STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155381	A. BUILDING 00 B. WING	04/24/2024

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00430518, IN00431838, IN00431938, IN00432126, and IN00432885. Complaint IN00430518 - No deficiencies related to the allegations are cited. Complaint IN00431838 - No deficiencies related to the allegations are cited. Complaint IN00431938 - Federal/State deficiencies related to the allegations are cited at F610. Complaint IN00432126 - No deficiencies related to the allegations are cited. Complaint IN00432885 - No deficiencies related to the allegations are cited. Survey dates: April 23 & 24, 2024 Facility number: 000551 Provider number: 155381 AIM number: 100267400 Census Bed Type: SNF/NF: 104 SNF: 12 Residential: 52 Total: 168 Census Payor Type: Medicare: 9 Medicaid: 79 Other: 28 Total: 116	F 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 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 May 17th, 2024.We are respectfully requesting paper compliance for this survey.	

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. 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. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to complete an investigation of an allegation of verbal abuse for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: 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 join her and another resident entered the room. She felt the Activities Director (AD) got the idea that Resident D had rejected the resident to sit at	F 0610	F610 **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Investigation was started immediately. **how other residents having the potential to be affected by the same deficient practice will be**	05/17/2024

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	her table. The AD began to yell loudly at her that she was not in control and how dare she turn away an old woman. Resident D indicated she was humiliated and embarrassed, and felt very hurt. She cried a lot over the next few days. She indicated the AD had not followed up with her or apologized. She felt that the AD had a bad day, and Resident D had since forgiven the AD and began to attend activities again. Nothing further had been said about the incident. The clinical record for Resident D was reviewed on 4/23/24 at 11:15 a.m. Diagnoses included major depressive disorder and morbid obesity. A quarterly Minimum Data Set (MDS) assessment, dated 4/16/24, indicated the resident was cognitively intact, had no hallucinations, delusions, and no verbal or physical behaviors. She could make herself understood and could understand others. During an interview on 4/23/24 at 1:20 p.m., Physical Therapy staff (PT) 2 indicated Resident D reported the incident in activities to her, and was extremely upset during the conversation. PT 2 reported the incident to her supervisor and felt it had been reported to the Administrator and/or DON. During a telephone interview on 4/23/24 at 2:36 p.m., PT 3 indicated she had informed the DON regarding the resident's allegation as soon as PT 2 had communicated it to her. During an interview on 4/24/24 at 1:45 p.m., the DON indicated she was unaware of an allegation of verbal abuse regarding Resident D and the Activities Director.		**identified and what corrective action(s) will be taken.** Residents alleging verbal abuse have the potential to be affected by this deficient practice and have been audited to ensure no other allegations of verbal abuse which require notification to the Indiana State Department of Health. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** PT, Therapy supervisor and DON have been educated on the abuse policy with a focus on reporting. **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 5 residents with verbal abuse allegations to ensure Administrator was notified correctly. Administrator or designee will interview 5 staff members to ensure Administrator was notified correctly related to 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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	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: "Purpose...Administrative staff will immediately report the following incidents to the Indiana Department of Health...1. Any/all alleged violation involving mistreatment, neglect or abuse." This citation relates to Complaint IN00431938. 3.1-28(d)		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	