	Γ OF HEALTH AND HU R MEDICARE & MEDIC					FORM APPROVED OMB NO. 0938-039	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	î î	JILDING	00	COMPLETED	
		155653	B. WI		<u></u>	02/28/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE				ICCOOK AVE		
HARBOF	R HEALTH & REHA	B	EAST CHICAGO, IN 46312		CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
F 0000							
Bldg. 00							
Blug. 00	This visit was for t	he Investigation of Complaints	F 00	000	Please reference the enclose	d	
		401921, and IN00401979.	1.00	000	2567 as "plan of correction" f		
	1100100505, 1100	101921, and 1100101979.			Complaint survey that was		
	Complaint IN0040	0563 - Substantiated.			conducted at Harbor Health 8	k l	
	-	encies related to the			Rehab		
	allegations are cite	d at F686 and F921.			I will submit signature		
	C				sheets of the in-servicing,		
	Complaint IN0040	1921 - Substantiated.			content of in-service and		
	Federal/state defici	encies related to the			audit tools.		
	allegations are cite	d at F580, F655, F684, and F697.			Preparation and / or		
					execution of this plan of		
	Complaint IN0040	1979 - Substantiated. No			correction does not constitute	•	
	deficiencies related	to the allegations are cited.			admission or agreement by		
					the provider of the truth facts		
	Unrelated deficient	cy is cited.			alleged or conclusion set forth	n	
					in the statement of		
	Survey date: Febru	ary 28, 2023			deficiencies. This plan of		
					correction is prepared and /		
	Facility number: 0				or executed solely because it		
	Provider number:				is required by the provision of	f	
	AIM number: 100	267410			the Federal State Laws. This		
	~				facility appreciates the time		
	Census Bed Type:				and dedication of the Survey		
	SNF/NF: 76				Team; the facility will accept		
	Total: 76				the survey as a tool for our		
	Course Doorse Trees				facility to use in continuing to		
	Census Payor Type Medicare: 12	51			better our Elders in our		
	Medicare: 12 Medicaid: 63				community.		
	Other: 1				The Plan of Correction		
	Total: 76				submitted on 3/23/23		
	10tal. /0				serves as our allegation		
	These definiencies	reflect State Findings cited in			of compliance. The provider		
	accordance with 41	-			respectfully request a desk review on or after 3/28/2023.		
		N IAC 10.2-3.1.			Should you		
	Quality review con	n leted on $3/2/23$			have any questions or conce	rne	
					regarding our		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETITLE(X6) DATEsherri shelbyNHA03/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

PRINTED: 04/13/2023 FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155653	A. BUILDING B. WING	00	COMPLETED 02/28/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C	COD	
HARBOR	R HEALTH & REHA	ΑB	EAST	CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI		(X5) COMPLETION DATE
= 0580 SS=D Bidg. 00	483.10(g)(14)(i)-(Notify of Change §483.10(g)(14) N (i) A facility must resident; consult physician; and no her authority, the when there is- (A) An accident in results in injury a requiring physicia (B) A significant of physical, mental, (that is, a deterio psychosocial stat conditions or clin (C) A need to alte (that is, a need to form of treatment consequences, o of treatment); or (D) A decision to resident from the §483.15(c)(1)(ii). (ii) When making	s (Injury/Decline/Room, etc.) lotification of Changes. immediately inform the with the resident's otify, consistent with his or resident representative(s) hvolving the resident which nd has the potential for an intervention; change in the resident's or psychosocial status ration in health, mental, or tus in either life-threatening ical complications); er treatment significantly o discontinue an existing		Plan of Correction , ple hesitate to Contact me. Sherri Shelby RN, HFA Please accept the foll the facility's plan of c This plan of correctio not constitute an adm guilt or liability by the and is submitted only response to the regul requirement.	owing as orrection. n does hission of facility	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u> </u>		
		155653	B. WING		02/28	3/2023
NAME OF	PROVIDER OR SUPPLIE	ŪR.		ET ADDRESS, CITY, STATE, ZIP O	COD	
HARBUI	R HEALTH & REH/	4B	EAS	T CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COL		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		is available and provided				
	upon request to t					
		ust also promptly notify the				
		resident representative, if				
	any, when there					
	•	oom or roommate				
		pecified in §483.10(e)(6); or resident rights under Federal				
		egulations as specified in				
	paragraph (e)(10					
		ust record and periodically				
		ess (mailing and email) and				
	phone number of	,				
	representative(s)					
	§483.10(g)(15)					
	Admission to a c	omposite distinct part. A				
	-	omposite distinct part (as				
	-	5) must disclose in its				
	admission agree					
	-	luding the various locations				
		e composite distinct part,				
		the policies that apply to				
	-	etween its different locations				
	under §483.15(c	(9). eview and interview, the facility	E 0590	EE90 Notify of Chang	~~	02/28/202
		notify the resident's family after	F 0580	F580 Notify of Chang	62	03/28/202
		idents reviewed for falls.		The facility requests	nanor	
	(Resident C)			compliance for this c		
	(itesitaein e)					
	Finding includes:			This Plan of Correction	n is the	
				center's credible alleg		
	The closed record	for Resident C was reviewed on		compliance.		
		n. The resident was admitted on				
		arged to hospital on $1/20/23$.		Preparation and/or ex	ecution of	
	Diagnoses include	d but were not limited to,		this plan of correction		
		pressure, non traumatic		constitute admission o		
		age, craniectomy, and		by the provider of the	truth of the	
	osteoarthritis.			facts alleged or conclu		
				forth in the statement	of	1

NAME OF PRO HARBOR I (X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O		5025 N EAST	00 ADDRESS, CITY, STATE, ZIP COD ACCOOK AVE	COMPLETED 02/28/2023
HARBOR I (X4) ID PREFIX TAG	HEALTH & REHA SUMMARY (EACH DEFICIEN REGULATORY O	AB STATEMENT OF DEFICIENCIE	5025 N EAST	ICCOOK AVE	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE	EAST		
PREFIX TAG	(EACH DEFICIEN REGULATORY O			CHICAGO, IN 46312	
TAG	REGULATORY O	YOV MUST DE DRECEDED DV EULI	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
		NCT MUST BE FRECEDED BT FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
	The 5 Day Minimu	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	The 5 Day Milling	ım Data Set (MDS) assessment,		deficiencies. The plan of	
		cated the resident was		correction is prepared and/or	
	cognitively intact a	nd was an extensive assist for		executed solely because it is	
	all of Activities of	Daily Living (ADLs).		required by the provisions of	
	Nurses' Notes, date	ed 1/19/23 at 11:20 p.m.,		federal and state law.	
		r was informed by the nurse the			
		d to the floor on the 3-11 shift.		Immediate action taken for	
		bserved sleeping at an angle in		those residents identified?	
		egs towards the edge of the		Resident C no longer resides in	
		pre placed on both sides of the		the facility.	
		wedges were placed on the		the leastly.	
	sides of the residen	e 1		How the facility identified othe	r
				residents?	
		mentation the resident's family			
	was notified the res	sident had fallen out of bed.		All residents who reside in the	
				facility have the potential to be	
		ed 1/20/23 at 2:37 a.m., indicated		affected by this deficient	
	-	hter had called the facility and		practice.	
	-	er well being. The daughter			
		e resident's slip to the floor on		Measures put into	
	-	nd floor mats were placed on ent's bed for safety and wedges		place/System changes?	
				Lissness d Otaff have have	
		ident's daughter was		Licensed Staff have been	
		nother and requested for the g (DON) to call her father in the		educated on the importance of notifying family for change of	
	morning.	g (DON) to call her father in the		conditions.	
	A Dist M				
	-	nt Assessment, dated 1/19/23,		How will the corrected actions	
		l time of fall was at 9:00 p.m.		be monitored?	
		the writer the resident was in a			
		on the floor. The bed was in a		Director of Nursing or Designee	
		he pillow had fallen out of bed looked as though she had slid		will audit falls 5 days a week the	
	-	looked as though she had she		3x's a week then weekly thereat	
		she did not know what		to ensure that family members	
		gns at the time of fall were blood		have been notified of falls. The	
		eart rate was 80, oxygen		Director of Nursing is responsible	
		6, and respirations were 17. A		for compliance of this deficiency	
		essment was completed and		The results of these audits will be reviewed in Quality	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DAT	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COM	PLETED
		155653	B. WING		02/2	8/2023
		70	STREE	T ADDRESS, CITY, STATE, ZIP CO)D	
	PROVIDER OR SUPPLII			MCCOOK AVE		
HARBOF	R HEALTH & REH	AB	EAST	CHICAGO, IN 46312		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF		COMPLETION
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	active range of mo	otion times 4 was noted. The		Assurance Meeting mo	onthly for	
	resident had no co	mplaints of pain. The resident		6 months or until an av	verage of	
	was assisted back	to bed using hoyer mechanical		90% compliance or gre	eater is	
	lift.			achieved x3 consecuti		
				months. The QA Com		
	Interview with the	e DON on 2/28/21 at 3:30 p.m.		will identify any trends		
		lent's family was not notified of		patterns and make		
		aughter had called in, however,		recommendations to r	ovice the	
		resident's spouse in the				
		resident's spouse in the		plan of correction as in	naicated.	
	morning.					
	The current and u	odated 11/13/18.		Date of Completion: 03	3/28/2023	
		Notification-Change in				
		, provided by the DON on				
		m., indicated the facility will				
	-	's legal representative or an				
		nember where there has been a				
		in the resident's physical,				
	mental or psychos	ocial status.				
	This Federal Tag	relates to Complaint IN00401921.				
	3.1-5(a)(2)					
- 0655	483.21(a)(1)-(3)					
SS=D	Baseline Care P	lan				
Bldg. 00	§483.21 Compre	hensive Person-Centered				
	Care Planning					
	§483.21(a) Base	line Care Plans				
	- , ,	ne facility must develop and				
		eline care plan for each				
		udes the instructions needed				
		ve and person-centered care				
		at meet professional				
		lity care. The baseline care				
	plan must-					
	1 '	within 48 hours of a				
	(I) Be developed resident's admis	within 48 hours of a				
		inimum healthcare				
	I information nece	ssary to properly care for a				

STATEMENT OF DEF AND PLAN OF CORRI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/28/2023	
NAME OF PROVIDER			5025	et address, city, state, zip cod MCCOOK AVE I CHICAGO, IN 46312		
TAG REC	ACH DEFICIEN GULATORY OI nt including	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION , but not limited to-	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRC DEFICIENCY)	DBE COMPLETIO	
(B) Ph (C) Die (D) Th (E) So (F) PA §483.2 compri- baselir plan- (i) Is c resider (ii) Me paragr	ysician ord etary orders erapy servi cial service SARR reco 21(a)(2) The ehensive can he care plan developed v nt's admiss ets the requ raph (b) of t	s. ces. s. ommendation, if applicable. e facility may develop a are plan in place of the n if the comprehensive care vithin 48 hours of the ion. uirements set forth in his section (excepting				
§483.2 residen summa include (i) The (ii) A s and dia (iii) Ar admini acting (iv) An details necess Based failed t comple residen	 paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on record review and interview, the facility failed to ensure a baseline Care Plan was completed within 48 hours off admission for 1 of 8 resident C) 	e facility must provide the representative with a aseline care plan that t limited to: ls of the resident. f the resident's medications ctions. and treatments to be he facility and personnel of the facility. nformation based on the prehensive care plan, as view and interview, the facility aseline Care Plan was 8 hours off admission for 1 of 8	F 0655	F655 Baseline Care Plans The facility requests paper compliance for this citation <i>This Plan of Correction is t</i> <i>center's credible allegation</i> <i>compliance.</i>		

NTERS FO			ava	CONTRACTOR	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155653	B. WING		- 02/28/2023
NAME OF	PROVIDER OR SUPPLIE	B		ET ADDRESS, CITY, STATE, ZIP CO	DD
				5 MCCOOK AVE	
HARBO	R HEALTH & REHA	Ъ	EAST CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	RECTION (X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX		OULD BE COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	2/28/23 at 1:50 p.n	n. The resident was admitted on		Preparation and/or exe	cution of
	1/16/23 and discha	rged to hospital on 1/20/23.		this plan of correction d	loes not
	Diagnoses included	d but were not limited to,		constitute admission or	agreement
	stroke, high blood	pressure, non traumatic		by the provider of the tr	ruth of the
	subdural hemorrha	ge, craniectomy, and		facts alleged or conclus	sions set
	osteoarthritis.			forth in the statement o	f
				deficiencies. The plan	of
	The 5 Day Minimu	um Data Set (MDS) assessment,		correction is prepared a	
	dated 1/20/23, indi	cated the resident was		executed solely becaus	
	cognitively intact a	nd was an extensive assist for		required by the provisio	
		Daily Living (ADLs).		federal and state law.	
	A Resident/Family	Notification, dated 1/16/23,		1) Immediate action	ns taken
	-	ent was high risk for falls with a		for those residents ide	
	score of 18.	5		Resident C no longer re	
	-			the facility.	
	The Baseline Care	Plan, dated 1/16/23, was			
		re was no Care Plan for falls.		2) How the facility i	dentified
	1			other residents:	
	Nurses' Notes, date	ed 1/19/23 at 11:20 p.m.,			
	indicated the write	r was informed by the nurse the		All residents who admit	to the
	resident had slippe	d to the floor on the 3-11 shift.		facility have the potentia	al to be
	The resident was o	bserved sleeping at an angle in		affected by the alleged	deficient
	the bed with both l	egs towards the edge of the		practice.	
	bed. Floor mats we	re placed on both sides of			
	resident's bed and	wedges were placed on the			
	sides of the resider	t for safety.		3) Measures put int	o place/
				System changes:	
	A Care Plan for fal	ls was put into place on 1/19/23.			
				Licensed staff will be re	
		Director of Nursing (DON) on		on the importance of co	
	-	n. indicated the baseline Care		Baseline care plans wit	hin 48
		as not completed within 48		hours of admission.	
	hours of admission				
				4) How the corrective	
	This Federal tag re	lates to Complaint IN00401921.		actions will be monito	
				Director of Nursing or d	-
	3.1-35(a)			complete admission au	
				a week to ensure that b	
				care plans have been in	nitiated

	NT OF DEFICIENCIES	CAID SERVICES	(X2) MULTIPLE C	ONCTRUCTION		1B NO. 0938-039
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIE		5025 N	ADDRESS, CITY, STATE, ZIP COD MCCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PREFIX PR		(X5) COMPLETION DATE
				 within 48 hours of admissio Director of Nursing is respo for compliance of this defici The results of these audits be reviewed in Quality Assurance Meeting month months or until an average 90% compliance or greate achieved x3 consecutive months. The QA Committ will identify any trends or patterns and make recommendations to revis plan of correction as indice 5) Date of compliance: 03/28/2023 	nsible ency. s will ly x6 e of r is ee e the	
F 0684 SS=D Bldg. 00	applies to all treat facility residents. comprehensive a facility must ensu- treatment and ca professional stan comprehensive p and the residents Based on record re failed to ensure fal an assessment of the	a fundamental principle that tment and care provided to Based on the ssessment of a resident, the re that residents receive re in accordance with dards of practice, the erson-centered care plan, ' choices. view and interview, the facility I follow up with vital signs, and he resident was completed for for 2 of 3 residents reviewed for	F 0684	F684 Quality of Care The facility requests paper compliance for this citation. <i>This Plan of Correction is th</i> <i>center's credible allegation</i> <i>compliance.</i>		03/28/2023

STATEME	NT OF DEFICIENCIES	DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155653	B. WING		02/28/2023	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP COD	•	
	R HEALTH & REH			ICCOOK AVE CHICAGO, IN 46312		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE COMPLETIC	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	1. The closed reco	rd for Resident C was reviewed				
		p.m. The resident was admitted		Preparation and/or execution	on of	
		scharged to hospital on 1/20/23.		this plan of correction does	s not	
	-	ed, but were not limited to,		constitute admission or agi	reement	
	-	pressure, non traumatic		by the provider of the truth	of the	
		age, craniectomy, and		facts alleged or conclusion	s set	
	osteoarthritis.			forth in the statement of		
				deficiencies. The plan of		
	The 5 Day Minim	um Data Set (MDS) assessment,		correction is prepared and/	′or	
	dated 1/20/23, ind	icated the resident was		executed solely because it	is	
	cognitively intact	and was an extensive assist for		required by the provisions	of	
	all of Activities of	Daily Living (ADLs).		federal and state law.		
	A Resident/Family	y Notification, dated 1/16/23,		1) Immediate actions take	n for	
	indicated the resid score of 18.	ent was high risk for falls with a		those residents identified	:	
				1. Resident C no longer		
	The Baseline Care	e Plan, dated 1/16/23, was		resides in the facility.		
	incomplete and th	ere was no Care Plan for falls		2. Resident E no negati	ve	
	within 48 hours of	f admission.		outcome noted for inaccura follow up.	ate fall	
	A Care Plan, dated	d 1/19/23, indicated the resident				
	was at risk for fall	s secondary to impaired		2) How the facility identifi	ed	
	mobility.			other residents:		
	Nurses' Notes, dat	ed 1/16/23 at 7:46 p.m.,		All residents who reside in	the	
	indicated the resid	lent was admitted to the facility.		facility have the potential to	be	
	The resident was a	alert and oriented times 3 with		affected by this deficient pr	actice	
	the admitting diag	noses of stroke, right				
	craniectomy with	evacuation of hematoma, and				
	right occipital hen	norrhage and subdural		3) Measures put into place	e/	
	hematoma.			System changes:		
	Nurses' Notes, dat	ed 1/18/23 at 8:08 a.m., indicated		Staff will be re-educated or	ı	
	the resident was a	lert and oriented times 2. The		assessing and completing	post-fall	
	resident was obser	rved thrashing around in the		follow up assessments acc		
	bed and disrobing	, this continued for 6 minutes. A		to reflect a current set of vi		
	helmet was on at t	his time for protection.				
	Nurses' Notes, dat	ed 1/19/23 at 11:20 p.m.,		4) How the corrective acti	ons	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	COMP	e survey leted 8/2023
	PROVIDER OR SUPPLIE		5025 N	ADDRESS, CITY, STATE, ZIP C MCCOOK AVE CHICAGO, IN 46312	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C indicated the write resident had slippe The resident was of the bed with both bed. Floor mats we resident's bed and sides of the resident Nurses' Notes, dat the resident's daug was asking about 1 was informed of th the previous shift a both sides of resid were used. The resident	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION or was informed by the nurse the ed to the floor on the 3-11 shift. Observed sleeping at an angle in legs towards the edge of the ere placed on both sides of wedges were placed on the nt for safety. ed 1/20/23 at 2:37 a.m., indicated hter had called the facility and ner well being. The daughter ne resident's slip to the floor on and floor mats were placed on ent's bed for safety and wedges sident's daughter was mother and requested for the	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SP CROSS-REFERENCED TO THE A DEFICIENCY) will be monitored: Director of Nursing or of review fall follow up do 5 days a week for 4 week 3x's a week for 4 week weekly thereafter to en the follow up fall assess accurate and have curr The Director of nursing responsible for the over deficiency. The results of these a be reviewed in Quality Assurance Meeting m months or until an ave 90% compliance or gr	HOULD BE APPROPRIATE designee will ocumentation eeks then asure that asments are rent vitals . g is ersight of this udits will y conthly x6 erage of	(X5) COMPLETIO DATE
	Director of Nursin morning. A Risk Manageme indicated the actua The CNA notified side lying position low position and the with the patient. It out of the bed from resident indicated happened. Vital si pressure 121/64, h saturation was 969 full head to toe ass active range of mor no complaints of p back to bed using A Nurses' Note, dat indicated the resid her legs off the sid sheet, and pillow v	g (DON) to call her father in the ent Assessment, dated 1/19/23, al time of the fall was at 9:00 p.m. the writer the resident was in a on the floor. The bed was in a he pillow had fallen out of bed looked as though she had slid in leaning on her side. The she did not know what gns at the time of fall were blood eart rate was 80, oxygen %, and respirations were 17. A sessment was completed and tion times 4. The resident had wain. The resident was assisted hoyer mechanical lift. ated 1/20/23 at 3:13 a.m., ent was observed in bed with le of the mattress. The blanket, were on the floor. The resident to the side of the bed pulling at		achieved x3 consecut months. The QA Com will identify any trend patterns and make recommendations to plan of correction as i 5) Date of compliance 03/27/2023	tive nmittee s or revise the indicated.	

	R MEDICARE & MEDIC		(22) 1		NSTRUCTION		OMB NO. 0938-03 TE SURVEY	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î			. ,		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00		APLETED	
		155653	B. V	VING		02/	02/28/2023	
				STREET A	DDRESS, CITY, STATE, ZIP	COD		
NAME OF	PROVIDER OR SUPPLIEF			5025 MC	CCOOK AVE			
HARBO	R HEALTH & REHA	В		EAST C	HICAGO, IN 46312			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIC DI AN OF O	OBRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	DATE	
	the disposable brief	The resident was						
	repositioned in bed							
	A Follow Up Fall N	Note: dated 1/20/23 at 4:42 a.m.,						
		recent pulse was checked on						
		., the most recent blood						
		ed on 1/18/23 at 3:15 p.m., and						
	the resident had no							
		Pulli.						
	There was no asses	sment of the resident's helmet						
	if it was on at the ti	me of the fall or thereafter.						
	There were no Phys	sician's Orders for the resident						
		he only mention/assessment of						
		/18/23 in the Nursing Progress						
	Notes.	66						
	A Fall IDT Brograd	s Note, dated 1/20/23 at 9:50						
	-	resident had a recent fall						
		to sliding out of the air loss						
		vill be ordered and placed on						
		mat will be placed on the open						
	side of the bed.							
	A Nurses' Note dat	ed 1/20/23 at 10:59 a.m.,						
		nt was transported to the						
	hospital for an eval							
		Director of Nursing (DON) on						
		. indicated the resident was						
		he helmet as it was there after						
		here was no assessment of the						
		e documentation and she ed her staff to have assessed						
	-	ne of admission. The vital						
		the fall for the fall follow up						
		d fall assessments were to be						
		72 hours. The resident had						
		ing to the affected side due to						
		ir loss mattress was slippery						
		in 1999 materies was supporty						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/28/2023	
NAME OF	PROVIDER OR SUPPLIE	ER	5025 M	ADDRESS, CITY, STATE, ZIP CO ICCOOK AVE)	
HARBOI	R HEALTH & REH	AB	EAST	CHICAGO, IN 46312		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF	JLD BE	(X5) COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	place. 2. Resident 2/28/23 at 10:38 a	wedges were immediately put in E's record was reviewed on .m. Diagnoses included, but were onic obstructive pulmonary y of stroke.				
	assessment, dated was cognitively in He required super	nimum Data Set (MDS) 12/29/22, indicated the resident tact for daily decision making. vision for activities of daily ed mobility, transfers, dressing,				
	indicated the resid became weak whit out. The Interdisci discussed the resid	ated 12/14/22 at 9:49 a.m., ent reported he had a fall as he le transferring and his legs gave plinary Team met and dent's fall. The physician gave resident to receive physical e strength.				
	2:02 a.m., had vita beats per minute),	Assessment, dated 12/15/22 at al signs which included pulse (84 respirations (24 breaths per d pressure (117/72) assessed 5:14 a.m.				
	a.m. were used for on 12/15/22 at 10:	tal signs from 12/12/22 at 5:14 the Fall Follow-up Assessment 02 a.m., 12/15/22 at 6:02 p.m., .m., and 12/16/22 at 9:18 a.m.				
	at 3:58 p.m., indic copied and pasted	Director of Nursing on 2/28/23 ated the vital signs were being within the documentation ot prompting the nurse to the of vital signs.				
		Il Reduction Program," received of Nursing on 2/28/23 at 4:27				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIE		5025	ET ADDRESS, CITY, STATE, ZIP CO MCCOOK AVE F CHICAGO, IN 46312	DD	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	DULD BE	(X5) COMPLETION
= 0686 SS=D Bldg. 00	 p.m., indicatedF Guidelines O. Each nurse, eac document for 72 h record. i. Vital signs ii. Neuro-checks (fiii. Behavior chang iv. Physical chang v. Neurological charged 3.1-37(a) 483.25(b)(1)(i)(ii) Treatment/Svcs for Ulcer §483.25(b)(1) (r) Based on the cord a resident, the far (i) A resident rec professional star pressure ulcers a pressure ulcers a pressure ulcers a pressure ulcers a pressure ulcers a pressure ulcers a promote healing, new ulcers from Based on record ref failed to ensure a n received the neces promote healing, 	es anges elates to Complaint IN00401921. to Prevent/Heal Pressure Integrity essure ulcers. mprehensive assessment of cility must ensure that- eives care, consistent with dards of practice, to prevent and does not develop unless the individual's clinical strates that they were h pressure ulcers receives nent and services, consistent standards of practice, to prevent infection and prevent developing. eview and interview, the facility esident with pressure ulcers sary treatment and services to elated to treatments not red for 1 of 3 residents reviewed	F 0686	DEFICIENCY) F686 Treatment/Svcs to Prevent/Heal Pressure The facility requests pay compliance for this citat This Plan of Correction	Ulcer per ion.	03/28/202

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE C A. BUILDING B. WING	onstruction (x 00	3) DATE SURVEY COMPLETED 02/28/2023
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
HARBO	R HEALTH & REH/	AB		CHICAGO, IN 46312	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIC
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Finding includes:			center's credible allegation of	
	D 1 . I			compliance.	
		l was reviewed on 2/28/23 at			
		ses included, but were not limited		Preparation and/or execution of	
		l hemiparesis following cerebral		this plan of correction does not	
		g right dominant side, diabetes ure, and peripheral vascular		constitute admission or agreeme	
	disease.	and peripricial vascular		by the provider of the truth of the facts alleged or conclusions set	
	uisease.			forth in the statement of	
	The Quarterly Min	umum Data Set (MDS)		deficiencies. The plan of	
	The Quarterly Minimum Data Set (MDS) assessment, dated 12/15/22, indicated the resident			correction is prepared and/or	
		itively impaired. She required		executed solely because it is	
		nsive assistance with one person physical		required by the provisions of	
		ility, dressing, toilet use, and		federal and state law.	
		The resident had 1 unstageable			
	deep tissue injury.			1) Immediate actions taken for	
				those residents identified:	
	A Physician's Ord	er, dated 12/15/22, indicated to		Treatment to resident's D's righ	t
	cleanse the right h	eel with normal saline or wound		heel was completed.	
	cleanser, pat dry, a	and apply betadine every day			
	shift.			2) How the facility identified	
				other residents:	
		Treatment Administration			
	· · · ·	dicated the treatment was not		All residents who have pressure	
	-	red on 1/1/23, 1/5/23, 1/6/23,		areas have the potential to be	
	1/8/23, 1/13/23, 1/	/19/23, and 1/27/23.		affected by this deficient practice	э.
		er, dated 2/14/23, indicated to			
	U	eel with normal saline or wound		3) Measures put into place/	
	shift.	and apply skin prep every day		System changes:	
				Licensed Staff will be re-educate	
		3 TAR, indicated the treatment		on the importance of ensuring th	
	-	l as ordered on 2/16/23, 2/17/23,		residents have dressings in plac	
	and 2/21/23.			to pressure ulcers and treatmen	IS
	Tuton ' 'd d	Warrand Name 2/20/22		are completed per physicians'	
		Wound Nurse on 2/28/23 at		orders.	
	-	ed she completed the treatments			
		not have signed them out on		4) How the corrective action	
	the TAR.			4) How the corrective actions	

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	A. BUILDING <u>00</u> C		COMI	(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIE		5025	t address, city, state, zip co MCCOOK AVE TCHICAGO, IN 46312	D		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
		elates to Complaint IN00400563.		 will be monitored: Director of Nursing or decomplete 5 observations then 3 observations a w substantial compliance i residents with pressure ensure that the dressing dry and intact. Also audi to ensure that the treatm has been signed out. Th of Nursing is responsible compliance. The results of these au be reviewed in Quality Assurance Meeting mo months or until an aver 90% compliance or gre achieved x3 consecutive months. The QA Comr will identify any trends patterns and make recommendations to re plan of correction as in 	s a week eek until s met on ulcers to i is clean, it the TAR nent order ie Director e for dits will onthly x6 rage of ater is ve mittee or evise the idicated.		
F 0697 SS=D Bldg. 00	require such serv professional stan comprehensive p and the residents Based on record re failed to ensure a r	Management.	F 0697	03/28/2023 F697 Pain Management The facility requests pap		03/28/202	

STATEME	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X2) MULTIPLE CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	ATION NUMBER A. BUILDING 00		00	COMPLETED	
155653		155653	B. WI	NG		02/28	/2023
	PROVIDER OR SUPPLIEI			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAMEOF	FRO VIDER OR SUFFLIEI	< compared with the second sec		5025 N	ICCOOK AVE		
HARBO	R HEALTH & REHA	В		EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLET
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	not administered as	ordered for 1 of 3 residents			compliance for this citation.		
	reviewed for pain.	(Resident J)					
					This Plan of Correction is the		
	Finding includes:				center's credible allegation of	F	
					compliance.		
	Resident J's record	was reviewed on 2/28/23 at					
	2:54 p.m. Diagnose			Preparation and/or execution	of		
	to, hemiplegia and			this plan of correction does n			
	infarction affecting			constitute admission or agree	ement		
	mellitus, heart failu	re, and peripheral vascular			by the provider of the truth of		
	disease.				facts alleged or conclusions s		
					forth in the statement of		
	The Quarterly Mini	mum Data Set (MDS)			deficiencies. The plan of		
		2/15/22, indicated the resident			correction is prepared and/or		
		tively impaired. She required			executed solely because it is		
		e with one person physical			required by the provisions of		
		lity, dressing, toilet use, and			federal and state law.		
	personal hygiene.						
					1) Immediate actions taken	for	
	A Physician's Orde	r, dated 2/21/23, indicated			those residents identified:		
	hydrocodone-aceta	minophen (a pain medication)					
	5-325 milligrams (1	ng), 1 tablet by mouth two times			Resident J received p	ain	
	a day for pain.				medication as ordered.		
	The February 2023	Medication Administration			2) How the facility identified		
	Record (MAR), ind				other residents:		
	hydrocodone-aceta	minophen pain medication was			All residents receiving pain		
		lministered on the following			medications have the potentia	al to	
	dates and times:	e			be affected by this alleged		
					deficient practice.		
	- 2/21/23 at 8:00 p.	m.					
	- 2/22/23 at 8:00 a.t				An audit was completed on a	11	
	- 2/22/23 at 8:00 p.	m.			residents with pain medicatio		
	- 2/23/23 at 8:00 a.t				ensure that medications were		
	- 2/23/23 at 8:00 p.				available.		
	- 2/24/23 at 8:00 a.						
	- 2/26/23 at 8:00 a.				3) Measures put into place/		
	- 2/27/23 at 8:00 p.				System changes:		
	2,2,725 at 0.00 p.				Licensed Staff was educated	on	
	Interview with the	Director of Nursing on 2/28/23			the importance of monitoring,		
		5 n color of 1 turbing off 2/20/23				1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/28/2023	
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO	D	
HARBOR	R HEALTH & REHA	Ъ	EAST	CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE
F 0757 SS=D Bldg. 00	REGULATORY O at 4:07 p.m., indica information to pro- medication. This Federal tag re 3.1-37(a) 483.45(d)(1)-(6) Drug Regimen is Drugs §483.45(d) Unne Each resident's of from unnecessar drug is any drug §483.45(d)(1) In	R LSC IDENTIFYING INFORMATION ated she had no further vide regarding the pain dates to Complaint IN00401921. Free from Unnecessary cessary Drugs-General. lrug regimen must be free y drugs. An unnecessary when used- excessive dose (including	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY) assessing, documenting providing pain medication according to physician's resident plan of care. 4) How the corrective at will be monitored: Director of Nursing or de review documentation 5 week to ensure that pain medications were given available. The Director of is responsible for compli The results of these au be reviewed in Quality Assurance Meeting mon months or until an aver 90% compliance or gre achieved x3 consecutive months. The QA Commission will identify any trends patterns and make recommendations to re plan of correction as in 5) Date of compliance: 03/28/23	g, and order and order and actions esignee will days a and of Nursing iance. dits will onthly x6 rage of ater is ve nittee or evise the idicated.	DATE
	§483.45(d)(1) In duplicate drug th					

PRINTED: 04/13/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 02/28/2023	
	provider or suppli R HEALTH & REH		5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
	§483.45(d)(3) W or §483.45(d)(4) W for its use; or §483.45(d)(5) In consequences w should be reduc §483.45(d)(6) At reasons stated i (5) of this sectio Based on record r failed to manage r to ensuring medic ordered for 1 of 3 in condition. (Res Finding includes: The closed record 2/28/23 at 1:50 p. 1/16/23 and disch Diagnoses include	eview and interview, the facility medications appropriately related ations were administered as residents reviewed for a change	F 0757	 F757 Drug Regimen is free from unnecessary Drugs The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement 	
	osteoarthritis. The 5 Day Minim dated 1/20/23, inc cognitively intact all of Activities of Physician's Order indicated the follo	age, craniectomy, and num Data Set (MDS) assessment, licated the resident was and was an extensive assist for f Daily Living (ADLs). s, dated 1/16/23 at 9:26 p.m., owing medications: ylate Tablet (a medication used		by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:	

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	X3) DATE SURVEY COMPLETED 02/28/2023
	PROVIDER OR SUPPLIEF		5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO IN 46312	
HARBO (X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF to lower the blood p Give 2.5 mg one tir - Atorvastatin Calci lower cholesterol) T time a day. - Vitamin D3 Table mcg one time a day - Glycolax Powder - Hydrochlorothiazi blood pressure) Tab every morning and - Doxycycline Hycl Tablet 100 mg. Giv days. - Docusate Sodium one time a day. The 1/2023 Medica (MAR), indicated th signed out as being 1/17/23 at 8:00 a.m	STATEMENT OF DEFICIENCIE ALSC IDENTIFYING INFORMATION pressure) 2.5 milligrams (mg). ne a day. ium (a medication used to Tablet 20 mg. Give 20 mg one et 25 micrograms (mcg). Give 50 r. give 17 grams one time a day. ide (a medication used to lower olet 12.5 mg. Give 12.5 mg at bedtime. late (an antibiotic medication) re 100 mg every 12 hours for 5 Tablet 100 mg. Give 1 capsule tion Administration Record he above medications were not administered on 1/16 and		CHICAGO, IN 46312 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Resident C no longer resides in the facility. 2) How the facility identified other residents: All residents who receive medications have the potential be affected by this deficient practice. 3) Measures put into place/ System changes: Licensed nurses will be educate on the importance of following u with the physicians and pharma when medications are not available for resident to receive 4) How the corrective actions will be monitored: The Director of Nursing or designee will complete a medication review audit 5 days week to ensure that residents have received medications per physician's order. The Director Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make	to ed up acy a of II

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653			A. BUILDING B. WING	00	COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIE		5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION	
				5) Date of compliance: 03/28/2023		
⁼ 0921 SS=D Bldg. 00	§483.90(i) Other The facility must	Sanitary/Comfortable Environ Environmental Conditions provide a safe, functional, nfortable environment for nd the public.				
	Based on observat failed to ensure the clean and in good doors, and door fra	ion and interview, the facility e residents' environment was repair related to marred walls, ames, and discolored caulking The First and Second Floors)	F 0921	F 921 The facility request paper compliance for this citatic PLAN OF CORRECTION		
	Second Floors on a following was obs a. Room 102 - The marred with black room door was ma crack in it. There w	e room and bathroom doors were scuff marks. The wall behind the urred and the closet door had a was 1 resident residing in the		Please accept the followin the facility's plan of corre This plan of correction do constitute an admission o or liability by the facility a submitted only in respons the regulatory requiremen	ction. es not if guilt nd is se to	
	 room and 3 residents who shared the bathroom. b. Room 204 - The walls, room door and bathroom door were marred. The door stopper was coming out of the wall. The baseboard was peeling away from the wall. The caulking around the toilet was yellow. There was 1 resident residing in the room and 2 residents who shared the bathroom. 			1. The corrective action taken for the resident four have been affected by the deficient practice: room 102, 204, 223, 227 w corrected.	nd to	
	gouged. The bathr	e bathroom door was marred and oom walls were marred as well There were 2 residents who		2. How facility identifie other residents to be at ris		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/28/2023	
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB			STREET 5025 N EAST			
HARBOF (X4) ID PREFIX TAG	R HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION shared the bathroom. d. Room 227 - The wall behind the bed was white and patched and in need of painting. There was 1 resident residing in the room . Interview with the Administrator on 2/28/23 at 3:00 p.m., indicated all of the above was in need of cleaning and/or repair. This Federal tag relates to Complaint IN00400563. 3.1-19(f)		ID PREFIX TAG	PREFIX CREACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Audit was completed by admin of all rooms requiring touch ups. List is being addressed. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: daily guardian angel rounds & preventative maintenance program 4. To ensure the deficient practice does not reoccur, the monitoring system established		
				 is to: Administrator / Designee will monitor 3 rooms weekly for 4 weeks. Then 2 rooms weekly weeks Any issues will be address immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine continued auditing is necess once 100% compliance threshold is achieved for two consecutive months. This pl to be amended when indicated. 5. Completion date systemic changes will be completed: 3/28/23 Update 	for 4 sed if sary o an	

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/28/2023		
	NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB				ADDRESS, CITY, STATE, ZIP COD CCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 131211 Facility ID: 000108

Page 22 of 22 If continuation sheet