STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155381	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident care received immediate care following a fall, which resulted in a injury for 1 of 3 reviewed for quality of care (Resident B). Findings include: The closed clinical record for Resident B was reviewed on 3/4/20 at 9:32 a.m. [DIAGNOSES REDACTED]. A progress note, dated 12/2/19 at 4:00 p.m., indicated the resident was admitted to the facility. An admission observation report, dated 12/2/19 at 9:56 p.m., indicated the resident had fallen within the past month and had an unsteady gait. Review of the vital sign record, the initial set of vital signs were taken on admission at 9:49 p.m. A second set of vital signs were obtained at 2:10 a.m. The Plan of Care (POC) history record, indicated the resident was last provided Activities of Daily (ADL) care on 12/2/19 at 10:37 p.m. On 12/3/19 at 1:17 a.m., Resident B's medications arrived from the pharmacy and she refused to take them. A late entry progress note entered 12/3/19 at 7:21 p.m., indicated on 12/3/19 at 3:22 a.m., a staff member heard someone saying help and and making a noise on the toilet. The resident was found on the floor and when attempted to assist the resident from the floor, yelled out in pain. She indicated she felt like she fractured the other hip. A progress note, dated 12/3/19 at 3:44 a.m., indicated the resident was ambulating without her walker and without assistance. She was banging on toilet. The resident indicated she felt like she did when she broke her other hip. A progress note, dated 12/3/19 at 3:44 a.m., indicated a family member was contacted concerning the fall and the Emergency Medical Team (EMT) arrived at this time. The family member was to meet the resident at the hospital. The nurse attempted to contact the physician and was waiting for a call-back. A discharge and transfer report, completed 12/3/19 at 4:00 a.m., indicated the resident was sent to the local hospital. She indicated a pain level 7, out of 10, but no pain medication was given. The admitting [DIAGNOSES REDACTED]. Review of the face sheet, Resident B did not have any advance directive, Power of Attorney (POA) or health care representative listed. During an interview with the Administrator and Director of Nursing (DON) on 3/4 12:30 p.m., the DON was unable to find an event for the fall or an order to send the resident to the hospital. She indicated staff were to check on residents every 2 hours, but they do not document the times they provide ADL care. She was not sure why the vital signs were done at 2:10 a.m. and the resident was not sent out until 3:51 a.m. During a telephone interview on 3/4/20 at 1:05 p.m., LPN 1 indicated the vital signs that were taken at 2:10 a.m. after she had fallen. She was trying to get a hold of the family because it was up to them if she was sent out or not. Review of a current facility Admission and Payment Agreement, provided by the Administrator on 3/4/20 at 2:03 p.m. The policy indicated the following: .Emergency Services: The Resident/Legal Representative authorizes the Facility to arrange for any emergency medical treatment deemed necessary, unless indicated the the signing of specific Advance Directives In the absence of a specific direction prohibiting same, the Facility shall provide emergency medical treatment or transfer the Resident to a hospital or other medical facility This Federal Tag relates to complaint IN 361. 3.1-37(a)
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure pain medication was available and given for 1 of 3 residents review for pain medication. (Resident D) Findings include: During an interview on 3/3/20 at 11:20 p.m., Resident D indicated he arrived at the facility around 4:00 p.m. today. He told staff that he received 2 pain pills daily. He was currently in a lot of pain, his ankle was throbbing and he was not able to sleep. He just received his pain pill, but had to be up by 6:00 a.m. for an appointment. He indicated he did just yelled at someone that he was in pain and had been for a while. He was not sure who the person was, but thought it was the nurse. During a second interview with Resident D and his spouse on 3/4/20 at 9:45 a.m., the spouse indicated she actually had to call the nurse and tell her he was in pain and she should not have to do that. The resident indicated he just felt like he could have gotten his pain medication earlier than he did, but the nurse said something about not being able to get into the cabinet. The clinical record for Resident D was reviewed on 3/4/20 at 10:15 a.m. [DIAGNOSES REDACTED]. A progress note, dated 3/3/20 at 4:11 p.m., indicated the resident was admitted from home one day after being discharged from a hospital. The resident was alert and oriented and able to make his needs known. He had 3 surgical sites; left upper chest, right knee and right outer ankle. An admission observation report, dated 3/4/20 at 4:11 p.m., indicated the resident had moderate pain in the last 4 weeks and no trouble with sleep. He did not currently have any pain. A physician's orders [REDACTED]. The general admission report, indicated Qualified Medication Aide (QMA) 5 documented the resident did not have any pain on 3/3/20 from 3:00 p.m. through 7:00 a.m. the following day. Review of an automated pharmacy dispensing record, [MEDICATION NAME]-[MEDICATION NAME] was removed from the pharmacy on 3/3/20 at 11:00 p.m. by LPN 2. The Medication Administration Record [REDACTED]. She thought the resident got upset with an aide related to his pain. On 3/4/20 at 2:35 p.m., the Administrator indicated LPN 3 had not pulled medication from the automated dispensing machine before and had to ask another nurse to pull it for her. During the exit conference, the Director of Nursing (DON) indicated during all the assessments, the resident did not indicated he was in any pain. She just felt like by the time he asked for a pain pill, the pain was too much. A current facility policy, dated May 15, 2015, titled Pain Policy, provided by the DON on 3/4/20 at 2:23 p.m., indicated the following: Policy Statement Each resident experiences pain in an individual manner. Pain is defined as unpleasant sensory and emotional experience that can be acute, recurrent, or chronic/persistent Pain is whatever the experiencing person says it is, existing whenever he/she says it does. The goal for managing pain should be to achieve a consistent level of comfort while maintaining as much function as possible 3.1-37(a)

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

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.