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	05/19/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interview, the facility failed to develop and implement a process to ensure the identity and competency of agency staff. This deficient practice had the potential to affect 122 of 122 residents in the facility. Findings include:During a confidential interview, on 5/18/26 at 11:43 a.m., it was indicated they were advised of a situation where CNA 8 was discovered to be working in more than one facility on the same date at the same time. They were able to contact both facilities and were provided with photographic evidence of CNA 8 and another employee, CNA 9, in different locations during this time frame. During an internal investigation, it was discovered that CNA 8 and CNA 9 had shared a staffing agency account and a banking account.A facility reported incident, provided by the Administrator on 5/18/26 at 11:45 a.m., indicated the following: On 5/8/26, a corporate payroll accounting discovered CNA 8 had worked the 2:00 p.m. - 10:00 p.m. shift on 5/3/26 at one facility through an agency contract while also working the 6:00 a.m. - 10:00 p.m. shift on 5/3/26 through her weekend option employment with another facility.A review of the facility investigation file, provided by the Administrator on 5/18/26 at 11:45 a.m., included the following:A copy of the facility reported incident page.An e-mailed internal investigation, from the staffing agency, indicating the following was discovered: CNA 8 was working at one facility from 6:00 a.m. - 10:00 p.m. CNA 9 had accepted a posted open shift at another facility while logged into CNA 8's agency account. CNA 9 worked a 2:00 p.m. - 10:00 p.m. shift at the other facility acting as CNA 8. Both facilities provided photographic evidence of each CNA working in their facilities. CNA 8 and CNA 9 had shared an agency account and a bank account which was against the agency's policies.A facility list of residents on CNA 9's assignment.Progress notes for each of the residents on CNA 9's assignment. Skin assessments, pain assessments, and psychosocial assessments were completed without concerns.A 5/8/26, in-service sign-in sheet related to education of the new process for verification of agency staff members. The sign-in sheet contained 7 facility employee names.A 5/11/26, current open shift listing for the staffing agency with the new instructions.During an interview, on 5/18/26 at 11:30 a.m., the Facility Scheduler indicated she posted detailed descriptions of each shift and its role on the agency website. The agency staff accepted the open shifts on the agency app. The facility had access to the agency staff licensure and profiles only. The open shift descriptions contained instructions for the agency staff members to report to the [NAME] nurse station, locate their name in the assignment log and report to the unit for hand off report and to relieve the outgoing staff member. These instructions were changed recently due to the events that occurred on 5/3/26. The current instructions indicated the agency staff member must report to the [NAME] nurse station and provide a photo identification (ID) to a nurse. A review of the schedules dated 5/4/26 - 5/17/26, provided by the ADON on 5/18/26 at 11:20 a.m., indicated the following: Two sets of initials beside each date an agency CNA had an assignment. (5/8/26, 5/9/26, 5/10/26, 5/11/26, 5/12/26, 5/15/26, 5/16/26, & 5/17/26)An online review of the professional licensing agency website, on 5/18/26 at 1:04 p.m., indicated the following:CNA 8 had an active CNA licensure and CNA 9 had an active CNA licensure.Resident B's clinical record was reviewed on 5/18/26 at 1:36 p.m. Diagnosis included Neuromyelitis optica (an autoimmune disorder), hypokalemia, and stage 3 pressure ulcer (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(full-thickness skin loss) of the sacral region. A 2/9/26, quarterly, Minimum Data Set (MDS) assessment indicated Resident B was dependent on staff assistance for toileting hygiene, personal hygiene, and transfers. Resident C's clinical record was reviewed on 5/19/26 at 11:21 a.m. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypertension, and major depressive disorder. A 2/27/26, quarterly MDS assessment indicated Resident C was dependent on staff assistance for toileting hygiene, lower body dressing, and transfers. Resident D's clinical record was reviewed on 5/19/26 at 11:40 a.m. Diagnosis included Parkinson's disease, Alzheimer's disease, and peripheral vascular disease. A 2/25/26, quarterly MDS assessment indicated Resident D required substantial assistance from staff for toileting hygiene, personal hygiene, and transfers. During a telephone interview, on 5/19/26 at 9:40 a.m., CNA 8 indicated she was contacted by the facility corporate office and told she was found to be logged in working at two different facilities on 5/3/26 at the same time. On 5/3/26, she had been working at her weekend option job location and had worked a double shift from 6:00 a.m. - 10:00 p.m. A few days later another representative from the corporate office contacted her and showed her a photo of the other staff member. CNA 8 recognized the employee and identified her to the corporate office representative as CNA 9. CNA 8 and CNA 9 had a personal connection and relationship outside of work. CNA 8 had utilized CNA 9's cell phone to accept a different shift through the staffing agency app. CNA 8 thought she had logged out of her account, but it's possible she did not. CNA 9 was unable to obtain her own bank account and CNA 8 had allowed her to share her banking information. CNA 8 indicated she spoke with the agency to ensure documentation that the banking information was being used by two separate employees. CNA 8 indicated she thought CNA 9 made a mistake and was logged into the wrong account when she accepted the shift. CNA 8 indicated she had assisted in all investigations related to this incident.CNA 9 was unable to be contacted during the survey time period.A review of the agency identification folder, provided by the DON on 5/19/26 at 10:21 a.m., contained the following: Twenty-six (26) photocopied identification cards and/or passports. Some of the copies were labeled with the shift worked. The folder was kept in DON's office.A review of the agency education binder, located at the [NAME] nurse station, on 5/19/26 at 11:00 a.m. contained the following: Copies of the following policies and procedures - Resident Rights, Abuse, Standard Precautions, Spills, Hand hygiene, Respiratory etiquette, and Contact Isolation. The current sign-in sheet started on 5/8/26. During an interview, on 5/19/26 at 11:01 a.m., RN 6 indicated there was now a new process when an agency CNA arrived to the facility. The agency staff member must take a photo ID to the [NAME] nurse station. There, a facility nurse would make a copy of the ID and give it to the DON. The facility nurse and agency CNA both initialed the schedule to confirm that the verification took place. The agency CNA then reviewed the education binder and signed on the sign-in sheet. Once those steps were completed, the agency CNA reported to their assignment, received a tour of the unit, and got hand-off report. On 5/19/26 at 11:03 a.m., LPN 10 indicated all agency CNAs followed the instructions on the agency app. On 5/19/26 at 12:23 p.m., the DON indicated the situation was discovered on 5/8/26 when the corporate office was reviewing timecards. It was discovered that CNA 8 was working at two separate facilities at the same time on 5/3/26. The facility management started an investigation and interviewed the facility staff members to see which agency staff members they worked with on that day. The facility employees indicated the agency staff member identified herself as CNA 8. The management reviewed photographic evidence from the 5/3/26 shift. CNA 9 was seen on the photographic evidence. The facility staff interviewed all the residents on the affected assignment and found no concerns. Skin assessments, pain assessments, and psychosocial questions were completed for all affected residents without findings. On 5/19/26 at 12:35 p.m., the Administrator indicated the corporate office had reviewed timecards and discovered that CNA 8 had worked in two facilities at the same time on 5/3/26. Once he was made aware of the situation, he started an investigation and contacted the other facility and asked them to interview CNA 8. He asked the staffing agency to explore any other options that could cause this type of discrepancy. Through (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his investigation, communication with the secondary facility, and the staffing agency, it was discovered that CNA 8 was not the staff member working on 5/3/26 at this facility. CNA 9 was working under the account of CNA 8. The facility staff working on 5/3/26 indicated in interviews that they worked with an agency staff member who identified themselves as CNA 8. The facility interviewed the residents living on the affected assignment and there were no concerns. The facility completed skin assessments, pain assessments, and psychosocial follow-up on the resident living on the affected assignment and no concerns were noted. The facility had no specific agency staffing policies or procedures. They had a contract with the staffing agency who verified the agency staff members' identity and licensure. This citation relates to Intake 3011813 and Intake 3009363.410 IAC (Indiana Administrative Code) 16.2-3.1-14(i)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post current and accurate nursing staff information daily for residents, resident representatives, and/or visitors. Findings include:During an observation, on 5/18/26 at 9:00 a.m., the facility nurse staffing, dated 5/15/26 was posted on the wall across from the receptionist desk in the front lobby. The nursing staff posting, dated 5/15/26, included the following:Census: 116 Number of Registered Nurses (RN): Day shift hours: 24.00, Evening shift hours: 12.00, and Night shift hours: 16.00.Number of Licensed Practical Nurses (LPN): Day shift hours: 48.00, Evening shift hours: 36.00, and Night shift hours: 24.00. Number of Qualified Medication Aides (QMA): Day shift hours: 8.00, Evening shift hours: 16.00, and Night shift hours: 0.00.Number of Certified Nursing Assistant (CNA): Day shift hours: 80.00, Evening shift hours: 64.00, and Night shift hours: 48.00.During an observation, on 5/18/26 at 9:34 a.m., the facility nurse staffing posting was updated. The updated staff post was dated 5/18/26 and included the following:Census: 122Number of RN: Day shift hours: 24.00, Evening shift hours: 24.00, and Night shift hours: 0.00.Number of LPN: Day shift hours: 32.00, Evening shift hours: 48.00, and Night shift hours: 32.00. Number of QMA: Day shift hours: 16.00, Evening shift hours: 8.00, and Night shift hours: 8.00.Number of CNA: Day shift hours: 72.00, Evening shift hours: 64.00, and Night shift hours: 48.00.During an interview, on 5/18/26 at 11:00 a.m., the Facility Scheduler indicated she updated the facility nurse staff posting every morning when she arrived at work. This was usually between 8:00 a.m. and 8:30 a.m., expect on Mondays since she had other duties to complete first thing. The posting on Mondays was completed around 9:00 a.m. She utilized the daily schedules to populate the posting information. She indicated there was not a staff member over the weekends to complete this task. She didn't prepopulate the weekend staff posting information due to daily changes to the schedule, such as call-ins. The staff posting was to be completed daily at the start of each day and contain accurate staffing information.During an interview, on 5/19/26 at 12:35 p.m., the Administrator indicated the facility nurse staff posting was to be updated daily and posted at the beginning of each shift. The facility needed a process in place to ensure the nurse staff posting was updated appropriately over the weekends. A current facility policy, dated 6/16/19, titled, Staffing Policy, provided by the Administrator on 5/19/26 at 10:00 a.m., indicated the following: . 5. Direct care staffing information is posted each day pursuant to CMS Requirements of Participation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store drugs and biologicals in a safe and secure manner for 18 of 18 residents' treatments stored in the Rehab Hall treatment cart. Findings include:During a walk-through observation, on 5/18/26 at 9:45 a.m., the medication treatment cart on the Rehab unit was unlocked and unattended.During a continuous observation on 5/18/26 from 9:45 a.m. to 9:51 a.m., the medication treatment cart remained unlocked. During this time frame, the following were observed near the unlocked and unattended medication treatment cart: a housekeeping staff member, a laundry staff member and a Certified Nursing Assistant (CNA).During a medication storage observation of the Rehab treatment cart, accompanied by LPN 5, on 5/18/26 at 9:51 a.m., following medications were observed:Two (2) tubes of zinc oxide (to protect skin) ointment,Four (4) tubes of 1% diclofenac sodium (to treat joint pain) gel,Two (2) tubes of nystatin (an antifungal) 100,000 units cream,One tube of 2% miconazole (an antifungal) cream,One bottle of 0.05% fluocinonide (a corticosteroid) eye drops,Two (2) tubes of 0.05% clobetasol (a super-high-potency topical steroid) cream,Two (2) tubes of 12% ammonium lactate (to treat dry skin) cream,One tube of bacitracin (an antibiotic) gel,One bottle of antifungal (to treat fungal infections) powder,One tube of menthol (to treat pain) gel, And one container of hemorrhoid medipads (premoistened) wipes. During an interview, at the time of the observation, LPN 5 indicated there were 18 treatment medications kept on the Rehab treatment cart. The treatment cart should remain locked to prevent access to medications and ensure the safety of residents and visitors. During an interview, on 5/18/26 at 9:57 a.m., RN 6 indicated the treatment medication carts should remain locked when unattended. This was done to ensure patient safety and to protect residents. On 5/18/26 at 10:40 a.m., the Unit Manager indicated the treatment medication carts needed to remain locked to protect the residents and visitors. An unlocked cart could pose a risk to residents' safety. On 5/19/26 at 12:23 p.m., the DON indicated treatment cart should remain locked when not in use. This protects residents, staff, and visitors as the treatment carts contain prescription medications with resident identifiers. An undated facility policy, titled, Drug Storage, provided by the Administrator on 5/19/26 at 10:01 a.m., indicated the following: . Drugs shall be stored in an orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding. All medications and other drugs, including treatment items, need to be stored in a locked cabinet or room, inaccessible to residents and visitors.410 IAC (Indiana Administrative Code) 16.2-3.1-25(j)410 IAC 16.2-3.1-25(k)