PRINTED: 05/21/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155381	B. WING				
				CED DE	TARRES CITY CTATE TIN COR		
NAME OF P	ROVIDER OR SUPPLIER	t .			T ADDRESS, CITY, STATE, ZIP COD		
LIABBOL		LL Q L IV/INIO CONANALINITY/		1667 SHERIDAN RD			
HARBOU	JR MANOR HEALTI	H & LIVING COMMUNITY		NOBL	LESVILLE, IN 46060		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for the Investigation of Complaints		F 0000		Submission of this plan of		
	IN00430518, IN004	431838, IN00431938, IN00432126,			correction in no way constitu	ıtes	
	and IN00432885.				an admission by Harbour Manor		
					Health and Living or its		
	-	0518 - No deficiencies related to			management company that		
	the allegations are c	eited.			1 -	allegations contained in the survey	
					report is a true and accurate		
	Complaint IN00431838 - No deficiencies related to				portrayal of the provision of nursing		
	the allegations are cited.				care or other services provide		
					this facility. The Plan of Cor		
	Complaint IN00431938 - Federal/State deficiencies				is prepared and executed so	-	
	related to the allega	tions are cited at F610.			because it is required by Fe	deral	
	a 11 . Drag (0.0				and State Law. This plan of		
	-	2126 - No deficiencies related to			correction is also Harbour M		
	the allegations are c	eited.			Health & Living Community'		
	C1-:4 INIO0422	0005 N- 4-£-:1-4-44-			credible allegation of compli		
	the allegations are c	2885 - No deficiencies related to			We allege substantial comp	iance	
	the allegations are c	ented.			on May 17th, 2024.We are	_	
	Survey dates: April 23 & 24, 2024				respectfully requesting paper		
	Survey dates. April	23 & 24, 2024			compliance for this survey.		
	Facility number: 00	0551					
	Provider number: 1:						
	AIM number: 10020						
	7 111VI Hullioci. 10020	07100					
	Census Bed Type:						
	SNF/NF: 104						
	SNF: 12						
	Residential: 52						
	Total: 168						
	-						
	Census Payor Type:	:					
	Medicare: 9						
	Medicaid: 79						
	Other: 28						
	Total: 116						

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.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER 155381	A. BUILDING B. WING	00	COMPLETED 04/24/2024	
		100001			0 1/2 1/2021	
NAME OF I	PROVIDER OR SUPPLIEF	2		T ADDRESS, CITY, STATE, ZIP COD SHERIDAN RD		
HARBOU	JR MANOR HEALT	H & LIVING COMMUNITY		LESVILLE, IN 46060		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION  These deficiencies reflect State Findings cited in		TAG	DETERMENT	DATE	
	accordance with 41	C				
	Quality review completed May 2, 2024.					
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:					
	§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.					
	- ' ' ' '	vent further potential abuse, on, or mistreatment while s in progress.				
	investigations to the her designated resignated resignated resignated resignated resignation in accordation is alleged violation is corrective action resignation.		F.0.610	5040	05/15/2024	
	failed to complete a	and record review, the facility in investigation of an allegation	F 0610	F610	05/17/2024	
	of verbal abuse for 1 of 3 residents reviewed for abuse. (Resident D)  Findings include:			what corrective action(s) will be accomplished for those		
				residents found to have been affected by the deficient practice.	n	
	During an interview on 4/23/24 at 10:56 a.m.,					
	Resident D indicated she had an incident while in an activities group, before a Bingo game. She was seated at a table waiting for another resident to			Investigation was started immediately.		
	join her and another She felt the Activiti	r resident entered the room. es Director (AD) got the idea I rejected the resident to sit at		how other residents having to potential to be affected by the same deficient practice will be a same deficient practice.	ne	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/24/2024 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE her table. The AD began to yell loudly at her that identified and what corrective she was not in control and how dare she turn action(s) will be taken. away an old woman. Resident D indicated she was humiliated and embarrassed, and felt very hurt. Residents alleging verbal abuse She cried a lot over the next few days. She have the potential to be affected indicated the AD had not followed up with her or by this deficient practice and have apologized. She felt that the AD had a bad day, been audited to ensure no other and Resident D had since forgiven the AD and allegations of verbal abuse which began to attend activities again. Nothing further require notification to the Indiana had been said about the incident. State Department of Health. The clinical record for Resident D was reviewed what measures will be put into on 4/23/24 at 11:15 a.m. Diagnoses included major place and what systemic depressive disorder and morbid obesity. changes will be made to ensure that the deficient A quarterly Minimum Data Set (MDS) practice does not recur. assessment, dated 4/16/24, indicated the resident was cognitively intact, had no hallucinations, PT, Therapy supervisor and DON delusions, and no verbal or physical behaviors. have been educated on the abuse She could make herself understood and could policy with a focus on reporting. understand others. how the corrective action(s) During an interview on 4/23/24 at 1:20 p.m., will be monitored to ensure the Physical Therapy staff (PT) 2 indicated Resident deficient practice will not D reported the incident in activities to her, and recur, i.e., what quality was extremely upset during the conversation. PT 2 assurance program will be put reported the incident to her supervisor and felt it into place; and had been reported to the Administrator and/or DON. Administrator or designee will audit 5 residents with verbal abuse During a telephone interview on 4/23/24 at 2:36 allegations to ensure p.m., PT 3 indicated she had informed the DON Administrator was notified regarding the resident's allegation as soon as PT 2 correctly. Administrator or had communicated it to her. designee will interview 5 staff members to ensure Administrator During an interview on 4/24/24 at 1:45 p.m., the was notified correctly related to

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Activities Director.

DON indicated she was unaware of an allegation

of verbal abuse regarding Resident D and the

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abuse. Audits will occur weekly x

6 weeks, then monthly for 6

months. The results of these reviews will be discussed at the

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155381	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/24/2024		
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	A current facility policy, edited 8/2016, titled, "SNF Reportable Policy and Procedure," provided by the Corporate Nurse Consultant on 4/24/24 at 1:24 p.m., included the following: "PurposeAdministrative staff will immediately report the following incidents to the Indiana Department of Health1. Any/all alleged violation involving mistreatment, neglect or abuse."  This citation relates to Complaint IN00431938.  3.1-28(d)				monthly facility Quality Assura Committee meeting. Frequenand duration of reviews will be adjusted as needed if complia is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee		

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