STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Health & Rehab	5025 McCook Ave 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to ensure the mandatory submission of staffing information, based on payroll data, was electronically submitted to iQIES. This had the potential to affect the 70 residents who resided in the facility. Finding includes: Nurse Staffing information was reviewed on 12/16/25 at 3:30 p.m. The CMS Payroll Based Journal (PBJ) Staffing Data report for FY Quarter 4 2025 indicated the facility failed to submit data.During an interview on 12/16/25 at 4:20 p.m., the [NAME] President (VP) of Operations indicated he was able to pull up the submission log of PBJ for the 4th quarter for the facility. The information from iQIES indicated there was a connection error and files failed to send. He indicated Nurse Consultant 1, the Human Resource (HR) Director Consultant, and himself all sit down quarterly and go over all the schedules before submitting to iQIES. During an interview on 12/17/25 at 9:15 a.m., Nurse Consultant 1 indicated she had called iQIES the previous day and they informed her it was the facility's responsibility to make sure the PBJ was transmitted and submitted. She indicated the HR Director, the VP of Operations and herself met on 11/11/25 to finalize the 4th quarter PBJ as it was due on 11/14/25. She did not check to ensure submission had gone through.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to not offering beverages to residents while participating in activities. The facility also failed to ensure personal care signs were not posted in resident rooms for 4 of 4 residents reviewed for dignity. (Residents 2, 20, 1, and 43)Findings include:1. During a random observation on 12/11/25 at 10:28 a.m., Resident 2 was observed in the Second Floor dining room participating in an activity. The resident received a cup of coffee from the activity aide and proceeded to attempt to pick up the coffee and drink from the cup. At 10:33 a.m., a staff member removed the resident's cup of coffee from the table due to it not being thickened. The resident was not given anything else to drink and the residents around him continued to drink their coffee. On 12/12/25 at 9:58 a.m., the resident was again seated in the Second Floor dining room. Activity staff were passing out cups of coffee to the residents, however, Resident 2 was not offered anything to drink. The record for Resident 2 was reviewed on 12/16/25 at 2:17 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing) following stroke and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/1/25, indicated the resident was cognitively impaired for daily decision making and he required supervision or touching assistance for eating. During an interview on 12/16/25 at 1:58 p.m., the Assistant Director of Nursing (ADON) indicated the resident should have been provided a drink that had been thickened after his coffee had been removed. 2. During a random observation on 12/15/25 at 10:30 a.m., five residents were observed in the Second Floor dining room. Resident 20 entered the dining room and asked the Activity Aide for a cup of coffee. The Activity Aide told the resident they didn't have any coffee, only juice. The resident proceeded to state, It's the coldest day of the year and we have no coffee? The Activity Aide again told the resident she only had juice to offer him. She did not make any attempts to call the kitchen to see if the resident could have a cup of coffee. During an interview on 12/16/25 at 2:00 p.m., the Director of Nursing indicated coffee was always available and the Activity Aide should have called the kitchen to get the resident a cup of coffee. 3. During random observations on 12/12/25 at 10:16 a.m. and 2:10 p.m., on 12/15/25 at 9:13 a.m. and 11:24 a.m., and on 12/16/25 at 8:29 a.m., 9:34 a.m., 11:15 a.m., and 1:30 p.m., there was a sign above Resident 1's bed that indicated Swallow Precautions. The record for Resident 1 was reviewed on 12/15/25 at 9:37 a.m. The resident was admitted to the facility on [DATE] and diagnoses included, but were not limited to, dysphagia (swallowing difficulties), stroke, and dementia. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/26/25 admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident had a loss of liquids from his mouth while eating and drinking and was observed holding food in his mouth/cheeks after meals. The resident was on a mechanically altered diet. There was no care plan the resident wished for his personal information to be posted on the wall above his bed. During an interview on 12/16/25 at 1:35 p.m., the Director of Nursing indicated she was unaware the swallowing signs were on the resident's wall in his room in plain sight. 4. During random observations on 12/12/25 at 10:35 a.m. and 1:57 p.m., 12/15/25 at 9:45 a.m., and 12/16/25 at 3:38 p.m., Resident 43 was observed resting in bed. A sign with swallowing instructions was posted above her bed. The resident's record was reviewed on 12/16/25 at 2:36 p.m. Diagnoses included, but were not limited to, vascular dementia and dysphagia (difficulty swallowing). The Annual Minimum Data Set (MDS) assessment, dated 11/13/25, indicated the resident had moderate cognitive impairment, was dependent in ADLs and transfers, and had difficulty swallowing. During an interview on 12/17/25 at 1:34 p.m., the DON indicated the signs should not be posted in plain view and speech therapy would be educated. 3.1-3(t)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, record review and interview, the facility failed to ensure a resident's privacy was respected related to completing a room search of their personal belongings without permission for 1 of 1 resident reviewed for privacy. (Resident 4)Finding includes:On 12/12/25 at 2:02 p.m., Resident 4 was observed lying in his bed, staring at the divider curtain while a movie was playing on his laptop. He appeared visibly upset, and was slow to speak. At that time, he indicated staff made him go to the resident Christmas party on the previous afternoon. He indicated he watched everyone else exchange gifts while he got nothing. When staff returned the resident to his room, the Director of Nursing (DON) informed him staff went through his belongings looking for smoking materials. The resident indicated he was upset he was not informed the sweep was going to happen, and that he was not given the opportunity to be there. The record for Resident 4 was reviewed on 12/12/25 at 2:35 p.m. Diagnoses included, but were not limited to, quadriplegia, trauma, depression, and post-traumatic stress disorder (PTSD).The admission Minimum Data Set (MDS) assessment, dated 10/30/25, indicated the resident was cognitively intact for daily decision making, and was dependent in activities of daily living (ADLs) and transfers.A Nurse's Note, dated 12/11/25 indicated, . sweeps performed; resident is an active smoker. Positive findings. Writer educated resident of smoking policy and materials confiscated.An admission Contract, signed by the resident on 10/23/25, indicated, .Right To Privacy. Each resident shall have the right to retain, store securely, and use personal possessions (including some furnishings) and appropriate clothing, as space permits, unless to do so would infringe upon the rights of health and safety of the resident or of other residents -- in which case the facility shall explore alternatives through discussion with the resident, the Residents' Council or the Interdisciplinary Team and provide or assist in the arrangement of storage for possessions .A Smoking Consent, signed by the resident on 11/20/25, indicated, . I understand that my clothing, bags, and room can be searched for smoking materials . The consent did not indicate searches may be conducted without resident knowledge or presence.During an interview on 12/16/25 at 3:50 p.m., the DON indicated she was told the social worker was going to inform the residents that they were going to go through their belongings looking for smoking materials. When informed of the resident's concerns, the DON indicated it should not have happened that way. 3.1-3(s)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with activities of daily living (ADLs) related to having their hair washed for 1 of 3 residents reviewed for ADLs. (Resident 24)Finding includes:During an interview on 12/12/25 at 9:35 a.m., Resident 24 indicated she did not like to go into the shower room and preferred a bed bath. She indicated she did not remember the last time her hair was washed. At that time, the resident's hair was greasy with a large amount of dandruff flakes noted. During random observations on 12/15/25 at 10:55 a.m., on 12/16/25 at 1:14 p.m., and on 12/17/25 at 9:55 a.m., the resident was observed in bed and her hair was greasy with flakes of dandruff noted. The resident indicated her hair had not been washed. The record for Resident 24 was reviewed on 12/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, major depressive disorder, anxiety, and osteoarthritis. The 8/31/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed substantial to maximal assistance with bathing and showering. A Care Plan, revised on 12/11/25, indicated the resident required assistance with ADLs including bed mobility, transfers, and bathing. A Care Plan, revised on 12/11/25, indicated the resident was resistive to care related to ADL refusal. A Physician's Order, dated 8/17/23, indicated Selsun Blue Salon External Shampoo 1%, apply to hair topically every evening shift on Tuesday and Friday for dandruff. The 11/2025 Medication Administration Record (MAR) indicated the Selsun Blue shampoo was signed out as being applied to the resident's hair on 11/11, 11/14, 11/18, 11/21, 11/25, and 11/28/25. The 12/2025 MAR indicated the Selsun Blue shampoo was signed out as being applied on 12/2, 12/5, 12/9, and 12/12/25. The Skin Shower Sheets provided by the Assistant Director of Nursing indicated the resident received a complete bed bath on 11/25, 11/28, 12/2, 12/5, 12/9, and 12/14/25. There was no documentation the resident's hair was washed during those baths, nor was there any documentation the resident refused to have her hair washed. During an interview on 12/16/25 at 4:00 p.m., the Director of Nursing indicated there was no place to document the resident's hair being washed on the current shower sheets. 3.1-38(a)(3)(B)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure follow up documentation after a fall was completed for 1 of 1 resident reviewed for change in condition. The facility also failed to apply compression wraps as ordered for edema for 1 of 1 resident reviewed for edema. (Residents 19 and 1) Findings include: 1. The record for Resident 19 was reviewed on 12/12/25 at 2:00 p.m. Diagnoses included, but were not limited to, stroke, major depressive disorder, dementia, and high blood pressure. The 9/13/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and needed substantial to maximal assistance for transfers. The resident had no falls since the last assessment. A Care Plan, revised on 10/29/25, indicated the resident had a fall due to an unsteady gait. A Nurse's Note, dated 10/28/25 at 11:56 a.m., indicated the resident had a witnessed fall out of the wheelchair. A Post Fall Observation form, dated 10/28/25 at 1:25 p.m., indicated the resident had a fall that was witnessed by the staff nurse. The Fall Follow Up Assessment, dated 10/28/25 at 9:56 p.m., indicated the most recent vital signs were dated 10/29/25 at 8:43 a.m. The Fall Follow Up Assessments, dated 10/29/25 at 5:56 a.m. and 11:41 a.m., indicated the most recent vital signs were dated 10/29/25 at 8:43 a.m. The vital signs were only documented one time on 10/29/25 at 8:43 a.m. in the vital signs section in the clinical record. During an interview on 12/17/25 at 9:00 a.m., Nurse Consultant 2 indicated there was no fall follow up completed for the evening shift on 10/29/25 and the vital signs were incorrectly documented on 10/29/25. Nursing staff were to document every shift for 72 hours after a fall. 2. During an observation on 12/12/25 at 10:24 a.m., Resident 1 was observed in bed. At that time, both of his ankles were observed with edema (swelling) and he was wearing ankle socks to both of his feet. There were no compression socks or wraps on his legs. During random observations on 12/15/25 at 9:13 a.m. and 10:31 a.m., the resident was observed sitting in his wheelchair in the second floor dining room. At those times, he was wearing shoes and no socks. The backs of the shoes were folded down and his feet were not completely inside them. He was not wearing compression socks or ace wraps to his legs. At those times, his ankles were observed with edema. During random observations on 12/16/25 at 9:34 a.m., and 11:15 a.m., the resident was observed in bed and dressed in street clothes. He was not wearing any compression socks or ace wraps to his legs. At those times, his ankles were observed with edema. During an observation on 12/16/25 at 1:30 p.m., the resident was sitting in his wheelchair in his room. He was dressed in street clothes with shoes and plain socks on both feet. There were no ace wraps observed on his legs. The record for Resident 1 was reviewed on 12/15/25 at 9:37 a.m. The resident was admitted to the facility on [DATE] and diagnoses included, but were not limited to, chronic kidney disease, stroke, anxiety disorder, schizophrenia, bipolar disorder, dementia, and high blood pressure. The 11/26/25 admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. A Care Plan, dated 12/9/25, indicated the resident was at risk for impaired circulation related to dependent edema. The approaches were to apply compression bandages for bilateral lower extremity edema, on in the morning and off at night. Weekly Skin Observations, dated 12/3/25, indicated the resident had edema to his bilateral lower extremities. A Skin Observation form, dated 12/10/25, indicated the resident had no edema. A Nurse's Note, dated 12/3/25 at 10:30 a.m., indicated the resident had pitting edema to his bilateral lower extremities. A Nurse's Note, dated 12/4/25 at 11:05 a.m., indicated a message was left for the the physician regarding the edema. A Physician's Order, dated 12/4/25, indicated compression bandages, apply to bilateral lower extremities daily for edema, on in the a.m. and off in the p.m. A Physician's Progress Note, dated 12/10/25, indicated the resident had bilateral lower extremity edema which was acute and unstable. During an interview on 12/16/25 at 2:00 p.m., the Director of Nursing had no additional information to provide. 3.1-37(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided related to the serving of hot beverages and thickened liquids as well as a resident using a vape pen in their room for 2 of 3 residents reviewed for accidents. (Residents 2 and 63)Findings include: 1. During a random observation on 12/11/25 at 10:28 a.m., Resident 2 was observed in the Second Floor dining room participating in an activity. The resident received a cup of coffee from the activity aide that was not thickened. As she put the cup of coffee on the table, she told the resident to be careful because the coffee was hot. The resident proceeded to pick up the cup of coffee and it started to spill on the table and his hands due to his tremors. He waited a few seconds and attempted to pick up the cup again. The resident continued to shake but he was able to put the cup to his mouth and drink some of the coffee. There was no lid on the cup and he drank approximately a quarter of the coffee. At 10:33 a.m., a staff member came to the table and removed the resident's coffee. The record for Resident 2 was reviewed on 12/16/25 at 2:17 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing) following stroke and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/1/25, indicated the resident was cognitively impaired for daily decision making and he required supervision or touching assistance for eating. A Care Plan, dated 1/4/25 and reviewed on 10/1/25, indicated the resident had a swallowing problem related to the diagnosis of dysphagia. Interventions included, but were not limited to, diet to be followed as prescribed and resident is to eat only with supervision. A Physician's Order, dated 9/17/25, indicated the resident was to receive a pureed diet with nectar thickened liquids. During an interview on 12/16/25 at 1:58 p.m., the Assistant Director of Nursing (ADON) indicated the resident did have tremors and should have been assisted with the coffee and it should have been thickened. 2. During a random observation on 12/11/25 at 10:00 a.m., Resident 63 was observed sitting in her wheelchair in her room by the bed. At that time she was observed with a vape pen and was vaping inside her room. Restorative CNA 1 was observed sitting on the resident's bed watching the resident vape. The Housekeeping Director was also observed in the room and then walked out of the room. The resident's roommate was observed in her bed with her eyes closed while the resident was vaping. During an interview at that time, Restorative CNA 1 indicated the resident was allowed to vape in her room. She was informed by the Activity Director the resident could vape inside the facility. The record for Resident 63 was reviewed on 11/12/25 at 2:40 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), anxiety disorder, heart failure, and high blood pressure. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/26/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. A Care Plan, dated 12/11/25, indicated the resident was a tobacco user. The approaches were for the resident to adhere to the smoking policy. A Smoking Risk Assessment, dated 11/21/25, indicated the resident did not currently smoke. A Smoking Risk Assessment, dated 12/11/25, indicated the resident actively smoked and was able to vape with one to one supervision. During an interview on 12/16/25 at 2:00 p.m., the Director of Nursing (DON) was unaware the resident was vaping in her room. During an interview on 12/17/25 at 10:50 a.m., the Activity Director indicated she was new to smoking facilities because she had not worked in one before. She indicated she did not vape and she did not know where a resident could vape, so she reached out to the DON and she told her the resident could vape in her room, Just pull the curtain back and she can do it. She indicated she was just doing what she was told to do. During an interview on 12/17/25 at 11:00 a.m., the Administrator indicated the DON told her it was a miscommunication with the Activity Director and her instructions on where the resident could vape. The current 9/2022 Resident Smoking policy, provided by the Administrator on 12/11/25, indicated smoking by residents and their visitors was permitted only in designated areas. Possessing, carrying, or holding materials used to smoke by residents who required supervision was prohibited inside the building. 3.1-45(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure indwelling Foley (urinary) catheter bags and tubing were kept off of the floor, nephrostomy tube equipment was changed and the site was monitored for 1 of 2 residents reviewed for Foley catheters and 1 of 1 resident reviewed for nephrostomy tubes. (Residents 1 and 6)Findings include:1. During random observations on 12/16/25 at 8:29 a.m., LPN 3 was observed preparing medications for the resident outside of Resident 1's door. The door was wide open and the resident was observed in bed. The resident told the nurse to come back later to give him his medications and to close the door. At that time, the resident's Foley catheter bag and tubing was observed on the floor next to his bed. LPN 3 closed the resident's door and did not pick up the Foley bag off of the floor. During random observations on 12/16/25 at 9:34 a.m. and 11:15 a.m., Resident 1 was observed in bed. At those times, his Foley catheter bag and tubing was observed on the floor next to his bed. During a random observation on 12/16/25 at 1:30 p.m., the resident was observed sitting in his in the wheelchair in his room. At that time, the Foley catheter bag and tubing was on the floor by the wheelchair. The record for Resident 1 was reviewed on 12/15/25 at 9:37 a.m. The resident was admitted to the facility on [DATE] and diagnoses included, but were not limited to, chronic kidney disease, stroke, anxiety disorder, schizophrenia, bipolar disorder, dementia, and neuromuscular dysfunction of the bladder. The 11/26/25 admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident was frequently incontinent of urine. A Care Plan, dated 12/14/25, indicated the resident had a Foley catheter. A Nurse's Note, dated 12/12/25 at 4:50 a.m., indicated a urine specimen was collected from the resident. The urine culture lab report, dated 12/14/25, indicated the resident had an urinary tract infection with greater than 100,000 colonies of Klebsiella-Extended-spectrum beta-lactamase (ESBL) A Physician's Order, dated 12/13/25, indicated the resident had a Foley catheter, size:18 French, balloon size, 30 milliliters (ml). Change as needed for dislodgement, leaking or blockage. A Physician's Order, dated 12/14/25, indicated Fosfomycin Tromethamine Oral Packet (an antibiotic), give 3 grams by mouth one time a day every 2 day(s) for ESBL in urine for 3 administrations. During an interview on 12/16/25 at 2:00 p.m., the Director of Nursing indicated the Foley catheter bag and tubing should not have been on the floor. The current 10/9/21 Urinary Catheter Care policy, provided by Nurse Consultant 2 on 12/17/25 at 9:00 a.m., indicated urinary drainage bags and tubing should be positioned to prevent touching the floor directly. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation of nephrostomy (a tube inserted through the back to drain the kidney) care for Resident 6 on 12/16/25 at 1:31 p.m., the Wound Nurse removed the old dressing covering the insertion site. A StatLock (a medical securement device that adheres to the skin) was in place with the edges coming up. The tubing was connected to a collection bag. Neither the Statlock nor the collection bag were dated. At that time, the Wound Nurse indicated she did not normally perform the nephrostomy care, and was not sure if/when the Statlock or collection bags were changed. The resident's record was reviewed on 12/15/25 at 10:28 a.m. Diagnoses included, but were not limited to, urinary tract infection, stage 4 pressure ulcer of sacrum, and artificial opening of the urinary tract. The Quarterly Minimum Data Set (MDS) assessment, dated 11/30/25, indicated the resident was cognitively intact for daily decision making, and required substantial assistance with ADLs. A Physician's Order, dated 10/29/25, indicated to change the nephrostomy bag every Sunday night shift and as needed. The order was discontinued on 11/22/25. A Physician's Order, dated 11/26/25, indicated to monitor the right nephrostomy site and document output every shift. Notify the physician of any abnormalities. The record lacked documentation of changing the nephrostomy bag and instruction for use/change of the StatLock. The record lacked documentation of output from the nephrostomy on the following shifts: 11/29/25 first and second shifts, 11/30/25 first and second shifts, 12/4/25 first and second shifts, and 12/5/25 third shift. There was no documentation of the physician being notified of no urine output. A Care Plan, revised on 12/5/25, indicated the resident was at risk for complications due to the right nephrostomy tube. Interventions included monitoring, recording, and reporting to the physician for signs and symptoms of UTI, including no urine output. During an interview on 12/16/25 at 3:37 PM, the Director of Nursing (DON) was informed of the findings. She indicated the drainage bag was being changed every Sunday, and the order must have gotten left off when the resident went out and returned from the hospital. She indicated the output should have been measured three times a day, once each shift, and that she did not know anything about the Statlock that was in use, but would look into it. 3.1-41(a)(2)

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	155653	A. Building B. Wing	12/17/2025

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview, the facility failed to check for peg tube (a tube inserted directly into the stomach for nutrition) placement properly prior to medication administration for 1 of 1 resident observed for peg tube medication administration. (Resident 11)Finding includes:During a medication administration observation on 12/16/25 at 8:02 a.m., RN 1 poured and prepared medications for Resident 11 to be administered through his peg tube. She entered the resident's room and placed his enteral tube feeding on hold. The RN removed the connection device and hung it over the pole. She then removed the syringe and placed it into one of the two ports on the peg tube. She poured 30 cubic centimeters (cc) of water down the tube via gravity. She removed the syringe and placed the piston inside and pulled back (checking for residual) the stomach contents. She pulled back less than five cc of fluid from each port. At that time, she indicated she was supposed to be able to pull back 30 cc of residual so she was going to notify the physician. During an interview at that time, RN 1 indicated the new policy to check for peg tube placement was to pour 30 cc of water down the tube first and pull back the 30 cc of fluid. The record for Resident 11 was reviewed on 12/16/25 at 3:45 p.m. Diagnoses included, but were not limited to gastrostomy tube. A Physician's Order, dated 11/19/25, indicated enteral feed every shift and check enteral feeding tube placement by aspirating 30 milliliters (ml) and then return, if unable to verify via aspiration, hold feeding and notify the physician. During an interview on 12/16/25 at 9:52 a.m., Nurse Consultant 1 indicated the RN should have checked for residual by aspirating fluid first before flushing the tube with 30 cc of water. The current 11/19/25 Placement and Residual Volume Check of Enteral Feeding Tubes policy, provided by Nurse Consultant 1 on 12/16/25 at 9:50 a.m., indicated check placement and residual using the aspiration method. Attach a large 60 cc syringe, aspirate 30 cc of stomach content, replace aspirated stomach contents back. If acceptable placement and gastric residual volume is verified, flush feeding tube with 30 cc of water or as ordered by the physician. 3.1-44(a)(2)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure an implanted port device was assessed and monitored for 1 of 1 resident reviewed for parental/IV fluids. (Resident 63) Finding includes:During a random observation on 12/12/25 at 2:00 p.m., Resident 63 was observed sitting in a wheelchair by the elevator. At that time, her shirt was falling off of her shoulder and an implanted port device was observed with a white bandage over it. The record for Resident 63 was reviewed on 12/12/25 at 2:40 p.m. Diagnoses included, but were not limited to, vulva cancer, adult failure to thrive, chronic obstructive pulmonary disease (COPD), anxiety disorder, heart failure, and high blood pressure. The 9/26/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. A Care Plan, dated 12/14/25, indicated the resident had a right chest port-a-cath (PAC). The approaches were to monitor the port and report changes to the physician. An admission Assessment, dated 8/2/25, indicated the resident had a right upper chest PAC. Physician's Orders, dated 8/2/25 and 8/20/25, indicated to monitor the central venous access port to the right upper chest. Report any abnormalities to provider. The resident was admitted to the hospital on [DATE] and after her return there were no orders to monitor the PAC. A Physician's Order, dated 12/12/25, indicated to monitor the right chest port and report any swelling, drainage, or pain at the site to the physician. During an interview on 12/16/25 at 2:00 p.m., the Director of Nursing indicated the nurses should be monitoring the device, however, a new physician's order was not put into place after her most recent hospitalization. The current 9/1/22 Implanted Vascular device/Accessing, Blood draw, Maintenance (Port-a-Cath) policy, provided by Nurse Consultant 2 on 12/12/25 at 1:35 p.m., indicated ports must be flushed according to physician order (every four weeks if not in use). Document flushes in the medical record. The site must be assessed for signs of infection prior to each use. All procedures must be documented in the medical record. 3.1-47(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interview, the facility failed to ensure proper medication storage related to pre-filled saline syringes used to flush implanted port devices stored in the resident's room for 1 of 6 residents observed during medication pass. (Resident 74)Finding includes:During a medication pass observation on 12/15/25 at 2:12 p.m., LPN 2 entered Resident 74's room with an Intravenous (IV) antibiotic medication and two pre-filled normal saline syringes to flush the resident's line before the IV administration. At that time, inside the resident's room, there was a pre-filled normal saline syringe laying on the resident's over bed table as well as two pre-filled normal saline syringes on top of the night stand. The LPN used the two pre-filled syringes she had brought into the room to flush the resident's port and then placed the other three syringes on top of the night stand before she left the room She informed the resident she would be back in one hour to take the IV down and disconnect the tubing. At 3:28 p.m. LPN 2 entered the resident's room with a pre-filled normal saline syringe to take the IV down, however, it was not completely infused. She left the pre-filled normal saline syringe on the over bed table and left the room. At 3:40 p.m., LPN 2 entered the resident's room again and the IV antibiotic had infused. She used the pre-filled syringe on top of the resident's over bed table, flushed the line and left the room. The other 3 pre-filled syringes of normal saline remained on the night stand. During an interview on 12/15/25 at 3:42 p.m., LPN 2 indicated she was unaware the normal saline syringes were left in the room and she would remove them. During an interview on 12/16/25 at 2:00 p.m., the Director of Nursing had no additional information to provide. The current 3/1/25 Medication Storage policy, provided by Nurse Consultant 1 on 12/16/25 at 4:15 p.m., indicated the facility should ensure medications and biologicals were stored in an orderly manner and locked in cabinets, drawers, carts, and refrigerators. 3.1-25(m)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food was served at a palatable temperature for one of one meal observation. (Residents 4, 24, and 42)Finding includes:During an interview on 12/11/25 at 11:16 am, Resident 4 indicated the facility's food was bad, and most of the time, he did not want to eat it. During an interview on 12/12/25 at 9:41 a.m., Resident 24 indicated the facility's food was often cold. During a resident council interview on 12/15/25 at 3:09 p.m., Resident 42 indicated food taste and temperature had been a concern brought up in resident council. He indicated the food was often cold when they received it. During a meal observation on 12/16/25 at 11:44 a.m., lunch trays were brought up on a non-insulated cart for the second floor dining room. On 12/16/2025 at 11:53 a.m., the test tray temperatures were checked by the Kitchen Manager as follows: chicken-104 degrees, rice-120 degrees, and black beans-120 degrees via a manual thermometer. The Kitchen Manager indicated she thought there was something wrong with the thermometer. She covered the food and went to get a digital thermometer. At 12:05 p.m., she returned, unable to find batteries for the digital thermometer. The food was tasted and was not hot. During an interview on 12/16/25 at 12:14 p.m., CNA 1 indicated she passed all of the room trays along with getting drinks for residents by herself. A policy titled, Food and Nutrition Services, received as current from Nurse Consultant 2 on 12/17/25 at 9:44 a.m. indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident . Food and nutrition services staff will inspect food trays to ensure the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature .3.1-21(a)(1)(2)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident received physical therapy as ordered by the physician for 1 of 1 resident reviewed for rehabilitation services. (Resident 10)Finding includes:During an interview on 12/11/25 at 11:16 a.m., Resident 10 indicated he did not receive therapy and sometimes went many days without it. The record for Resident 10 was reviewed on 12/15/25 at 1:20 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited, chronic kidney disease and post surgical Thoracic 11 thru Lumbar 1 laminectomy (a procedure to remove pressure from the spinal cord). The admission Minimum Data Set (MDS) assessment, dated 11/5/25, indicated the resident was cognitively intact for daily decision making and received speech, occupational, and physical therapy. A Physician's Order, dated 11/1/25, indicated physical therapy was to see the resident for five times a week for 30 days for therapeutic exercises, activity tolerance training, gait training, bed mobility training and transfer training, one time a day five days on and two days off. A Physician's Order, dated 11/11/25, indicated to continue skilled physical therapy three times a week for four weeks addressing therapeutic exercise, activity, and gait training. A Physical Therapy certification and evaluation, dated 11/1/25, indicated the resident was to receive physical therapy for five times a week for 30 days. The resident was seen by physical therapy on 11/1, 11/5, 11/6 and 11/7/25. A Physical Therapy certification and evaluation dated 11/11/15, indicated the resident's payor source changed, therefore the therapy times and schedule changed as well. The new orders for physical therapy were three times a week for four weeks. The resident was seen on 11/11 and 11/12/25. Physical Therapy notes indicated the resident was unavailable on 11/14/25 (no reason was documented). The resident was seen on 11/19 and 11/21/25. Physical Therapy notes indicated the resident's session was canceled by another staff member on 11/20/25. The resident was not picked up for a third day of physical therapy for the above weeks. The resident was not seen three times a week as ordered by the physician. During an interview on 12/16/25 at 2:15 p.m., the Rehab Director indicated she was the only full time staff member due to census. She indicated the start of a therapy week began on a Saturday and ended on the following Friday. The resident was not seen five times a week the first week he was here and was only seen two times a week for the next two weeks. She indicated her staff were PRN (as needed) and were only in the building sometimes for three hours at a time as they would go to other sister facilities to work During an interview on 12/16/25 at 2:30 p.m., the Administrator indicated the residents should receive therapy as ordered by the physician. 3.1-23(a)(1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure the medical record was complete and accurate related to inaccurate tube feeding residual amounts and incorrect resident information in a record for 1 of 21 records reviewed. (Resident 11) Finding includes:The record for Resident 11 was reviewed on 12/16/25 at 1:56 p.m. Diagnoses included, but were not limited to, congestive heart failure (CHF), dysphagia (trouble swallowing), and gastrostomy (a feeding tube inserted through the abdomen). The Significant Change Minimum Data Set (MDS) assessment, dated 11/17/25, indicated the resident had moderate cognitive impairment, required substantial assist with activities of daily living (ADLs), and had an enteral (tube) feeding.A Physician's Order, dated 11/19/25, indicated to verify the enteral feeding residual every shift, if more than 100 milliliters (ml), hold the feeding and notify the physician.The December 2025 Medication Administration Record (MAR) indicated the following enteral tube feeding residual amounts: 12/1 1st shift-300, 12/4 2nd shift-300, 12/8 1st shift-300, 12/9 1st shift-250, 2nd shift-300, and 12/10/25 2nd shift-560. There were no narrative notes that indicated the resident had a residual over 100 ml, was not tolerating the feedings, or that the physician was notified. A Progress Note by NP 1, dated 12/16/25, included a full assessment and history for Resident 34. During an interview on 12/16/25 at 3:45 p.m., the Director of Nursing (DON) indicated the resident had never had a problem with tolerating feedings, and the nurses had documented incorrectly. The DON indicated NP 1 entered the wrong resident's information in Resident 11's record, and they would have to remove it. 3.1-50(a)(1)3.1-50(a)(2)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and a system of monitoring to improve resident outcomes and reduce antibiotic resistance related to a resident remaining on an antibiotic after the organism was determined to be resistant to the medication and prescribing antibiotics for not true infections based on the McGeer Criteria for 1 of 1 resident reviewed for urinary catheters. (Resident 8)Finding includes: During an interview on 12/12/25 at 10:23 a.m., Resident 8 indicated he was having issues with frequent urinary tract infections. The record for Resident 8 was reviewed on 12/16/25 at 10:37 a.m. Diagnoses included, but were not limited to, chronic kidney disease, renal dialysis, and obstructive and reflux uropathy (blockage of urine flow). The Quarterly Minimum Data Set (MDS) assessment, dated 9/10/25, indicated the resident was cognitively intact and had an indwelling catheter. A Care Plan, dated 3/28/24 and reviewed on 9/10/25, indicated the resident had a suprapubic catheter (a tube that drains urine from the bladder through a small opening in the lower abdomen) in place related to obstructive uropathy with urinary retention. Interventions included, but were not limited to, monitor and document for pain and discomfort due to catheter and monitor, record, and report to the physician signs and symptoms of a urinary tract infection (UTI). A Nurse's Note, dated 7/20/25 at 6:28 p.m., indicated the resident complained of pain when urinating. He stated he felt an aching and discomfort. The resident's suprapubic catheter was intact and patent with no signs of redness, swelling, or drainage noted. The physician was made aware and new orders were obtained for a urinalysis with culture and sensitivity. A Physician's Order, dated 7/21/25, indicated the resident was to receive Ciprofloxacin HCl (an antibiotic) 500 milligrams (mg) daily for five days for a UTI. A urine culture, dated 7/23/25, indicated the resident tested positive for 50-100,000 colonies of proteus mirabilis (a bacteria known for causing UTIs) and the bacteria was resistant to Ciprofloxacin. The resident received the full five days of Ciprofloxacin. There was no documentation in the resident's record indicating the physician had been notified of the culture results. During an interview on 12/17/25 at 11:25 a.m., the Director of Nursing indicated the resident should not have received the Cipro for his UTI since it was resistant and the physician should have been notified. 3.1-18(b)(1)