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	06/19/2024

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. --	A Pre-Occupancy Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/19/24 Facility Number: 000551 Provider Number: 155381 AIM Number: 100267400 At this Pre-Occupancy Emergency Preparedness survey, Harbour Manor Health & Living Community was found in 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 118. Quality Review completed on 06/24/24	E 0000		
K 0000 Bldg. 01	A Pre-Occupancy 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: 06/19/24 Facility Number: 000551 Provider Number: 155381 AIM Number: 100267400 At this Pre-Occupancy Life Safety Code survey,	K 0000	**Submission of this plan of correction in no way constitutes an admission by Harbour Manor Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacob Atkinson	Executive Director	07/01/2024

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	155381	A. BUILDING 01 B. WING	06/19/2024

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	Harbour Manor Health & Living Community was found not in compliance with Requirements for Participation in 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 118 at the time of this visit. The scope of work included the following: Remove all existing locking hardware from the cross-corridor door and allow free egress through and accessing of the former locked portion of the 200 wing (former rooms 200A, 200B, and 201-209). There will be no locked unit at this facility. General remodeling of existing corridors and creation of new corridor walls and doors to alter an existing smoke barrier. Remodel an existing resident activity room into two new resident rooms (to be numbered 210 and 212) each with a private toilet room. Creation of new resident room 210 includes closing of an exterior patio door and a creation of new exterior wall and window. Remodel an existing nurse station and staff restroom into a new resident room (to be numbered 211) with a private toilet room. Remodel an existing medication room to close an existing doorway and construct a new doorway to the corridor. All areas where residents have customary access		**executed solely because it is required by Federal and State Law.** **This plan of correction is also Harbour Manor Health & Living Community's credible allegation of compliance.** **We allege substantial compliance on July 1st 2024.** **We are respectfully requesting paper compliance for this survey.**	

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	were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/24/24			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			

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	Based on observation and interview, the facility failed to ensure 1 of 1 storage room on the 200 hall greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 2 residents in the 200 hall. Findings include: Based on observation and interview during a tour of the facility with Assistant Administrator (AA) on 06/19/24 at 10:15 a.m., Resident Room #211, which the AA stated was intended to be a single room following the renovation, contained 2 resident beds, no divider curtain, and several large cardboard boxes making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the AA agreed the room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was acknowledged by the Assistant Administrator at the time of discovery and again during the exit conference. 3.1-19(b)	K 0321	K321 **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Boxes located in the 200 hall have been removed and extra bed removed. **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.** 2 Residents could be affected by the deficient practice. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator and Maintenance team educated self-closing doors related to combustible items. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will audit new rooms areas. Audits	07/01/2024

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			will occur Monthly x 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	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure all smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or	K 0372	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Walls in rooms 210 and 212 have been covered to create smoke barrier.	07/01/2024

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	by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 4 residents and staff on the 200 hallway. Findings include: Based on observation and interview during a tour of the facility with Assistant Administrator (AA) on 06/19/24 at 10:20 a.m., the following locations which were part of the renovation were missing completely sealed walls which would resist the passage of smoke; A. Resident Room #210 B. Resident Room # 212 The finding was acknowledged by the Assistant Administrator at the time of discovery and again during the exit conference. 3.1-19(b)		**how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Residents could be affected by the deficient practice. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator and Maintenance team educated on smoke barrier walls. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will audit new rooms areas. Audits will occur Monthly x 6 Months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff in the 200 hall. Findings include: Based on observation and interview during a tour of the facility with Assistant Administrator (AA) on 06/19/24 at 10:20 a.m., the electrical panel in the 200 hall near RR # 210, 211 and 212 (which were the focus of the renovation) was unlocked when tested. The finding was acknowledged by the Assistant Administrator at the time of discovery and again	K 0511	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Electrical panel in the hall was locked. **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.** West Hall residents could be affected by the deficient practice. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator and Maintenance team educated on electrical panel locking. **how the corrective action(s) will be monitored to ensure the**	07/01/2024

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	during the exit conference. 3.1-19(b)		**deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will audit west hall electrical panel. Audits will occur Monthly x 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	