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	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour Manor Health & Living Community	1667 Sheridan Rd Noblesville, IN 46060

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to initiate and conduct a 72-hour care plan meeting for a resident following admission to ensure the development of a person-centered care plan addressing the resident's immediate needs. This deficient practice had the potential to affect the resident by delaying the identification and coordination of care needs, and increased the risk for unmet needs, decline in condition, and lack of interdisciplinary oversight. (Resident B)Findings include:Resident B's clinical record was reviewed on 2/12/26 at 11:00 a.m. Diagnoses included fracture of unspecified neck of right femur post-surgical repair, signs and symptoms involving cognitive functions following a cerebrovascular accident, repeated falls, hypertension, conversion disorder with seizures or convulsions, osteoporosis, and chronic pain.Resident B was admitted to the facility on [DATE]. The clinical record lacked documentation that a 72-hour care plan meeting was initiated or conducted within the required timeframe. Review of the most current admission MDS (Minimum Data Set) assessment, dated 1/6/26, indicated the resident had moderate cognitive impairment, used a wheelchair for mobility, was frequently incontinent of bladder, occasionally incontinent of bowel and was impaired on one side of her lower extremities.Review of the clinical record indicated the initial care conference for Resident B took place on 1/9/26, nine days after Resident B was admitted to the facility.During an interview with the Social Service Director on 2/13/26 at 9:52 a.m., she indicated she called resident representatives the day after the admission date to set up a care conference. It was usually 24 to 48 hours after admission when she contacted the representative(s). Generally, she would not document if she were unable to reach a resident's representative. During a care conference, social services, therapy, and nursing were present to discuss care provided by the facility, including any discharge plan(s). Care was planned in coordination with the residents and their families. Such documentation would be located under Care Conference Summary in the electronic health record.During an interview with the admission Coordinator on 2/13/26 at 12:15 p.m., she indicated Resident B's representative was contacted on 1/5/26 at 4:05 p.m. via phone. She left a voice mail requesting a return call from the representative. Resident B was admitted to the facility on [DATE]. Since it was a holiday, 1/5/26 was the first opportunity she had to contact Resident B's representative.During an interview with the Transitional Care Nurse on 2/13/26 at 3:42 p.m., she indicated the Unit Manager (UM) completed the initial assessment for a new resident. If the UM was not available, the floor nurse would perform the assessment and enter new orders. Orders were then discussed during the morning meeting the following day. Care plans were found in the electronic health record and staff used those as a means of knowing how to provide care for residents. The Transitional Care Nurse knew Resident B's care conference was delayed and had been scheduled to accommodate the representative's schedule. Resident B's representative wanted to be present during the care conference. Initial care conferences usually took place 48 to 72 hours after admission. The facility did their best to accommodate (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	representatives' preferences when scheduling the initial care conferences.A current facility policy, titled Resident Care Planning - Resident Summary Policy, provided by the DON on 1/12/26 at 3:25 p.m., indicated the following: .The Community must take reasonable steps to ensure the development of the person-centered, baseline care plan within 48 hours of a new resident's admission, providing a written summary of the baseline care plan to the resident and/or representative. The baseline care plan includes resident medications, dietary instructions, services, treatments and pertinent updates by the date of the initial Interdisciplinary Team (IDT) care conference.This citation relates to Intake 2740980.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to protect the safety of a cognitively impaired resident from potential harm by not providing supervision at an outside appointment for 1 out of 3 residents reviewed to accidents. (Resident B) Findings include:Resident B's clinical record was reviewed on 2/12/26 at 11:00 a.m. Diagnoses included fracture of unspecified part of neck of right femur post-surgical repair, symptoms and signs involving cognitive functions following other cerebrovascular disease, repeated falls, hypertension, conversion disorder with seizures or convulsions, osteoporosis, and chronic pain. Review of the most current admission MDS (Minimum Data Set) assessment, dated 1/6/26, indicated the resident had moderate cognitive impairment, used a wheelchair for mobility, was frequently incontinent of bladder, occasionally incontinent of bowel and was impaired on one side in the lower extremities.Review of the hospital discharge orders, dated 12/31/25, indicated a follow up appointment with the orthopedic surgeon on 1/12/26.Review of the clinical record indicated the following orders:Appointment 1/19/26 at 2:15 p.m. (physician name, location and telephone number). Start date: 1/18/26. Discontinued date: 1/19/26.Appointment 1/19/26 at 2:15 p.m. (physician name, location and telephone number). Start date: 1/18/26. Discontinued date: 1/13/26.Review of a progress note, dated 1/5/26 at 1:36 p.m., indicated Resident B had a fall on 1/4/26. The root cause of the fall was determined to be the resident had poor safety awareness. The resident was incontinent at time of the fall.Review of a progress note dated 1/11/26 at 11:14 p.m., the resident was found on the floor next to the bathroom. The resident indicated she was trying to get up and couldn't. Resident denied need to use the bathroom.Review of a progress note, dated 1/12/26 at 2:52 p.m., indicated Resident B was taken to a follow up orthopedic appointment as scheduled per hospital discharge. Transportation reported they were called to pick up the resident because the resident did not have an appointment this date. The resident was without supervision for approximately 2.5 hours. The appointment was rescheduled for 1/19/26 at 2:15pm. Transport was requested.Review of an Interdisciplinary Team (IDT) post fall assessment, dated 1/12/26 at 3:17 p.m., indicated the resident was found on the floor in the bathroom on 1/11/26. The Resident was not incontinent at the time of the fall. The root cause was determined to be due to safety awareness. Review of a physician's note, dated 1/11/26 at 10:50 p.m., indicated the reason for visit was due to fall without injury. The noted indicated the resident had confusion and a poor historian.During an interview on 2/12/26 at 11:39 a.m., the Orthopedic office front desk receptionist indicated, on 1/12/26 at 1:00 p.m., Resident B arrived at the office at 12:30 p.m. The resident was confused and agitated and asked the receptionist to call her family. The office chart indicated the resident was to be accompanied by a caregiver for appointments. The receptionist called the family and informed them the resident was in the office without an appointment and unsupervised. The receptionist indicated they sat with the resident for 1-1.5 hours while they waited for the facility to pick the resident up.During an interview on 2/13/26 at 1:12 p.m., Unit Manager 1 indicated the facility received the 1/12/26 appointment in the hospital discharge orders. The facility did not call the family to ask about transportation arrangements. The appointment was sent to transportation through the facility. The resident arrived at the scheduled appointment on 1/12/26 but it had been cancelled. There had been a communication breakdown, and the facility had not been aware the appointment had been cancelled. The resident had periods of confusion after surgery and was not safe to be unsupervised.During an interview on 2/13/26 at 3:33 p.m., the transportation driver indicated, on 1/12/26, he transported the resident to a scheduled physician appointment. After they arrived at the physician's office, they were informed the resident did not have an appointment, but the office would be able to see the resident. He left the resident at (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the physician's office and went to get something to eat. Approximately 45 minutes later, he received a call instructing him to return the resident to the facility. When he arrived to pick up the resident, he was informed she had not been seen by the physician. He indicated he did not call the facility to confirm the appointment or inform them of the mishap.During an interview on 2/13/26 at 3:33 p.m. the Clinical Support Consultant indicated the facility did not have a policy related to transportation and/or conduct for the transportation of residents. During an interview on 2/13/26 at 3:42 p.m., the Transitional Care Nurse indicated transportation arrangements to and from appointments for Resident B were not discussed during the initial care conference. The initial care conference usually took place 48-72 hours after admission. The facility did their best to accommodate the families' schedules when scheduling the initial care conference.Review of the clinical record indicated the initial care conference for Resident B took place on 1/9/26. Attendees included the resident's Power of Attorney (POA).This citation relates to Intake 2740980. 3.1-45(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interview, the facility failed to ensure controlled substance inventory was accurately documented on individual narcotic record sheets per facility policy to mitigate risk for drug diversion for 6 of 6 residents reviewed during a medication storage observation. (Residents J, K, L, M, N, and O)Findings include:During an observation of the [NAME] 1 medication cart, accompanied by LPN 10 and LPN 11, on 2/12/26 at 1:49 p.m., LPN 11 indicated she did not document the removal of the controlled medications she administered that morning on the individual controlled medication inventory record sheets. Review of the individual narcotic sheets indicated the documentation had not been completed. LPN 11 indicated the [NAME] 1 medication cart contained medications for 18 residents, six of which received controlled medications from the cart. LPN 11 indicated she administered Resident J's pregabalin (anticonvulsant) 50 mg and hydrocodone acetaminophen (opioid pain medication) 5-325 mg the morning of 2/12/26.An observation during the interview indicated the controlled medication binder indicated the following concerns:Resident J had 25 remaining pregabalin 50 mg pills. The pregabalin blister card had 24 pills remaining. The controlled medication binder indicated Resident J had 29 remaining hydrocodone acetaminophen 5-325 mg pills. The hydrocodone acetaminophen 5-325 blister card had 28 pills remaining.LPN 11 indicated she administered Resident K's tramadol (opiate pain medication) 50 mg the morning of 2/12/26. An observation during the interview indicated the controlled medication documentation for Resident K had nine remaining tramadol 50 mg pills. The tramadol 50 mg blister card had eight pills remaining.LPN 11 indicated she administered Resident L's lorazepam (anti-anxiety medication) 0.5 mg the morning of 2/12/26. The controlled medication binder indicated Resident L had 37 remaining lorazepam 0.5 mg pills. The lorazepam 0.5 mg blister card had 36 pills remaining.LPN 11 indicated she administered Resident M's tramadol 50 mg the morning of 2/12/26. The controlled medication binder indicated Resident M had 20 remaining tramadol 50 mg pills. The tramadol 50 mg blister card had 19 pills remaining.LPN 11 indicated she administered Resident N's hydrocodone acetaminophen 7.5-325 mg the morning of 2/12/26. The controlled medication binder indicated Resident N had two remaining hydrocodone acetaminophen 7.5-325 mg pills. The hydrocodone acetaminophen 7.5-325 mg blister card had one pill remaining.LPN 11 indicated she administered Resident O's clonazepam (anti-anxiety medication) 0.5 mg and pregabalin 75 mg the morning of 2/12/26. The controlled medication binder indicated Resident O had 16 remaining clonazepam 0.5 mg pills. The clonazepam 0.5 blister card had 15 pills remaining. The controlled medication binder indicated Resident O had 15 remaining pregabalin 75 mg pills. The pregabalin 75 mg blister card had 14 pills remaining.Resident J's clinical record was reviewed on 2/12/26 at 2:04 p.m. Resident J was severely cognitively impaired. Diagnoses included hyperlipidemia, hemiplegia, seizure disorder, depression, and a history of cerebrovascular accident.Resident K's clinical record was reviewed on 2/12/26 at 2:10 p.m. Resident K was cognitively intact. Diagnoses included anemia, hypertension, and chronic obstructive pulmonary disease.Resident L's clinical record was reviewed on 2/12/26 at 2:22 p.m. Resident L was cognitively intact. Diagnoses included anemia, neurogenic bladder, hyperlipidemia, and chronic obstructive pulmonary disease.Resident M's clinical record was reviewed on 2/12/26 at 2:36 p.m. Resident M was severely cognitively impaired. Diagnoses included coronary artery disease, hypertension, hyperlipidemia, and Parkinson's disease.Resident N's clinical record was reviewed on 2/12/26 at 3:12 p.m. Diagnoses included type 2 diabetes mellitus, pain - unspecified, a history of cerebrovascular accident, hypertension, and cardiomyopathy.During an interview with the Unit Manager, on 2/12/26 at 2:00 p.m., she indicated LPN 11 should have documented in the controlled medication binder each time she removed a controlled medication to show how many pills had been (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed and what time they were removed.During an interview with the Director of Nursing (DON) on 2/13/26 at 4:58 p.m., she indicated the expectation was for nurses to sign out controlled medications as soon as they pulled them, before administering to the residents. There was the potential for the controlled medication count to be incorrect, and the nurse would not know what time the medication was administered.A current facility policy, titled Managing Controlled Substances, provided by the DON on 2/13/26 at 1:23 p.m., indicated the following: .Drugs with high abuse potential are subject to special handling, storage, disposal, and record keeping.7) Immediate after a dose of a controlled drug is administered, the licensed nurse administering the drug is to enter all of the following information on the proof-of-use record: a) Date and time of administration. b) Dose administered. c) Signature of the nurse administering the dose. d) Remaining doses.This citation relates to Intake 2740980.3.1-25(3)(e)(2)