STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00363269, IN00363497 and IN00364449. Complaint IN00363269 - Substantiated. Federal/State deficiencies related to the allegations are cited at F759. Complaint IN00363497 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00364449 - Substantiated. Federal/State deficiencies related to the allegations are cited at F925. Survey dates: October 7 and 8, 2021. Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census Bed Type: SNF/NF: 76 Total: 76 Census Payer Type: Medicare: 5 Medicaid: 69 Other: 2 Total:76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/12/21.	F 0000	Please reference the enclosed 2567 as “plan of correction” For the complaint and Annual survey that was conducted at Harbor Health & Rehab I will submit signature sheets of the in-servicing, content of in-service and audit tools. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on 10/19/2021 serves as our allegation of compliance. The provider respectfully request a desk review on or after October 22nd 2021Should you have any questions or concerns	

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

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			regarding our Plan of Correction , please don't hesitate to Contact me. Sherri Shelby RN, HFA **Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure a dependent resident received assistance with ADLs (activities of daily living) related to bathing for 1 of 3 residents reviewed for ADLs. (Resident B) Finding includes: The record for Resident B was reviewed on 10/7/21 at 10:04 a.m. The Quarterly Minimum Data Set assessment, dated 9/30/21, indicated the resident had severe cognitive deficit. She required extensive assistance of one for bed mobility, and extensive assistance of two for transfers. Diagnoses included, but were not limited to, dementia, atrial fibrillation and breast	F 0677	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 677 ADL for Dependent**	10/22/2021

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	cancer. The first floor shower schedule indicated the resident was scheduled for showers on Tuesdays and Thursdays during day shift. The electronic charting for the past 30 days indicated the resident received bathing assistance on 9/11, 9/18 and 9/22/21. The shower sheets indicated the resident received a shower on 9/6, 9/10, 9/21 and 10/5/21. There was no documentation the resident received a shower or bath between 9/21 and 10/5; thirteen days. Interview with the first floor Unit Manager, on 10/7/21 at 2:57 p.m., indicated showers should be documented in the electronic chart, or on shower sheets as a back up. Interview with the Director of Nursing, on 10/7/21 at 3:20 p.m., she indicated the facility was in the process of updating their computer system and some of electronic charting after 9/28 was lost . She provided shower sheets and indicated there were no additional shower sheets for the resident. This Federal tag relates to Complaint IN00363497. 3.1-38(a)(3)		**Residents** It is the facility policy to ensure that each resident's receive showers and baths as per preference. **1. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·RB received a shower on 10.7.21. her shower preference was reviewed & she is scheduled to receive shower 2x/week with staff assistance @ her preferred time. **1. How the facility will identify other residents having the potential to be affected by the same deficient practice.** ·All residents have the potential to be affected by the alleged deficient practice. **1. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** ·The Nursing staff was in-serviced on ensuring that residents receive showers/ bed baths as scheduled per their preference. In-servicing completed 10/13/21	

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			·The Nursing staff was in-serviced on proper documentation for showers/bed baths. In-servicing completed 10/13/21 **1. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur.** ·Audit tool for monitoring resident showers/bathes developed. ·DON or designee will audit to ensure that each resident is being scheduled to receive a shower/bed bath 2x/week and such care services are properly documented on the resident's medical records. At least five random residents will be selected per audit. This will be completed daily Monday through Friday for 4 weeks. Then 3 x per week for 5 months. · The results of the audit observations will be reported, reviewed, and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months and then randomly thereafter for further recommendations. This will be completed daily Monday through Friday for 4 weeks. Then 3 x per week for 5 months. Audit tool Attached ·Date of completion/compliance 10-22-21.	

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F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 3 residents observed during medication pass. Two errors were observed during 29 opportunities for errors during medication administration. This resulted in a medication error rate of 6.9 percent. (Resident B) Finding includes: On 10/7/21 at 9:50 a.m., RN 1 was observed preparing Resident B's medications. Two medications were not available during medication pass; Xarelto 10 mg (an anticoagulant) and Anastrozole 1 mg (breast cancer medication). The RN looked in the overflow cart and the medication room, but indicated the medications were not available and she would order them. The resident's record was reviewed on 10/7/21 at 10:04 a.m. The Quarterly Minimum Data Set assessment, dated 9/30/21, indicated the resident had severe cognitive deficit. She required extensive assistance of one for bed mobility, and extensive assistance of two for transfers. Diagnoses included, but were not limited to, dementia, atrial fibrillation and breast cancer. A Physician's order, dated 5/3/21, indicated the resident was to receive Xarelto 10 mg daily for atrial fibrillation.	F 0759	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 759 Free of Medication Errors** It is the facility policy to ensure that medication error rates are not 5 percent or greater. **1. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R B was assessed for any possible side effects of the medication omission. R B is in stable condition with no signs and symptoms of possible ill effects from medication omission. No	10/22/2021

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	A Physician's order, dated 5/3/21, indicated the resident was to receive Anastrozole 1 mg daily for breast cancer. The current policy, "Medication Administration", was provided by the Director of Nursing (DON) on 10/7/21 at 2:20 p.m., indicated, "..."Medications are administered in accordance with written orders of the prescriber...." Interview with the DON, on 10/8/21, indicated medications should be ordered by the nurses through the electronic system when they are running low. This Federal tag relates to Complaint IN00363269. 3.1-48(c)(1)		further meds needed to be reordered. The medication in mention had been reordered 2 days prior and when the nurse called pharmacy regarding it not being available, they informed her it was stored in different packaging than it was actually sent in and made it difficult to locate. The nurse eventually located it and RB continues to receive her meds as ordered. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents that are administered medication have the potential to be affected by the alleged deficient practice. 3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·RN1 was provided with 1:1 education and competency on medication pass ·Inservice will be provided on the following topic: Reordering & storage of medications. ·DON or designee will audit 1 resident daily, 5 days per week, for 1 month. Then 3 residents weekly for 5 months.	

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			4. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction observation audits will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for six (6) Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 5. Dates when corrective action will be completed: October 22, 2021	
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to maintain an effective pest control program related to roaches in the facility for 1 of 2 units observed. (First floor) Finding includes:	F 0925	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and*	10/22/2021

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	On 10/8/21 at 8:44 a.m., there was a bug, later identified as a roach, crawling on the conference room wall. There were two sticky bug traps on the conference room floor that had several dead roaches in them. At 8:47 a.m., a partially squashed roach was observed on the kitchen wall. There were sticky bug traps in the pantry and kitchen area that had several dead roaches in them. At 8:50 a.m., a dead roach was observed on the kitchen floor. During an interview with the Dietary Manager, on 10/8/21 at 8:50 a.m., she indicated they had roaches, but the pest company had been out on Tuesday and sprayed, and they were much better now then they used to be. Interview with the Maintenance Director, on 10/8/21 at 9:15 a.m., indicated the pest company came out two times a month to spray for roaches. He indicated if they were seen in between, he would spray them with an insecticide. The sticky traps were laid out weekly and checked daily by him. The current policy, "Safe Environment", provided by the Nurse Consultant, on 10//8/21 at 10:37 a.m., indicated, "...The facility will maintain an effective pest control program so that the facility is free of pests and rodents." This Federal tag relates to Complaint IN00363449. 3.1-19(f)(4)		*submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 925 Maintains Effective Pest Control Program** It is the policy of the facility to maintain an effective pest control program so that the facility is free of pests and rodents. **1.Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·No resident was affected by this deficient practice. 1.How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents residing in the facility have the potential to be affected by the deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Monroe Pest Control had made a service call on 10/5/2021. They continue to treat facility twice	

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			monthly and as needed. ·Inservice will be provided to all staff to maintain cleanliness of the environment and reporting immediately any observation of pest infestation. ·An observation tool was developed to check the facility for any pests. This observation will be conducted 5 times weekly for four weeks and issues identified will be addressed immediately. Then twice weekly for 5 months. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction observation tool will be reported by the Administrator , Dietary Manager and Housekeeping/Maintenance Director to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 1.Dates when corrective action will be completed: October 22nd, 2021	