STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155653	A. BUILDING B. WING	00	COMPLETED 09/25/2024
		100000		ADDRESS SITE OF THE SOR	00/20/2021
NAME OF I	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD	
HARBOF	R HEALTH & REHA	В		CHICAGO, IN 46312	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
0000					
Bldg. 00					
	This visit was for a	Post Survey Revisit (PSR) to	F 0000		
	the Recertification and State Licensure Survey completed on 8/9/24.				
	Survey dates: Sept	ember 24 and 25, 2024			
	Facility number: 00	0108			
	Provider number: 1				
	AIM number: 1002	67410			
	Census Bed Type:				
	SNF/NF: 61 Total: 61				
	10(a): 01				
	Census Payor Type	:			
	Medicare: 3				
	Medicaid: 55				
	Other: 3				
	Total: 61				
	These deficiencies	reflect State Findings cited in			
	accordance with 41	•			
	Quality review com	pleted on 10/1/24.			
F 0684	483.25				
SS=D	Quality of Care				
Bldg. 00					
		view and interview, the facility	F 0684	Please accept the following as	s the 10/10/2024
		od pressure medications were		facility's credible allegation of	
		itside of the physician-ordered		compliance. This plan of	
	•	3 residents reviewed for blood		correction does not constitute	
	pressure medication	ns. (Residents 2, 3, and 7)		admission of guilt or liability by	
	Findings includes:			facility and is submitted only in response to the regulatory	1
	- manigo merades.			requirement.	
	1. The record for R	esident 2 was reviewed on		'	
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

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

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Administrator

10/29/2024

continued program participation.

Craig Clemons

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	NG		09/25/	2024
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ICCOOK AVE		
	R HEALTH & REHA	D			CHICAGO, IN 46312		
HANDOF	TILALIII & NEIIA	В		EAST	ETIICAGO, IN 40312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		. Diagnoses included, but were			The facility requests paper		
	not limited to, Alzh	eimer's disease and high blood			compliance for this citation		
	pressure.						
					F684 Quality of Care		
		ly Minimum Data Set (MDS)					
	assessment indicated the resident was moderately				It is the policy of Harbor		
	impaired for daily d	lecision making.			Healthcare to ensure its		
					residents receive treatment		
	1 -	dated 7/24/24, indicated the			and care in accordance with		
	following:				professional standards of		
	* `	edication used to treat high			practice.		
	blood pressure) 10 milligrams (mg), give 1 tablet						
	•	hold for blood pressure less			What corrective action(s) wil	I	
	than 130/60.				be accomplished for those		
	· ·	tion used to treat high blood			residents found to have been	า	
		ily. Hold for blood pressure			affected by the deficient		
	less than 130/80.				practice.		
	The Medication Ad	ministration Record (MAR) for			R2, R3, R7- All remain in the		
		4 indicated the Amlodipine and			facility and have had their		
		istered on 9/8/24 with a blood			medication administered as		
		and on 9/11/24 with a blood			ordered by the physician		
	pressure of 119/63.				within the specified		
	pressure of 119703.				parameters		
	During an interview	v on 9/25/24 at 10:30 a.m., the			parameters		
	_	g indicated the resident's			How the facility will identify		
	_	have been held when outside			other residents having the		
		dered parameters. The nursing			potential to be affected by th	е	
		education on when to hold and			same deficient practice and		
	administer the medi				what corrective action will be	9	
					taken.		
	2. The record for Re	esident 3 was reviewed on			All residents residing in the fac	cility	
	9/24/24 at 1:00 p.m	. Diagnoses included, but were			have the potential to be affect	-	
		ction of the spinal cord, heart			by these alleged deficient		
		pressure, type 2 diabetes,			practice		
		sorder, and anxiety disorder.					
					What measures will be put in	ito	
	The 8/18/24 Quarte	erly Minimum Data Set (MDS)			place or what systemic		
	assessment indicate	ed the resident was cognitively			changes will be made to		
	intact for daily deci		1		oneuro that the deficient		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155653	B. W	NG		09/25/	/2024
		1		CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			CCOOK AVE		
H∆RR∩E	R HEALTH & REHA	R			CHICAGO, IN 46312		
HAINDOI	· · · · · · · · · · · · · · · · · · ·			LAST			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					practice does not recur.		
	1 -	dated 8/3/24, indicated					
	_	e (a medication used to lower			All nursing staff have been		
		and the heart rate) 25			in-serviced on the importance	of	
		ive 0.5 tablet by mouth three			assessing and administering		
		ng). Hold the medication for			medications as ordered by the	3	
	blood pressure less	than 120/60.			physician within the specified		
					parameters for administration.		
	1 -	dated 8/5/24 indicated					
		nedication used to raise the					
		mg, give 1 tablet by mouth			How the corrective action(s)		
	three times a day. Hold the medication for blood				will be monitored to ensure	the	
	pressure greater that	ın 110/60.			deficient practice will not		
					recur, i.e., what quality		
		lministration Record (MAR) for			assurance programs will be	put	
		4 indicated the a.m. Metoprolol			into place.		
		as administered with a blood					
	1 ~	and on 8/30/24 with a blood			The Director of Nursing /Design	gnee	
	1 ~	The evening dose on 8/31/24			will complete Medication		
	was administered w	with a blood pressure 100/70.			administration Record		
					observations/audits 3x/ week		
		ndicated the Metoprolol was			weeks then weekly for 6 mont		
		7/24 for the evening dose with a			confirming that medications th		
	_	04/60 and on 9/8/24 with a			have administration paramete		
	blood pressure of 1	00/60.			are administered within those		
			1		parameters.		
		ndicated the Midodrine was					
		e midday dose on 9/16/24 with			The Administrator/designee v		
	•	118/74. The evening doses			present a summary of the aud	lits	
		on 9/12/24 with a blood			to the Quality Assurance		
	_	9/18/24 with a blood pressure			committee monthly for 6 mont		
		with a blood pressure of 130/74,			Thereafter, if determined by the		
	and on 9/20/24 with	h a blood pressure of 138/74.			Quality Assurance committee		
		il il veli:			auditing and monitoring will be)	
	_	prolol and the Midodrine, the			done quarterly and present		
		igned out with a "4" (meaning			quarterly.		
		arameters for Administration)					
		ed on the following days:					
	- a.m. doses on 9/20		1				
	L - Midday doses on	9/4 9/8 9/18 and 9/20/24	1		I		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G	00	COMPL	ETED
		155653	B. WING		_	09/25/	/2024
NAME OF P	DOMINED OF CUIDDLES		STRI	EET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER				CCOOK AVE		
HARBOR	R HEALTH & REHA	B 	EAS	ST C	HICAGO, IN 46312		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	\dashv	DEFICIENC 11		DATE
	During an interview	on 9/25/24 at 10:30 a.m., the					
	_	indicated the resident's					
		have been held when outside					
	of the physician ord	lered parameters. The nursing					
		ducation on when to hold and					
		ications. 3. The record for					
		ewed on 9/24/24 at 10:41 a.m.					
		, but were not limited to, high chronic venous hypertension.					
	olood pressure and	emonic venous hypertension.					
	The Annual Minim	um Data Set (MDS)					
	assessment, dated 6/26/24, indicated the resident						
	was cognitively inta	act.					
	1 -	dated 8/3/24, indicated					
		ication used to lower the blood					
		grams (mg), 1 tablet three times blood pressure less than					
	130/60.	nood pressure less than					
	The Medication Ad	ministration Record (MAR) for					
		4 indicated the Hydralazine was					
	administered on the	_					
		d pressure of 112/68.					
		d pressure of 131/51.					
		d pressure of 115/66. d pressures of 109/66, 121/66,					
	and 120/67.	d pressures of 109/00, 121/00,					
	During an interview	on 9/25/24 at 10:36 a.m., the					
		indicated the staff needed to					
		ne blood pressure parameters					
		y hold and administer the					
	resident's medicatio	ons.					
	This deficiency was	s cited on 8/9/24. The facility					
		a systemic plan of correction					
	to prevent recurrence	• •					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	ING		09/25/	/2024
NAME OF B	PROVIDER OR SUPPLIER	,	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUFFLIER				ICCOOK AVE		
HARBOR	R HEALTH & REHA	В		EAST (CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-37(a)						
F 0685	483.25(a)(1)(2)						
SS=D		s to Maintain Hearing/Vision					
Bldg. 00	Treatment Bevice	3 to Maintain Floating, Vision					
3	Based on observation	on, record review, and	F 00	585	Please accept the following	as	10/25/2024
	interview, the facili	ty failed to ensure glasses were			the facility's credible allegation		
	received as ordered	and a follow up audiology (a			of compliance. This plan of		
	physician who treat	s hearing issues) appointment			correction does not constitu	te	
	_	2 of 2 residents reviewed for			an admission of guilt or liabi	lity	
		sident reviewed for hearing.			by the facility and is submitt	ed	
	(Residents 4, 3, and	16)		only in response to t			
					regulatory requirement.		
	Findings include:				The facility requests paper		
	1 The manual for D	esident 4 was reviewed on			compliance for this citation		
		. Diagnoses included, but were			F685 Treatment /Devices to		
		2 diabetes and end stage renal			Maintain Hearing/Vision What corrective action(s) wil	ı	
	disease.	2 diabetes and end stage renar			be accomplished for those	11	
	uis cusc.				residents found to have been	n	
	The Annual Minim	um Data Set (MDS)			affected by the deficient		
	assessment, dated 6	/11/24, indicated the resident			practice:		
	was cognitively inta	act. The resident was			Resident 3: Resident added to)	
	identified as having	adequate vision with			audiology schedule and was s	seen	
	corrective lenses.				on 9/30/2024. Medical clearar	nce	
		0.7.0			and audiometric test form		
		9/7/21 and reviewed on			completed by MD and sent ba		
		he resident's vision was			to audiologist for hearing aids.		
	_	se of glasses, which he reading. Interventions			Resident 4 & 6: Attestation for	m	
	1	not limited to, arrange			for replacement glasses completed. Resident's glasses	2	
		ye care practitioner as required			ordered and scheduled to be	3	
	·	iate visual aids (glasses) were			delivered to facility once glass	es	
		the resident's participation in			arrive to optometrist. Residen		
	activities.	• •			&6 received glasses on		
					10/10/2024.		
	The resident had an	eye exam on 12/19/23. New			How the facility will identify		
		mended and were to be			other residents having the		
		roval. Documentation in the			potential to be affected by th	ie	
	vision progress note	es indicated the resident			same deficient practice and		

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PRINTED: 11/13/2024

	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES							
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	_	1B NO. 0938-039 SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00		LETED	
	or conditions	155653	B. WI		<u> </u>	09/25/2024		
						00/20		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
		_			ICCOOK AVE			
HARBO	R HEALTH & REHA	AB .		EAST	CHICAGO, IN 46312			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		d full time use was to be			what corrective action will	be		
	encouraged for dist	tance and reading.			taken:			
					All facility residents requiring			
	-	cial Service Progress Notes,			vision and/or audiology servi			
		08 p.m., indicated the Social			have the potential to be affect			
		ad reached out to the optometry			by the alleged deficient pract			
	_	nformation on how the			Whole house audit complete			
	_	his replacement glasses. A			those residents needing aud			
	_	ed and submitted in an attempt			and optometry services were			
	to secure the reside	ent's replacement eye glasses.			added to the ancillary provid	ers		
					list.			
		cial Service Progress Notes,			What measures will be put	into		
		0:31 a.m., indicated the resident's			place or what systemic			
	-	ed yesterday and the			changes will be made to			
		ent to the lab. Once the glasses			ensure that the deficient			
		would be shipped directly to			practice does not recur:			
	the facility.				Social Services Director rece	eived		
	D				additional education on the			
	_	w on 9/25/24 at 9:30 a.m., the ector indicated the resident's			following:			
		e been ordered by the plan of			Ensuring residents are	list as		
	_	8/29/24. 2. During an interview			added to the optometry visit			
		p.m., Resident 3 indicated he			needed and follow-up is com	-		
		diologist since last year.			for referrals including obtaini glasses.	iig		
	nad not seen an add	diologist since last year.			Ensuring residents are			
	The record for Res	ident 3 was reviewed on 9/24/24			added to the audiology visit l	iet ae		
		oses included, but were not			needed and follow-up is com			
		on of the spinal cord, heart			including obtaining hearing a	•		
		l pressure, type 2 diabetes,			How the corrective action(s			
	_	isorder, and anxiety disorder.			will be monitored to ensure	•		
		-,			deficient practice will not			
	The 8/18/24 Ouarte	erly Minimum Data Set (MDS)			recur, i.e., what quality			
		ed the resident was cognitively			assurance programs will be	e put		
	intact for daily dec				into place:			
	 				Administrator/designee will a	udit		
	An Audiology Exa	m report, dated 9/6/23,			2x weekly for 1 month and th			
		or family had noticed a			weekly for 5 months to ensur			

decrease in responsiveness from the resident. The

hearing loss (damage in the inner ear) in both ears.

resident had moderate to severe sensorineural

residents on the optometry and/or

audiology visit list are seen, and recommendations received are

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	ING		09/25/	/2024
		l		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			CCOOK AVE		
H∆RR∩□	R HEALTH & REHA	В			CHICAGO, IN 46312		
HARDOR	TILALIII & NENA			LASIC	HOAGO, IN 40012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	aken and a hearing aid was			followed up timely including		
		left ear half concha (the hollow			obtaining eyeglasses and hea	ring	
	depression in the middle auricle of the ear) and will return for hearing aid fitting.				aids.		
					Administrator/designee will		
					present a summary of the aud	its	
		ote, dated 9/23/24 at 2:37 p.m.,	1		to the Quality Assurance		
		ned out to the audiologist to			committee monthly for 6 mont		
		vith obtaining his hearing aid.			Thereafter, if determined by th		
	•	indicated, since the order for	1		Quality Assurance committee,		
	_	s over a year old, the resident			auditing and monitoring will be	9	
		e-evaluated by the audiologist.			done quarterly and present		
	* *	s requested for an audiology			quarterly at the QA meeting.		
	_	ative indicated they would			Monitoring will be on going.		
		eduling team to get the					
	resident scheduled	for a visit.					
	A Capial Campian N	oto dotod 0/24/24 ot 8,44 o m					
	indicated the audiol	ote, dated 9/24/24 at 8:44 a.m.,					
		hearing aid was scheduled for					
	10/9/24.	ricaring aid was scheduled for					
	10/9/24.						
	During an interview	on 9/24/24 at 2:20 p.m., the					
	_	ctor (SSD) indicated he had just					
		udiologist's office on 9/23/24					
		aring aid. The appointment					
	was just scheduled						
		y					
	During an interview	y 9/24/24 at 2:30 p.m., the					
		ated he had been looking at					
		d checking the clinical records	1				
		hings were not completed. He					
		on 9/23/24 and told him he					
	_	of making the appointments					
		llary services for the resident.					
		•					
	The Plan of Correct	tion indicated the resident was					
	to be added to the fa	acility's audiology visit. The					
		ated there were no visits for					
	•	3, 8/26-8/30, 9/2-9/6, and	1				
		ng an interview on 9/24/24 at					

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155653		O	(X3) DATE SURVEY COMPLETED 09/25/2024			
	PROVIDER OR SUPPLIER R HEALTH & REHAB	5025 MCCO	STREET ADDRESS, CITY, STATE, ZIP COD 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 CR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	11:28 a.m., Resident 6 indicated he had not received his glasses and was still waiting for them.						
	The record for Resident 6 was reviewed on 9/24/24 at 10:40 a.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 9/4/24, indicated the resident was cognitively intact. The resident was also independent.						
	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 Optometry 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.						
	During an interview on 9/25/24 at 9:10 a.m., the Social Service Director indicated he ordered the glasses yesterday, and had not gotten around to ordering them earlier.						
	This deficiency was cited on 8/9/24. The facility failed to implement a systemic plan of correction to prevent recurrence.						
	3.1-39(a)(1)						
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155653	B. WI	NG		09/25/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	L			CCOOK AVE		
	R HEALTH & REHA	B			CHICAGO, IN 46312		
HARDUR	· · · · · · · · · · · · · · · · · · ·			EMOT			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		on, record review, and	F 06	595	Please accept the following as	s the	10/10/2024
	interview, the facility failed to ensure oxygen was				facility's credible allegation of		
	set at the correct flow rate for 1 of 3 residents				compliance. This plan of		
	reviewed for respira	atory care. (Resident 5)			correction does not constitute		
					admission of guilt or liability by		
	Finding includes:				facility and is submitted only ir	า	
					response to the regulatory		
		p.m., Resident 5 was observed			requirement.		
		ing outside smoking. The			The facility requests paper		
		aring any oxygen, the oxygen			compliance for this citation		
	tank was off and in	the corner of the room.					
	0.005/04 .005				F695 Respiratory/Tracheosto	omy	
		a.m., and 10:01 a.m., the resident			care and Suctioning		
		, the oxygen was on, and the			What corrective action(s) wil	I	
	flow rate was set un	ider 2 liters.			be accomplished for those		
	0.0/05/04 . 10.14	10.21			residents found to have been	n	
		l a.m., 10:31 a.m., and 10:45 a.m.,			affected by the deficient		
		arned from smoking and was			practice.		
	_	ner wheelchair watching			R5 remains in the facility with		
	1	gen was on and the flow rate			oxygen on the correct settings	3	
		liter line. The resident was not			How the facility will identify		
	wearing the oxygen	•			other residents having the		
	During an intervious	on 9/25/24 at 10:45 a.m., RN 1			potential to be affected by the	ie	
		nt's oxygen flow rate was not			same deficient practice and what corrective action will be	•	
		should be between the 2-liter			taken.	5	
		are the resident was not			All residents receiving oxygen		
	wearing her oxygen				have the potential to be affect		
	caring ner oxygen	•			by this deficient practice	Ju	
	Resident 5's record	was reviewed on 9/24/24 at			What measures will be put in	nto	
		s included, but were not limited			place or what systemic		
		(low iron), chronic			changes will be made to		
		ary disease (COPD),			ensure that the deficient		
	depression and low	-			practice does not recur.		
	1	•			All Staff were in-serviced with		
	The Quarterly Mini	mum Data Set (MDS)			regards to monitoring and ass		
	· · ·	/2/24, indicated the resident			that residents' concentrators a	•	
		act for daily decision making			set to the correct parameters.		
	and required oxygen	-			education given to non-clinica		
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	17			management team members		

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Event ID:

5YDM12 Facility ID: 000108

If continuation sheet Page 9 of 17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/25/2024	
	PROVIDER OR SUPPLIER		5025 M	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
F 0757	A Physician's Order administer oxygen a continuously every The Medication Ad 9/2024 indicated ox administered at 2 lit During an interview Administrator indic oxygen concern and to provide. During an interview Director of Nursing required oxygen im should have had her	ministration Record (MAR) for tygen was signed out as being ters on 9/24/24 and 9/25/24. You on 9/25/24 at 10:59 a.m., the ated he understood the d had no additional information You on 9/25/24 at 11:18 a.m., the (DON) indicated the resident mediately after she smoked and roxygen on.	TAG	how to properly read oxygen settings on concentrator and notify nursing if concentrator is set to ordered liter flow. Additional item to check "02 liflow set as ordered by physic added to daily Angel Rounds checklist. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place. The Director of Nursing /Desi will observe 5 residents with oxygen to ensure concentrate set to correct liter flow as ordered in the completed 2x week for 6 months. Non-clinical management tea will continue to utilize Angel Rounds sheet to audit those residents with oxygen orders ensure concentrator is set to correct liter flow. This will be completed daily 5x week for 6 months. The Administrator/designee were present a summary of the audit of the Quality Assurance committee monthly for 6 mon Thereafter, if determined by the Quality Assurance committee auditing and monitoring will be done quarterly and present quarterly.	is not iter iter ian" the put gnee or is ered. ekly m to o vill dits ths. he
SS=D		Free from Unnecessary			

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Event ID:

5YDM12 Facility ID: 000108

If continuation sheet Page 10 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BI	ILDING	00	COMPL	ETED
		155653	B. WI			09/25/	
		100000	D	_		00/20/	2021
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP COD		
01 1	no (IBEN ON BOLLEIN				CCOOK AVE		
HARBOR	R HEALTH & REHAI	B		EAST C	CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	Drugs						
	Based on record rev	riew and interview, the facility	F 07	757	Please accept the following as	the	10/10/2024
	failed to appropriate	ely monitor blood pressures			facility's credible allegation of		
	(BP) related to medications with BP parameters,				compliance. This plan of		
	for 2 of 3 residents reviewed for blood pressure				correction does not constitute	an	
	medications (Residents 2 and 3)				admission of guilt or liability by	the	
					facility and is submitted only in	1	
	Findings includes:				response to the regulatory		
	-				requirement.		
	1. The record for Re	esident 2 was reviewed on			The facility requests paper		
	9/25/24 at 8:45 a.m.	Diagnoses included, but were			compliance for this citation		
	not limited to, Alzh	eimer's disease, and high blood					
	pressure.	_			F757 Drug regimen is free fro	m	
	•				unnecessary Drugs		
	The 8/9/24 Quarterl	y Minimum Data Set (MDS)			, , ,		
		d the resident was moderately			It is the policy of Harbor		
	impaired for daily d	-			Healthcare to ensure that its		
					residents blood pressure		
	Physician's Orders,	dated 7/24/24, indicated the			parameters related to blood		
	following:				pressure medications are		
	- Amlodipine (a me	dication used to treat high			appropriately monitored.		
	- '	nilligrams (mg), give 1 tablet			What corrective action(s) will	I	
	one time a day and	hold for blood pressure less			be accomplished for those		
	than 130/60.	•			residents found to have been	1	
	- Cozaar (a medicat	ion used to treat high blood			affected by the deficient		
	pressure) 50 mg dai	ly. Hold for blood pressure			practice.		
	less than 130/80.	•			R3 DON spoke with MD and		
					received clarification on BP		
	The Medication Ad	ministration Record (MAR) for			medications & parameters. Ne	•W	
		indicated the Amlodipine and			orders obtained from MD.		
		vith a "4" (meaning Vitals			R2 DON spoke with MD and		
		ers for Administration) and			received clarification BP		
		nistered 9/6, 9/13, and 9/19/24.			parameters. New orders received	ved	
		nented blood pressure for			to discontinue to parameters d		
	those days.	F			controlled blood pressure.		
	j						
		on 9/25/24 at 10:30 a.m., the			How the facility will identify		
	-	indicated the resident's blood			other residents having the		
	_	documented in the clinical			potential to be affected by the	е	
	record and nursing s	staff needed more education.			same deficient practice and		

PRINTED: 11/13/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	DING	00	COMPL	ETED
		155653	B. WIN	G		09/25/	2024
							-
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
					CCOOK AVE		
HARBOF	R HEALTH & REHAI	В		EAST C	HICAGO, IN 46312		
(VA) ID	CIMMADV	STATEMENT OF DEFICIENCIE	 _	ID I			(V5)
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		REFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG			DATE
					what corrective action will be)	
					taken.		
		esident 3 was reviewed on			All residents receiving Blood		
	_	. Diagnoses included, but were			pressure medication have the		
	not limited to, infar	ction of the spinal cord, heart			potential to be affected by this		
	disease, high blood	pressure, type 2 diabetes,			deficient practice		
	major depressive di	sorder, and anxiety disorder.					
					What measures will be put in	to	
	The 8/18/24 Quarte	rly Minimum Data Set (MDS)			place or what systemic		
	assessment indicate	d the resident was cognitively			changes will be made to		
	intact for daily deci-	sion making.			ensure that the deficient		
		· ·			practice does not recur.		
Physician's Orders, dated 8/3/24, indicated				Nursing and QMA's received			
		(a medication used to lower			additional 1:1education on		
	_	and the heart rate) 25			monitoring and documenting b	lood	
	_	ve 0.5 tablet by mouth three			pressures. Additional educatio		
		g). Hold the medication for			given on administering BP	11	
	blood pressure less				medications within ordered		
	blood pressure less	than 120/00.					
	Dii-i-ul- Oud-u-	1-4-10/5/24 :1:4-1			parameters.	!:4	
	1 -	dated 8/5/24, indicated			DON completed whole house	audit	
	,	nedication used to raise the			on residents receiving BP		
		mg, give 1 tablet by mouth			medications. Resident physicia		
	1	Told the medication for blood			contacted for clarification on B		
	pressure greater that	n 110/60.			medications & parameters. Or		
					updated according to physicial	n	
		ministration Record (MAR) for			request.		
		th medications were not					
		ere was no documented blood			How the corrective action(s)		
	1 ~	for the midday dose and on			will be monitored to ensure t	he	
	-	g dose. A "4" was coded for			deficient practice will not		
		hich indicated the medication			recur, i.e., what quality		
	was not given due to	o vitals were outside of			assurance programs will be p	out	
	parameters.				into place.		
					The Director of Nursing /Desig	nee	
	During an interview	on 9/25/24 at 10:30 a.m., the			will audit those residents who		
		indicated the resident's blood			receiving blood pressure		
		documented in the clinical			medications with parameters 5	5	
	1 ~	staff needed more education.			days per week x2 weeks then		
					bi-weekly for 6 months.		
l .	Ī			Į.	2 ooning for o monthino.		

This deficiency was cited on 8/9/24. The facility

The Administrator/designee will

If continuation sheet

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/25/2024	
	PROVIDER OR SUPPLIER		5025 N	ADDRESS, CITY, STATE, ZIP COD MCCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	failed to implement to prevent recurrence 3.1-48(a)(3)	a systemic plan of correction ce.		present a summary of the audito the Quality Assurance committee monthly for 6 mont Thereafter, if determined by the Quality Assurance committee auditing and monitoring will be done quarterly and present quarterly.	hs. ne	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergend	cy Dental Srvcs in NFs				
	interview, the facili received routine der decayed and broken reviewed for dental Finding includes: During an interview Resident 3 indicated since the survey on about seeing the deriget dentures. During the resident had obto decayed teeth. The record for Resi at 2:00 p.m. Diagnor limited to, infarction disease, high blood major depressive di The 8/18/24 Quarte assessment indicate intact for daily deci	ted 4/8/24, indicated there were	F 0791	Please accept the following the facility's credible allegate of compliance. This plan of correction does not constitute an admission of guilt or liable by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. 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 3 was seen by dentate facility on 10/01/2024. Facility received referral for resident to receive additional dental service outside of the facility. Resident follow-up appointment schedule for 10/14/2024.	te ility ed II n al at o ces it	
	root tips present on	many teeth and the resident		How the facility will identify		

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Event ID:

5YDM12 Facility ID: 000108

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X:		(X3) DATE S	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
155653		B. W	ING	_	09/25/2	2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					CCOOK AVE		
HARBOR HEALTH & REHAB			_		CHICAGO, IN 46312		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		teeth. The gums were red and			other residents having the		
		were caried and/or decayed			potential to be affected by th	e	
	_	nber 3, 13, 20, 21, 22, 23, 24, 27,			same deficient practice and		
		nendations were to have xrays			what corrective action will be	9	
		sit as well as full mouth views			taken.		
	and xrays and to set up a treatment plan.				All :		
	TEN A	1 . 1			All residents requiring dental		
	i nere were no othe	other dental visits for the resident.			services have the potential to be		
	D	0/24/24 -4 1 40 41 -			affected by the alleged deficie	nt	
	_	on 9/24/24 at 1:40 p.m., the			practice.		
		ctor (SSD) indicated he was nt had seen the dentist since			What measures will be put in	ito	
		nt had seen the dentist since			place or what systemic		
	the survey.				changes will be made to		
	A Secial Security New Joseph 0/04/04 of 1/47 in in-				ensure that the deficient		
	A Social Service Note, dated 9/24/24 at 1:47 p.m., indicated staff met with the resident to discuss				practice does not recur.		
	ancillary services. The resident requested to be				Social service director receive	۵	
		-			additional education on:	u	
	enrolled into dental services and scheduled an appointment for 10/1/24.				Ensuring consent for den	tol	
	appointment for 10/	1/27.			services are obtained and resi		
	During an interview	v on 9/24/24 at 2:20 p.m., the			is added to dental list timey.	ideni	
		resident had not seen a dentist			Reviewing dental service		
		d scheduled an appointment			with residents regularly and as		
	•	He did not follow up with the			needed with residents/respons		
		-			parties	SIDIC	
	resident after he wanted to see a dentist in 8/2024.				Whole house audit completed	and	
	During an interview on 9/24/24 at 2:30 p.m., the				those residents requiring dent		
		dicated he had been looking at			services were added to the	~·	
		d checking the clinical records			ancillary providers list.		
		hings were not completed. He			How the corrective action(s)		
	spoke with the SSD on 9/23/24 and told him he		will be monitored to ensure the				
	_	of making the appointments			deficient practice will not		
	and getting the ancillary services for the resident.		recur, i.e., what quality				
	and getting the anomary services for the resident.				assurance programs will be	_{put}	
	During an interview on 9/25/24 at 8:45 a.m., the				into place.	•	
	-	lentist was last in the facility			Administrator/Designee will au	ıdit l	
		esident was not seen.			2x weekly for 1 month and 1x		
					weekly for 5 months to ensure		
	The Plan of Correct	tion indicated the resident			new admissions and residents		
		the next dental visit.			with needs for dental services		
			1		1		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
		155653	B. WI	B. WING		09/25/2024		
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB				STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST CHICAGO, IN 46312				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
F 0842 SS=D Bldg. 00	Weekly audits indic provided on the foll - 8/12 through 8/16/- 8/19/24-8/23/24 - 8/26-8/30/24 - 9/2-9/6/24 dental stresidents - 9/9-9/13/24 This deficiency was failed to implement to prevent recurrence 3.1-24(a)(1) 483.20(f)(5), 483.7 Resident Records Based on record reversaled to maintain of complete and accurate documentation of a resident reviewed for Finding includes: The record for Resident Provided to the second stress of the second sec	services provided for 6 other services provided for 6 other	F 08		added to the dental schedule recommendations are completed. The Administrator/designee with present a summary of the audit to the Quality Assurance committee monthly for 6 month 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. Please accept the following at the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation 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 4 dialysis site access orders were clarified and update the complete of the control of	ted. ill its hs. he e	10/10/2024	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
15565		155653	B. W	ING		09/25/2024	
<u> </u>				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u>. </u>	
NAME OF PROVIDER OR SUPPLIER					ICCOOK AVE		
HARBOR HEALTH & REHAB					CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF			
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	-	ons included, but were not					
	_	heter site clean and dry,			How the facility will identify		
		, swelling, any discharge,		other residents having the			
	increased pain or warmth due to infection.				potential to be affected by the	ne	
	A Physician's Order, dated 8/26/24, indicated the			same deficient practice and			
	-				what corrective action will be	e	
	_	ccess site was to be assessed ess, swelling, pain, and			All regidents who receive dish	voio	
		sician was to be notified with			All residents who receive dialy		
					have the potential to be affect by this alleged deficient practi		
	any symptoms and documentation was to be completed in the progress note. A "+" was to be				by this alleged deficient practi	ce.	
	documented for abnormalities and a "-" for no				What measures will be put in	nto	
	abnormalities.				place or what systemic		
	abilotinanties.				changes will be made to		
	The September 2024 Medication Administration				ensure that the deficient		
	Record (MAR), indicated both a "+" and a "-"				practice does not recur;		
	symbol were documented on the following dates				Nursing staff received		
	and times:				1:1education by DON on how	to	
	- Day shift: 9/1 and 9/2/24				assess and accurately docum		
	- Evening shift: 9/1, 9/3, 9/5, 9/6, 9/9, and 9/12/24				dialysis access sites in the		
	- Night shift: 9/24/24				medical record.		
	During an interview on 9/25/24 at 10:30 a.m., the				How the corrective action(s)		
	_	g indicated more education			will be monitored to ensure	the	
	_	rovided regarding the			deficient practice will not		
	documentation of the assessment of the				recur, i.e., what quality		
	permacath.				assurance programs will be	put	
	W 11 P 10/2 0/4 0/9 0/42				into place;		
	· · · · · · · · · · · · · · · · · · ·	npleted 9/2-9/6, 9/9-9/13 and			DON/designers will so dit !	4AD	
		ated documentation had been			DON/designee will audit the N	/IAK	
	completed accurate	ıy.			for those residents receiving		
	This deficiency	s cited on 8/9/24. The facility			hemodialysis 2x weekly for 6 months to ensure there is an		
		_			accurate assessment of the		
	failed to implement a systemic plan of correction				dialysis site documented in the		
	to prevent recurrence.				medical record.	C	
	3.1-50(a)(2)				medical record.		
	3.1 30(u)(2)				DON/designee will present a		
					summary of the audits to the		
					Quality Assurance committee		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED				
155653		B. WING		09/25/2024				
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST CHICAGO, IN 46312					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
				monthly for 6 months. Thereat if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring won going.	g y at			

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