STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	R-C 09/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00356566 and IN00357133 completed on 8/5/21.

This visit was in conjunction to the PSR to the PSR completed on 8/5/21 to the Recertification and State Licensure Survey completed on 6/11/21.

Complaint IN00356566 - Corrected.

Complaint IN00357133 - Corrected

Survey dates: September 7, 2021

Facility number: 000108
Provider number: 155653
AIM number: 100267410

Census Bed Type:
SNF/NF: 71
Total: 71

Census Payor Type:
Medicare: 6
Medicaid: 62
Other: 3
Total: 71

Harbor Health and Rehab was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00356566 and IN00357133.

Quality review completed on 9/10/21.

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