff near room 16. ensure that the deficient practice does not recur. Findings include: Administrator and Maintenance Based on a facility tour and interview with the team educated on smoke barrier Director of Maintenance and Executive Director requirements. (Attachment 2) on 09/01/22 between 12:15 p.m. and 2:30 p.m., an unsealed penetration was discovered in the smoke how the corrective action(s) barrier wall above the drop ceiling near Resident will be monitored to ensure the Room 16. Three wires were running along a pipe deficient practice will not and created a hole/gap approximately 1/2inch recur, i.e., what quality around the pipe. The Director of Maintenance assurance program will be put stated that he believed this was done by into place; and telephone contractors. Administrator or designee will This finding was acknowledged by the Director of audit 5 smoke barriers. Audits will Maintenance at the time of observation and occur Weekly x 4 weeks, Monthly discovery and again at the exit conference with x 6 months (Attachment 1). The the Director of Maintenance and Executive results of these reviews will be Director present at 3:00 p.m. discussed at the monthly facility **Quality Assurance Committee** 3.1-19(b) meeting. Frequency and duration

of reviews will be adjusted as

CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	NT 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		09/01/2022
	PROVIDER OR SUPPLIEI	H & LIVING COMMUNITY	1667 S	ADDRESS, CITY, STATE, ZIP COD SHERIDAN RD ESVILLE, IN 46060	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				needed if compliance is below 100%. Ongoing frequency ar duration will be determined by Quality Assurance Committee Date of Compliance: Septem 9, 2022.	nd y the
K 0511	NFPA 101				
SS=E	Utilities - Gas and	Flectric			
Bldg. 01	Utilities - Gas and				
3 -		gas or related gas piping			
		PA 54, National Fuel Gas			
	Code, electrical wiring and equipment				
	complies with NFI	PA 70, National Electric			
		stallations can continue in			
	service provided r				
	18.5.1.1, 19.5.1.1				
		on, the facility failed to ensure	K 0511	what corrective action(s) wil	09/09/2022
		ction boxes in the attic were		be accomplished for those	
		e operating condition. LSC illities comply with Section 9.1.		residents found to have bee	n
	_	electrical wiring and equipment		affected by the deficient practice.	
	_	PA 70, National Electrical Code.		practice.	
		ition, Article 314.28(3) (c) states		Cover plate added to	
		l be provided with covers		electrical junction box.	
	-	e box and suitable for the		,	
	conditions of use.	Where used, metal covers shall		how other residents having	the
	comply with the gr	ounding requirements of		potential to be affected by the	те
		cient practice could affect staff		same deficient practice will	be
	and 28 residents in	the memory care area.		identified and what corrective	/e
				action(s) will be taken.	
	Findings include:			28 residents and staff could b	e l
	Based on a facility	tour and interview with the		affected by the deficient pract	
	-	nance and Executive Director		Junction box cover added.	
		en 12:15 p.m. and 2:30 p.m., an			
		pox in the attic near the		what measures will be put in	nto
		nory care unit did not contain a		place and what systemic	
	cover and had expo	sed electrical wiring hanging		changes will be made to	

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out of the box. The box was approximately

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ensure that

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the deficient

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155381	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  09/01/2022			
	PROVIDER OR SUPPLIEF	H & LIVING COMMUNITY	1667 S	STREET ADDRESS, CITY, STATE, ZIP COD 1667 SHERIDAN RD NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5) UULD BE COMPLETE PROPRIATE DATE	ION		
	appeared to connect Based on interview observations, the Dacknowledged the exprovided with a country of the finding was act Maintenance at the discovery and again	electrical junction box was not ever and had exposed wires.  knowledged by the Director of time of observation and at the exit conference with intenance and Executive		Administrator and Maint team educated on requi electrical code related to box covers. (Attachmen how the corrective acti will be monitored to en deficient practice will recur, i.e., what quality assurance program will into place; and  Administrator or designe audit 5 attic spaces for punction box coverings. occur Weekly x 4 weeks x 6 months (Attachment results of these reviews discussed at the month! Quality Assurance Commeeting. Frequency an of reviews will be adjust needed if compliance is 100%. Ongoing frequent duration will be determine Quality Assurance Commete of Compliance: See 9, 2022.	enance rements of o junction t 2)  on(s) sure the not  I be put  ee will proper Audits will s, Monthly 1). The will be y facility mittee d duration eed as below ncy and ned by the mittee			
K 0712 SS=C Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying at quarterly on each shift. Ir with procedures and is						

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ľ		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER				COMPLETED	
	155381		B. WING 09/01/2022				2022
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 PROVIDERS PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL)  CROSS-REFERENCED TO THE APPR		TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	aware that drills at routine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1 Based on record reversity failed to conduct quantification unexpected days and varying conditions. affect all residents, affect all residents. Findings include:  Based on records reproduced between 9 quarterly fire drills 28th and 31st day of do not allow fire drills 28th and 31st day of do not allow fire drills 31st finding was ac Maintenance at the discovery and again	re part of established ills are conducted between AM, a coded ay be used instead of 9.7.1.7 riew and interview, the facility arterly fire drills on d at unexpected times under This deficient practice could staff and visitors in the facility.  view of the "Logbook arding Fire Drills" and Director of Maintenance on :30 a.m. and 12:15 p.m., 9 of 12 were conducted between the f the month. These conditions ills to be conducted at knowledged by the Director of time of observation and at the exit conference with intenance and Executive	K 0	TAG	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  Quarterly fire drills will be scheduled at unexpected date and times.  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.  The deficient practice could affected all residents, staff and visitors Corrective actions include most fire drills at unexpected date at time.  what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.  Administrator and Maintenance team educated on fire drill propand procedure. (Attachment 2 how the corrective action(s)	n elect nthly and tto	09/09/2022
					will be monitored to ensure t	the	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155381		A. BUILDING B. WING	01	COMPLETED 09/01/2022			
NAME OF PROVIDER OR SUPPLIER  HARBOUR MANOR HEALTH & LIVING COMMUNITY  SUMMARY STATEMENT OF DEFICIENCIE		1667 S	STREET ADDRESS, CITY, STATE, ZIP COD 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		
				deficient practice will not recur, i.e., what quality assurance program will be pinto place; and  Administrator or designee will audit Fire Drills. Audits will or quarterly (Attachment 1). The results of these reviews will be discussed at the monthly facil Quality Assurance Committee meeting. Frequency and dura of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency are duration will be determined by Quality Assurance Committee Date of Compliance: Septem 9, 2022.	ccur e e iity e ation v ad		
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity	d electrical equipment					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CO		COMPLETED		
15		155381	B. W	B. WING		09/01/2022	
				STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				1667 S	HERIDAN RD		
HARBOUR MANOR HEALTH & LIVING COMMUNITY				NOBLE	SVILLE, IN 46060		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		ds. All power strips are					
	_	I precautions. Extension					
	cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was						
	•	ets the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
	,	(D) (NFPA 70), TIA 12-5					
		on and interview, the facility	K 0920		what corrective action(s) will	09/09/2022	
		f 1 flexible cords were installed			be accomplished for those	07/07/2022	
	properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1				residents found to have been	n	
					affected by the deficient		
					practice.		
	through 10.2.4.2.3	shall be permitted. Section			ļ ·		
	10.2.4.2.3 states the	e cabling shall comply with			Power Cord adapte	r	
	10.2.3. Section 10.2	2.3.5.1 states cord strain relief			has been secured to wall.		
	shall be provided a	t the attachment of the power					
		ce so that mechanical stress,			how other residents having t	the	
	either pull, twist, or bend, is not transmitted to				potential to be affected by the	ie	
	internal connections. This deficient practice could				same deficient practice will be	ре	
	affect 1 resident and 2 staff in the MDS office.				identified and what corrective	re e	
					action(s) will be taken.		
	Findings include:						
	D 1 6 33	y teger earla			The deficient practice could at		
		tour and interview with the nance and Executive Director			1 resident and 2 staff. Correct	ive	
		en 12:15 p.m. and 2:30 p.m., in			actions include mounting the		
		ower strip was being used to			power cord adapter.		
	_	uipment and was not secured,			what measures will be put in	to	
		walls underneath the desk. This			place and what systemic		
		t stress on the power cord			changes will be made to		
	_	the power cord. Based on			ensure that the deficient		
		ne of observations, the Director			practice does not recur.		
	of Maintenance agreed the power strip was						
	_	ed, and stated the power strip			Administrator and Maintenance	ce	
		unted or set on the floor.			team educated on cord adapter		
					and extension cord procedure		
	This finding was ac	cknowledged by the Director of			(Attachment 2)		
		time of observation and			l` '		

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STATEMENT OF DEFICIENCIES X1) I		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPLETED		
		155381	B. WING			09/01/	/2022	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIE	R						
H∆RR∩U	IR MANOR HEALT	H & LIVING COMMUNITY	1667 SHERIDAN RD NOBLESVILLE, IN 46060					
HARBOO	IN MANOR FILAL	TT & ETVING COMMONTT	NOBLESVILLE, IN 40000					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	IENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE	
		n at the exit conference with			how the corrective action(s)			
		ntenance and Executive		will be monitored to ensure the				
	Director present at	3:00 p.m.			deficient practice will not			
	2.4.40(1)			recur, i.e., what quality				
	3.1-19(b)				assurance program will be p	out		
					into place; and			
					Administrator or designee will			
					audit staff offices for proper co	ord		
					adapters. Audits will occur	_		
					Weekly x 4 weeks, Monthly x	6		
					months (Attachment 1). The			
					results of these reviews will b			
					discussed at the monthly facil	-		
					Quality Assurance Committee			
					meeting. Frequency and dura			
					of reviews will be adjusted as			
					needed if compliance is below			
					100%. Ongoing frequency ar			
					duration will be determined by			
					Quality Assurance Committee			
					Date of Compliance: Septem	ber		
					9, 2022.			

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