| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155653 | A. Building<br>B. Wing | 02/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Harbor Health & Rehab | 5025 McCook Ave<br>East Chicago, IN 46312 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified of a roommate change for 1 of 3 residents reviewed for notification of change. (Resident B) Finding includes:The record for Resident B was reviewed on 2/23/26 at 9:53 a.m. Diagnoses included, but were not limited to, Alzheimer's, psychotic disorder, hypertension (high blood pressure), depression, anemia (low iron), depression, and COPD. The Quarterly Minimum Data Set (MDS) assessment, dated 11/4/25, indicated Resident B was cognitively impaired for daily decision making. A Nurse's Progress Note, dated 1/22/26 at 12:46 a.m., indicated the resident appeared to be adjusting well to his new roommate. There was no documentation of the resident's Responsible Party being notified of the new roommate. During an interview on 2/24/26 at 10:25 a.m., the Director of Nursing did not notify the Responsible Party of the roommate change, she was under the impression notification was only to be reported for a room change. She was now educating the staff to notify appropriate parties when a new roommate is brought in. This citation relates to Intake 2739564. 3.1-5(b)(1) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on record review and interview, the facility failed to ensure Care Plans were updated with interventions for residents who had behaviors, falls, schizophrenia, and abuse care plans for 4 of 4 residents reviewed for care plans (Resident B, C, D, and E) Findings include:1. The record for Resident B was reviewed on 2/23/26 at 9:53 a.m. Diagnoses included, but were not limited to, Alzheimer's, psychotic disorder, hypertension (high blood pressure), depression, anemia (low iron), depression, and COPD.The Quarterly Minimum Data Set (MDS) assessment, dated 11/4/25, indicated Resident B was cognitively impaired for daily decision making.A facility reported incident, dated 12/11/25, indicated Resident B went to offer Resident D a piece of candy and Resident D had swatted at Resident B, which knocked the candy to the floor. A nurse had witnessed the incident, and no physical contact was made between the two residents and no injuries were noted. An investigation was initiated.A facility reported incident, dated 2/2/26, indicated staff had overheard a verbal altercation between Resident B and Resident C. Resident B was observed on the floor in the doorway. Resident B was assessed and had pain in his right leg and hip. All parties were notified and Resident B was sent to the hospital for further evaluation and Resident C was sent to the hospital for a psychiatric evaluation. An investigation was initiated.A Care Plan, dated 5/17/26 and revised on 2/3/26, indicated Resident B was an elopement risk and wandered. The interventions included, but were not limited to, providing distraction from wandering, 15-minute safety checks, and wearing a wander guard.The interventions for the elopement and wandering care plan were last revised on 6/10/25.A Care Plan, dated 5/22/24, indicated the resident was at risk for abuse/neglect. Interventions included, but were not limited to, report abuse per policy and assess for potential risk factors.Interventions for the abuse/neglect care plan were last revised on 5/22/24.A Care Plan, dated 5/17/24 and revised on 11/21/25, indicated the resident was at risk for falls related to antidepressant medication use, diagnosis of Alzheimer's dementia with poor safety awareness and wandering. Interventions included, but were not limited to, place call light within reach and PT (physical therapy) to evaluate and treat for gait and balance training.Interventions for the fall care plan were last updated on 7/17/25.During an interview on 2/25/26 at 1:37 p.m., the Director of Nursing, Nurse Consultant, and Administrator indicated the interventions should have been updated and they understood the concern. They had no additional information to provide. 2. The record for Resident C was reviewed on 2/24/26 at 2:47 p.m. Diagnoses included, but were not limited to, schizophrenia, dementia, dysphagia (difficulty swallowing), depression, anxiety, mild cognitive impairment, mild intellectual abilities, restlessness and agitation, HIV, and alcohol abuse.The Quarterly Minimum Data Set (MDS) assessment, dated 11/4/25, indicated Resident C was cognitively intact for daily decision making.A Nurse's Note, dated 12/23/25, indicated the resident was placed on 30 minutes checks for 72 hours. There were six behavior notes on 12/23/25 that indicated the resident was verbally aggressive toward staff and residents.A Nurse's Note, dated 12/24/25, indicated the resident was sent out to the hospital for evaluation.A Nurse's Note, dated 12/26/25 at 2:40 p.m., indicated the resident returned to the facility.A Nurse's Note, dated 12/27/25 at 8:45 a.m., indicated the resident was verbally aggressive to staff and was placed on 15-minute safety checks.A Nurse's Note, dated 12/27/25 at 12:18 p.m., indicated the resident was sent out to the hospital behavioral health unit for further evaluation.Nurse's Notes on 1/6, 1/13, 1/14, 1/17, 1/18, 1/19, 1/24, 1/25, 1/27, and 1/28/26 documented verbally aggressive behavior by the resident.A facility reported incident, dated 2/2/26, indicated staff had overheard a verbal altercation between Resident B and Resident C. Resident B was observed on the floor in the doorway. Resident B was assessed and had pain in his right leg and hip. All parties were notified and Resident<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | B was sent to the hospital for further evaluation and Resident C was sent to the hospital for a psychiatric evaluation. An investigation was initiated.A Care Plan, dated 9/2/23 and revised on 2/3/26, indicated Resident C had a behavior problem. Interventions included, but were not limited to, praise progress/improvement in behavior, and intervene as necessary to protect the rights and safety of others and minimize potential for disruptive behaviors and placed on 15-minute safety checks.Interventions for the behavior care plan were last updated on 2/16/26 after the resident returned from a 15-day stay at the psychiatric hospital. The last intervention prior to the resident's 2/2/26 incident was 9/16/24.During an interview on 2/25/26 at 1:37 p.m., the Director of Nursing, Nurse Consultant, and Administrator indicated the interventions should have been updated after the resident returned from his second hospital stay on 12/27/26. 3. The record for Resident D was reviewed on 2/25/26 at 11:09 a.m. Diagnoses included, but were not limited to, suicidal ideations, dementia, anxiety, hypertension, major depressive disorder, and psychotic disorder.The Quarterly Minimum Data Set (MDS) assessment, dated 1/19/26, indicated Resident D was cognitively intact for daily decision making.A Facility reported incident, dated 12/11/25, indicated Resident B went to offer Resident D a piece of candy and Resident D had swatted at Resident B, which knocked the candy to the floor. A nurse had witnessed the incident, and no physical contact was made between the two residents and no injuries were noted. Investigation was initiated.A Care Plan, dated 8/2/24 and revised on 2/10/26, indicated the resident was at risk for abuse and neglect. Interventions included, but were not limited to, assuring the resident that they were in a safe environment, and reporting abuse per policy.The abuse/neglect care plan interventions were last revised on 8/2/24.A Care Plan, dated 9/5/24 and revised on 12/11/25, indicated the resident displayed socially inappropriate and maladaptive behavior. Interventions included, but were not limited to, exercising the resident at regular intervals, report behaviors to psych services, and use frequent reassuring phrases.The socially inappropriate/maladaptive behavior care plan interventions were last revised on 9/14/25.During an interview on 2/25/26 at 1:37 p.m., the Director of Nursing, Nurse Consultant, and Administrator indicated the interventions should have been updated and they understood the concern. They had no additional information to provide. 4. The record for Resident E was reviewed on 2/25/26 at 11:09 a.m. Diagnoses included, but were not limited to, hemiplegia (one side of the body has paralysis), hypotension (low blood pressure), paranoid schizophrenia, aphasia (difficulty talking), epilepsy, dysphagia (difficulty swallowing), and contracture of the right hand.A facility reported incident, dated 12/26/25, indicated Resident E had displayed aggressive behavior toward Resident D. Head to toe assessments were done on both resident's and no injuries were noted. The physician and the family were notified. Resident D was sent out to the hospital for evaluation.A Care Plan, dated 5/21/24 and revised on 12/28/25, indicated the resident was at risk for abuse/neglect. Interventions included, but were not limited to, assuring the resident knew they were safe, and reporting abuse per policy.The abuse/neglect care plan interventions were last revised on 5/21/24.A Care Plan, dated 5/7/24 and revised on 12/28/25, indicated the resident had paranoid schizophrenia. Interventions included but were not limited to, refer to psych services and observe for mood/behaviors related to paranoid schizophrenia and develop interventions for dealing with them as needed.The schizophrenia care plan interventions were last updated on 5/7/24.This citation relates to Intakes 2739564 and 2742394.3.1-35(a) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on record review and interview, the facility failed to ensure care plan meetings occurred for 1 of 3 residents reviewed for care planning. (Resident B)Finding includes:The record for Resident B was reviewed on 2/23/26 at 9:53 a.m. Diagnoses included, but were not limited to, Alzheimer's, psychotic disorder, hypertension (high blood pressure), depression, anemia (low iron), depression, and COPD.The Quarterly Minimum Data Set (MDS) assessment, dated 11/4/25, indicated Resident B was cognitively impaired for daily decision making.A Social Services Note, dated 9/23/25, indicated the Social Service Director (SSD) had called to schedule a care plan meeting with the resident's daughter. She had stated she was on her way to visit her father and could have the meeting when she arrived at the facility. The SSD indicated she was free to conduct the meeting when she arrived.The resident's last Care Plan Meeting was on 9/23/25.There was no documentation indicating a care plan meeting had occurred after 9/23/25.During an interview on 2/24/26 at 11:33 a.m., the Nurse Consultant indicated she had called the previous social worker to see if she could provide any input on why there was no documentation of a scheduled or rescheduled care plan meeting. At 4:11 p.m., the nurse consultant indicated the care meeting should have been documented as rescheduled if it was scheduled and cancelled.This citation relates to Intake 2739564. 3.1-35 |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident with behaviors received appropriate treatment and services to meet his needs, related to ongoing consistent behaviors without updated behavior interventions following an incident on 12/24/26 that resulted in 2 hospitalizations within 48 hours, and lacked 15-minute safety checks upon the resident's return for 1 of 4 residents reviewed for behaviors. (Resident C)Finding includes:The record for Resident C was reviewed on 2/24/26 at 2:47 p.m. Diagnoses included, but were not limited to, schizophrenia, dementia, dysphagia (difficulty swallowing), depression, anxiety, mild cognitive impairment, mild intellectual abilities, restlessness and agitation, HIV, and alcohol abuse.The Quarterly Minimum Data Set (MDS) assessment, dated 11/4/25, indicated Resident C was cognitively intact for daily decision making. Verbal behaviors were exhibited and the resident's current behavior was worse than the previous assessment.A Nurse's Note, dated 12/23/25, indicated the resident was placed on 30-minute safety checks for 72 hours.There were six behavior notes on 12/23/25 that indicated the resident was verbally aggressive toward staff and residents.A Nurse's Note, dated 12/24/25, indicated the resident was sent out to the hospital for evaluation.A Nurse's Note, dated 12/26/25 at 2:40 p.m., indicated the resident returned to the facility.A Physician's Order, dated 12/27/25, indicated to initiate 15-minute safety checks every shift and complete the safety log for monitoring. The order was discontinued when the resident was admitted to the hospital on [DATE].A Nurse's Note, dated 12/27/25 at 8:45 a.m., indicated the resident was verbally aggressive to staff and was placed on 15-minute safety checks.A Nurse's Note, dated 12/27/25 at 12:18 p.m., indicated the resident was sent out to the hospital's behavioral health unit for further evaluation.The record lacked 15-minute safety checks from 12/27/25- 2/2/26.Nurse's Note's on 1/6, 1/13, 1/14, 1/17, 1/18, 1/19, 1/24, 1/25, 1/27, and 1/28/26 documented verbally aggressive behavior by the resident.A Care Plan, dated 1/15/26, indicated the resident had aggression toward staff and residents related to mental illness. Interventions included, but were not limited to, administer medications as ordered, assess resident's coping skills, and assess resident's understanding of the situation.A Nurse's Note, dated 2/2/26 at 16:11 p.m., indicated that the resident was noted with verbal and physical aggression towards staff and another resident. The resident was isolated from all other residents for safety, resident was unable to be redirected with his behavior. The physician ordered the resident to be sent to the hospital for a psychological evaluation due to uncontrolled behavior. A Facility Reported Incident, dated 2/2/26, indicated staff had overheard a verbal altercation between Resident B and Resident C. Resident B was observed on the floor in the doorway of Resident C's room. Resident B was assessed and had pain in his right leg and hip. All parties were notified and an investigation was initiated. Resident B was sent to the hospital for further evaluation and Resident C was sent to the hospital for a psychiatric evaluation. An investigation was initiated.A Physician's Order, dated 2/2/26, indicated to initiate 15-minute safety checks for 72 hours.A Physician's Order, dated 2/2/26, indicated to send the resident to the hospital for a psychological evaluation.A Care Plan, dated 9/2/23 and revised on 2/3/26, indicated the resident had a history of a behavior problem evidenced by displaying verbal and physically aggressive behaviors towards peers related to schizophrenia. Interventions included, but were not limited to, praise progress/improvement in behavior, and intervene as necessary to protect the rights and safety of others and minimize potential for disruptive behaviors and placed on 15-minute safety checks.Interventions for the behavior care plan were last updated on 2/16/26 after the resident returned from a 15 day stay at the psychiatric hospital. The last intervention prior to the resident's recent 2/2/26 incident and the 12/24/25 and<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 12/27/25 hospital stay was on 9/16/24.A Physician's Order, dated 2/16/26, indicated to initiate 15-minute safety checks every shift for monitoring.During an interview on 2/24/26 at 10:35 a.m., the Assistant Director of Nursing indicated they had tried to identify a pattern or triggers for the resident's outburst but they were none, they were just random. She indicated the resident was recently in the behavioral unit in the hospital for a couple weeks and he was placed on 1:1 supervision for 72 hours when he returned and then placed on 15-minute checks.During an interview on 2/24/26 at 11:49 a.m., CNA 1 indicated the resident did not have a de-escalation technique that worked for him. Once [Resident C] gets started he doesn't stop until he is ready. She indicated he had hit their coworker recently right across the face, and he is verbally aggressive to residents with nothing triggering him.During an interview on 2/24/26 at 12:03 p.m., CNA 2 indicated Resident C had called her a b***h and slapped her across the face on 12/24/25. He was not provoked in any way. The facility called the police and the resident was taken to the behavioral hospital since she did not press charges.During an interview on 2/25/26 at 10:31 a.m., the Director of Nursing indicated the resident did not strike any residents prior to his 12/24/26 admission but he did slap a staff member. Resident C was not on 15-minute safety checks when he returned back from his two psychological evaluations at the hospital. She reported he did not get placed on them again until he returned from the behavioral hospital this last time on 2/12/26, he had 1:1 supervision for 72 hours and had been on 15-minutes safety checks since.This citation relates to Intakes 2739564 and 2742394.3.1-37(a) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to 15 minute safety checks for residents who had behaviors for 1 of 4 residents reviewed for abuse. (Resident C)Finding includes:The record for Resident C was reviewed on 2/24/26 at 2:47 p.m. Diagnoses included, but were not limited to, schizophrenia, dementia, dysphagia (difficulty swallowing), depression, anxiety, mild cognitive impairment, mild intellectual abilities, restlessness and agitation, HIV, and alcohol abuse.The Quarterly Minimum Data Set (MDS) assessment, dated 11/4/25, indicated Resident C was cognitively intact for daily decision making. Verbal behaviors were exhibited and the resident's current behavior was worse than the previous assessment.A Physician's Order, dated 2/16/26, indicated to initiate 15-minute safety checks every shift for monitoring.Safety logs were observed on the second floor and Resident C's 15-minute safety checks were not signed out from 3:00 p.m. to 4:00 p.m. on 2/24/26.During an interview on 2/24/26 at 4:15 p.m., LPN 2 indicated she should have charted the 15-minute checks after she performed them but she hadn't had a chance to do so.During an interview on 2/24/26 at 4:46 p.m., the Director of nursing indicated she would expect her nursing staff to complete the 15-minute safety checks on all the residents who had them on the unit and then sign off in their logs each time it was completed. She acknowledged the 15-minute safety checks should have been signed off for the previous hour.This citation relates to Intakes 2739564 and 2742394.3.1-50(a)(2) |