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 _____	R **07/26/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Pre-Occupancy Survey conducted on 06/19/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/26/24 Facility Number: 000551 Provider Number: 155381 AIM Number: 100267400 At this PSR Pre-Occupancy Life Safety Code survey, Harbour Manor Health & Living Community was found 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	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 1 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 were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/27/24	{K 000}		