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	12/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00368715 and IN00369637. Complaint IN00368715 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00369637 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey date: December 29, 2021 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 5 Medicaid: 65 Other: 3 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/3/22.	F 0000	Please reference the enclosed 2567 as “plan of correction” For the complaint survey that was conducted at Harbor Health & Rehab I will submit signature sheets of the in-servicing, content of in-service and audit tools. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on 1/14/22 serves as our allegation of compliance. The provider respectfully request a desk review on or after 1/17/22. Should you have any questions or concerns regarding our	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			Plan of Correction , please don't hesitate to Contact me. Sherri Shelby RN, HFA **Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	
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 a dependent resident received assistance with ADLs (activities of daily living) related to personal hygiene for 1 of 3 residents reviewed for ADLs. (Resident B) Finding includes: Observations of Resident B on 12/29/21 at 10:05 a.m. and 11:45 a.m. in her wheelchair, and at 1:35 p.m., in her bed, noted the resident to have facial hair on her chin, and long fingernails with debris under her nails. The resident's record was reviewed on 12/29/21 at 10:15 a.m. Diagnoses included, but were not limited to, Stroke, High Blood Pressure, Dementia, Depression, and Behavioral Disturbance.	F 0677	**F677** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	01/17/2022

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	The Quarterly Minimum Data Set assessment, dated 12/17/21, indicated the resident had moderate cognitive impairment. She required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. A Care Plan, dated 12/14/21, indicated the resident resists care. Interventions included avoiding power struggles, praising resident when her behavior is appropriate, and encouraging her to express her feelings. A Care Plan indicated the resident requires assistance with ADLs, including personal hygiene. Interventions included checking nail length and trim and clean on bath day, and as necessary, report any changes to the nurse. The first-floor shower schedule indicated the resident was scheduled for showers on Tuesdays and Fridays during day shift. The electronic charting for personal hygiene for the past 30 days indicated the resident's personal hygiene had been completed daily, and the resident had refused her shower only once in the month of December 2021. The Nursing Progress Notes from 12/1/21-12/29/21 indicated there were no documented notifications of refusals of care. . Interview with RN 1 on 12/29/21 at 1:41 p.m., indicated the resident should not have facial hair present and there should not be debris under the resident's fingernails. Interview with the Director of Nursing on 12/29/21 at 2:45 p.m., indicated the resident		*federal and state law.* **1) Immediate actions taken for those residents identified:** Resident (B) facial hair was removed, and fingernail care was provided. **2) How the facility identified other residents:** All ADL dependent residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Nursing staff will be re-educated regarding bathing schedules, preferences, refusals and documentation. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will observe three residents daily, 5 times per week for 4 weeks, then weekly thereafter to ensure nail and shaving care is provided. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90%	

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	should not have facial hair present or debris under her nails, and refusals should be documented. This Federal tag relates to Complaints IN00368715 and IN00369637. 3.1-38(a)(3)		compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 1/17/22**	