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	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST 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) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 5, 6, 7, 8, and 9, 2024 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 7 Medicaid: 51 Other: 2 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/16/24.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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

Craig Clemons | Administrator | 08/29/2024

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.

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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to a cognitively impaired dependent resident being dressed in a hospital gown during the day for 1 of 1 resident reviewed for dignity. (Resident 58) Finding includes: During random observations on 8/5/24 at 11:30	F 0550	Please accept the following as the facility's credible allegation of compliance. 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. F550 Resident Rights/Exercise of Rights	08/29/2024

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	a.m. and 2:55 p.m., on 8/6/24 at 9:58 a.m.,1:00 p.m., 1:45 p.m., and 2:24 p.m., and on 8/7/24 at 10:30 a.m., Resident 58 was observed in bed wearing a hospital gown. The record for Resident 58 was reviewed on 8/6/24 at 1:20 p.m. The resident was admitted to the facility on 6/7/24. Diagnoses included, but were not limited to, stroke, obesity, dysphagia, type 2 diabetes, high blood pressure, heart disease, peg tube (a tube inserted directly into the stomach for nutrition), restlessness and agitation. The 7/9/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident did not participate in the activity/preference interview, so staff completed it for him. There was no care plan the resident preferred to stay in and be dressed in a hospital gown. An Activity Assessment, dated 6/14/24, indicated it was not fully completed. The resident's recreation interests, habits, preferences, additional information, and summary and plan were blank. During an interview on 8/8/24 at 11:30 a.m., the Director of Nursing indicated the resident had no clothes, however, there was no care plan regarding that issue. 3.1-3(t)		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident 58's plan of care was updated to with preference to wear gown while in bed for comfort. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were educated on: Providing residents with care in accordance with their preference and maintaining dignity. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. Facility Angels will audit 3 residents 3 times per week to ensure dignity is maintained and care is provided per preference with a special focus on wearing gowns. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee,	

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			auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/29/2024	
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 observation, record review, and interview, the facility failed to ensure dependent residents received assistance with activities of daily living (ADL's) related to the cleaning and cutting of fingernails, oral care, and getting out of bed for 2 of 10 residents reviewed for ADL's. (Residents 45 and 58)	F 0677	Please accept the following as the facility's credible allegation of compliance. 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.	08/29/2024
	Findings include:		F677 ADL Care Provided for Dependent Residents	
	1. During random observations on 8/5/24 at 10:25 a.m., on 8/6/24 at 2:45 p.m., and on 8/7/24 at 10:15 a.m., Resident 45 was observed in bed with long and dirty fingernails.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	
	During an interview on 8/5/24 at 10:25 a.m., the resident stated "I need nail care really bad."		Nail and oral care were provided for Resident 58. Resident 58's plan of care was updated to include residents' preference to remain in bed related to decline in care and admission to hospice for comfort.	
	The record for Resident 45 was reviewed on 8/7/24 at 11:20 a.m. Diagnoses included, but were not limited to, infarction of the spinal cord, heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, urine retention, and neuromuscular of the bladder.		Nail care was provided for resident 45.	
			How the facility will identify other residents having the potential to	

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	The 5/30/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed partial to moderate assistance with personal hygiene and set up or clean up assistance with oral hygiene. The resident had no issues with his teeth or gums and a had a suprapubic catheter. The resident's hearing was adequate and he had no hearing aide. A Care Plan, revised on 7/9/24, indicated the resident needed assistance with ADL's. The approaches were to assist with personal hygiene including dressing/grooming as needed. The CNA task section indicated nail care was last completed on 7/29/24. During an interview on 8/7/24 at 3:15 p.m., QMA 1 indicated she provided a.m. care to the resident today, however, she did not perform nail care for him. During an interview on 8/8/24 at 2:15 p.m., the Director of Nursing indicated nail care should be done as needed. 2. During random observations on 8/5/24 at 11:30 a.m. and 2:55 p.m., Resident 58 was observed in bed and his fingernails were long on both hands. During a random observation on 8/6/24 at 9:58 a.m., the resident was observed in bed, with long fingernails observed to both hands. At that time, the resident had a large amount of dried mucous on his bottom lip and in the corners of his lips. On 8/6/24 at 1:00 p.m., the resident was observed in bed, his fingernails were long and the dried mucous remained around his lips and mouth.		be affected by the same deficient practice and what corrective action will be taken; All residents requiring assistance with ADL Care have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on providing residents with assistance with Activities of Daily Living (ADL's) per plan of care/preferences with a special focus on: · Providing nail care · Providing oral care · Assistance with getting out of bed as tolerated/preferred How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will observe 3 residents 3 times per week to ensure residents are assisted with Activities of daily Living with special focus on nail care, oral care, and assistance getting out of bed is rendered as tolerated/per preference. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee,	

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	On 8/6/24 at 2:24 p.m., CNA 1 and CNA 3 were asked to reposition the resident. The resident's fingernails were long and the dried mucous remained around his lips and mouth. During an interview at that time, CNA 3 indicated she had not performed oral care for the resident at all today. She came in at 10 a.m. and the CNA before her might have done oral care, but she was unsure. During random observations on 8/7/24 at 8:30 a.m., and 9:05 a.m., the resident was observed in bed and his fingernails were long to both hands, and his lips had dried mucous on them. During an interview on 8/7/24 at 9:05 a.m., CNA 2 indicated she did not do nail care as the facility had special staff to do that. She had not performed oral care for the resident. CNA 2 had taken care of the resident yesterday (8/6/24) and did oral care for him in the morning. On 8/7/24 at 10:33 a.m., the resident was observed in bed. The record for Resident 58 was reviewed on 8/6/24 at 1:20 p.m. The resident was admitted to the facility on 6/7/24. Diagnoses included, but were not limited to, stroke, obesity, dysphagia, type 2 diabetes, high blood pressure, heart disease, peg tube (a tube inserted directly into the stomach for nutrition), restlessness and agitation. The 7/9/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. The resident did not participate in activity/preference interview, so staff completed it for him. The resident had functional limitation of range of motion to 1 side of his upper and lower		auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/29/2024	

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	extremities. The resident was dependent on staff to roll to the right and the left, transfer out of bed, personal hygiene and oral care. A Care Plan, revised on 6/21/24, indicated the resident had a ADL self care deficit related to his need for more assist due to a recent stroke. The CNA task section, indicated nail care was completed on 7/8, 7/10, 7/11, 7/13, 7/14, 7/15, 7/17, 7/18, 7/22, 7/24, 7/25 (2 times), 7/26, 7/30, 8/1, 8/3, 8/4, and 8/5/24. There was no documentation of oral care being performed at least daily. A Nurses' Note, dated 7/2/24 at 3:15 p.m., indicated the resident was readmitted from the hospital and his fingernails and toenails were overgrown. There was no physician's order for the resident to be on bed rest. During an interview on 8/6/24 at 2:30 p.m. CNA 3, indicated the resident did not get out of bed. During an interview on 8/8/24 at 11:30 a.m., the Director of Nursing indicated staff had not been getting the resident out of bed because a lot of movement made the resident restless, however, there was no care plan or physician's order for bed rest. She indicated nail care and oral care should have been completed as needed. 3.1-38(a)(2)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(E)			

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F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to provide a personalized activity program for cognitively impaired and dependent residents related to ongoing stimulation and being invited to activities for 2 of 2 residents reviewed for activities. (Residents 24 and 58) Findings include: 1. On 8/6/24 at 12:58 p.m., 2:10 p.m., and 3:03 p.m., Resident 24 was observed in his room in bed. The resident's eyes were closed and no television or radio were present in the resident's room. On 8/7/24 at 9:05 a.m., 10:05 a.m., 11:39 a.m., and 1:28 p.m., the resident was observed in his room in bed. His eyes were closed and there was no television or radio present in his room. On 8/8/24 at 11:00 a.m. and 1:10 p.m., the resident was observed in his room in bed. His eyes were closed and there was no television or radio present in his room. On 8/9/24 at 8:47 a.m., the resident was observed	F 0679	Please accept the following as the facility's credible allegation of compliance. 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. F679 Activities Meet Interest/Needs of Each Resident It is the policy of Harbor Healthcare to ensure that it provides on going activity programs that meet the needs of its residents and enhance quality of life. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. R24 Remains in the facility and was provided with an activities calendar and along with reminders and invites from activities staff R58 Remains in facility under hospice care and receiving Music	08/29/2024

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	in his room in bed. His eyes were closed and there was no television or radio present in his room. The record for Resident 24 was reviewed on 8/6/24 at 2:22 p.m. Diagnoses included, but were not limited to stroke, epilepsy, chronic respiratory failure, and major depressive disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 6/14/24, indicated the resident was in a persistent vegetative state. The activity preference section was not completed due to the resident being in a persistent vegetative state. A Care Plan, dated 6/14/24, indicated the resident would benefit from the 1:1 program. Interventions included, but were were not limited to, 1:1 visits from activity staff 3 times a week, music stimulation at least twice a week, and offer sensory stimulation. The One to One Room Visit Log, dated August 2024, indicated the resident had listened to music on 8/1 and was read a story on 8/3 and 8/4/24. The Initial Activity Assessment, dated 6/19/24, indicated listening to music was a current interest of the resident. During an interview on 8/9/24 at 12:02 p.m., the Activity Director indicated the resident received 1:1 visits but she would also get the resident a radio for his room so he had some type of ongoing stimulation. 2. During random observations on 8/5/24 at 11:30 a.m. and 2:55 p.m., on 8/6/24 at 9:58 a.m., 1:00 p.m., and 2:24 p.m., and on 8/7/24 at 8:30 a.m., 9:05 a.m., and 10:33 a.m., Resident 58 was observed in bed. At those times the television was turned off and there was no		therapy How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents residing in the facility have the potential to be affected by the alleged deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All activities staff were in-serviced with regards to assuring that all residents have a current activities calendar and are reminded / invited to events How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The Administrator /Designee will complete interviews/ observations 3x/ week x2 weeks then weekly for 6 months for residents confirming that residents have activities calendars and have been reminded/invited to participate in activities The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	

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	radio in the room. The television set was located on a dresser facing the wall and the resident's head of the bed was facing the doorway, therefore, the resident could not see the television set. The resident was not observed out of bed from 8/5-8/7/24 during the day time. The record for Resident 58 was reviewed on 8/6/24 at 1:20 p.m. The resident was admitted to the facility on 6/7/24. Diagnoses included, but were not limited to, stroke, obesity, dysphagia, type 2 diabetes, high blood pressure, heart disease, peg tube (a tube inserted directly into the stomach for nutrition), restlessness and agitation. The 7/9/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident did not participate in activity/preference interview, so staff completed it for him. The resident enjoyed listening to music, doing favorite activities, and keeping up with the news. A Care Plan, revised on 6/20/24, indicated the resident needed some encouragement or supervision to successfully pursue activities of interest. The approaches were to offer "a la carte activities" such as books, magazines, cards, word puzzles, newspapers, CDs, movies, or handheld games, offer individual activities designed to match the goal of therapy, such as puzzles or simple exercise, offer interesting and contemporary movies or travelogues and provide an activity calendar to identify times and days of activities of interest. An Activity Assessment, dated 6/14/24, indicated it was not fully completed with the resident's recreation interests, habits, preferences, additional			

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	information, and summary and plan. The CNA task section indicated the resident was coded as watching TV alone on 7/11, 7/15, and 7/18/24. The resident was readmitted to the facility on 7/2/24 after having another stroke. The resident had a significant decline in activities of daily living, had a peg tube, and was now NPO. An Activity Group Participation record, dated 6/2024, indicated the resident attended current events and pokeno on 6/23/24. The resident did not participate in any group activities in 7/2024 or 8/2024. The resident had 1 to 1 visits three times a week on 7/6, 7/7, 7/10, 7/13, 7/14, 7/17, 7/20, 7/21, 7/25, 7/27, and 7/28/24. The activity was listening to music or conversation. The 1 to 1 visits for 8/2024 occurred on 8/1, 8/2 and 8/3/24 which was listening to music. The 8/2024 Activity calendar indicated church services were every Saturday. During the survey week (8/5-8/9) the following were scheduled and the resident was not present: 8/6 the activity of men's group, and 8/7/24 sit and be fit and men's group. During an interview on 8/8/24 at 9:10 a.m., the Activity Director indicated she had started 1 to 1 services for the resident when he came back from the hospital after having another stroke. He had not been out of bed since coming back from the hospital. She was aware of how the television set was located in his room and his inability to see it. She indicated the care plan was not reflective of the resident's current status. There was no radio			

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	in his room for him to listen to music all the time. During an interview on 8/8/24 at 11:30 a.m., the Director of Nursing indicated staff had not been getting the resident out of bed because a lot of movement made the resident restless, however, there was no care plan or physician's order for bed rest. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure areas of discoloration and treatments for non-pressure areas were completed and/or ordered for 2 of 2 residents reviewed for non-pressure related skin conditions (Residents 13 and 57) Findings include: 1. During a random observation on 8/5/24 at 2:40 p.m., Resident 13 was observed in bed. At that time, her feet were very dry and flaky with peeling skin. The resident had an open area on her right ring finger that was uncovered. During an interview at that time, the resident indicated the treatment to the finger was last done on Friday 8/2/24, and it was done every Monday,	F 0684	Please accept the following as the facility's credible allegation of compliance. 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. F684 Quality of Care It is the policy of Harbor Healthcare to ensure its residents receive treatment and care in accordance with professional standards of practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	08/29/2024

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	08/09/2024

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	Wednesday and Friday. She indicated staff did not put any special lotion on her feet. During an interview on 8/7/24 at 1:50 p.m., the resident indicated she had seen the wound physician today and the treatment to her finger was not completed yesterday (8/6/24). The record for Resident 13 was reviewed on 8/7/24 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, type 2 diabetes, major depressive disorder, chronic kidney disease, heart disease, heart failure, atrial fibrillation, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 7/12/24, indicated the resident was cognitively intact for daily decision making. A Care Plan, revised on 6/21/24, indicated the resident had a skin tear to right 4th anterior finger. The approaches were to keep the skin clean and dry and use lotion on dry scaly skin. A Wound Physician Progress Note, dated 7/31/24, indicated the right finger area measured 0.2 centimeters (cm) by 0.2 cm. A new treatment was to be completed of betadine every day and leave open to air. Physician's Orders, dated 7/31/24, indicated cleanse the right anterior 4th finger wound with normal saline and/or wound cleanser and apply betadine every day shift and leave open to air. The Treatment Administration Record (TAR) for the month of 8/2024, indicated the betadine treatment was signed out as being completed on 8/3, 8/4, and 8/6/24.		practice. R57, R13, - Remain in the facility and have received skin care in accordance with the standard of practice without adverse reaction and ongoing treatment and monitoring. R57- Remains in facility and will be followed by GuideStar for the management of his antipsychotic medications and has an appropriate indication of for How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents residing in the facility have the potential to be affected by these alleged deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nursing staff have been in-serviced on the process for assessing, reporting, treating, and monitoring residents for changes in condition, this includes alterations in skin condition and documentation of vital signs. Additionally, upon receiving orders for antipsychotic medications, add an appropriate indication for use. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The Director of Nursing /Designee will complete observations/audits 3x/ week x2	

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	During an interview on 8/7/24 at 9:45 a.m., the Wound Nurse indicated the treatment to the finger was to be completed every day and she was aware the resident was cognitively intact. During an interview on 8/8/24 at 11:30 a.m., the Director of Nursing indicated the treatment was to be completed as ordered by the physician. 2. During a random observation on 8/5/24 at 2:30 p.m. Resident 57 was observed sitting in a chair in the hallway. At that time, a large red and purple discoloration was observed to his left forearm. The record for Resident 57 was reviewed on 8/8/24 at 8:40 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, high blood pressure, anemia, and osteoarthritis. The resident was admitted to the facility on 5/16/24. The Modification of the Admission Minimum Data Set (MDS) assessment, dated 5/23/24, indicated the resident was moderately impaired for daily decision making and had the behavior of wandering which occurred 4 to 6 times during the reference period. The resident received an antipsychotic medication which was scheduled and no gradual dose reduction (GDR) had been attempted. A Weekly Skin Observation, dated 8/5/24 at 4:38 p.m., indicated the resident had no skin issues other than an abrasion to the penis. There was no documentation in the clinical record from 8/1-8/7/24 regarding a discoloration to his arm. During an interview on 8/7/24 at 10:23 a.m., LPN 1		weeks then weekly for 6 months confirming that care and treatment is being provided for those residents who are experiencing a change in condition this includes changes in skin condition and or documentation vital signs confirming indication for use for those residents receiving antipsychotic medications. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	

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	indicated she was unaware the resident had a discoloration to the left arm. During an interview on 8/7/24 at 10:30 a.m., RN 1 indicated she was taking care of the resident today, and was not given any information regarding a bruise to his left forearm. During an interview on 8/8/24 at 11:30 a.m., the Director of Nursing indicated she assessed the discolored area yesterday and asked the resident what had happened, he told her it happened outside, and he gets them all the time. There was no assessment of the discoloration to his arm in the clinical record. The 3/13/21 "Wound Management" policy, provided by Nurse Consultant 2 on 8/9/24 at 9:52 a.m., indicted the purpose of this program was to assist the facility in the care, services, and documentation relate to the occurrence, treatment, and prevention of pressure as well as non-pressure related wounds. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a			

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	professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review, and interview, the facility failed to ensure glasses were received as ordered and a follow up audiology (a physician who treats hearing issues) appointment was completed for 3 of 4 residents reviewed for vision and hearing. (Residents 2, 45, and 34) Findings include: 1. During an interview on 8/5/24 at 1:32 p.m., Resident 2 indicated he needed new glasses and he had told the staff. The resident was not wearing glasses at the time of the interview. The record for Resident 2 was reviewed on 8/9/24 at 9:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes and end stage renal disease. The Annual Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the resident was cognitively intact. The resident was identified as having adequate vision with corrective lenses. A Care Plan, dated 9/7/21 and reviewed on 6/17/24, indicated the resident's vision was adequate with the use of glasses, which he utilized mainly for reading. Interventions included, but were not limited to, arrange consultation with eye care practitioner as required and ensure appropriate visual aids (glasses) were available to support the resident's participation in activities. The resident had an eye exam on 12/19/23. New glasses were recommended and were to be delivered upon approval. Documentation in the	F 0685	Please accept the following as the facility's credible allegation of compliance. 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. F685 Treatment /Devices to Maintain Hearing/Vision What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 34- has been added to the facility optometry visit list. Residents 2 and 45 have been added to the facility audiology visit list. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents requiring vision and/or audiology services have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Social Services were educated on: · Ensuring residents are added to the optometry visit list as needed and follow-up is completed for referrals including obtaining	08/29/2024

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	vision progress notes indicated the resident required glasses and full time use was to be encouraged for distance and reading. There was no documentation in the social service or nursing progress notes related to the resident receiving new glasses. During an interview on 8/9/24 at 10:41 a.m., the Social Service Director indicated the resident was last seen by the eye doctor on 12/19/23. After doing some research, Medicaid would not cover the resident's glasses and the resident would owe $215 out of pocket. The Social Service Director indicated he had only been working at the facility for 95 days and he would follow up with the issue and assist the resident with getting his glasses. 2. During an interview on 8/5/24 at 10:30 a.m., Resident 45 indicated he had been fitted for a hearing aide "months ago", but had not received any follow up. The record for Resident 45 was reviewed on 8/7/24 at 11:20 a.m. Diagnoses included, but were not limited to, infarction of the spinal cord, heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, urine retention, and neuromuscular of the bladder. The 5/30/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed partial to moderate assistance with personal hygiene and set up or clean up assistance with oral hygiene. The resident had no issues with his teeth or gums and a had a suprapubic catheter. The resident's hearing was adequate and he had no hearing aide. There was no care plan for hearing difficulties.		glasses. · Ensuring residents are added to the audiology visit list as needed and follow-up is completed including obtaining hearing aides. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/designee will audit weekly to ensure residents on the optometry and/or audiology visit list are seen, and recommendations received are followed up timely including obtaining devices. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/29/2024	

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	An Audiology Exam report, dated 9/6/23, indicated the staff or family had noticed a decrease in responsiveness from the resident. The resident had moderate to severe sensorineural hearing loss (damage in the inner ear) in both ears. Impressions were taken and a hearing aid was recommended for a left ear half concha (the hollow depression in the middle auricle of the ear) and will return for hearing aid fitting. During an interview on 8/8/24 at 2:15 p.m., the Social Service Director indicated he had only been employed for 90 days at the facility and was unaware the resident needed a hearing aide.3. During an interview on 8/5/24 at 11:20 a.m., Resident 34 indicated he saw the eye doctor "months ago" and had not received his eye glasses. The record for Resident 34 was reviewed on 8/8/24 at 1:40 p.m. Diagnoses included, but were not limited to, chronic kidney disease, irritable bowel syndrome, depressive disorder, and unsteadiness on feet. The Quarterly Minimum Data Set (MDS) assessment, dated 5/18/24, indicated the resident was cognitively intact. A Care Plan, dated 5/23/24, indicated the resident had an impaired visual function and was being followed by the optometrist. The approaches were to utilize glasses and to arrange a consultation with the eye care practitioner as required. An eye doctor visit report, dated 12/19/23, indicated the resident was examined and encouraged to use glasses full time for distance and reading. New glasses were recommended and awaiting approval.			

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	During an interview on 8/8/24 at 2:38 p.m., the Social Service Director indicated the resident should have had glasses once the recommendation for his glasses was made by the eye doctor on 12/19/23. 3.1-39(a)(1)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure sore received the necessary treatment and services to promote healing related to providing a treatment as ordered by the physician for 1 of 2 residents reviewed for pressure ulcers. (Resident 58) Finding includes: During a random observation on 8/6/24 at 2:24 p.m., CNA 1 and CNA 3 were observed in Resident 58's room. At that time, they were asked	F 0686	Please accept the following as the facility's credible allegation of compliance. 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. F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers It is the policy of Harbor Healthcare to maintain pressure ulcer treatments as ordered by the	08/29/2024

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	to reposition the resident onto his left side so the bandage on the pressure ulcer could be observed. CNA 3 removed the resident's bed linens and the peg tube was disconnected from the enteral feeding as there was feeding all over his gown. CNA 1 left the room to get the nurse to reconnect the tube feeding. Once CNA 1 was back, accompanied by LPN 2, they rolled the resident over and removed his brief. At that time, there was no bandage covering the pressure ulcer. The resident had several ulcers observed on his buttocks and sacral area. The areas were pink, red and had a moderate amount of drainage noted. The sacral area also had necrotic (dead) tissue observed. During an interview at that time, CNA 3 indicated the resident was last changed around 11:30 a.m., and there was no bandage covering those areas. During an interview at that time, LPN 2 indicated she believed the treatment was for barrier cream. On 8/7/24 at 9:05 a.m., the Wound Nurse and CNA 2 entered the room to perform a skin assessment of the pressure sore on the sacrum. At that time, the resident was rolled over to his left side and the brief was removed. There was no bandage covering the open area. The Wound Nurse indicated the right buttock open area and the area on upper part of the sacrum was new and had evolved since Monday, the last time she had changed the bandage. CNA 2 indicated she had not checked or changed the resident since the start of her shift at 7 a.m. The record for Resident 58 was reviewed on 8/6/24 at 1:20 p.m. The resident was admitted to the facility on 6/7/24. Diagnoses included, but were not limited to, stroke, obesity, dysphagia, type 2		physician for those residents receiving wound care to promote healing What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. R58 Remains in the facility with his dressing in place as prescribed by the physician How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents residing in the facility have the potential to be affected by the alleged deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. CNAs were instructed to report Missing, Soiled, saturated wound dressings to the nurse immediately before proceeding with care Nursing staff were instructed to replace /apply missing, soiled, saturated wound dressings immediately as ordered by the physician. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The Director of Nursing /Designee will complete observations 3x/ week x2 weeks then weekly for 6	

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	diabetes, high blood pressure, heart disease, peg tube (a tube inserted directly into the stomach for nutrition), restlessness and agitation. The 7/9/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident was dependent on staff to roll to the right and the left, transfer out of bed, personal hygiene and oral care. The resident had a peg tube and received 51% or more of his nutrition through the peg tube. The resident had 1 unstageable pressure ulcer that was present on admission. A Care Plan, revised 7/31/24, indicated the resident had a friction abrasion to the sacrum. The approaches were to provide treatment as ordered by physician. Nurses' Notes, dated 7/29/24 at 8:12 p.m., indicated the resident had a skin tear on the sacrum. A dry dressing was applied and the wound nurse would be contacted for a recommended treatment. The Wound Physician Progress Note, dated 7/31/24, the resident had acquired a non-pressure abrasion to the sacral area. The open area measured 3 centimeters (cm) by 0.5 cm and had 100% granulation tissue. The treatment was hydrocolloid three times a week for 30 days. Physician's Orders, dated 7/31/24, indicated cleanse sacrum with normal saline and/or wound cleanser, apply skin prep to surrounding skin and cover with hydrocolloid dressing three times a week. A Wound Physician Progress Note, dated 8/7/24,		months confirming that residents receiving wound care have dressing in place as ordered. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	

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	indicated the sacral wound was now unstageable and measured 7.5 cm by 9 cm. The tissue was nonviable and necrotic with 40% necrosis and 60% granulation. Physician's Orders, dated 8/7/24, indicated cleanse the sacral wound with normal saline and/or wound cleanser and apply skin prep to surrounding skin and cover with a foam dressing every day shift every Monday, Wednesday, and Friday and PRN (as needed). During an interview on 8/7/24 at 9:30 a.m., the Wound Nurse indicated there should have been a bandage on the resident's open area and the treatment should have been completed as ordered by the physician. During an interview on 8/7/24 at 2:30 p.m., the Wound Nurse indicated the treatment for wound was changed and was now classified as an unstageable pressure ulcer. A Wound Physician's Consult Note, dated 8/7/24, indicated since the initial evaluation by a collegue, the wound had changed obviously to a pressure injury/ unstageable necrosis with features of a possibly evolving KTU (Kennedy Terminal ulcer - unavoidable decline). The resident had additional wounds that were new and had recently rapidly declined and was now on hospice. Anticipate additional increase in severity of this injury as well as potentially new lesions. During an interview on 8/8/24 at 11:30 a.m., the Director of Nursing indicated the treatment should have been completed as ordered. 3.1-40(a)(2)			

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F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a dependent resident received adequate assistance and supervision to prevent accidents related to only one staff person assisting during a mechanical lift transfer for 1 of 2 residents reviewed for falls. (Resident 3) This deficient practice resulted in the resident falling and receiving a fracture to her leg. The deficient practice was corrected on 7/22/24, prior to the start of the survey, and was therefore past noncompliance. The facility identified the concern, completed a house wide sweep of the Hoyer lifts (a mechanical lift) and Hoyer slings, an inservice was held related to transfer techniques and two person staff assist while using the Hoyer lift, return demonstration by staff was observed, and audits related to the use of the Hoyer lift were being completed weekly. Finding includes: During an interview on 8/6/24 at 9:25 a.m., Resident 3 indicated she had fallen from the Hoyer lift about 3 weeks ago and she hurt her leg. She indicated she had been transferred by 1 staff person.	F 0689	Past noncompliance: no plan of correction required.	08/09/2024

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	155653	A. BUILDING 00 B. WING	08/09/2024

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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	The record for Resident 3 was reviewed on 8/6/24 at 3:17 p.m. Diagnoses included, but were not limited to, fracture of upper and lower end of right fibula, type 2 diabetes, chronic pain syndrome, and age-related osteoporosis. A Quarterly Minimum Data Set (MDS) assessment, dated 4/23/24, indicated the resident was cognitively intact, dependent on staff for bed mobility and transfers, and had no falls since the prior assessment. A Care Plan, dated 12/4/23, indicated the resident was at risk for falls secondary to: ADL and mobility dysfunction, lack of coordination, neuromuscular weakness, gait abnormality, osteoporosis, CVA, emphysema/COPD, and disease process. Interventions included, but were not limited to, assess resident's transfer status and provide assistance as needed, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, encourage use of appropriate non-skid footwear while ambulating/transferring, place floor mat and bed in low position while the resident is in bed. A Change of Condition assessment, dated 7/17/24 at 5:30 p.m., indicated the resident had a fall and to refer to the Post Fall Evaluation for details. The Post Fall Observation sheet, dated 7/17/24 at 5:30 p.m., indicated the event happened in the resident's room and she was transferring immediately prior to the event. The event was witnessed by CNA 3. The resident denied the fall as well as pain. The resident's wheelchair and a			

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	Hoyer were in use at that time. Nurses' Notes, dated 7/19/24 at 11:40 p.m., indicated while the resident was receiving care, she stated that she had pain in her right leg and shoulder due to a fall that she had "the other day." The resident recalled falling to the floor during a transfer from the wheelchair to the bed with the Hoyer lift. The resident indicated she did not have any pain initially, but since the incident she had been sore on the areas mentioned. The physician, Director of Nursing, and the resident's family were notified. Orders were received for a STAT (immediate) x-ray. Nurses' Notes, dated 7/19/24 at 11:53 p.m., indicated the contracted x-ray company was contacted, and their estimated time of arrival was the morning of 7/20/24. Nurses' Notes, dated 7/20/24 at 12:53 a.m., indicated the resident was in bed awake and watching television. The resident asked the writer if they had heard what happened to her and the resident was allowed to tell what occurred related to the recent fall. The resident allowed staff to obtain her vital signs and assess her. There were no signs of bruising, swelling, or redness to affected areas or otherwise. The resident was informed x-rays would be completed in the morning. She currently denied pain to the affected areas but did say her left heel was hurting. She was able to move extremities with assistance. Heel protectors were placed on the resident with immediate relief. The resident informed staff that she would let them if she was "hurting" in order to receive pain medication. Nurses' Notes, dated 7/20/24 at 8:59 a.m., indicated the x-rays were obtained as ordered.			

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	Nurses' Notes, dated 7/20/24 at 10:53 a.m., indicated the physician was notified of the x-ray results which indicated the resident had an acute fracture of the right distal fibula (lower leg). Orders were received to send the resident to the emergency room for evaluation. Nurses' Notes, dated 7/20/24 at 4:00 p.m., indicated the resident returned to the facility with a splint to the right lower leg. No swelling was noted, and the resident denied any pain. A Physician's Order, dated 7/20/24, indicated to monitor the splint to the right leg and notify the physician of any abnormal findings such as increased swelling, discoloration, or reports of increased pain every shift. The Fall Interdisciplinary Team (IDT) Note, dated 7/21/24 at 12:14 p.m., indicated the summary of the fall on 7/17/24 at 5:30 p.m. was due to inappropriate staff transfer. Review of the facility fall investigation on 8/9/24 at 10:34 a.m., indicated an inservice for nursing staff was held on 7/22/24 related to the use of the Hoyer lift. An audit tool was also implemented on 7/22/24 related to the use of the Hoyer lift and to ensure 2 staff members were present. Ten residents would be randomly audited weekly. Staff competencies were also completed related to use of the total mechanical lift, one person gait belt transfer, and sit to stand lift. Documentation of facility inservices and subsequent auditing was reviewed and confirmed to be completed by 7/22/24. Staff interviews and observations also indicated adequate knowledge related to Hoyer lift transfers.			

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	During an interview on 8/9/24 at 10:55 a.m., the Director of Nursing (DON) indicated she was made aware of the fall on 7/17/24. She interviewed the resident, and the resident denied she fell but she was being monitored. On 7/19/24, the resident started complaining about pain to her leg. At that time x-rays were ordered and the resident indicated there was an incident with the Hoyer "the other day." CNA 3, who was caring for the resident on 7/17/24, was suspended but was not terminated because she admitted she transferred the resident by herself as she couldn't find anyone else to help her and the resident was demanding to get back into bed. Per the DON, the CNA indicated the resident started to lean in the sling and she got under her to break the fall and she thought the resident's leg may have hit the Hoyer lift. The resident also had a diagnosis of osteopenia (bone loss). A full house sweep was conducted related to the Hoyer slings and the Hoyer lifts themselves. An inservice was held related to Hoyer use, audits were initiated, and staff competencies were completed related to transfers and Hoyer use. During an interview on 8/9/24 at 2:35 p.m., the Assistant Director of Nursing indicated the facility practice was to have 2 staff member assistance for Hoyer transfers and that was the standard prior to the resident's incident. The Hoyer lift manufacturer's recommendations included using two staff during transfers. 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence.			

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	§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident with a suprapubic foley (urinary) catheter received foley catheter care for 1 of 1 resident reviewed for catheters. (Resident 45)	F 0690	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in	08/29/2024

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	Finding includes: During a random observation on 8/5/24 at 10:31 a.m., Resident 45 was observed in bed. At that time, the resident was asked to lift his gown so his the stoma for his suprapubic catheter could be seen. The bandage around the stoma was dated 8/2/24 and had dried brown blood on it. The record for Resident 45 was reviewed on 8/7/24 at 11:20 a.m. Diagnoses included, but were not limited to, infarction of the spinal cord, heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, urine retention, and neuromuscular of the bladder. The 5/30/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed partial to moderate assistance with personal hygiene. The resident had a suprapubic catheter. A Care Plan, revised on 7/9/24, indicated the resident was attention-seeking related to catheter care. The approaches were to provide catheter care as ordered. Physician's Orders, dated 7/18/24, indicated catheter care every shift. During an interview on 8/8/24 at 11:15 a.m., the Director of Nursing indicated she had no additional information to provide. The current 2/12/21 "Suprapubic Site Care" policy, provided by Nurse Consultant 2, indicated suprapubic site care will be provided to decrease the risk of infection. Using gauze pads, soap and water, gently clean the area immediately surrounding the stoma and continue working		response to the regulatory requirement. F690 Bowel/Bladder Incontinence, Catheter, UTI What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 45 catheter care was rendered immediately. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with indwelling catheters have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on: · Ensuring catheter care orders are in place and catheter care is rendered as per orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Nurse managers will audit 2 residents with catheters 2 times per week to ensure catheter care is rendered per orders. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months.	

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	outward in a circular motion and pat dry after cleaning. Evaluate the stoma site for redness, pain, soreness, swelling or drainage. 3.1-41(a)(1)		Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/29/2024	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure a resident was positioned upright at least 45 degrees while an enteral feeding was infusing into a peg tube (a tube inserted directly into the stomach to provide	F 0693	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the	08/29/2024

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	nutrition) for 1 of 1 resident reviewed for tube feeding. (Resident 58) Finding includes: During a random observation on 8/6/24 at 2:24 p.m., CNA 1 and CNA 3 were observed in Resident 58's room. At that time, they were asked to reposition the resident onto his left side so the bandage on the pressure ulcer could be observed. CNA 3 took the bed remote and started to lower the resident's head of the bed to 5 degrees. At that time, she was asked to stop due since the enteral tube feeding was currently infusing into the peg tube. The CNA stated "You are absolutely right. Can I put the peg tube on hold?" She was asked if she was allowed to do that and the CNA stated "Yes, the nurses let us do that all the time." The CNA walked over to the enteral feeding pump and put the feeding on hold. The record for Resident 58 was reviewed on 8/6/24 at 1:20 p.m. The resident was admitted to the facility on 6/7/24. Diagnoses included, but were not limited to, stroke, obesity, dysphagia, type 2 diabetes, high blood pressure, heart disease, peg tube (a tube inserted directly into the stomach for nutrition), restlessness and agitation. The 7/9/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident was dependent on staff to roll to the right and the left, transfer out of bed, personal hygiene and oral care. The resident had a peg tube and received 51% or more of his nutrition through the peg tube. A Care Plan, dated 7/25/24, indicated the resident was at risk for complications secondary to		facility and is submitted only in response to the regulatory requirement. F693 Tube feeding Management /restore eating skills It is the policy of Harbor Healthcare to ensure that all staff are trained and practice within their scope What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. R58 remains in the facility without adverse reactions. Staff observed notifying nurse prior to beginning care How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents receiving g-tube feedings have the potential to be affected by this potentially deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All Staff were in-serviced on: 8/09/2024 with regards to notifying the nurse prior to starting Peri/Adl care for residents receiving tube feedings How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.	

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	requiring a tube feeding. The approaches were to keep the head of the bed elevated 30-45 degrees during and thirty minutes after tube feed. Physician's Orders, dated 7/2/24, indicated the resident was NPO and an enteral feeding of Glucerna 1.5 was to infuse at 75 cc (cubic centimeters) on at 3:00 a.m. and off at 11:00 p.m. During an interview on 8/8/24 at 11:30 a.m., the Director of Nursing indicated the CNA should not have lowered the head of the bed while the feeding was infusing or placed the tube feeding on hold. 3.1-44(a)(2)		The Director of Nursing /Designee will observe 5 staff members per week providing ADL/Peri care for residents receiving tube feedings This will be completed for 5x/ week x2 weeks then weekly for 6 months. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 1 of 3 residents reviewed for respiratory care. (Resident 13) Finding includes: During random observations on 8/5/24 at 10:40 a.m. and 2:41 p.m., and on 8/6/24 at 10:00 a.m., Resident 13 was observed in bed wearing oxygen	F 0695	Please accept the following as the facility's credible allegation of compliance. 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. F695 Respiratory/Tracheostomy care and Suctioning	08/29/2024

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	per nasal cannula at 1.5 liters. The record for Resident 13 was reviewed on 8/7/24 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, type 2 diabetes, major depressive disorder, chronic kidney disease, heart disease, heart failure, atrial fibrillation, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 7/12/24, indicated the resident was cognitively intact for daily decision making. The resident did not wear oxygen. A Care Plan, revised on 4/12/24, indicated the resident had complications of shortness of breath when lying flat in bed. The approaches were to encourage the use of supplemental oxygen at 2 liters. A Care Plan, revised on 7/26/24, indicated the resident required the use of oxygen therapy. The approaches were to set the oxygen at 2 liters per physician orders. Physician's Orders, dated 7/10/24, indicated oxygen at 2 liters via nasal cannula every shift as needed for shortness of breath. During an interview on 8/8/24 at 11:30 a.m., the Director of Nursing indicated the oxygen flow rate should be on as ordered by the physician. 3.1-47(a)(6)		It is the policy of Harbor Healthcare to ensure that all residents receive care and services as ordered by the physician What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. R15 remains in the facility with her oxygen on the correct settings How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents receiving oxygen have the potential to be affected by this deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All Staff were in-serviced with regards to monitoring and assuring that resident s concentrators are set to the correct parameters How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The Director of Nursing /Designee will observe 5 residents per week who receive oxygen for compliance. This will be completed for 5x/ week x2 weeks then weekly for 6 months. The Administrator/designee will present a summary of the audits	

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			to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and			

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	§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to establish and/or maintain a system that accounted for, periodically reconciled, and ensured the disposition of all controlled drugs, related to inaccurate documentation of narcotic medications for 1 of 1 resident reviewed for narcotics. (Resident 33) Finding includes: On 8/5/23 at 11:18 a.m., an investigation of a narcotic diversion regarding a previously employed nurse was reviewed. The file folder was full of old narcotic sheets from a resident for whom the narcotic diversion was suspected. During the investigation, there was a discrepancy noted earlier on the narcotic log than what was reported on 7/31/24. The record for Resident 33 was reviewed on 8/07/24 at 3:16 p.m. The diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body), stage 4 sacral wound, anemia, anxiety, hypertension (high blood pressure), depression, and colostomy status. The Significant Change Minimum Data Set (MDS) assessment, dated 7/8/24, indicated the resident was cognitively intact. The resident used hospice services and used medicine from high-risk drug classes such as opioids and anti-anxiety medication. A Care Plan, dated 7/3/24, indicated the resident was prescribed an opioid medication and was at risk for constipation, respiratory failure, and	F 0755	Please accept the following as the facility's credible allegation of compliance. 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. F755 Pharmacy Svcs/Procedures/Pharmacist/ Records It is the policy of Harbor Healthcare to ensure that it maintains its medical records What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. R33 remains in the facility receiving her narcotic analgesic as ordered without discrepancies on her control sheet How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents receiving Narcotics management have the potential to be affected by this deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All Staff were in-serviced with	08/29/2024

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	08/09/2024

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	lethargy. Interventions were to administer medications as ordered and observe effectiveness. A Physician's Order, dated 6/28/24, indicated to administer Morphine Sulfate 0.5 milliliters (ml) by mouth under the tongue twice a day for pain and shortness of breath. The Morphine Sulfate narcotic log was started on 6/28/24 with a starting dose of 30 ml. The prescribed dose of 0.5 ml was signed out given on 6/28/24 at 5:00 p.m. The amount left dose after administering 0.5 ml was 29.5 ml. The remaining dates and doses were documented as follows with a discrepancy noted on 7/6/24. Morphine Sulfate 0.5 ml was recorded as administered on the following dates: 6/29 at 8:00 a.m. with a remaining dose of 29 ml 6/29 at 8:00 p.m. with a remaining dose of 28.5 ml 6/30 at 8:00 a.m. with a remaining dose of 28 ml 6/30 at 8:00 p.m. with a remaining dose of 27.5 ml 7/1 at 8:00 a.m. with a remaining dose of 27 ml 7/1 at 8:00 p.m. with a remaining dose of 26.5 ml 7/2 at 9:00 a.m. with a remaining dose of 26 ml 7/2 at 5:00 p.m. with a remaining dose of 25.5 ml 7/3 at 5:43 p.m. with a remaining dose of 25 ml 7/4 at 8:00 a.m. with a remaining dose of 24.5 ml 7/4 at 6:00 p.m. with a remaining dose of 24 ml 7/5 at 8:00 a.m. with a remaining dose of 23.5 ml 7/5 at 5:fpm. with a remaining dose of 23.0 ml 7/6 at 8:00 a.m. with a remaining dose of 25.5 ml 7/7 at 8:00 a.m. with a remaining dose of 25 ml 7/8 at 8:00 a.m. with a remaining dose of 24.5 ml 7/8 at 6:00 p.m. with a remaining dose of 24 ml The remaining doses were consecutive until a discrepancy was found and reported on 7/31/24. A reportable was filed, the nurse was terminated after refusing a drug screen and a police report		regards to maintaining the narcotics log and reporting discrepancies immediately How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The Director of Nursing /Designee will audit the narcotic log three days per week x2 weeks then weekly for 6 months. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	

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	was filed. The Medication Administration Record (MAR) indicated the medication was signed out as given twice a day from 7/1/24- 7/31/24. The Morphine was signed out on the narcotic log as given only one time on the following dates: 7/3/24 7/6/24 7/7/24 During an interview on 8/06/24 at 10:01 a.m., the Administrator indicated the RN signed her voluntary termination after she refused a drug screen. During an interview on 8/6/24 at 1:11 p.m., the Nurse Consultant 1 indicated there must have been a diversion issue prior to their reportable filed on 7/31/24. The nurse was interviewed who administered the morphine sulfate on 7/6/24 at 8:00 a.m., the nurse indicated she wrote exactly what was left in the bottle. The nurse did not notify the Director of Nursing (DON) or the Administrator with the discrepancy. The narcotic log should have matched the MAR. 3.1-48(a)(3)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or			

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	§483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to appropriately monitor blood pressures (BP) related to medications with BP parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 58) Finding includes: The record for Resident 58 was reviewed on 8/6/24 at 1:20 p.m. The resident was admitted to the facility on 6/7/24. Diagnoses included, but were not limited to, stroke, obesity, dysphagia, type 2 diabetes, high blood pressure, heart disease, peg tube (a tube inserted directly into the stomach for nutrition), restlessness and agitation. The 7/9/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. The resident was dependent on staff to roll to the right and the left, transfer out of bed, personal hygiene and oral care.	F 0757	Please accept the following as the facility's credible allegation of compliance. 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. F757 Drug regimen is free from unnecessary Drugs It is the policy of Harbor Healthcare to ensure that its residents blood pressure parameters related to blood pressure medications are appropriately monitored. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. R58 remains in the facility and has his blood pressure monitored per physician orders How the facility will identify other	08/29/2024

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	Physician's Orders, dated 7/20/24, indicated Hydralazine (a medication used to lower the blood pressure) 50 milligrams (mg), 1 tablet three times a day and hold for systolic blood pressure less than 110. The Medication Administration Record (MAR), for the months of 7/2024 and 8/2024, indicated there was no documented blood pressure prior to the administration of the Hydralazine. The last documented blood pressure in the vital section was on 7/28/24 at 9:21 a.m. During an interview on 8/7/24 at 11:25 a.m., LPN 3 indicated she checked the resident's blood pressure in the morning prior to the administration of the Hydralazine. There was no place to document the blood pressure in the computer. During an interview on 8/7/24 at 2:00 p.m., the Assistant Director of Nursing indicated the blood pressure should have been recorded on the MAR or in the record before the administration of the medication. During an interview on 8/8/24 at 11:30 a.m., the Director of Nursing indicated the resident's blood pressures were not documented in the clinical record before the administration of the Hydralazine. 3.1-48(a)(3)		residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents receiving Blood pressure medication have the potential to be affected by this deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nursing and QMA's were in-service on monitoring and documenting blood pressures within their ordered parameters for those residents with orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The Director of Nursing /Designee will audit those residents who are receiving blood pressure medications 3 days per week x2 weeks then weekly for 6 months. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use			

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	§483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for			

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	the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure an adequate indication for the use of an antipsychotic medication was documented in the clinical record for 1 of 5 residents reviewed for unnecessary medication. (Resident 5) Finding includes: The record for Resident 57 was reviewed on 8/8/24 at 8:40 a.m. Diagnoses included, but were not limited to, Alzheimer's disease (dementia), high blood pressure, anemia, and osteoarthritis. The resident was admitted to the facility on 5/16/24. The Modification of the Admission Minimum Data Set (MDS) assessment, dated 5/23/24, indicated the resident was moderately impaired for daily decision making and had the behavior of wandering which occurred 4 to 6 times during the reference period. The resident received an antipsychotic medication which was scheduled and no gradual dose reduction (GDR) had been attempted. A Care Plan, dated 5/21/24, indicated the resident received an antipsychotic medication for behavior management. A Nurses' Note, dated 5/17/24 at 8:57 p.m., indicated the physician was notified to address the resident's insomnia as he was pacing back and forth. The resident had indicated he was having trouble going to sleep. New orders were received	F 0758	Please accept the following as the facility's credible allegation of compliance. 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. F758 Free from unnecessary psychotropic meds/PRN It is the policy of Harbor Healthcare to ensure that it maintains its medical records What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. R57 Remains in the facility receiving his antipsychotic medication as prescribed for behavior management related to his diagnosis of Alzheimer's disease How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents receiving antipsychotic medications have the potential to be affected by this deficient practice What measures will be put into	08/29/2024

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	for Seroquel (an antipsychotic medication) 25 milligrams (mg) at bed time. Physician's Orders, dated 5/17/24, indicated Seroquel 25 mg at bed time. A Physician Progress Note, dated 5/21/24 at 3:00 p.m., indicated "discussed with nursing staff medication changes. Discontinue seroquel 25 mg at night and melatonin. Starting seroquel 50 mg at bedtime and seroquel 25 mg in the morning...." (sic) Physician's Orders, dated 5/21/24, indicated Seroquel 50 mg at bed time for restlessness. Physician's Orders, dated 5/22/24, indicated Seroquel 25 mg in the morning for restlessness. There was no documentation of any behaviors or an adequate indication for the use of the antipsychotic medication in the clinical record. The resident had not received any visits from the contracted behavioral health Nurse Practitioner (NP). A professional resource regarding approved uses for seroquel, found at https://www.accessdata.fda.gov/drugsatfda_docs /label/2022/020639s072lbl.pdf, indicated seroquel was approved by the FDA (U.S. Food and Drug Administration) for schizophrenia and bipolar disorder. A black box warning indicated, "Increased Mortality in Elderly Patients with Dementia-Related Psychosis: Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. SEROQUEL is not approved for elderly patients with dementia-related psychosis."		place or what systemic changes will be made to ensure that the deficient practice does not recur. All Staff were in-serviced with regards to obtaining a diagnosis from the prescriber at the order is received. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The Director of Nursing /Designee will complete an audit for those residents receiving antipsychotic medications and confirm that there is an appropriate Dx for use, then a review will be completed 3x/ week x2 weeks then weekly for 6 months for residents with new orders including new and readmissions. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly	

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	During an interview on 8/8/24 at 3:15 p.m., the Director of Nursing indicated the resident had not seen the contracted behavioral health NP. There was no approved diagnosis for the use of the Seroquel medication. 3.1-48(a)(4)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the			

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	delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, record review, and interview, the facility failed to ensure a resident received routine dental services related to decayed and broken teeth for 1 of 2 residents reviewed for dental services. (Resident 45) Finding includes: During an interview on 8/5/24 at 10:28 a.m., Resident 45 indicated he had seen the dentist about 5 months ago, and the dentist indicated they were going to pull his teeth as they were bad, but he has heard nothing more of it. Resident 45 indicated it was hard to eat with his teeth as they were brittle. During an observation at that time, the resident had obvious broken, loose and decayed teeth. The record for Resident 45 was reviewed on 8/7/24 at 11:20 a.m. Diagnoses included, but were not limited to, infarction of the spinal cord, heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, urine retention, and neuromuscular of the bladder.	F 0791	Please accept the following as the facility's credible allegation of compliance. 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. F791 Routine/Emergency Dental Services in SNFs What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 45 was noted to have no emergent dental needs. Resident 45 was added to the facilities next dental visit list. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring dental services have the potential to be	08/29/2024

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	The 5/30/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed partial to moderate assistance with personal hygiene and set up or clean up assistance with oral hygiene. The resident had no issues with his teeth or gums and a had a suprapubic catheter. The OBRA MDS/Look back Documentation, dated 5/30/24, indicated the resident had no oral problems. There was no care plan for dental issues. A dental exam, dated 4/8/24, indicated there were root tips present on many teeth and the resident had non-restorable teeth. The gums were red and inflamed and there were caried and/or decayed teeth present at number 3, 13, 20, 21, 22, 23, 24, 27, and 28. The recommendations were to have xrays taken at the next visit as well as full mouth views and xrays and to set up a treatment plan. During an interview on 8/7/24 at 1:50 p.m., the MDS Coordinator indicated she was unaware the resident had decayed or caried teeth. She obtained the information regarding the resident's teeth off of the MDS look back assessment, not observation, and there was no documentation his teeth were bad. During an interview on 8/8/24 at 2:15 p.m., the Social Service Director indicated the resident had not seen a dentist since 4/2024. The facility switched dentists and the new company had been at the facility in 6/2024 and 8/2024 but had not seen the resident. The resident had told him he did not want to see the dentist because he did not want to start the process over.		affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Facility staff were educated on: · Notifying the nurse/social services of need for dental services so that resident can be placed on the facility dental services list. MDS staff was educated on: · Documenting resident assessments accurately Social service was educated on: · Ensuring consent for dental services are obtained and resident is added to dental list timey. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/Designee will audit weekly to ensure new admissions and residents with needs for dental services are added to the dental schedule. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic	

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	3.1-24(a)(1)		corrections will be completed: 8/29/2024	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, record review, and interview, the facility failed to ensure food was prepared in a form to meet individual needs related to not following the pureed recipe. This had the potential to affect 2 residents who received a pureed diet. (Cook 1) On 8/7/24 at 11:37 a.m., a pureed demonstration of barbeque chicken was observed with Cook 1. The pureed barbeque chicken was precooked and 2 servings were measured out from the mechanical barbeque chicken mixture and added to the blender. There were no additional ingredients that were added to the mixture. The barbeque chicken puree was pudding thick, and the mixture was even with no clumps. Cook 1 measured out 2 servings and placed them in 2 serving bowls. On 8/7/24 at 11:45 a.m., Cook 1 measured out 2 servings of precooked broccoli and added to the blender. There were no additional ingredients added to the mixture. The consistency was even with no lumps or clumps. Cook 1 then measured out 2 servings and placed them in 2 serving bowls. During an interview on 8/7/24 at 11:37 a.m., Cook 1 indicated she did not use recipes when preparing pureed meals and the food used for pureed meals	F 0805	Please accept the following as the facility's credible allegation of compliance. 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. F805 Food in Form to Meet Individual Needs What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Dietary manager was immediately provided with the puree recipe. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary managers/dietary staff	08/29/2024

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	08/09/2024

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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	was precooked. A recipe titled; "Pureed BBQ Chicken" was provided by the Dietary Manager on 8/7/24 at 2:53 p.m. This current recipe indicated, " ... Place prepared poultry and bread in a sanitized food processor. Gradually add sauce and blend until smooth..." A recipe titled; "Pureed Broccoli" was provided by the Dietary Manager on 8/7/24 at 2:53 p.m. This current recipe indicated, " ... Place prepared vegetables and margarine in a washed and sanitized food processor and blend until smoothed..." During an interview on 8/7/24 at 2:54 p.m., the Dietary Manager indicated the pureed recipes should have been followed. 3.1-21(a)(3)		were re-educated on: · Following the recipes when preparing meals including altered consistency food items. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Dietary Manager/Designee will audit altered diets preparation 2 times per week to ensure the recipe is followed and consistency is accurate. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Date by which systemic corrections will be completed: 8/29/2024	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.			

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	§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or			

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	(iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to documentation of a dialysis access site for 1 of 1 resident reviewed for dialysis (Resident 2) and the correct medication administration route for 1 of 1 resident reviewed for unnecessary medications (Resident 58). Findings include: 1. The record for Resident 2 was reviewed on 8/9/24 at 9:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes and end stage renal disease. The Annual Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the resident was cognitively intact. The resident was receiving dialysis services. A Care Plan, reviewed on 6/17/24, indicated the resident had a right permacath (a flexible, soft	F 0842	Please accept the following as the facility's credible allegation of compliance. 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. F842 Resident Records-Identifiable Information What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 2's has had no adverse reaction. Dialysis communication forms are being completed per protocol with documentation regarding the access site Resident 58's medication route was clarified. How the facility will identify other residents having the potential to	08/29/2024

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	plastic tube used for short term dialysis treatment) in place. Interventions included, but were not limited to, keep catheter site clean and dry, observe for redness, swelling, any discharge, increased pain or warmth due to infection. A Physician's Order, dated 2/7/24 and listed as current on the August 2024 Physician's Order Summary (POS), indicated the resident's dialysis access site was to be assessed every shift for redness, swelling, pain, and drainage. The physician was to be notified with any symptoms and documentation was to be completed in the progress note. A "+" was to be documented for abnormalities and a "-" for no abnormalities. The July 2024 Medication Administration Record (MAR) indicated both a "+" and a "-" symbol were documented on the following dates and times: - Day shift: 7/10, 7/25, 7/27, 7/28, and 7/29/24 - Evening shift: 7/5, 7/13, 7/17, 7/18, 7/19, 7/22, 7/25, 7/27, 7/28, 7/29, and 7/31/24 During an interview on 8/9/24 at 10:15 a.m., the Director of Nursing indicated the July MAR should have been coded correctly related to abnormalities to the dialysis access site. 2. The record for Resident 58 was reviewed on 8/6/24 at 1:20 p.m. The resident was admitted to the facility on 6/7/24. Diagnoses included, but were not limited to, stroke, obesity, dysphagia, type 2 diabetes, high blood pressure, heart disease, peg tube (a tube inserted directly into the stomach for nutrition), restlessness and agitation. The 7/9/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident had a peg tube and received 51% or		be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were educated on: · Completing timely and accurate documentation in the resident's medical record including dialysis communication forms. · Verifying medication administration route orders are correct in the medical record How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/designee will audit 2 residents receiving hemodialysis weekly to ensure there is documentation regarding the access site. DON/Designee will audit 2 weekly residents with enteral feeding to ensure medication routes are documented accurately. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at	

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	more of his nutrition through the tube. Physician's Orders, dated 7/2/24, indicated NPO (nothing by mouth). Physician's Orders, dated 7/3/24, indicated the following medications: - Furosemide (a diuretic medication) 40 milligrams (mg), 1 tablet by mouth in the morning. - Amlodipine Besylate (a blood pressure medication) 10 mg, 1 tablet by mouth one time a day. - Atorvastatin (a medication used to reduce cholesterol) 40 mg give 1 tablet by mouth in the evening. - Clopidogrel Bisulfate (a medication used to prevent blood clots) 75 mg, 1 tablet by mouth in the morning. - Isosorbide Mononitrate ER (a blood pressure medication) 60 mg, give 1 tablet by mouth in the morning. - Losartan Potassium-HCTZ (a blood pressure medication) 100-25 mg, 1 tablet by mouth in the morning. - Carvedilol (a blood pressure medication) 25 mg, 1 tablet by mouth two times a day. - Apixaban (a blood thinner) 5 mg, 1 tablet by mouth every morning and at bedtime. - Hydralazine (a blood pressure medication) 50 mg, 1 tablet by mouth three times a day. During an interview on 8/7/24 at 11:25 a.m., LPN 3 indicated she was aware the resident was NPO and took his medications via the peg tube, however was not sure why the orders indicated by mouth. During an interview on 8/7/24 at 2:00 p.m., the Assistant Director of Nursing indicated the physician's orders should have indicated all the		the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/29/2024	

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	medications were to be administered through the peg tube because the resident was NPO. 3.1-50(a)(2)			
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.			

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	§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence,			

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	prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans			

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	of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on record review and interview, the facility failed to identify unresolved quality deficiencies, which had been cited on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiencies through the quality assessment and assurance (QAA) process, as evidenced by the number of repeated deficiencies cited for pest control related to gnats in resident rooms. This deficient practice had the potential to affect 60 of 60 residents residing in the facility. Finding includes: During an interview on 8/9/24 at 11:30 a.m., the Administrator indicated the Quality Assessment and Assurance (QAA) Committee had a meeting on 7/18/24 and the committee consisted of the Medical Director, the Administrator, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Minimum Data Set (MDS) Nurse, the Food Sanitation Supervisor, the Social Service Director, the Activity Director, Housekeeping and Maintenance Directors. The committee met on the third Thursday of the month. The Quality Assurance and Performance Improvement (QAPI) plan was a general outline of how to set up a QAPI committee and what the committee should do. The QAPI plan was a data driven, proactive approach for improving the quality of life, care and services in long term care.	F 0867	Please accept the following as the facility's credible allegation of compliance. 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. F867 QAPI/QAA Improvement Activities What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; QAPI plan was developed related to pest control. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents can be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Administrator, maintenance, department heads, and staff were educated on the monitoring required to prevent further repeated deficiencies related to pest	08/29/2024

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	The activities of QAPI involved members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement and improvement or corrective plan and continuous monitoring of interventions. The following deficiency was cited on this survey at an isolated scope with potential for more than minimal harm and had been cited previously: - F925 Maintains an Effective Pest Control Program was previously cited on the Annual survey dated 7/28/23. Cross reference F925. There was no evidence the facility had identified, developed, or implemented action plans and/or continued to monitor any corrective actions taken when these deficiencies were cited previously. During an interview on 8/9/24 at 11:30 a.m., the Administrator indicated there was no Performance Improvement Plan (PIP) in place for the prevention of gnats. He was aware there was a gnat problem and has had pest control coming in on a weekly basis, however, they did not always treat for gnats. He had asked the pest control company for a copy of the current contract they had previously signed with the facility so he could look at it and make revisions if needed. 3.1-52(b)(2)		control. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The administrator will review and update Pest Control QAPI Plan monthly. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/29/2024	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for			

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	residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was in good repair related to marred walls, loose baseboards and missing bolts around the toilet for 1 of 2 floors observed. (First Floor) Findings include: During the Environmental Tour on 8/9/24 at 9:30 a.m. with the Maintenance Director, the following observed: First Floor a. Room 101 - The cove base was pulling away from the wall near the entrance of the room. The walls were marred under the chair rail. The base of bathroom door was scratched and marred. There were 2 residents who resided in room and 4 residents shared the bathroom. b. Room 107 - The wall the behind the bed was marred and gouged. There was 1 resident who resided in the room. c. Room 108 - The door frame was marred by the closet and the cove base was loose in the entry way of the room. The walls in the bathroom were marred. There were 2 residents who resided in the room and shared the bathroom. d. Room 111- The bathroom door frame was marred and the paint on the walls was chipped. The bolts were exposed at the base of the toilet. There was 1 resident who resided in the room and 3 residents shared the bathroom. e. Room 112 - The bathroom door frame was marred and the paint was chipped. There were 2	F 0921	Please accept the following as the facility's credible allegation of compliance. 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. F921 Safe/Functional/Sanitary/Comfortable Environment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Maintenance was notified of marred walls, door frame, and peeling cove base. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were educated on: · The process of notifying maintenance/environmental services of any necessary repairs or cleaning needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be	08/29/2024

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	residents who resided in the room and 3 residents who shared the bathroom. During an interview on 8/9/24 at 9:30 a.m., the Maintenance Director indicated all the above was in need of repair. 3.1-19(f)		put into place; The Maintenance Director will audit 5 rooms per week on alternating units for maintenance issues. Any issues will be corrected. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/29/2024	
F 0925 SS=D 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, record review, and interview, the facility failed to ensure the residents' environment was free of pests related to gnats for 1 of 1 residents observed with gnats in their room. (Resident 33) Finding includes: On 8/5/24 at 10:12 a.m., Resident 33 was observed lying in bed with gnats flying in the room and landing on her bed linen and right lower leg wound dressing. On 8/5/24 at 11:04 a.m., the Wound Nurse was observed entering the resident's room and	F 0925	Please accept the following as the facility's credible allegation of compliance. 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. F925 Maintains Effective Pest Control Program It is the policy of Harbor Healthcare to maintain an effective pest control program so that it is free of pest and rodents What corrective action(s) will be	08/29/2024

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	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	attempting to complete wound care. There were gnats observed in the air, on the resident's gown, and on the wound dressing. The wound nurse removed several layers of the bandages and several gnats were observed inside the bandages and on the resident's open ulcerations to the right lower leg. During an interview at that time, the Wound Nurse indicated they were attempting to get rid of the gnats and had put a work order in for treatment. There were gnat strips hanging in the room, and she was aware the gnats were flying on and around the wound during the treatment. The Wound Nurse indicated the Director of Nursing was also aware and saw the gnats on the wound and bandages. The record for Resident 33 was reviewed on 8/5/24 at 9:10 a.m. Diagnoses included, but were not limited to, pressure ulcers, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. The resident also received hospice services. The Significant Change Minimum Data Set (MDS) assessment, dated 7/8/24, indicated the resident was cognitively intact, and had pressure ulcers upon admission. A Pest Control document, provided by the Administrator on 8/5/24 at 1:48 p.m., indicated on 7/24/24, fruit flies were treated in the following areas; the laundry room, restrooms, kitchen, main kitchen, the kitchen dish room, the janitor closet, and kitchen janitor closet. The pest control company had been at the facility and treated bed bugs and cockroaches on 7/30/24 and 8/2/24. Gnats were not treated anywhere in the facility on either of those visits.		accomplished for those residents found to have been affected by the deficient practice. R33 Remains in the facility without further incident and no adverse reactions from pest. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents residing in the facility have the potential to be affected by the alleged deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All staff were in-serviced on the process for reporting pest and rodents utilizing the pest control log The maintenance director was in–serviced on assuring and confirming follow–up of all issues noted on the log, including the use of outside vendors to assist with eradication. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The administrator /Designee will complete observations 5x/ week x2 weeks then weekly for 6 months confirming that the facility with special focus on resident care areas are free of pests and rodents.	

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	During an interview on 8/5/24 at 3:54 p.m., the Administrator indicated the resident was moved to a different room and the room was deep cleaned. During an interview on 8/5/24 at 4:05 p.m., the Wound Nurse retracted her statement about seeing the gnats on the resident and on the wound. She indicated her statement was misunderstood regarding the gnats being in the room, on the resident's wound, and on the bandages. A facility policy titled, "Safe Environment", provided by the Administrator on 8/9/24 at 11:00 a.m., indicated..."the facility will maintain an effective pest control program so that the facility is free of pests and rodents"... 3.1-19(f)(4)		The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	