

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2021
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NAME OF PROVIDER OR SUPPLIER  HARBOR HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00356566 and IN00357133.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on June 11, 2021.</p> <p>Complaint IN00356566 - Substantiated. Federal/State deficiencies related to the allegations are cited at F661.</p> <p>Complaint IN00357133 - Substantiated. Federal/State deficiencies related to the allegations are cited at F697.</p> <p>Survey dates: August 3, 4, and 5, 2021</p> <p>Facility number: 000108 Provider number: 155653 AIM number: 100267410</p> <p>Census Bed Type: SNF/NF: 70 Total: 70</p> <p>Census Payor Type: Medicare: 9 Medicaid: 60 Other: 1 Total: 70</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on 8/9/21.</p>	F 0000	<p>Please reference the enclosed 2567 as "plan of correction" For the complaint and Annual survey that was conducted at Harbor Health &amp; Rehab</p> <p>I will submit signature sheets of the in-servicing, content of in-service and audit tools.</p> <p>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.</p> <p>The Plan of Correction submitted on 8/17/ 2021 serves as our allegation of compliance. The provider respectfully request a desk review on or after August 7th 2021Should you have any questions or concerns</p>	
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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.

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F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is		regarding our Plan of Correction , please don't hesitate to Contact me. Sherri Shelby RN, HFA <b>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.</b>	

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	<p>developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>Based on record review and interview, the facility failed to ensure discharge instructions were provided at the time of discharge for 1 of 1 residents reviewed for admission/ transfer/ discharge. (Resident B)</p> <p>Finding includes:</p> <p>The closed record for Resident B was reviewed on 8/5/21 at 10:13 a.m. Diagnoses included, but were not limited to, hypertension, difficulty walking, muscle weakness, need for assistance with personal care, and morbid obesity.</p> <p>The Discharge Return not Anticipated Minimum Data Set (MDS) assessment, dated 6/11/21, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance for bed mobility and toilet use and was totally dependent for transfers.</p> <p>A Nurses' Note, dated 6/11/21 at 1:30 p.m., indicated the resident was being discharged from the facility via two attendants on a stretcher bed. The resident voiced no complaints of pain or discomfort upon discharge. The resident was being discharged home with family.</p> <p>There was no documentation indicating the resident had received any discharge instructions.</p>	F 0661	<p><i>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.</i></p> <p><b>F 661 Discharge Summary</b></p> <p><b>Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>·Resident B is no longer a resident of the facility</li> </ul> <p>1. How the facility will identify other residents having the potential to be affected by the same deficient practice.</p>	08/14/2021

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	<p>Interview with the Social Service Designee on 8/5/21 at 11:42 a.m., indicated the resident received a copy of the transfer form at the time of discharge, but nursing would have provided the discharge instructions.</p> <p>Interview with the Director of Nursing on 8/5/21 at 12:00 p.m., indicated the resident was seen by her Physician two days before discharge and he went over her plan of care. She also indicated the resident should have received a copy of her discharge instructions.</p> <p>This Federal tag relates to Complaint IN00356566.</p>		<p>·All residents have the potential to be affected by the deficient practice</p> <p>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.</p> <p>·Nurses will be in serviced with ensuring that residents with discharge orders will be given discharge instructions at the time of discharge.</p> <p>·The DON/designee will audit all discharges weekly for 4 weeks and then 2 random residents weekly for 6 months. All deficiencies will be corrected immediately</p> <p>1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.</p> <p>·All plan of correction audit will be reported 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.</p>	

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F 0697 SS=D Bldg. 00	<p>483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>Based on record review and interview, the facility failed to ensure scheduled pain medications were given timely for a resident with a history of pain for 1 of 3 residents reviewed for unnecessary medications. (Resident C)</p> <p>Finding includes:</p> <p>Interview with Resident C on 8/3/21 at 1:10 p.m., indicated there were times when her pain pill was given late.</p> <p>The record for Resident C was reviewed on 8/4/21 at 3:00 p.m. Diagnoses included, but were not limited to, hemiplegia (muscle weakness) following a stroke, diabetes mellitus, low back pain, and chronic pain.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 7/30/21, indicated the resident was cognitively intact for daily decision making. She required extensive assistance for bed mobility and transfers. She also received scheduled pain medications. Her pain was frequent and moderate intensity. The resident had received an opioid medication 4 days during</p>	F 0697	<p>1.Dates when corrective action will be completed:8/14/21</p> <p><i>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.</i></p> <p><b>F 697 Pain Management</b></p> <p><b>Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>·Resident C's pain assessment is completed, and pain is monitored and managed with pain</p>	08/14/2021

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	<p>the assessment reference period.</p> <p>A Care Plan, revised on 7/14/21, indicated the resident was at risk for pain related to gall stones, muscle spasms, lymphedema, hemiplegia following a stroke, low back pain, and chronic pain. Interventions included, but were not limited to, administer analgesia per orders.</p> <p>A Physician's Order, renewed on 7/9/21, indicated the resident was to receive Norco (a narcotic pain medication) 7.5-325 milligrams (mg) give 1 tablet every 6 hours for pain. The medication was scheduled for 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m.</p> <p>The July 2021 Controlled Drug Record form indicated the resident received her Norco on the following dates and times:</p> <p>7/8/21 at 9:30 a.m. and 4:00 p.m. There was no documentation indicating the 12:00 a.m. dose had been given.</p> <p>7/9/21 at 8:00 p.m.</p> <p>7/10/21 no documentation of 12:00 a.m. dose being given</p> <p>7/11/21 at 3:00 p.m.</p> <p>7/13/21 at 8:00 p.m.</p> <p>7/14/21 at 2:00 a.m. and 8:00 p.m.</p> <p>Interview with the Director of Nursing on 8/5/21 at 11:19 a.m., indicated the resident's Norco had been given late. She indicated the medication should have been given no later than an hour after each prescribed time.</p>		<p>medication as ordered.</p> <p>1. How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the deficient practice</li> </ul> <p>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.</p> <ul style="list-style-type: none"> <li>·Nurses will be in serviced with ensuring that resident's pain is assessed appropriately and ordered pain medication is administered timely</li> <li>·The DON/designee will audit 5 random residents weekly for 4 weeks then 2 random residents weekly for 6 months to ensure that resident's pain is assessed properly, and pain medication is administered timely. All deficiencies will be corrected immediately</li> </ul> <p>1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.</p> <ul style="list-style-type: none"> <li>·All plan of correction audit will be reported to the Quality Assurance Committee and reviewed by the Committee per</li> </ul>	

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	This Federal tag relates to Complaint IN00357133.  3.1-37(a)		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: <u>8/14/21</u>	