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	12/05/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to provide a notice of transfer/discharge and a bed hold policy notification to the resident or resident representative for 2 of 3 residents reviewed for hospitalizations. (Residents 5 and 15) Findings include:1. Resident 5's clinical record was reviewed on 12/4/24 at 9:27 a.m. Diagnoses included dysphagia following other cerebrovascular disease with a risk for malnutrition, iron deficiency anemia, other vitamin B12 deficiencies, and abdominal distention.A 8/27/25, annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact.A 4/22/25 progress note indicated Resident 5 had experienced multiple episodes of coffee ground-like emesis (vomit) and requested to be sent out to the emergency room.A 4/22/25, Resident Transfer Form observation note indicated the resident was transferred to the hospital for nausea, vomiting, and diarrhea. The observation note was unsigned.A 4/22/25, discharge MDS indicated the resident discharged with a return anticipated.The clinical record lacked documentation that the resident or resident's representative was provided with a copy of the bed hold policy and notice of transfer.A 7/23/25 progress note indicated Resident 5 had experienced three (3) episodes of coffee ground-like emesis and requested to be sent out to the emergency room.A 7/23/25, discharge MDS indicated the resident discharged with a return anticipated.A 7/23/25, Resident Transfer Form observation note indicated the resident was transferred to the hospital for nausea and vomiting. The observation note was unsigned.The clinical record lacked documentation that the resident or resident's representative was provided with a copy of the bed hold policy and notice of transfer.2. Resident 15's clinical record was reviewed on 12/3/25 at 12:55 p.m. Diagnoses included malignant neoplasm of middle lobe, bronchus or lung-stage IV, unspecified neuromuscular dysfunction of bladder, and chronic kidney disease, stage 4.A 10/7/25, significant change MDS assessment indicated the resident had severe cognitive impairment.A 9/24/25 progress note indicated the resident was lethargic and unable to be woken up with verbal stimuli. The resident's blood pressure was 94/65 mmHg (millimeters of mercury). The Nurse Practitioner (NP) was called and provided an order to send the resident to the emergency room. A voice mail was left for the resident's family.A 9/24/25 discharge MDS indicated the resident discharged with a return anticipated.A 9/24/25 Resident Transfer Form observation note indicated the resident was transferred to the hospital for hematuria and lethargy. The observation note was unsigned.The clinical record lacked documentation that the resident or resident's representative was provided with a copy of the bed hold policy and notice of transfer.During an interview, on 12/4/25 at 2:58 p.m., the RN Support indicated the Resident Transfer Form observation had a check box on page four (4) that indicated the following documents were sent with the resident: Medication Sheet, CCD Document, Notice of Transfer, Request for Hearing, Bed Hold Policy, and a copy of the Transfer Observation. During a follow-up interview, on 12/4/25 at 3:05 p.m., the RN Support confirmed the check box previously mentioned did not indicate who had received the documents. She indicated the facility's normal practice would not include providing documents to residents who were cognitively impaired.On 12/4/25 at 4:51 p.m., the RN Support indicated she was unable to locate the notice of transfer or bed hold policies provided to either Resident 5 or 15.On 12/5/25 at 10:03 a.m., LPN 4 indicated when a (continued on next page)

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.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident required transfer to the hospital she would ensure there was an order from the physician, open the Discharge Event in the electronic medical record (EMAR), monitor the resident's vital signs, call the facility DON and Administrator, and contact the resident's family. LPN 4 would also call for transportation, call report into the hospital, print the residents' Continuity of Care Document (CCD) and face sheet and provide these papers to the Emergency Medical Services (EMS) drivers. She would document all her actions in the Discharge Event and progress notes sections of the resident's clinical record. On 12/5/25 at 10:12 a.m., LPN 5 indicated when a resident needed to be sent out to the hospital, she would immediately obtain an order from the physician or NP. She would print out any necessary documents such as the residents' CCD form and face sheet, the transfer form, and a bed hold policy. She would call for transportation, remain with the residents and give reports to the hospital. She prints up three (3) copies of the documents and gives two (2) sets of the documents to the EMS drivers. She notified the family and documents all her actions in the residents' progress notes and observations. On 12/5/25 at 10:23 a.m., LPN 6 indicated she had placed a red binder at all nurse stations to assist the floor staff with providing the appropriate forms to the resident or resident representative. She indicated when a resident was discharged , the resident or resident representative should receive the notice of transfer form and a bed hold policy. The resident or resident representative would be asked to sign the notice of transfer. The staff should document who received the papers and any attempts to contact the responsible party in the resident's clinical record.On 12/5/25 at 11:11 a.m., the ADON indicated the floor staff would ensure the resident or the resident representative received the notice of transfer, request for hearing form, and the bed hold policy. The staff would need to contact the resident's family to pick up the forms, if the resident was not provided with the forms. The clinical record should indicate who received the necessary forms, all attempts made to contact the representatives, and if the forms had been sent out in the mail.A current facility policy, effective 11/14, titled, Resident Discharge and Transfer Policy, provided by the Administrator on 12/4/25 at 3:30 p.m., indicated the following: . The policy outlines the process for determining when discharge or transfers is appropriate and the expectations for how the process should occur. By encompassing federal and state requirements, this policy provided specific procedures on how to discharge/transfer a resident the paperwork that must accompany the process. Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident's clinical record and transmit a copy to the following, a. The resident, b. A family member of the resident, if known.Notice may be made as soon as practicable before transfer or discharge when:. (d) An immediate transfer or discharge is required by the resident's urgent medical needs.(1) Prior to a hospital transfer or a therapeutic leave (twenty-four (24) hours duration or longer), the facility must provide written information to the resident and a family member or legal representative that specifies the following: (i) The duration of the bed-hold policy under the Medicaid state plan during which the resident is permitted to return and resume residence in the facility.3.1-12 (a)(4)3.1-12(a)(6)(A)(i)3.1-12 (a)(26)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, record review, and interview, the facility failed to follow professional nursing standards for PICC (Peripherally Inserted Central Catheter) line dressing changes to mitigate the risk for infection for 1 of 1 resident reviewed for IV (Intravenous) medications. (Resident 71)During an observation and interview on 12/3/25 at 10:21 a.m., Resident 71 was fully dressed seated upright in a specialty bed. There was an IV pole to the right side of the bed. Resident 71 indicated they had a PICC line and were getting IV antibiotics for a MRSA (methicillin-resistant staphylococcus aureus bacteria) infection. The staff provided the antibiotic medication on second shift around 7:00 p.m. every day. The PICC line was located on the right upper arm. The clear dressing covering the PICC line insertion site was dated 11/24/25.Resident 71's clinical record was reviewed on 12/4/25 at 11:54 a.m. Diagnoses included unspecified local infection of the skin and subcutaneous tissue, fusion of spine cervical region and thoracic regions, and weakness.Current orders included the following: PICC line dressing change- change needle free valve during each dressing change, once a day on Mondays on day shift (10/30/25), and PICC line flush- normal saline 5 mL's every shift for each lumen. If a medication is due during your shift flush with 5mL's of normal saline before the medication, followed by 5mL's of normal saline after the medication administrations for each lumen, every shift (10/30/25).A 9/22/25, quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and was dependent on staff assistance for all ADL's (activities of daily living).A 11/4/25, IV antibiotic care plan, indicated Resident 71 requires antibiotics related to an infection and had the potential for complications. Interventions included the following: administer IV medications as ordered (11/4/25), change IV dressing as ordered (11/4/25), and flush IV per orders (11/4/25).A review of the December 2025, Medication Administration History report indicated the PICC line dressing change due for Monday, December 1, 2025, was not completed due to the resident preferring another staff member to change the dressing.During an observation of the PICC line dressing change on 12/4/25 at 4:42 p.m., RN 8 confirmed the PICC line dressing was dated 11/24/25.During an interview, at the time of the observation, RN 8 indicated she was asked to change the dressing on Monday, 12/1/25, by another nurse but was extremely busy on her own assignment and had forgotten to do it. RN 8 indicated the PICC line was flushed every shift and the other nursing staff should have recognized the date was past due and made attempts to change the dressing.During an interview, on 12/5/25 at 11:11 a.m., the ADON indicated the expectation was for staff follow professional nursing standards for PICC line care. The standard practice indicated a PICC line dressing change was to be completed every seven (7) days. These standards helped to prevent infection. The nursing staff should have been assessing and evaluating the PICC line site and noticed the date was past due. The nursing staff should have made attempts to change the dressing, and any refusals should have been documented in the resident's clinical record.A current facility policy, dated 4/09, titled, Central Venous Catheter Dressing Changes, provided by the Administrator on 12/4/25 at 3:18 p.m., indicated the following: The purpose of this procedure is to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. 1. Change transparent semi-permeable membrane (TSM) dressings at least every 7 days and PRN (when wet, soiled, or not intact) .7. Change needleless access device, extension tubing, and stabilization device at time of routine dressing change . 3.1-47(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure a resident who required oxygen received services to ensure clean supplies and humidification to reduce side effects for 1 of 1 resident reviewed for oxygen. (Resident 110)Findings include:During an observation and interview on 12/1/25 at 3:30 p.m., Resident 110 was fully dressed and seated in the recliner beside the bed. He was wearing a nasal cannula. The oxygen tubing was undated. He indicated his oxygen was ordered at 3 liters per minute. On 12/2/25 at 10:36 a.m., Resident 110 was fully dressed and seated in the recliner beside the bed. He was wearing a nasal cannula. He indicated he could not recall the last time staff checked on his oxygen level or changed his tubing. He wears oxygen constantly. The oxygen concentrator was set to 5 liters per minute, and the water humidification bottle was empty. The sides and bottom of the water bottle were covered with a white discoloration resembling coarse salt. The oxygen tubing was undated.On 12/3/25 at 10:30 a.m., Resident 110 was fully dressed and seated in the recliner beside the bed. He was wearing a nasal cannula. The oxygen concentrator was set to 5 liters per minute, and the water humidification bottle was empty. The sides and bottom of the water bottle were covered with a white discoloration resembling coarse salt. The oxygen tubing was undated. A portable concentrator sat on the floor in the far corner. The oxygen tubing was undated and laying on the floor. He indicated his nose was dry and itchy, he felt congested, and it was difficult to breathe through his nose.Resident 110's clinical record was reviewed on 12/3/25 at 3:03 p.m. Diagnoses included Tetralogy of Fallot (a congenital heart abnormality), acute respiratory failure with hypoxia, and COPD (Chronic Obstructive Pulmonary Disease).Current order included continuous oxygen at 3-5 liters per minute by nasal cannula, every shift (11/6/25) and change and date oxygen tubing and humidifier bottle, change weekly and PRN (as needed) once a day on Sundays (11/6/25).A 11/6/25, impaired gas exchange care plan indicated the resident required oxygen related to COPD and acute on chronic respiratory failure. Interventions included administer oxygen as ordered (11/6/25), monitor lung sounds as needed (11/6/25), and report signs of hypoxia (11/6/25). A 11/18/25, admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and required oxygen therapy.A review of the November 2025, Medication Administration History report indicated the change and date oxygen tubing and humidification bottle order was checked off as completed on 11/30/25.During an observation and interview, on 12/3/25 at 10:33 a.m., LPN 9 indicated when a resident wore oxygen, she checked the oxygen level, checked the residents' respiratory vitals, checked the tubing for cleanliness, and checked the water level in the humidification bottle. LPN 9 indicated she had changed Resident 110's oxygen tubing recently but did not remember the date and forgot to mark the tubing. She confirmed the resident's oxygen concentrator was set to 5 liters per minute and the water humidification bottle was completely empty. A resident might experience dry sinuses and discomfort from wearing oxygen without water humidification.During an interview, on 12/3/25 at 10:48 a.m., the Unit Manager indicated the oxygen tubing change orders were set for Sunday nights. She checked on Monday and Resident 110's oxygen tubing had been changed appropriately. She indicated it could have been changed again after she looked and someone forgot to date the tubing. The nurses should be checking the water humidification on oxygen concentrators on each shift. Resident 110 utilized oxygen at 5 liters per minute, and the water would be used more quickly than those using a lower oxygen level. The staff should be aware of this and check his water bottle more frequently.A current facility policy, revised 3/04, titled, Oxygen Administration, provided by the Administrator on 12/4/25 at 3:19 p.m., indicated the following: The purpose of this procedure is to provide guidelines for safe oxygen administration.Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: . 12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. 14. Periodically re-check water level in humidifying jar. 3.1-47 (a)(6)