STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00127894 and IN00126416. This visit was in conjunction with the Investigation of Complaint IN00131636. Complaint IN00127894-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00126416-Substantiated. Federal/state deficiencies related to the allegation are cited at F353. Survey dates: June 24, 25, 26, 27 and 28, 2013 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Survey team: Lara Richards, RN-TC Heather Tuttle, RN Cynthia "Cyndy" Stramel, RN Yolanda Love, RN Kathleen "Kitty" Vargas, RN	F000000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
	(6/24-6/26/13) Census bed type: SNF/NF: 125 Total: 125 Census payor type: Medicare: 16 Medicaid: 101 Other: 8 Total: 125 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on July 7, 2013, by Janelyn Kulik, RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	and how to receive refunds for previous payments covered by such benefits. Based on observation and interview, the facility failed to ensure information related to how to contact the State Agency, how to apply for Medicare and Medicaid, and the phone numbers for these agencies were prominently displayed for the residents and visitors. The facility also failed to provide advance notice of the termination of Medicare services for 2 of 3 residents reviewed for liability notices. (Residents #114 and #15) Findings include: 1. During the Environmental tour on 6/27/13 at 3:00 p.m., the following was observed: a. Information related to how to apply for Medicare and Medicaid and how to contact the Stage Agency was posted on a wall across from the Nurses' station in the Main hall. There was a hoyer lift (a machine used to transfer residents) placed in front of the information as well as the crash cart. The information was not readily accessible to the residents. b. A sign with the phone numbers of the State Agency, the Ombudsman,	F000156	1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Information related to how to contact the State Agency, How to apply for Medicaid and Medicare Services, and phone numbers was moved to a more prominent area of the facility. Residents #114 & #15 were contacted via phone during discharge process and were aware of the termination of Medicare Services. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Resident Council Meeting will review the new location of the information for Medicare & Medicaid Services and phone numbers for such agencies. Residents with the potential to be affected by this alleged deficient practice for advance notice to Medicare within the last 30 days were reviewed for compliance. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: Signage will remain in new designated area. Social Services and Admissions were educated on the Medicare Advance notice of termination	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	and Medicare/Medicaid offices was posted in the hallway between the Admissions and Business offices. This information was not prominently displayed in the hallway for residents and visitors to see. Interview with the Administrator on 6/28/13 at 4:00 p.m., indicated the information should be readily accessible to residents and visitors. 2. Interview with the Administrator on 6/26/13 at 11:21 a.m., indicated the last covered Medicare day for Resident #114 was 2/8/13. She indicated the resident had used 36 days of her Medicare benefits and had 64 days of Medicare benefits remaining. The resident remained in the facility after her Medicare services ended. The Administrator indicated a "Notice of Medicare Provider Non-Coverage" form was not provided to the resident prior to the last day of Medicare services. 3. Interview with the Administrator on 6/26/13 at 11:25 a.m., indicated the last covered Medicare day for		process. 1.How the corrective action will be monitored to ensure the deficient practice will not recur; ie QA program put into place: Resident Council will review the placement of the above mentioned signage for 6 months. Executive Director/Designee will review all Medicare cuts and discharges to ensure that they are given Medicare Termination notices in advance as required. The Executive Director/Designee will present a summary of the audit findings to the Quality Assurance Committee for nine months. Committee will then decide if continued monitoring is necessary for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	Resident #15 was 1/22/13. She indicated the resident had used 65 days of his Medicare benefits and had 35 days of Medicare benefits remaining. The resident remained in the facility after the Medicare services ended. She indicated the resident was not provided a "Notice of Medicare Provider Non-Coverage" form prior to the last day of Medicare coverage. Interview with the Medical Records Consultant on 6/26/13 at 11:30 a.m., indicated the "Notice of Medicare Provider Non-Coverage" form was to be completed no later than two days before the termination of Medicare services. Interview with the Administrator on 6/26/13 at 11:35 a.m., indicated Resident #15 and Resident #114 did not receive the "Notice of Medicare of Non-Coverage" 2 days prior to the termination of their Medicare services. 3.1-4(j)(3)(A) 3.1-4(l)(1) 3.1-4(j)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155469		06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
F000164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.			
	Based on observation, record review and interview, the facility failed to ensure each resident's privacy was maintained related to Medication Administration Records (MAR's) left open during medication pass for 2 of 7 Licensed staff Nurses observed and for 2 of 12 residents observed during	F000164	**F 164** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	medication pass. (Residents #108 and #171) (LPN #2 and LPN #3) Findings include: 1. On 6/25/13 at 9:26 a.m., the medication cart for the Apple Lane was located in front of Resident #171's room. There was no staff member at the cart and there were other residents in the hall. At that time, the Medication Administration Record (MAR) book was open and Resident #171's medication sheets were in view of anyone walking down the hallway. LPN #2 then came out of Resident #171's room. She indicated she had gone into the resident's room to administer his medications. The LPN further indicated at the time, the MAR book was supposed to be closed before leaving her cart. 2. On 6/25/13 at 7:45 p.m., LPN #3 was observed during medication pass on the Daisy Lane. At that time, the LPN was preparing to do a glucometer check for Resident #108. The LPN had the Medication Administration Record (MAR) opened to the resident's medications. The LPN then took the glucometer down the hall to perform the glucometer check. At that time, she left the MAR		R 108's medication administration records are covered when not being actively used. R 171's medication administration records are covered when not being actively used. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents with medication administration records have the potential to be affected by the same alleged deficient practice. Nurses #2 and #3 were in-service by the Director of Nursing on: ·The importance of ensuring each resident's privacy and confidentially is maintained related to medication administration records. ·Ensuring that the medication administration record is closed or properly covered when not being actively used.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	book open and the resident's medications were in full view for anyone passing by. Interview with the Director of Nursing (DoN) on 6/28/13 at 1:01 p.m., indicated the nurses were supposed to close the MAR book before leaving the medication cart. *3.1-3(p)(3)*		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing/ designee in-serviced licensed nurses on: ·The residents right to personal privacy and confidentially of his or her personal clinical records. ·The importance of ensuring each resident's privacy is maintained related to medication administration records. ·Ensuring that the medication administration record is closed and properly covered when not being actively used. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
			programs will be put into place; The DON / designee will monitor five medication administration books on alternating shifts weekly to ensure that the resident's privacy and confidentially is maintained by ensuring that the medication administration record is closed and properly covered when not being actively used. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation and interview, the facility failed to ensure residents were addressed by their name by facility staff members for 2 of 2 breakfast meals observed. (Residents #B, #C, and #174) Findings include: 1. On 6/27/13 at 7:44 a.m., Residents #B and #C were observed in the Daisy Lane dining room having breakfast. Occupational therapist #1 entered the dining room at this time. She addressed the residents as "baby" when greeting them. 2. On 6/28/13 at 8:44 a.m., Resident #174 was observed seated in his wheelchair in the Daisy Lane dining room. Occupational therapist #1 entered the dining room at this time to take the resident to therapy. As she was moving the resident's wheelchair, she indicated for the resident to "lift your feet baby." Interview with the SCU Coordinator	F000241	1. What corrective Action will be accomplished for those residents found to have been affected by the deficient practice: Residents #B, #C, and #174 were monitored for any signs of emotional distress, no distress or change of daily routine occurred. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Staff Members were in-serviced on dignity and respect of individuality to ensure that we promote care for residents in a manner and environment as required by state. All residents have the potential to be affected by the alleged	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155469		06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
	on 6/28/13 at 8:50 a.m., indicated the Occupational therapist should have referred to the residents by their name rather than "baby." 3.1-3(t)		deficient practice. Random rounds were completed at various times to observe residents being addressed by their name. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: Social Services/Designee in-serviced staff on residents' right with emphasis on residents being properly addressed by their name. 1.How the corrective action will be monitored to ensure the deficient practice will not recur; ie QA program put into place: Executive Director/Designee will perform random walking rounds 2 times a day, five times a week at various times to observe staff care and treatment to ensure that residents right to be addressed by their name is upheld. The Executive Director/Designee will present a summary of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
			audit findings to the Quality Assurance Committee for nine months. Committee will then decide if continued monitoring is necessary for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on observation, record review and interview, the facility failed to ensure each resident had a choice in regards to bathing for 1 of 3 residents reviewed for choices of the 5 residents who met the criteria for choices. (Resident #10) Findings include: On 6/24/13 at 2:31 p.m., Resident #10 was interviewed. At that time, the resident indicated it had been over 15 years since he had taken a bath and indicated he would like to take a bath at the facility. The resident further indicated he did not think there was a bath tub at the facility because he was never offered one. On 6/26/13 at 8:15 a.m., the resident was observed in bed. The resident indicated at the time, he thought it was his shower day. The resident further indicated no one from the	F000242	1. What corrective Action will be accomplished for those residents found to have been affected by the deficient practice: Resident #10 was spoken to by social services and indicated not having a preference for a shower or tub bath. Resident Documentation indicates that showers have been given without concern. Resident stated he is comfortable with showers. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice. Residents in house were reviewed and offered	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	facility had asked him if he wanted to take a tub bath instead of the shower. On 6/26/13 at 8:40 a.m., the Main Unit Manager was interviewed. She indicated she was unaware the resident wanted to take a tub bath. She further indicated the resident care cards were located in the resident's rooms inside the bathroom door. She indicated the care cards had the resident's information regarding preferences. The Unit Manager indicated she had thought there were bath tubs available in the facility. Interview with the Nurse Consultant on 6/26/13 8:50 a.m., indicated the facility was equipped with two bath tubs, however neither one of them were in working condition. She further indicated the Activity Director interviewed the residents regarding preferences for the Minimum Data Set (MDS) assessment and she had no idea what she does with that information. The Nurse Consultant also indicated she does not know if the residents were aware the facility does not have operable bath tubs. The record for Resident #10 was reviewed on 6/26/13 at 10:16 a.m. The resident was admitted to the		the preference of a bath or shower. All preferences were updated on the care cards. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: Staff Members were In-serviced on the resident right to be offered the choice of a bath or Shower. Activities manager was also in-serviced to indicate resident preference of bath or shower upon admission, significant change or annual assessment review. These preferences are then updated on the Care Card. 1.How the corrective action will be monitored to ensure the deficient practice will not recur; ie QA program put into place: Executive Director/Designee will review at least 2 or 50% of Admission/Annual/Significant Change Assessments per week to ensure that bathing preferences are offered and indicated on resident care cards.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	facility on 2/10/10. Review of the significant change MDS assessment dated 12/18/12, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15, indicating he was alert and oriented. The resident's preferences for choosing between a shower and tub bath indicated it was not very important to him. Review of the quarterly MDS assessment dated 5/12/13, indicated the resident's BIMS score was 12, indicating the resident was alert and oriented. The resident required supervision with bathing. Review of the current plan of care updated 5/2013, indicated there was no care plan regarding the resident's choice to choose between a shower or tub bath or what his preferences were. Review of the shower sheets for the month of June 2013, indicated the resident's shower days were Wednesdays and Saturdays. Further review of the shower sheets, indicated there was no information regarding residents' preferences between a shower or tub bath. Review of the resident's care card,		The Executive Director/Designee will present a summary of the audit findings to the Quality Assurance Committee for nine months. Committee will then decide if continued monitoring is necessary for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	indicated there was no information regarding the resident's preferences for bathing. Interview with the Activity Director on 6/26/13 at 1:23 p.m., indicated she completed the Activity and Daily Preferences Sections on the MDS assessments. She further indicated she had never offered residents a choice of a tub bath. The Activity Director indicated she just did a resident interview today for a new admission and for the first time, she informed the resident there was no working bath tubs in the facility. She indicated prior to today, she had not informed the residents of that information. 3.1-3(u)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure a sanitary and comfortable environment was maintained related to urine odors in resident bathrooms as well as in the common bathrooms for 1 of 3 units throughout the facility. This had the potential to affect the 26 residents residing on Daisy Lane. (Daisy Lane) Findings include: 1. On 6/25/13 at 9:08 a.m., a strong urine odor was observed in the bathroom of Room 45. Two residents resided in this room. On 6/26/13 at 8:30 a.m., a strong urine odor was again observed in the bathroom. On 6/27/13 at 7:45 a.m., the strong urine odor remained in the bathroom. Further, the floor was damp where it had just been mopped by housekeeping. 2. On 6/24/13 at 3:18 p.m., a strong urine odor was observed in the bathroom of Room 54. Two residents	F000253	1. What corrective Action will be accomplished for those residents found to have been affected by the deficient practice: Bathrooms identified were deep cleaned and are being monitored for increased deep cleaning as needed. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	resided in this room. 3. On 6/24/13 at 3:58 p.m., a strong urine odor was observed in the bathroom of Room 55. Two residents resided in this room. 4. During the Environmental tour on 6/27/13 at 1:45 p.m., with the Maintenance and Housekeeping Supervisors, the following was observed on Daisy Lane: a. The common bathroom located in the hall by the dining room was observed with a strong urine odor. b. The bathroom in Room 54 was observed with a strong urine odor. c. The bathroom in Room 45 was observed with a strong urine odor. Interview with the Housekeeping Supervisor at the time, indicated all of the above listed bathrooms had a urine odor. He indicated the bathrooms were to be cleaned daily and that Room 45 needed to be a priority. Confidential family interviews conducted on 6/24/13 at 6:00 p.m. and on 6/27/13 at 7:20 p.m., indicated the unit had a urine odor as well as		Housekeeping will follow an enhanced deep cleaning schedule to ensure that bathroom odors are kept under control. 1.How the corrective action will be monitored to ensure the deficient practice will not recur; ie QA program put into place: Executive Director/Designee will make weekly rounds of all scheduled cleanings and repair projects to validate completion as scheduled. The Housekeeping Director/Designee will present a monthly summary of the progress towards odor control and cleaning projects to the Quality Assurance Committee. This will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	the bathrooms. 3.1-19(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
F000272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on observation,, record review and interview, the facility failed to ensure a dental assessment was completed upon admission to the facility for 1 of 3 residents reviewed	F000272	**F 272** **What corrective action(s) will**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	for Dental Status and Services of the 3 residents who met the criteria for Dental Status and Services. (Resident #173) Findings include: On 6/25/13 at 8:41 a.m., Resident #173 was observed in his bed. At that time, the resident's bottom teeth were chipped. On 6/25/13 at 3:01 p.m., on 6/26/13 at 2:20 p.m., and 6/27/13 at 7:23 a.m., the resident was observed in bed. At those times, the resident's bottom teeth were noted to be chipped. The record for Resident #173 was reviewed on 6/27/13 at 12:42 p.m. The resident was admitted to the facility on 6/18/13 from the hospital. Review of the History and Physical from the hospital indicated the resident had lived alone prior to admission. The Minimum Data Set (MDS) assessment had not been completed and was still in progress. Review of the Nursing Assessment forms in the resident's record, indicated there was no full body skin		**be accomplished for those residents found to have been affected by the deficient practice;** R 173s' oral observation was completed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents admitted or readmitted to the facility have the potential to be affected by the same alleged deficient practice. An audit was completed to ensure all facility residents have a completed current dental observation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	assessment form completed for the resident at the time of admission. On 6/27/13 at 1:50 p.m., the Assistant Director of Nursing (ADoN) went into the shower room where the resident was getting a shower and assessed the resident's teeth. After about five minutes she came out, and indicated the resident was very reluctant in letting her look at his teeth, but indicated there were teeth missing and they were discolored. She further indicated there was area on the bottom of his teeth that was curved and it looked as though the resident's teeth were grooved and there was a definite curvature in his bottom teeth. She indicated the resident was on the list to be seen by the facility's dentist on July 12, 2013. Interview with the Main Unit Manager on 6/27/13 at 2:00 p.m., indicated a full clinical body assessment was to be completed on each resident when they were admitted to the facility. She further indicated on the full clinical body assessment an oral exam which included an assessment of the resident's gums, mouth/oral cavity, oral mucosa, and color and texture of the tongue would be completed at that time. The Unit Manager indicated a paper copy of		Five days a week the interdisciplinary team will meet to ensure the oral exam portion of the full clinical/body observation is completed on all new admissions and readmissions. The Director of Nursing/ designee in-serviced licensed nurses on the importance of: ·ensuring the oral exam portion of the full clinical/body observation is completed. ·timely documentation of assessments. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON / designee will audit five residents monthly to ensure that the oral exam portion of the full clinical/body observation is completed on all new admissions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
	the Nursing Assessment was completed for the resident at the time of admission. She indicated the Nursing Assessment noted the resident's skin condition and nothing else. 3.1-31(c)(9)		and readmissions. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to monitoring bruises for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 6 residents who met the criteria for skin conditions (non-pressure related), not providing range of motion as ordered for 1 of 3 residents reviewed for range of motion of the 7 residents who met the criteria for range of motion and not arranging eye exams for 1 of 3 residents reviewed for vision of the 30 residents who met the criteria for vision. (Residents #4, #107 and #126) Findings include: 1. On 6/25/13 at 8:46 a.m., Resident #126 was observed with an approximate quarter sized area of red discoloration to the top of her right wrist. On 6/26/13 at 8:44 a.m., the area of reddish discoloration remained to the	F000282	**F 282** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 126's physician and family were made aware of the discoloration to the back of the right hand and right forearm. R126's clinical record and shower sheet are reflective of R 126 current skin condition. R 4's was reassessed by the restorative nurse and currently is receiving PROM as ordered. R 107 declined to see an optometrist or ophthalmologist at this time. The resident's plan of care has been updated.	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	resident's right wrist. On 6/27/13 at 12:56 p.m., the area of red discoloration was again observed on the resident's right wrist. On 6/28/13 at 8:30 a.m., an approximate dime sized area of reddish/purple bruising was observed on the top of the resident's right hand. The area of red discoloration remained to the resident's right wrist. The record for Resident #126 was reviewed on 6/28/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, vitamin deficiency and cognitive communication deficit. Review of the observation as well as the event sections of the clinical record, indicated no forms had been completed related to the resident's bruising. Review of the Nursing progress notes for the month of June 2013, indicated there was no documentation related to the resident's bruising. Review of the June 2013 shower sheet, indicated the resident's skin was listed as being intact on shower days. No bruising was documented. The resident was documented as		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. A facility audit was completed to identify residents with undocumented discoloration or bruising. Restorative C.N.A. #1 was in-serviced by the restorative nurse and therapist on how to complete range of motion exercises and interpret the plan of care related to range of motion exercises. A facility audit was completed on residents identified with having impaired vision to ensure care plan approaches and/or recommendations are being followed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	receiving a shower on 6/28/13 and her skin was listed as intact with no bruising. The plan of care dated 10/2/12 and reviewed in May 2013, indicated the resident was at risk for alteration in skin integrity related to hypertension (high blood pressure), dementia with behavior disturbance, dysphagia (difficulty swallowing), anxiety, congestive heart failure, osteoarthritis, pacemaker placement, incontinence of bowel and bladder, and decreased mobility. The interventions included, but were not limited to, observe skin daily with ADL care for changes such as redness, bruising, break in skin, or tender areas and report to Nurse. Interview with the Corporate Nurse Consultant on 6/28/13 at 4:15 p.m., indicated the resident's skin was documented as being intact on 6/28/13 on the shower sheet. She indicated the resident did have 2 bruises on her right hand and wrist. She also indicated documentation should have been completed in the resident's record.		The restorative nurse and therapist in-serviced the restorative C.N.A.s on: · the importance of following physician orders and the plan of care related to restorative/ Range of Motion (ROM) exercises. · how to complete range of motion (ROM) exercises. · how to interpret physician orders and the plan of care related to restorative/ Range of Motion (ROM) exercises. The Director of Nursing/ designee in-serviced nursing staff on the importance of: · following the plan of care with emphases given to: a. care plan approaches such as observing skin daily during ADL care for changes such as redness, bruising, break in skin, or tender areas and obligation to report to the nurse b. care plan approaches such as arranging for an optometrist or ophthalmologist consultation and implementing the recommendations as ordered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
			c. providing range of motion exercises. · following physician's orders related to providing range of motion exercises. · how to complete range of motion (ROM) exercises. · how to interpret physician orders and the plan of care related to restorative/ Range of Motion (ROM) exercises. · ensuring shower sheets are reflective of the resident's current skin condition. · ensuring proper clinical documentation is completed with each observation of a new skin condition. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
			The DON/ designee will observe five residents weekly to ensure any noted skin discolorations are documented properly in the clinical record and on the shower sheet. The restorative nurse will observe five residents weekly receiving ROM to ensure that the residents are receiving range of motion services per physicians orders and the plan of care. The social service staff will review 5 resident care plans weekly to ensure care plan approaches and or recommendations were followed. The DON /designee, their nurse and social service staff members will all present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
	2. On 6/24/13 at 2:54 p.m., Resident #4 was observed in bed. At that time, the resident was observed with a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	contracture to his left hand and arm. There was no splint observed on his left hand. On 6/25/13 at 3:00 p.m., the resident was observed in bed. The resident indicated staff provide range of motion to his left hand. He indicated he could move his left fingers with his right hand by himself. He further indicated he would not wear a hand splint. The resident's left hand and fingers were contracted and bent downward. The resident's left arm was also contracted as he could not fully extend his left arm. On 6/26/13 at 9:02 a.m., and 1:47 p.m., the resident was observed in bed. At those times, the resident was not wearing a hand splint to his left hand. The resident's left arm and hand were contracted. The resident indicated at the time, he was able to move his left hand and fingers with his right hand. He further indicated he could not open his left hand voluntarily and needed assistance. On 6/27/13 at 9:15 a.m., Restorative CNA #1 was going to perform passive range of motion services to the resident's left upper extremity. The CNA started with the resident's fingers. She moved the resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	four fingers up and down 10 times. She then ranged his left thumb in a circular motion eight times. The CNA then ranged his hand and wrist by moving it up and down for 14 times. The CNA then ranged his left forearm and elbow in a circular motion for 10 times. The CNA only preformed one set of exercises to his hand, fingers, forearm and elbow. She ranged each area one time. The CNA then performed range of motion to the resident's right arm. Interview with Restorative CNA #1, on 6/27/13 at 9:25 a.m., indicated the resident would not allow staff to put anything in his hand, or apply a splint to his left hand. The record for Resident #4 was reviewed on 6/27/13 at 8:50 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, cerebrovascular disease, high blood pressure, above the knee amputation, and convulsions. Review of Physician's Orders dated 11/27/11 and on the current Physician 6/2013 recap, indicated passive range of motion to the left upper extremity 10 reps times three sets, six to seven days a week.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	Review of the current plan of care dated 12/3/11 and updated 5/2013, indicated the resident was receiving Restorative Therapy for passive range of motion. The Nursing approaches were to provide passive range of motion to left upper extremity 10 reps times three sets six to seven days a week. Interview with Restorative CNA #1, on 6/27/13 at 2:16 p.m., indicated she completed a total of 30 repetitions to the resident's hand and wrist. She indicated she provided passive range of motion to the resident's hand, fingers and arm one time for a total of 30 repetitions. Interview with the Restorative Nurse on 6/27/13 at 3:03 p.m., indicated the Restorative CNA was supposed to provide 10 repetitions for the resident's hand, wrist, fingers, arm, elbow and shoulder times three sets, so that each joint was ranged 30 times a piece. 3. The record for Resident #107 was reviewed on 6/26/13 at 9:44 a.m. The plan of care dated 1/31/13, indicated the problem of impaired vision. The approaches included, but were not limited to, arrange an optometrist or ophthalmologist consultation and implement the recommendations as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	ordered. There was no documentation in the resident's record that a consultation had been done. Interview with the Social Service Director on 6/27/13 at 10:18 a.m., indicated the resident had not had an optometrist or ophthalmologist consultation as care planned. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided related to monitoring and assessing bruising for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 6 residents who met the criteria for skin conditions (non-pressure related). (Resident #126) Findings include: On 6/25/13 at 8:46 a.m., Resident #126 was observed with an approximate quarter sized area of red discoloration to the top of her right wrist. On 6/26/13 at 8:44 a.m., the area of reddish discoloration remained to the resident's right wrist. On 6/27/13 at 12:56 p.m., the area of red discoloration was again observed on the resident's right wrist.	F000309	**F 309** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 126's physician and family were made aware of the discoloration to the back of the right hand and right forearm. R126's clinical record and shower sheet are reflective of R 126 current skin condition. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	On 6/28/13 at 8:30 a.m., an approximate dime sized area of reddish/purple bruising was observed on the top of the resident's right hand. The area of red discoloration remained to the resident's right wrist. The record for Resident #126 was reviewed on 6/28/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, vitamin deficiency and cognitive communication deficit. Review of the Quarterly Minimum Data Set (MDS) assessment dated 5/6/13, indicated the resident was not cognitively intact and had no skin issues during the assessment reference period. Review of the observation as well as the event sections of the clinical record, indicated no forms had been completed related to the resident's bruising. Review of the Nursing progress notes for the month of June 2013, indicated there was no documentation related to the resident's bruising. Review of the June 2013 shower sheet, indicated the resident's skin was listed as being intact on shower days. No bruising was documented.		All facility residents have the potential to be affected by the same alleged deficient practice. A facility audit was completed to identify residents with undocumented discoloration or bruising and issued addressed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing/ designee in-serviced nursing staff on the importance of: · following the plan of care with emphasis given to: care plan approaches such as observing skin daily during ADL care for changes such as redness, bruising, break in skin, or tender areas and report to the nurse. · ensuring shower sheets are reflective of the resident's current skin condition. · ensuring proper clinical documentation is completed with each observation of a new skin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	The resident was documented as receiving a shower on 6/28/13 and her skin was listed as intact with no bruising. The plan of care dated 10/2/12 and reviewed in May 2013, indicated the resident was at risk for alteration in skin integrity related to hypertension (high blood pressure), dementia with behavior disturbance, dysphagia (difficulty swallowing), anxiety, congestive heart failure, osteoarthritis, pacemaker placement, incontinence of bowel and bladder, and decreased mobility. The interventions included, but were not limited to, observe skin daily with ADL care for changes such as redness, bruising, break in skin, or tender areas and report to Nurse. Interview with the Corporate Nurse Consultant on 6/28/13 at 4:15 p.m., indicated the resident's skin was documented as being intact on 6/28/13 on the shower sheet. She indicated the resident did have 2 bruises on her right hand and wrist. She also indicated documentation should have been completed in the resident's record. 3.1-37(a)		condition. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON/ designee will observe five residents weekly to ensure any noted skin discolorations are documented properly in the clinical record and on the shower sheet. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review and interview, the facility failed to ensure eye doctor appointments were arranged as well as providing eye glasses in a timely manner for 2 of 3 residents reviewed for vision services of the 30 residents who met the criteria for vision services. (Residents #107 and #126) Findings include: 1. On 6/26/13 at 8:44 a.m., Resident #126 was observed wearing no glasses. On 6/27/13 at 7:55 a.m., 10:35 a.m., and 12:56 p.m., the resident was seated in her wheelchair. The resident was not wearing glasses at the above times. On 6/28/13 at 8:30 a.m., the resident was seated in a chair and not wearing	F000313	**F 313** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 126 has received glasses. R 107 declined to see an optometrist or ophthalmologist at this time. The responsible party has been notified of resident's decision. The resident's plan of care has been updated. **How the facility will identify other residents having the potential to be affected by the**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	glasses. The record for Resident #126 was reviewed on 6/28/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, eye redness and cognitive communication deficit. Review of the resident's admission Minimum Data Set (MDS) assessment dated 10/9/12, indicated the resident's vision was adequate and she wore corrective lenses. Review of the Quarterly MDS(Minimum Data Set) assessment dated 5/6/13, indicated the resident's vision was moderately impaired and she did not have corrective lenses in use. The resident was seen by the eye doctor on 1/20/13. Review of the progress note dated 1/20/13, indicated the plan for the resident was glasses. There was no additional documentation completed by the eye doctor and there was no additional documentation completed in Social Service progress notes related to the resident's eye glasses. Interview with LPN #5 on 6/28/13 at		**same deficient practice and what corrective action will be taken;** All facility residents with impaired vision have the potential to be affected by the same alleged deficient practice. A review of all resident MDS's was completed to identify all residents with vision impairment. All residents identified with vision impairment have been reviewed and referred to the ophthalmologist if needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing/designee in-serviced MDS and Social Service Directors related to: Completion of an Ophthalmologist referral for any residents that have MDS section	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	4:15 p.m., indicated that he was not aware if the resident wore glasses. Interview with the Assistant Director of Nursing (ADoN) on 6/28/13 at 4:20 p.m., indicated the resident's name was listed on the clipboard for eye care for receiving new glasses. Interview with the SCU Coordinator on 6/28/13 at 4:20 p.m., indicated the resident was scheduled to receive new glasses on 6/29/13. Further interview at 4:59 p.m., indicated the resident was last seen by the eye doctor in January 2013. She indicated that she had previously asked the eye doctor the reason for the delay in obtaining the resident's glasses. She was informed to follow up with the office. The SCU Coordinator indicated that she was not aware why the resident had not received her glasses.		B1000 coded as impaired. Ensuring that follow-up is completed for all ophthalmologist recommendations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The Heath Information Manager/designee will review 10 residents monthly identified as having impaired vision to ensure referral was made to the ophthalmologist and follow-up is completed for all recommendations. The Health Information Manager will present a summary of audit findings to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
			Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
	2. The record for Resident #107 was reviewed on 6/26/13 at 9:44 a.m. The Minimum Data Set quarterly assessment dated 4/19/13, indicated the resident had moderately impaired vision. A plan of care dated 1/31/13, indicated the problem of impaired vision. The approaches included, but were not limited to, arrange an optometrist or ophthalmologist consultation and implement the recommendations as ordered. Review of the consultation section in the resident's record, indicated there were no progress notes related to an optometrist or ophthalmologist consultation being done. Interview with the Social Service Director on 6/27/13 at 10:18 a.m., indicated the resident had not had an optometrist or ophthalmologist consultation as care planned. 3.1-39(a) 3.1-39(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services to prevent further contractures related to passive range of motion therapy for 1 of 3 residents reviewed for range of motion services of the 7 who met the criteria for range of motion services. (Resident #4) Findings include: On 6/24/13 at 2:54 p.m., Resident #4 was observed in bed. At that time, the resident was observed with a contracture to his left hand and arm. There was no splint observed in his left hand. The resident could not open his left hand or completely straighten out all of his fingers without assistance, nor could he extend his left arm without assistance. On 6/25/13 at 3:00 p.m., the resident was observed in bed. The resident indicated staff provided range of	F000318	**F 318** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 4 was reassessed by the restorative nurse and currently is receiving PROM as ordered. R4's Joint Mobility Limitation-Range of Motion and Loss of Voluntary Movement observation was updated. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	motion to his left hand. He indicated he could move his left fingers with his right hand by himself. He further indicated he would not wear a hand splint. The resident's left hand and fingers were contracted and bent downward. The resident's left arm was also contracted as he could not fully extend his left arm. On 6/26/13 at 9:02 a.m., and 1:47 p.m., the resident was observed in bed. At those times, the resident was not wearing a hand splint to his left hand. The resident's left arm and hand were contracted. The resident indicated at the time, he was able to move his left hand and fingers with his right hand. He further indicated he could not open his left hand voluntarily and needed assistance. On 6/27/13 at 9:15 a.m., Restorative CNA #1 was going to perform passive range of motion services to the resident's left upper extremity. The CNA started with the resident's fingers. She moved the resident's four fingers up and down 10 times. She then ranged his left thumb in a circular motion eight times. The CNA then ranged his hand and wrist by moving it up and down for 14 times. The CNA then ranged his left forearm and elbow in a circular motion for 10		All facility residents have the potential to be affected by the same alleged deficient practice. The restorative nurse reviewed all facility residents Joint Mobility Limitation-Range of Motion and Loss of Voluntary Movement observations to ensure proper documentation was recorded. Updates to the Joint Mobility Limitation-Range of Motion and Loss of Voluntary Movement observations were made as needed. Restorative C.N.A. #1 was in-serviced by the restorative nurse and therapist on how to complete range of motion exercises and interpret the plan of care related to range of motion exercises. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The restorative nurse with the therapist, in-serviced the restorative C.N.A.'s on: · the importance of following	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	times. The CNA only preformed one set of exercises to his hand, fingers, forearm and elbow. She ranged each area one time. The CNA then performed range of motion to the resident's right arm. Interview with Restorative CNA #1, on 6/27/13 at 9:25 a.m., indicated the resident would not allow staff to put anything in his hand, or apply a splint to his left hand. The record for Resident #4 was reviewed on 6/27/13 at 8:50 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, cerebrovascular disease, high blood pressure, above the knee amputation, and convulsions. Review of the 5/29/13 Quarterly Minimum Data Set (MDS) assessment, indicated the resident's Brief Interview for Mental Status (BIMS) score was 14, indicating he was alert and oriented. The resident needed extensive assist with one person physical assist with bed mobility, personal hygiene and dressing. The resident had range of motion impairments to his upper extremity on one side. Review of Physician's Orders dated		physician orders and the plan of care related to restorative/ Range of Motion (ROM) exercises. · how to complete range of motion (ROM) exercises. · how to interpret physician orders and the plan of care related to restorative/ Range of Motion (ROM) exercises. The Director of Nursing/ designee in-serviced the restorative nurses on: ·how to complete the Joint Mobility Limitation-Range of Motion and Loss of Voluntary Movement observation. ·the importance of completing the Joint Mobility Limitation-Range of Motion and Loss of Voluntary Movement observation accurately. The Director of Nursing/ designee in-serviced nursing staff on the importance of: · following the plan of care with emphasis given to providing range of motion exercises.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	11/27/11 and on the current Physician 6/2013 recap, indicated passive range of motion to the left upper extremity 10 reps times three sets, six to seven days a week. Review of the current plan of care dated 12/3/11 and updated 5/2013, indicated the resident was receiving Restorative therapy for passive range of motion. The Nursing approaches were to provide passive range of motion to the left upper extremity 10 reps times three sets, six to seven days a week. Review of the 5/31/13 Restorative Progress Note, indicated the resident had maintained his previous level of independence with bed mobility and upper body strength. Passive range of motion programming had been successful in preventing any decline in range of motion, or physical functional ability. The resident had been getting up out of bed more frequently and had also shown an increase in quality interaction with staff, visitors, and other residents. Review of the 4/30/13 Restorative Progress Note, indicated the resident was a willing participant with passive range of motion to the left upper extremity with no increase in		· following physician's orders related to providing range of motion exercises. · how to complete range of motion (ROM) exercises. · how to interpret physician orders and the plan of care related to restorative/ Range of Motion (ROM) exercises. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The restorative nurse will observe five residents weekly receiving ROM to ensure that the residents are receiving range of motion services per physicians orders and the plan of care. The DON/designee will audit 5 residents' Joint Mobility Limitation-Range of Motion and Loss of Voluntary Movement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	contracture noted. Review of the 5/28/13 quarterly Restorative Nursing Assessment, indicated the resident received passive range of motion. The resident had limited voluntary movement to the left upper extremity related to decreased mobility and dexterity. The range of motion to the left upper extremity helped maintain present joint mobility function with minimal pain, discomfort and limited decline with range of motion. The resident participated with extensive assist of one staff, verbal cues and redirection with rest periods. The resident was to be provided with passive range of motion to the left upper extremity 10 repetitions times three sets of flexion/extension, adduction/abduction. Review of the joint mobility assessment dated 5/28/13, indicated the resident's left elbow had moderate (51-75%) available range of motion. The resident's left wrist and hand with palm down also had moderate (51-75%) range of motion. The resident's left hand/fingers were coded within normal limits (left palm up fingers spread: measure movement)		observations weekly to ensure accurate documentation. The DON and restorative nurse will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	Interview with Restorative CNA #1, on 6/27/13 at 2:16 p.m., indicated she completed a total of 30 repetitions to the resident's hand and wrist. She indicated she provided passive range of motion to the resident's hand, fingers and arm one time for a total of 30 repetitions. Interview with the Restorative Nurse on 6/27/13 at 3:03 p.m., indicated the Restorative CNA was supposed to provide 10 repetitions for the resident's hand, wrist, fingers, arm, elbow and shoulder times three sets, so that each joint was ranged 30 times a piece. He further indicated he would expect the left arm and elbow to be done 30 times with adduction and abduction and not just one set of 10 repetitions to the entire arm. The Restorative Nurse indicated the joint mobility assessment dated 5/28/13 was inaccurate for the resident's left hand/fingers. He indicated he had thought the assessment was based on how the resident moved their extremities with assistance. After reading through the joint mobility assessment, the Restorative Nurse indicated it was based on voluntary movement of the joints, therefore the resident's assessment was not accurately completed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
	3.1-42(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, record review and interviews, the facility failed to ensure the resident environment was free of accident hazards related to hot water temperatures that exceeded 120 degrees Fahrenheit for 2 of 5 units. This deficient practice had the potential to affect 52 residents who resided on the Bakersfield and Daisy Lane Units of the 125 residents who resided in the facility. Findings include: Observation on the Bakersfield Unit on 6/24/13 at 10:35 a.m., indicated the hot water from the sink in Room 69 felt hot to the touch. The hot water temperature was checked and registered 134.5 degrees Fahrenheit. The temperature of the hot water in the sink of Room 71 was observed on 6/24/13 at 10:37 a.m. and registered 134.5 degrees Fahrenheit. On 6/24/13 at 10:41 a.m., the hot water temperature in the sink in the	F000323	1. What corrective Action will be accomplished for those residents found to have been affected by the deficient practice: Boiler was replaced affecting Bakersfield and Daisy Lane Units. Residents on Bakersfield and Daisy Lane Units were observed to be clear of any burns or sores related to the temperature of the water at the time of the survey. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice. Temperatures were taken throughout the building to ensure that temps were below 120 degrees. No other concerns of water temperature were identified.	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	shower room on the Bakersfield Unit registered 134.5 degrees Fahrenheit. The hot water temperature of the shower head in the shower room of the Bakersfield Unit registered 133 degrees Fahrenheit. Observations on 6/24/13 between 10:45 a.m. and 11:00 a.m., indicated the following temperatures in the resident room sinks: On the Bakersfield Unit: In Room 58 the hot water temperature was 133 degrees Fahrenheit. In Room 59 the hot water temperature was 132 degrees Fahrenheit. In Room 60 the hot water temperature was 132 degrees Fahrenheit. On the Daisy Lane Unit: In Room 44 the hot water temperature was 133 degrees Fahrenheit. In Room 51 the hot water temperature was 132 degrees Fahrenheit. In Room 57 the hot water temperature was 132 degrees Fahrenheit. On 6/24/13 at 11:12 a.m., the hot water temperature in Room 44 on the Daisy Lane Unit, was obtained by the		1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: Temperatures are taken daily, 7 times a week to ensure water temperatures are maintained within guidelines. 1.How the corrective action will be monitored to ensure the deficient practice will not recur; ie QA program put into place: Maintenance Director/Designee will complete daily log of random rooms for each unit to ensure water temperature is maintained within state guidelines. Maintenance Director/Designee will present a summary of the log results to the Quality Assurance Committee for nine months. Committee will then decide if continued monitoring is necessary for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	Maintenance Supervisor. The temperature of the water was 127 degrees Fahrenheit. Interview with the Maintenance Supervisor at that time, indicated he monitored the hot water temperatures daily. He also indicated he had checked the water temperatures on the morning of 6/24/13 around 8:00 a.m. or 8:15 a.m. He indicated all the temperatures were below 120 degrees Fahrenheit. He indicated the current temperatures were too high, they should be less than 120 degrees Fahrenheit. Continued observation with the Maintenance Supervisor on 6/24/13 at 11:13 a.m., indicated the temperature of the hot water in the sink of Room 71 on the Bakersfield Unit, was 133 degrees Fahrenheit. The Maintenance Supervisor obtained the temperature. Interview with the Maintenance Supervisor at that time, indicated Room 71 was the closest room to the boiler that provided hot water to both the Bakersfield Unit and the Daisy Lane Unit. On 6/24/13 at 11:15 a.m., the boiler temperature gauge was observed and indicated the temperature of the water			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	leaving the tank was 135 degrees Fahrenheit. The gauge at the mixing valve indicated the temperature of the water leaving the tank after the mixing valve was 115 degrees Fahrenheit. Interview with the Maintenance Supervisor at that time, indicated there had to be a problem with the gauge on the mixing valve. He indicated the temperatures in the rooms could not be higher than the temperature of the water leaving the mixing valve. Continued observations of the temperatures of the sinks in the resident rooms taken by the Maintenance Supervisor indicated the following results: In Room 58 on the Bakersfield Unit, at 11:19 a.m. on 6/24/13, the temperature of the hot water at the sink was 132 degrees Fahrenheit. In Room 56 on the Daisy Lane Unit, at 11:21 a.m. on 6/24/13, the temperature of the hot water at the sink was 129 degrees Fahrenheit. Review of the June 2013 Water Temperature Long on 6/24/13 at 11:00 a.m., indicated temperatures were taken daily Monday through Friday. Review of the 6/2013 temperature log indicated no hot water temperatures above 120			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	degrees Fahrenheit had been recorded throughout the facility. On 6/24/12, the water temperature in room 59 registered 113 degrees Fahrenheit. Interview with the Maintenance Supervisor on 6/24/13 at 11:21 a.m., indicated he would get a new gauge for the mixing valve and would lower the temperature of the water. Interview with the Maintenance Supervisor on 6/24/13 at 12;00 p.m., indicated the water temperature were checked daily Mondy through Friday by himself between 8:00-8:30 a.m. as part of his morning rounds. The policy titled "Maintenance Policy" that was undated, was provided by the Director of Nursing on 6/24/13. She indicated the policy was current. The policy indicated: "Purpose: To ensure that the building (interior and exterior), grounds, and equipment are maintained in a safe and operable manner...Water temperatures will be measured and recorded to ensure they do not exceed 120 degrees Fahrenheit." 3.1-45(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure a gradual dose reduction was completed for a resident receiving an antipsychotic medication for 1 of 10 residents reviewed for unnecessary medications. (Resident #126) Findings include: The record for Resident #126 was reviewed on 6/26/13 at 11:14 a.m. The resident's diagnoses included,	F000329	**F 329** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 126's clinical record was updated by her physician to include the clinical reasons for his	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	but were not limited to, senile dementia and dementia with behavior disturbance. Review of the June 2013 Physician's order summary (POS), indicated the resident was receiving Risperdal (an antipsychotic medication) 0.5 milligrams (mg) twice a day. Review of the Pharmacy recommendation dated 1/22/13, indicated the resident had been receiving Risperidone (Risperdal) 0.5 mg twice a day since October 2012 along with Lorazepam (an antianxiety medication) 0.5 mg twice a day since October 2012 for anxiety and dementia with delusions. The recommendation indicated the following: "Please consider a gradual dose reduction, perhaps decreasing Risperidone to 0.5 mg daily while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated." The Physician declined the recommendation due to the resident's "symptoms got worse" with a previous gradual dose reduction. There was		declining of the gradual dose reduction, including description of the resident's symptoms. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents who have orders for psychotropic medications have the potential to be affected by the same alleged deficient practice. A letter with written examples was compiled and personally distributed to facility medical staff members identifying the facility's expectations of documentation specifics in relation to Gradual Dose Reductions. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The DON/ designee conducted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	no description of what the resident's "symptoms" were. Interview with the Director of Nursing (DoN) on 6/28/13 at 3:00 p.m., indicated the Physician did not document what the resident's "symptoms" were related to previous attempts at a gradual dose reduction. 3.1-48(b)(2)		educational training with licensed nurses on Gradual Dose Reductions (G.D.R's) with emphases given to: ·Specific time intervals ·If the GDR is clinically contraindicated then documentation must be provided by physician regarding these clinical contraindications by describing the specific resident target symptoms that would be worsened and likely impair the resident's function or cause psychiatric instability. ·Licensed nurse's role in documentation of resident target symptoms that would be worsened and likely impair the resident's function or cause psychiatric instability. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Monthly the DON/Designee will review any gradual dose reductions declined by the attending physician to ensure that documented clinical contraindications are specific to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
			resident's target symptoms. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.			
	Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% was maintained for 5 of 13 residents observed during medication pass. Five errors were observed during 27 opportunities for error during medication administration. This resulted in a medication error rate of 18%. (Residents #32, #108, #174, #176 and #G) Findings include: 1. On 6/25/13 at 8:31 p.m., LPN #4 was observed to administer 4 units of Novolog insulin to Resident #32. Interview with the LPN at the time, indicated the resident's insulin injection was scheduled to be administered at 5:30 p.m. The record for Resident #32 was reviewed on 6/28/13 at 10:15 a.m. The resident's diagnosis included, but was not limited to, diabetes. A Physician's order dated 6/7/13, indicated the resident was to receive Novolog insulin, 4 units every evening	F000332	**F 332** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 32's physician and family were updated. No new orders were received. R 108's physician and family were updated. No new orders were received. R174's physician and family were updated. No new orders were received. R176's physician and family were updated. No new orders were received. Resident G's physician and family were updated. No new orders were received. **How the facility will identify**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	at 5:30 p.m.		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents who have orders for blood glucose monitoring and insulin have the potential to be affected by the same alleged deficient practice. Nurse 3 was removed from the current duty schedule and was required to repeat facility orientation program. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing/ designee in-serviced licensed nurses on: ·the importance of following physicians' orders related to blood glucose monitoring and medication administration times. ·blood glucose monitoring and insulin administration times. ·Facility process to follow in the event of delays of medication administration including insulin.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
			·types and side effects of insulins with emphasis given to clinical impact of insulin replacement delays. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON / designee will monitor five medication administration passes on alternating shifts and units weekly to ensure that blood glucose monitoring and medication administration is completed timely. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
	2. On 6/25/13 at 7:32 p.m., LPN #3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	indicated none of her glucometers for 5:30 p.m. or insulins were administered. The LPN proceeded to check Resident #174's blood sugar at 7:40 p.m. The resident's glucometer reading was 164. She indicated the resident received a sliding scale insulin. The LPN then removed Novolog Insulin from the medication cart and drew up two units of insulin. She administered his insulin at 7:44 p.m. The record for Resident #174 was reviewed on 6/26/13 at 9:02 a.m. The resident's diagnosis included, but was not limited, to diabetes. Review of Physician Orders dated 6/21/13, indicated blood glucose monitoring before meals at 5:30 p.m. Further review of Physician Orders dated 6/21/13, indicated Novolog Insulin 100 unit/ml per sliding scale: 151-200 give 2 units. 3. On 6/25/13 at 7:45 p.m., LPN #3 obtained Resident #108's blood sugar. The resident's blood sugar was 233. The LPN indicated the resident had a routine insulin order. The LPN then removed Novolog Insulin from the medication cart and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	drew up 25 units. She then administered the resident's Insulin at 7:56 p.m. The record for Resident #108 was reviewed on 6/26/13 at 9:00 a.m. The resident's diagnosis included, but was not limited to, diabetes. Review of Physician Orders on the current 6/2013 recap, indicated Novolog Insulin 100 unit/ml 25 units twice a day. Blood glucose monitoring was to be completed four times a day before meals and at night time. 4. On 6/25/13 at 8:15 p.m., LPN #4 obtained Resident #176's blood sugar. The resident's blood sugar was 367. The LPN indicated the resident had a routine order of insulin. She was to receive Novolog Insulin five units with meals. The LPN administered the five units of Novolog insulin at 8:19 p.m. The record for Resident #176 was reviewed on 6/26/13 at 9:04 a.m. The resident's diagnosis included, but was not limited to, diabetes. Review of Physician Orders dated 6/13/13, indicated Novolog Insulin 100 unit/ml 5 units with meals. Blood			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	glucose monitoring was also to be done four times a day with meals and at night time. 5. On 6/25/13 at 8:21 p.m., LPN #3 was observed during medication pass. At that time she proceeded to obtain Resident #G's blood sugar. The resident's blood sugar was 238. The nurse indicated the resident had a routine order for Insulin. The LPN then drew up 25 units of Novolog Insulin and administered the insulin to the resident at 8:23 p.m. The record for Resident #G was reviewed on 6/26/13 at 9:10 a.m. The resident's diagnosis included, but was not limited to, diabetes. Review of Physician Orders on the current 6/2013 recap, indicated Novolog Insulin 100 unit/ml 25 units three times a day at 5:00 p.m. Another Physician's Order dated 9/20/11, indicated blood glucose monitoring four times a day before meals and at night time. Continued observation on 6/25/13, after all the residents were given their insulin injections and the glucometers had been completed, the time was 8:45 p.m. (three hours and 15 minutes late). At no time did the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	residents who received the insulin get any food or were offered food after the injection. The resident's ate their dinner meal at 5:30 p.m. Interview with the Assistant Director of Nursing (ADoN) on 6/25/13 at 8:13 p.m., indicated the insulins and the blood glucoses should have been obtained and administered at their scheduled medication time. She further indicated all five of the above mentioned residents were late in receiving their scheduled insulin. Interview with the Director of Nursing (DoN) on 6/28/13 at 1:01 p.m., indicated the residents should have been offered some sort of food after they received the short acting insulin. She indicated the insulin was supposed to be given before meals and since it was not, they should have been offered something at the time of administration. 3.1-48(c)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
F000333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure residents were free of significant medication errors, related to the failure to administer insulin at the appropriate time for 5 of 5 residents observed receiving insulin during medication administration. (Residents #32, #108, #174, #176, and #G) Findings include: 1. On 6/25/13 at 8:27 p.m., LPN #4 was observed to check Resident #32's blood sugar using a glucometer. The resident's blood sugar registered high at 353 (normal 70-100). At 8:31 p.m., the LPN was observed to administer 4 units of Novolog insulin to Resident #32. Interview with the LPN at the time, indicated the resident's insulin injection was scheduled to be administered at 5:30 p.m. The record for Resident #32 was reviewed on 6/28/13 at 10:15 a.m. The resident's diagnosis included, but was not limited to, diabetes. A	F000333	**F 333** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 32's physician and family were updated. No new orders were received. R 108's physician and family were updated. No new orders were received. R174's physician and family were updated. No new orders were received. R176's physician and family were updated. No new orders were received. Resident G's physician and family were updated. No new orders were received. **How the facility will identify other residents having the**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	Physician's order dated 6/7/13, indicated the resident was to receive Novolog insulin, 4 units every evening at 5:30 p.m.		**potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents who have orders for blood glucose monitoring and insulin have the potential to be affected by the same alleged deficient practice. Nurse 3 was removed from the current duty schedule and was required to repeat the facility orientation program. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing/ designee in-serviced licensed nurses on: ·the importance of following physicians' orders related to blood glucose monitoring and medication administration times. ·blood glucose monitoring and insulin administration times. ·Facility process to follow in the event of delays in medication administration including insulin. ·types and side effects of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
			insulin's with emphasis given to clinical impact of insulin replacement delays. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON / designee will monitor five medication administration passes on alternating shifts and units weekly to ensure that blood glucose monitoring and medication administration is completed timely. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	
	2. On 6/25/13 at 7:32 p.m., LPN #3 indicated none of her glucometers for 5:30 p.m. or insulins were administered.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	The LPN proceeded to check Resident #174's blood sugar at 7:40 p.m. The resident's glucometer reading was 164. She indicated the resident received a sliding scale insulin. The LPN then removed Novolog Insulin from the medication cart and drew up two units of insulin. She administered his insulin at 7:44 p.m. The record for Resident #174 was reviewed on 6/26/13 at 9:02 a.m. The resident's diagnosis included, but was not limited, to diabetes. Review of Physician Orders dated 6/21/13, indicated blood glucose monitoring before meals at 5:30 p.m. Further review of Physician Orders dated 6/21/13, indicated Novolog Insulin 100 unit/ml per sliding scale: 151-200 give 2 units. 3. On 6/25/13 at 7:45 p.m., LPN #3 obtained Resident #108's blood sugar. The resident's blood sugar was 233. The LPN indicated the resident had a routine insulin order. The LPN then removed Novolog Insulin from the medication cart and drew up 25 units. She then administered the resident's Insulin at 7:56 p.m.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	The record for Resident #108 was reviewed on 6/26/13 at 9:00 a.m. The resident's diagnosis included, but was not limited to, diabetes. Review of Physician Orders on the current 6/2013 recap, indicated Novolog Insulin 100 unit/ml 25 units twice a day. Blood glucose monitoring was to be completed four times a day before meals and at night time. 4. On 6/25/13 at 8:15 p.m., LPN #4 obtained Resident #176's blood sugar. The resident's blood sugar was 367. The LPN indicated the resident had a routine order of insulin. She was to receive Novolog Insulin five units with meals. The LPN administered the five units of Novolog insulin at 8:19 p.m. The record for Resident #176 was reviewed on 6/26/13 at 9:04 a.m. The resident's diagnosis included, but was not limited to, diabetes. Review of Physician Orders dated 6/13/13, indicated Novolog Insulin 100 unit/ml 5 units with meals. Blood glucose monitoring was also to be done four times a day with meals and at night time.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	5. On 6/25/13 at 8:21 p.m., LPN #3 was observed during medication pass. At that time she proceeded to obtain Resident #G's blood sugar. The resident's blood sugar was 238. The nurse indicated the resident had a routine order for Insulin. The LPN then drew up 25 units of Novolog Insulin and administered the insulin to the resident at 8:23 p.m. The record for Resident #G was reviewed on 6/26/13 at 9:10 a.m. The resident's diagnosis included, but was not limited to, diabetes. Review of Physician Orders on the current 6/2013 recap, indicated Novolog Insulin 100 unit/ml 25 units three times a day at 5:00 p.m. Another Physician's Order dated 9/20/11, indicated blood glucose monitoring four times a day before meals and at night time. Continued observation on 6/25/13, after all the residents were given their insulin injections and the glucometers had been completed, the time was 8:45 p.m. (three hours and 15 minutes late). At no time did the residents who received the insulin get any food or were offered food after the injection. The resident's ate their			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	dinner meal at 5:30 p.m. Interview with the Assistant Director of Nursing (ADoN) on 6/25/13 at 8:13 p.m., indicated the insulins and the blood glucoses should have been obtained and administered at their scheduled medication time. She further indicated all five of the above mentioned residents were late in receiving their scheduled insulin. Interview with the Director of Nursing (DoN) on 6/28/13 at 1:01 p.m., indicated the residents should have been offered some sort of food after they received the short acting insulin. She indicated the insulin was supposed to be given before meals and since it was not, they should have been offered something at the time of administration. 3.1-48(c)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation and interview, the facility failed to ensure sufficient nursing staffing was provided during dining for 1 of 1 evening meals observed for 6 of 26 residents residing on Daisy Lane. (Residents #B, #C, #D, #E, #F, and #G) Findings include: On 6/25/13 at 5:37 p.m., the tray cart for the evening meal was in the Daisy Lane dining room. Three staff members were passing trays at this	F000353	1. What corrective Action will be accomplished for those residents found to have been affected by the deficient practice: Resident #B, #C, #D, #E, #F, and #G have been monitored for intake and weight loss, no adverse effects from alleged deficient practice noted. 1.How other residents having	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	time. At 5:44 p.m., there were 3 trays inside the transportation cart and 2 trays on top of the cart. Resident #D and #G's trays were located inside the cart. At 5:47 p.m., Resident #C and Resident #F received their food. Their trays were uncovered at this time and no cueing was provided. Resident #B was resting her head on the table at this time and her hair landed on resident #F's tray. A new tray was then ordered for resident #F. At 5:57 p.m., the Wound nurse and the Director of Nursing entered the dining room. Resident #F received her new tray at this time and was repositioned in her broda chair by the Wound nurse. The Restorative Nurse entered the dining room and started to cue Residents #C and #F. The SCU Coordinator was also in the dining room at this time. At 5:59 p.m., Resident #D was brought to the dining room. As she was seated at the table, she started to reach for her tablemate's jello and needed to be redirected. The resident received her tray from the tray cart at 6:01 p.m. At 6:25 p.m., Resident #E was observed taking what was left of a sandwich off of his tablemate's plate.		the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents on Daisy Lane have the potential to be affected by the alleged deficient practice. Meal Service on Daisy has been observed, and residents screened where appropriate for speech therapy to ensure that proper levels of assistance are given. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: Daisy Lane dining room has been reorganized to better accommodate the needs of the resident during meal service. A designated Manager on Duty has been assigned to ensure that proper levels of assistance are provided during meal service times. Staff were in serviced by Executive Director on the requirement for sufficient staff being provided and the type of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	LPN #3 was not aware the resident was doing this. When informed, she removed resident #E's tray rather than the table mates until she was told that she had the wrong tray. Interview with CNA #3 at 6:09 p.m., indicated on the 3-11 shift, there are 2 CNA's in the dining room and a Nurse. She indicated the SCU Coordinator is not usually in the dining room. Interview with the SCU Coordinator at 6:29 p.m., indicated she is at the facility for all three meals and she floats between Daisy Lane and Bakersfield. She indicated Thursday night is usually her late day. At 6:32 p.m., Resident #G's dinner tray remained in the transportation cart. The resident was in her room sleeping at this time. At 6:41 p.m., the tray cart was removed from the dining room. Resident #G's tray was not taken out of the transportation cart prior to leaving the dining room. Interview with LPN #3 at the time, indicated when a resident does not eat at dinner they are offered a substitute. She also indicated their tray is to be kept in case they would want it warmed up later. She was not aware resident #G's tray was left on		assistance to be given during meal service times. 1.How the corrective action will be monitored to ensure the deficient practice will not recur; ie QA program put into place: Executive Director/Designee will complete a weekly log to monitor the dining service randomly throughout the week, but no less than 5 times a week, varying meal times, to ensure that sufficient staff is present. Executive Director/Designee will present a summary of the log results to the Quality Assurance Committee for nine months. Committee will then decide if continued monitoring is necessary for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	the transportation cart. During a confidential family interview on 6/25/13 at 7:50 p.m., it was indicated that there are only 2 aides in the dining room to start serving trays. Further interview indicated sometimes the nurse will come in and help. Interview with the Director of Nursing on 6/28/13 at 1:00 p.m., indicated she was working on some changes for the Daisy Lane dining room. 2. On 6/25/13 at 5:50 p.m., during a dining observation of the evening meal in the rainbow room, staff were observed bringing residents into the room. Continued observation at 6:22 p.m., indicated there were 14 residents in the room. Facility Staff identified these residents as needing assistance and/or cueing with meals. At that time, there were three CNA's, one nurse, and the Activity Director in the room waiting on the supper trays to arrive. The supper trays arrived to the dining room at 6:27 p.m. At that time, the 3-11 supervisor entered the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	room to assist in passing trays. After all the trays were passed, the staff sat down to feed the residents. The Activity Director was feeding one resident. The 3-11 supervisor was feeding one resident. The other nurse was assisting two residents. There were two CNA's assisting two residents and the other CNA was assisting one resident. At that time, the residents were served milk on their trays. Another tray with plastic cups and another tray with coffee cups were also on the cart. There were two pots of coffee, a pitcher of water and one pitcher of grape kool aid also on the cart. The kool aid was passed to the rest of the residents. The coffee nor the water was offered to any of the residents. Of the 14 residents, tem of those residents required total assistance with feeding. At 6:43 p.m., Restorative CNA #1 who worked the day shift came in and sat down to assist another resident who needed some cueing. Interview with Confidential Employee #1 on 6/25/13 at 6:44 p.m., indicated the employee works primarily the 3-11 shift. The Employee indicated there was usually only three CNA's and one			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	nurse that help to feed the residents in the rainbow room. The Employee indicated the Activity Director does not usually help with feeding, nor does the 3-11 supervisor. The Employee indicated there were plenty of Nursing Staff to take care of the residents on the Main Unit but when it comes to feeding there were just too many residents that needed assistance than we have staff. Interview with Confidential Employee #2 on 6/27/13 at 2:09 p.m., indicated there used to be more Nurses and CNA's on the main unit and the halls were divided up very fairly. The Employee indicated the Assistant Director of Nursing rarely helped the Nursing staff and the Unit Manager helps if asked. The employee indicated they appear to be helping us now that "you" were here, but this was not the normal. Interview with Confidential Employee #3 on 6/28/13 at 9:02 a.m., indicated the employee worked all three shifts and picked up when needed. The Employee indicated when working the Daisy Lane, during the evening meal, there were only two CNA's and one Nurse on the unit. The Employee indicated no other staff came to help during the evening meal. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	Employee further indicated the Special Care Unit Director rarely stayed over into the evening shift, and she rarely helped out on the Daisy Lane with supper. The Employee indicated sometimes we were still feeding the residents after 7:00 p.m. and trays arrive to the unit at 5:30 p.m. Review of the staffing sheet for the 3-11 shift for 6/25/13 indicated the following: On the main unit there was one call off for Nursing but covered by another nurse, so there were three nurses for Main unit and there were five CNA's scheduled for the Main unit in which all were there. On the Daisy lane there was one nurse and two CNA's scheduled for the unit, in which all were there. On the Bakersfield Unit there was one nurse and two CNA's scheduled for the unit, in which all were there. There was one house supervisor for the 3-11 shift. Interview with the Director of Nursing (DoN) on 6/28/13 at 12:49 p.m., indicated there was supposed to be a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	supervisor that goes to the Daisy Lane every night. She indicated since 6/25/13 she has assigned a supervisor on the Daisy Lane for everyday. She was also going to revamp the Restorative CNA's schedule and change their hours so they could help during the evening meals in both dining rooms. She indicated the residents on the Daisy Lane Unit were requiring more assistance now. This Federal Tag relates to Complaint IN00126416. 3.1-17(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to store and prepare food under sanitary conditions related to improper hand washing, lack of beard guards being worn and undated food in the freezer. This had the potential to effect 122 residents who received meals prepared in the kitchen. Findings include: 1. During the initial kitchen tour on 6/24/13 at 8:50 a.m., with the Dietary Manager, the following were observed: a. Dietary Aide (DA) #2 and DA #3 were not wearing beard guards. Interview with the Dietary Manager at that time, indicated they should have been wearing beard guards. b. In the walk in freezer, there were two roasts that were not labeled with a received on date. There was a bag of bagels that did not have a received	F000371	**What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.** ·One bowl of ice cream with plastic wrap covering not dated was discarded ·Two Roast found in freezer with no date was labeled and dated ·Bag of bagels found in freezer with no date on it was labeled and dated ·Bag of Parmesan Cheese found in freezer with no date, it was labeled and dated ·In-serviced Staff on Proper Handwashing and Glove Use ·In-serviced Staff on the use of Beard Covers/ masks ·In-serviced on Proper use of cleaning equipment: Wash, Rinse, Sanitize and Air Dry **How the facility will identify other residents having the potential to be affected by the same deficient practice** All areas are identified as having the potential to be affected by these alleged deficient practices. **The measures the facility will take or systems the facility will alter**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	on date. There was a bag of Parmesan cheese with no date on it. There was a bowl of ice cream with plastic wrap covering it that had no date on it. Interview with the Dietary Manager at that time, indicated all food should have the date it was received into the kitchen written on it. 2. During an observation in the kitchen on 6/28/13 at 11:25 a.m., a lid to a coffee pot fell on the floor. DA #1 picked it up with her ungloved hands, she rinsed it off with water and returned the lid to the coffee pot. She did not wash her hands. She then continued to prepare the lunch trays. An interview with DA #1 at that time, indicated she was unaware she should have washed her hands after picking an object up off the floor. A policy on hand washing and hand hygiene was received from the Assistant Director of Nursing on 6/26/13 at 9:16 a.m., it was dated August 2008 and identified as current. The policy indicated, "All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." 3.1-21(i)(3)		**to ensure that the problem will be corrected and will not recur. The facility must look at the existing system and determine if a change is necessary to correct the deficiency. If a system does not exist or if a revision to an existing system is necessary, then the facility must develop one.** Dietary Manager/Designee has conducted educational training with personnel on practicing the correct procedures of storing food, which includes labeling and dating, along with in-servicing on hand washing and proper glove use, following correct washing procedures and the wearing of beard covers Dietary Manager/Designee will audit the kitchen weekly to ensure proper storing of food by labeling and dating, beard covers are worn, hand washing and proper glove use is observed, and washing procedures are followed. **Quality Assurance** Dietary Manager/Designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, the Committee will continue to monitor quarterly through the QA process ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on record review and interview, the facility failed to ensure Pharmacy recommendations were implemented related to a gradual dose reduction for a resident receiving an antipsychotic medication for 1 of 10 residents reviewed for unnecessary medications. (Resident #126) Findings include: The record for Resident #126 was reviewed on 6/26/13 at 11:14 a.m. The resident's diagnoses included, but were not limited to, senile dementia and dementia with behavior disturbance. Review of the Pharmacy recommendation dated 1/22/13, indicated the resident had been receiving Risperidone (Risperdal) 0.5 mg twice a day since October 2012 along with Lorazepam (an antianxiety medication) 0.5 mg twice a day since	F000428	**F 428** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 126's clinical record was updated by her physician to include the clinical reasons for declining of the gradual dose reduction, including description of the resident's symptoms. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	October 2012 for anxiety and dementia with delusions. The recommendation indicated the following: "Please consider a gradual dose reduction, perhaps decreasing Risperidone to 0.5 mg daily while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated." The Physician declined the recommendation due to the resident's "symptoms got worse" with a previous gradual dose reduction. There was no description of what the resident's "symptoms" were. Interview with the Director of Nursing (DoN) on 6/28/13 at 3:00 p.m., indicated the Physician did not document what the resident's "symptoms" were related to previous attempts at a gradual dose reduction. 3.1-25(j)		All facility residents who have orders for psychotropic medications have the potential to be affected by the same alleged deficient practice. A letter with written examples was compiled and personally distributed to facility medical staff members identifying the facility's expectations of documentation specifics in relation to Gradual Dose Reductions. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The DON/ designee conducted educational training with licensed nurses on Gradual Dose Reductions (G.D.R's) with emphases given to: ·Specific time intervals ·If the GDR is clinically contraindicated then documentation must be provided by physician regarding these clinical contraindications by describing the specific resident target symptoms that would be worsened and likely impair the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
			resident's function or cause psychiatric instability. ·Licensed nurse's role in documentation of resident target symptoms that would be worsened and likely impair the resident's function or cause psychiatric instability. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Monthly the DON/Designee will review any gradual dose reductions declined by the attending physician to ensure that documented clinical contraindications are specific to resident's target symptoms are documented. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
			Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to	F000441	**F 441 What corrective action(s) will be accomplished**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	ensure infection control practices and standards were maintained related to, hand washing, cleaning of the glucometer, and exposed needles from insulin syringes for 1 of 1 observations of incontinence care, 1 of 2 observations of glucometers, and for 2 of 5 observations of insulin injections. (Resident's #G, #17, #102, #107, and #174) Findings include: 1. On 6/25/13 at 5:50 p.m., during the evening meal dining observation in the rainbow room, staff were observed bringing residents into the room. The Nursing staff were then observed using hand wipes to clean the residents' hands. At that time, the Activity Director was also observed helping with cleaning the residents' hands with the wipes. The Activity Director was using her bare hands to clean the residents' hands. She started cleaning Resident #17's hands with the wipes. After cleaning her hands, she threw away the wipes and grabbed new wipes and began cleaning Resident #102's hands. The Activity Director used her bare hands and did not use alcohol gel in between residents nor washed her hands with soap and water. After she was finished, she still did not use		**for those residents found to have been affected by the deficient practice;** R17 had no ill effects from having her hands cleaned. R 102 had no ill effects from having her hands cleaned. R 174 has had no ill effects from the insulin injection. R G had no ill effects from the insulin injection. R107 had no ill effects after receiving his ADL care. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. The activity director was in-serviced by the director of nursing/designee on the policy titled Handwashing/Hand Hygiene. L.P.N. #3 was in serviced on how to properly sanitize blood glucose meters and properly transport filled syringes. The facility has completed a staff in-service on hand washing using Glo Germ type products and black lights. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing/ designee in-serviced facility staff on the policies titled Handwashing/Hand Hygiene and Laundry and Bedding, Soiled with emphases	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	alcohol gel on her hands or wash her hands with soap and water. She then touched another resident's shoulder and then sat down at the desk and started typing on the computer. Interview with the Assistant Director of Nursing (ADoN) on 6/28/13, at 2:41 p.m., indicated her expectations for the Nursing staff was to wash their hands in between residents and after touching intact skin. 2. On 6/25/13 at 7:32 p.m. LPN #3 indicated none of the 5:30 p.m. glucometers were completed. At that time, she removed the glucometer from the medication cart and cleaned it with alcohol gel that she squirted onto a paper towel. She then wiped it down with another paper towel. At 7:34 p.m., she proceeded to obtain a blood glucose reading with the glucometer. After she was finished obtaining the glucometer reading, she returned to the cart and wrapped the glucometer with a Sani-Wipe (a germicidal wipe) at 7:36 p.m. The LPN indicated she was then going to obtain another blood glucose for a different resident. The LPN was then questioned on how long she leaves the Sani-Wipe in place. She indicated for two minutes. The LPN was unsure on how accurate the		given to: a. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. b. When assisting residents with hand washing at meal time staff must wash their hands for no less than 20 seconds using antimicrobial or non-antimicrobial soap and water or alcohol based hand rub containing 60-95% ethanol or isopropanol if hands are not visibly soiled with emphases given to compliance as follows: · before direct contact with residents. · after contact with a residents intact skin. · after contact with objects (e.g., residents linens and clothing). · before donning gloves and after removing gloves. c. Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g., gowns if soiling of clothing is likely). Employees must wash their hands for no less than 20 seconds using antimicrobial or non-antimicrobial soap and water with emphasis given to: · After handling items potentially contaminated with blood, body fluids, or secretions such as linens. The Director of Nursing/ designee and pharmacy nurse consultant in-serviced licenses staff on: a. how to properly sanitize blood glucose meters. b. different options to time the required sanitation period	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	timing of the two minutes would be, since she was not wearing a watch, there was no timer on top of the medication cart, nor was there a wall clock in plain sight. The LPN indicated the two minutes would "probably not" be accurate, since she had no way to tell the time lapse. Interview with the Assistant Director of Nursing (ADoN) on 6/28/13 at 2:55 p.m., indicated she was responsible for the Infection Control Process in the facility. She indicated the glucometer was to be cleaned with a Sani Wipe disinfectant/germicide and it was to be wrapped around the glucometer for two minutes. 3. On 6/25/13 at 7:40 p.m., LPN #3 was observed during medication pass. The LPN was drawing Insulin into a syringe, at that time she drew up two units of Novolog Insulin for Resident #174. She then proceeded to walk down to the resident's room. The needle for the syringe was exposed and not pulled back. The LPN entered the resident's room and placed the syringe with the needle exposed on the nightstand. She then applied clean gloves and administered the insulin injection. The LPN then walked back to her cart		including using an egg-type timer c. how to properly transport filled syringes **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON/ designee will observe five meals weekly to ensure staff are properly washing their hands when assisting residents with washing their hands before or after meals during. The DON/designee will observe 5 nurses weekly to ensure that proper sanitation of the blood glucose meter is completed and proper transportation of filled syringes is completed. The DON/designee will observe 5 nursing staff member weekly to ensure hand washing is completed with ADL care.. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	and disposed of the syringe into the needle box. At 8:23 p.m., the LPN then prepared an insulin injection for Resident #G. She drew up 25 units of Novolog Insulin into the syringe. At that time, the needle on the syringe was not pulled back. She walked down the hallway with the needle exposed and entered the resident's room. She then laid the syringe with the needle exposed on the bedside table. The LPN applied clean gloves and administered the insulin injection. Review of the undated current Safety Syringe Policy provided by the ADoN on 6/28/13 at 3:05 p.m., indicated "Fill syringe with medication while holding index finger against finger flange. Extend safety shield forward until you feel the positive stop and hear an audible snap. This will secure the safety shield for safe transportation to patient site." Interview with the ADoN on 6/28/13 2:55 p.m., indicated the needle on the insulin syringe should have been pulled back into a secured position to protect herself as well as other residents. 4. On 6/25/13 at 3:15 p.m., CNA #1 was observed providing care for Resident #107. The resident was laying on his bed, he was wearing an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	adult brief for urinary incontinence. Underneath the resident was a cloth pad and a fitted sheet. The fitted sheet under the cloth pad was wet. The brief and cloth pad were dry. The CNA changed the fitted sheet while the resident remained in bed. The CNA did not wash his hands or apply gloves. He then repositioned the resident, picked up the soiled fitted sheet and carried it into the hall where he placed it in the soiled laundry bin. He did not wash his hands afterward. Interview with CNA #1 on 6/25/13 at 3:30 p.m., indicated he did not wash his hands or apply gloves because he did not believe the wetness on the fitted sheet was urine. A policy for soiled laundry and bedding was received from the Assistant Director of Nursing (ADoN) on 6/26/13 at 9:16 a.m. The policy was dated August 2008, and identified as current. The policy indicated, "4. Anyone who handles soiled laundry must wear protective gloves." A policy for hand washing and hand hygiene was received from the ADoN on 6/26/13 at 9:16 a.m. The policy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	was dated August 2008, and identified as current. The policy indicated, "2. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:...c. After handling items potentially contaminated with blood, body fluids or secretions...". Further, the policy indicated, "4. The use of gloves does not replace hand washing/ hand hygiene." 3.1-18(b)(1) 3.1-18(l)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.			
	Based on observation and interview, the facility failed to ensure 2 of 2 bathtubs located within the facility were in operating condition. (The Pink and Blue shower rooms located on Main hall) Findings include: During the Environmental tour on 6/27/13 at 2:45 p.m., with the Maintenance and Housekeeping supervisors, the following was observed: a. The bathtubs located in the Pink and Blue shower rooms on the Main hall were not working. Interview with the Housekeeping supervisor at the time, indicated that he has worked at the facility for five years and the tubs have not worked since he has been there. Interview with the Maintenance supervisor at the time, indicated the tubs were going to be replaced but due to cost, they are going to be repaired instead. 3.1-19(bb)	F000456	1. What corrective Action will be accomplished for those residents found to have been affected by the deficient practice: Blue shower room tub has been repaired and parts are being ordered so that functionality can be resumed. Pink shower room tub will be removed. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents requesting a bath have the potential to be affected by the alleged deficient practice. Residents that have requested a tub bath have been informed that a tub will be available for their use.	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
			1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: Housekeeping supervisor/designee will complete a cleaning schedule of the tub to ensure that it is maintained per manufacturing guidelines. Licensed staff has been educated on cleaning process of tub, and to report to maintenance any functional concerns to ensure that tub stays in operating condition. 1.How the corrective action will be monitored to ensure the deficient practice will not recur; ie QA program put into place: Housekeeping and Maintenance Supervisor will present at the monthly Quality Assurance Committee Meeting to inform the Committee of:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
			· Progress towards and status of pending facility repairs and cleaning projects.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to stained and cracked floor tile, loose toilets, missing privacy hooks, loose drawer handles, lack of toilet paper holders, stained ceiling tiles, marred walls, doors, chairs and heat registers, and loose baseboard and plastic tile trim on 3 of 3 units throughout the facility. (The Main hall, Daisy Lane, and Bakersfield) Findings include: 1. During the Environmental tour on 6/27/13 at 1:45 p.m., with the Maintenance and Housekeeping supervisors, the following was observed on Daisy Lane: a. There was no toilet paper holder in the bathroom of Room 45. The toilet was also loose around the base. Two residents resided in this room. b. The walls located next to beds 1 and 2 in Room 46 were scratched and marred. There was a tear in the ceiling tile located above bed 1. The	F000465	**1. What corrective Action will be accomplished for those residents found to have been affected by the deficient practice:** Toilet Paper holders, ceiling tiles, privacy hooks, and drawer handles were replaced. Flooring and wall repairs were scheduled. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by the alleged deficient practice. **1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	privacy curtains for both bed 1 and 2 were missing privacy hooks. The plastic strip covering the tile located in the entry way to the room was missing. Two residents resided in this room. c. The floor tile in Room 48 was stained and discolored with wax build up. Further, the floor tiles were cracked along the edges. One resident resided in this room. d. The wall located next to the foot of bed 1 in Room 50 was scratched and marred. The handle on the drawer for the nightstand was loose and detached from the drawer. The ceiling tile in the bathroom was stained with an orange substance and there was no toilet paper holder. Two residents resided in this room. e. The wall behind the heads of beds 1 and 2 in Room 52 were scratched and marred. The door to the room and the closet door were also scratched and marred. The privacy curtain for bed 2 was missing hooks. The heat register was paint chipped and marred. There was no toilet paper holder in the bathroom as well as stained ceiling tiles. Two residents resided in this room.		Maintenance will follow a Preventative Maintenance Rounds tool to ensure that items are identified for repair and addressed timely throughout the facility. **1.How the corrective action will be monitored to ensure the deficient practice will not recur; ie QA program put into place:** Executive Director/Designee will make weekly rounds to validate cleaning and repair projects are being completed as scheduled. Large repairs and replacement items have been bid on and are in the process of replacement. The Maintenance Director/Designee will present a monthly summary of the progress towards and status of pending facility repairs and cleaning projects to the Quality Assurance Committee. This will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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. The floor tile in Room 53 was worn and cracked in sections. There was a faceplate for the electrical outlet that was not fastened to the wall. There was a small hole in the ceiling tile located by bed 2. Two residents resided in this room. g. The walls in Room 54 were scratched and marred. There were stained ceiling tiles in the bathroom. Two residents resided in this room. h. The floor mat located next to bed 1 in Room 55 was observed with torn areas. The walls in the room were scratched and marred. Two residents resided in this room. i. The walls in Room 57 were scratched and marred. The trim for the tile in the entry way of the room was missing. The floor tile throughout the room was worn and cracked along the edges. An accumulation of dead insects was observed in the light fixture in the bathroom. Two residents resided in this room. j. There were two holes in the wall above the baseboard located next to the entry doors of the unit. The base of the Janitor closet door was scratched and marred.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	k. The plastic tile trim located at the entry way of the dining room was missing. The walls throughout the dining room were scratched and marred. The heat registers located in the dining room were scratched and marred and had dried food spillage. Twelve dining room chairs had scratched arms and legs. The exit door was scratched and marred. The holder for the hand sanitizer located on the wall was loose. The tile located in the hall leading to the dining room was cracked and discolored. Twenty-six residents resided on the unit. l. The plastic edge of the handrail in the hallway was missing by the CNA charting station. m. The plastic light cover in the shower room was stained with a black substance. There were cracked ceramic tiles located by the entry way. There was an accumulation of dust in the ceiling vent located by the first shower stall. Twenty-six residents resided on this unit. 2. During the Environmental tour on 6/27/13 at 2:22 p.m., with the Maintenance and Housekeeping supervisors, the following was observed on the Bakersfield Unit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	a. The walls located in Room 58 were scratched and marred. The floor tile was worn and cracked along the edges. The heat register was paint chipped and marred. Two residents resided in this room. b. The walls located in Room 58 were scratched and marred. The floor tiles were worn and cracked around the edges. Two residents resided in this room. c. The floor tile in Room 61 was scuffed and discolored. Black marks were observed on the floor by bed 2. The base of the toilet was loose. Two residents resided in this room. d. A piece of ceramic wall tile located next to the heater in the bathroom of Room 64 was missing. Two residents resided in this room. e. There was an accumulation of debris in the ceiling light fixture cover in the bathroom of Room 66. The wall located behind the television was scratched and marred. Two residents resided in this room. f. There was a gouge on the wall near the door frame which was 8 inches by 4 inches in size in Room			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	68. Two residents resided in this room. g. There were stained ceiling tiles above bed 2 in Room 70. Two residents resided in this room. h. The Activity room had two cracked ceiling tiles. Eight chairs in the Activity room had scratched arms and legs as well as stained or faded seats. The door to the Activity room was scratched and marred. Twenty-six residents resided on this unit. i. The bottom shelf of the refrigerator in the Clean utility room had an accumulation of dried juice spillage and cracked plastic. Twenty-six residents resided on this unit. j. The grout throughout the floor tile in the shower room was discolored. The door frame was also paint chipped and marred. Twenty-six residents resided on this unit. k. The door and door frame in the dining room was scratched and marred. The wall along the chair rail was scratched and marred. The floor tile located beneath the hand sanitizing unit was cracked. 3. During the Environmental tour on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	6/27/13 at 2:49 p.m., with the Maintenance and Housekeeping supervisors, the following was observed on the Main hall: a. The bathroom walls in Room 9 were scratched and marred with areas of paint missing. The wall below the window was also scratched and marred. Two residents resided in this room. b. The plastic light fixture cover in Room 13 was loose and detached from the base. There was a hole in the plastic vent cover. Two residents resided in this room. c. An area of loose and missing base board near the bathroom door was observed in Room 14. The bathroom door was also scratched and marred. Two residents resided in this room. d. The bathroom door in Room 15 was scratched and marred. Two residents resided in this room. e. The wall behind the head of the bed in Room 18 was gouged and marred. One resident resided in this room. f. The floor tile in Room 19 was discolored. One resident resided in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	this room. g. The bathroom wall in Room 31 was scratched and marred. The base board located next to the bathroom door was torn at the corner. Two residents resided in this room. h. The grout throughout the floor tile was discolored in 2 of 2 common bathrooms located next to the Rainbow room. Seventy-three residents resided on the Main hall. i. The edge of the wall located across from the oxygen storage room was paint chipped and marred. j. Three of the chairs located in the Indiana dining room had scratched arms and legs. Seventy-three residents resided on the Main hall. k. There was a hole in the wall where the hoyer lifts were parked across from the Main Nurses' station. l. The grout throughout the floor tile in the Pink shower room was discolored. There was a hole in the wall behind the door in the bathroom. Seventy-three residents resided on this unit. m. The grout throughout the floor tile			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	was discolored in the Blue shower room. Two towel racks were loose across from shower stall 2. There were cracked ceramic tiles located on the outside of the bathroom door. Seventy-three residents resided on this unit. n. The edge of the wall at the Main Nurses' station located across from the Blue shower room was marred. o. Six floor tiles located next to the clean linen storage door were cracked. p. Sections of floor tile located in the Therapy and Restorative rooms were cracked. Interview with the Maintenance and Housekeeping supervisors at the time, indicated all of the above areas were in need of cleaning and/or repair. 3.1-19(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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
F000520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, record review and interview, the facility failed to ensure environmental issues related to urine odors, stained and cracked floor tile, loose toilets, missing privacy hooks, loose drawer handles, lack of toilet paper holders, stained ceiling tiles, marred walls, doors, chairs and heat registers, and loose baseboard and plastic tile trim on 3 of 3 units throughout the facility as well as infection control issues related to	F000520	**F 520** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	07/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	hand washing, cleaning of the glucometer, and exposed needles from insulin syringes for 1 of 1 observations of incontinence care, 1 of 2 observations of glucometers, and for 2 of 5 observations of insulin injections had been addressed by the Quality Assurance committee. (Resident's #G, #17, #102, #107, and #174) (The Main hall, Daisy Lane and Bakersfield Unit) Findings include: Interview with the Administrator on 6/28/13 at 10:30 a.m., indicated the Quality Assurance Committee met monthly. She indicated one of the way issues were brought to the meetings was based on what was found in the daily stand up meetings. She also indicated there was a monthly agenda. She also indicated the Maintenance and Housekeeping supervisors were not part of the Quality Assurance committee. When asked if the environmental or infection control issues related to hand washing, glucometer cleansing and needle exposure had been addressed in previous meetings, the Administrator indicated no. 1. On 6/25/13 at 5:50 p.m., during the evening meal dining observation		R17 had no adverse effects from having her hands cleaned. R102 had no adverse effects from having her hands cleaned. RG physician and family were updated. No new orders received. R174 physician and family were updated. No new orders received. R107 had no adverse effects having his ADL care provided. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All facility residents have the potential be affected by the alleged deficient practices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	in the rainbow room, staff were observed bringing residents into the room. The Nursing staff were then observed using hand wipes to clean the residents' hands. At that time, the Activity Director was also observed helping with cleaning the residents' hands with the wipes. The Activity Director was using her bare hands to clean the residents' hands. She started cleaning Resident #17's hands with the wipes. After cleaning her hands, she threw away the wipes and grabbed new wipes and began cleaning Resident #102's hands. The Activity Director used her bare hands and did not use alcohol gel in between residents nor washed her hands with soap and water. After she was finished, she still did not use alcohol gel on her hands or wash her hands with soap and water. She then touched another resident's shoulder and then sat down at the desk and started typing on the computer. Interview with the Assistant Director of Nursing (ADoN) on 6/28/13, at 2:41 p.m., indicated her expectations for the Nursing staff was to wash their hands in between residents and after touching intact skin. 2. On 6/25/13 at 7:32 p.m. LPN #3 indicated none of the 5:30 p.m.		Maintenance Supervisor was re-educated by the Facility Administrator the need to provide a weekly report of repair requests and their status. Housekeeping Supervisor was re-educated by the Facility Administrator the need to establish a schedule for all resident rooms and common areas identified as in need of cleaning and to provide a weekly status report. Activities Director was re-educated by the Facility Administrator regarding appropriate hand-washing and sanitizing techniques to be used when assisting with preparing residents for meal service(s). LPN 3 received 1:1 re-education from the Director of Nursing regarding glucometer cleaning requirements, including time interval during which disinfectant is to be applied AND the need for insulin syringe safety shields to be engaged. CNA 1 is no longer employed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	glucometers were completed. At that time, she removed the glucometer from the medication cart and cleaned it with alcohol gel that she squirted onto a paper towel. She then wiped it down with another paper towel. At 7:34 p.m., she proceeded to obtain a blood glucose reading with the glucometer. After she was finished obtaining the glucometer, she returned to the cart and wrapped the glucometer with a Sani-Wipe (a germicidal wipe) at 7:36 p.m. The LPN indicated she was then going to obtain another blood glucose for a different resident. The LPN was then questioned on how long she leaves the Sani-Wipe in place. She indicated for two minutes. The LPN was unsure on how accurate the timing of the two minutes would be, since she was not wearing a watch, there was no timer on top of the medication cart, nor was there a wall clock in plain sight. The LPN indicated the two minutes would "probably not" be accurate, since she had no way to tell the time lapse. Interview with the Assistant Director of Nursing (ADoN) on 6/28/13 at 2:55 p.m., indicated she was responsible for the Infection Control Process in the facility. She indicated the glucometer was to be cleaned with a		**What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DON/Designee conducted educational training with licensed professional staff on infection control procedures with emphases on hand-washing, glucometer cleaning and the required use of safety shields for transporting insulin syringes to resident care sites. The DON/Designee conducted educational training with non-licensed nursing staff on infection control procedures with emphases on hand-washing and incontinence care. The ADON/Designee conducted educational training with non-nursing staff on hand-washing and use of gloves. **How the corrective action(s) will be monitored to ensure the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	Sani Wipe disinfectant/germicide and it was to be wrapped around the glucometer for two minutes. 3. On 6/25/13 at 7:40 p.m., LPN #3 was observed during medication pass. The LPN was drawing Insulin into a syringe, at that time she drew up two units of Novolog Insulin for Resident #174. She then proceeded to walk down to the resident's room. The needle for the syringe was exposed and not pulled back. The LPN entered the resident's room and placed the syringe with the needle exposed on the nightstand. She then applied clean gloves and administered the insulin injection. The LPN then walked back to her cart and disposed of the syringe into the needle box. At 8:23 p.m., the LPN then prepared an insulin injection for Resident #G. She drew up 25 units of Novolog Insulin into the syringe. At that time, the needle on the syringe was not pulled back. She walked down the hallway with the needle exposed and entered the resident's room. She then laid the syringe with the needle exposed on the bedside table. The LPN applied clean gloves and administered the insulin injection. Review of the undated current Safety		**deficient practice will not recur, i.e. what quality assurance programs will be put in place:** The Maintenance and Housekeeping Supervisors will be required to attend the monthly Quality Assurance Committee Meeting to inform the Committee of: ·Issues raised and discussed at the monthly Safety Committee Meeting; ·Progress towards and status of pending facility repairs and cleaning projects. The Committee will track/trend infection control audits (**see F 441);** identified trends/patterns will require the development of a performance action plan that will be monitored by the committee at each meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	Syringe Policy provided by the ADoN on 6/28/13 at 3:05 p.m., indicated "Fill syringe with medication while holding index finger against finger flange. Extend safety shield forward until you feel the positive stop and hear an audible snap. This will secure the safety shield for safe transportation to patient site." Interview with the ADoN on 6/28/13 2:55 p.m., indicated the needle on the insulin syringe should have been pulled back into a secured position to protect herself as well as other residents. 4. On 6/25/13 at 3:15 p.m., CNA #1 was observed providing care for Resident #107. The resident was laying on his bed, he was wearing an adult brief for urinary incontinence. Underneath the resident was a cloth pad and a fitted sheet. The fitted sheet under the cloth pad was wet. The brief and cloth pad were dry. The CNA changed the fitted sheet while the resident remained in bed. The CNA did not wash his hands or apply gloves. He then repositioned the resident, picked up the soiled fitted sheet and carried it into the hall where he placed it in the soiled laundry bin. He did not wash his			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	hands afterward. Interview with CNA #1 on 6/25/13 at 3:30 p.m., indicated he did not wash his hands or apply gloves because he did not believe the wetness on the fitted sheet was urine. A policy for soiled laundry and bedding was received from the Assistant Director of Nursing (ADoN) on 6/26/13 at 9:16 a.m. The policy was dated August 2008, and identified as current. The policy indicated, "4. Anyone who handles soiled laundry must wear protective gloves." A policy for hand washing and hand hygiene was received from the ADoN on 6/26/13 at 9:16 a.m. The policy was dated August 2008, and identified as current. The policy indicated, "2. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:...c. After handling items potentially contaminated with blood, body fluids or secretions...". Further, the policy indicated, "4. The use of gloves does not replace hand washing/ hand hygiene."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	5. On 6/25/13 at 9:08 a.m., a strong urine odor was observed in the bathroom of Room 45. Two residents resided in this room. On 6/26/13 at 8:30 a.m., a strong urine odor was again observed in the bathroom. On 6/27/13 at 7:45 a.m., the strong urine odor remained in the bathroom. Further, the floor was damp where it had just been mopped by housekeeping. 6. On 6/24/13 at 3:18 p.m., a strong urine odor was observed in the bathroom of Room 54. Two residents resided in this room. 7. On 6/24/13 at 3:58 p.m., a strong urine odor was observed in the bathroom of Room 55. Two residents resided in this room. 8. During the Environmental tour on 6/27/13 at 1:45 p.m., with the Maintenance and Housekeeping Supervisors, the following was observed on Daisy Lane: a. The common bathroom located in the hall by the dining room was observed with a strong urine odor.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	b. The bathroom in Room 54 was observed with a strong urine odor. c. The bathroom in Room 45 was observed with a strong urine odor. Interview with the Housekeeping Supervisor at the time, indicated all of the above listed bathrooms had a urine odor. He indicated the bathrooms were to be cleaned daily and that Room 45 needed to be a priority. 9. During the Environmental tour on 6/27/13 at 1:45 p.m., with the Maintenance and Housekeeping supervisors, the following was observed on Daisy Lane: a. There was no toilet paper holder in the bathroom of Room 45. The toilet was also loose around the base. Two residents resided in this room. b. The walls located next to beds 1 and 2 in Room 46 were scratched and marred. There was a tear in the ceiling tile located above bed 1. The privacy curtains for both bed 1 and 2 were missing privacy hooks. The plastic strip covering the tile located in the entry way to the room was missing. Two residents resided in this room.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	c. The floor tile in Room 48 was stained and discolored with wax build up. Further, the floor tiles were cracked along the edges. One resident resided in this room. d. The wall located next to the foot of bed 1 in Room 50 was scratched and marred. The handle on the drawer for the nightstand was loose and detached from the drawer. The ceiling tile in the bathroom was stained with an orange substance and there was no toilet paper holder. Two residents resided in this room. e. The wall behind the heads of beds 1 and 2 in Room 52 were scratched and marred. The door to the room and the closet door were also scratched and marred. The privacy curtain for bed 2 was missing hooks. The heat register was paint chipped and marred. There was no toilet paper holder in the bathroom as well as stained ceiling tiles. Two residents resided in this room. f. The floor tile in Room 53 was worn and cracked in sections. There was a faceplate for the electrical outlet that was not fastened to the wall. There was a small hole in the ceiling tile located by bed 2. Two residents			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	resided in this room. g. The walls in Room 54 were scratched and marred. There were stained ceiling tiles in the bathroom. Two residents resided in this room. h. The floor mat located next to bed 1 in Room 55 was observed with torn areas. The walls in the room were scratched and marred. Two residents resided in this room. i. The walls in Room 57 were scratched and marred. The trim for the tile in the entry way of the room was missing. The floor tile throughout the room was worn and cracked along the edges. An accumulation of dead insects was observed in the light fixture in the bathroom. Two residents resided in this room. j. There were two holes in the wall above the baseboard located next to the entry doors of the unit. The base of the Janitor closet door was scratched and marred. k. The plastic tile trim located at the entry way of the dining room was missing. The walls throughout the dining room were scratched and marred. The heat registers located in the dining room were scratched and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	marred and had dried food spillage. Twelve dining room chairs had scratched arms and legs. The exit door was scratched and marred. The holder for the hand sanitizer located on the wall was loose. The tile located in the hall leading to the dining room was cracked and discolored. Twenty-six residents resided on the unit. l. The plastic edge of the handrail in the hallway was missing by the CNA charting station. m. The plastic light cover in the shower room was stained with a black substance. There were cracked ceramic tiles located by the entry way. There was an accumulation of dust in the ceiling vent located by the first shower stall. Twenty-six residents resided on this unit. 10. During the Environmental tour on 6/27/13 at 2:22 p.m., with the Maintenance and Housekeeping supervisors, the following was observed on the Bakersfield Unit. a. The walls located in Room 58 were scratched and marred. The floor tile was worn and cracked along the edges. The heat register was paint chipped and marred. Two			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	residents resided in this room. b. The walls located in Room 58 were scratched and marred. The floor tiles were worn and cracked around the edges. Two residents resided in this room. c. The floor tile in Room 61 was scuffed and discolored. Black marks were observed on the floor by bed 2. The base of the toilet was loose. Two residents resided in this room. d. A piece of ceramic wall tile located next to the heater in the bathroom of Room 64 was missing. Two residents resided in this room. e. There was an accumulation of debris in the ceiling light fixture cover in the bathroom of Room 66. The wall located behind the television was scratched and marred. Two residents resided in this room. f. There was a gouge on the wall near the door frame which was 8 inches by 4 inches in size in Room 68. Two residents resided in this room. g. There were stained ceiling tiles above bed 2 in Room 70. Two residents resided in this room.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	h. The Activity room had two cracked ceiling tiles. Eight chairs in the Activity room had scratched arms and legs as well as stained or faded seats. The door to the Activity room was scratched and marred. Twenty-six residents resided on this unit. i. The bottom shelf of the refrigerator in the Clean utility room had an accumulation of dried juice spillage and cracked plastic. Twenty-six residents resided on this unit. j. The grout throughout the floor tile in the shower room was discolored. The door frame was also paint chipped and marred. Twenty-six residents resided on this unit. k. The door and door frame in the dining room was scratched and marred. The wall along the chair rail was scratched and marred. The floor tile located beneath the hand sanitizing unit was cracked. 11. During the Environmental tour on 6/27/13 at 2:49 p.m., with the Maintenance and Housekeeping supervisors, the following was observed on the Main hall: a. The bathroom walls in Room 9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	were scratched and marred with areas of paint missing. The wall below the window was also scratched and marred. Two residents resided in this room. b. The plastic light fixture cover in Room 13 was loose and detached from the base. There was a hole in the plastic vent cover. Two residents resided in this room. c. An area of loose and missing base board near the bathroom door was observed in Room 14. The bathroom door was also scratched and marred. Two residents resided in this room. d. The bathroom door in Room 15 was scratched and marred. Two residents resided in this room. e. The wall behind the head of the bed in Room 18 was gouged and marred. One resident resided in this room. f. The floor tile in Room 19 was discolored. One resident resided in this room. g. The bathroom wall in Room 31 was scratched and marred. The base board located next to the bathroom door was torn at the corner. Two			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	residents resided in this room. h. The grout throughout the floor tile was discolored in 2 of 2 common bathrooms located next to the Rainbow room. Seventy-three residents resided on the Main hall. i. The edge of the wall located across from the oxygen storage room was paint chipped and marred. j. Three of the chairs located in the Indiana dining room had scratched arms and legs. Seventy-three residents resided on the Main hall. k. There was a hole in the wall where the hoyer lifts were parked across from the Main Nurses' station. l. The grout throughout the floor tile in the Pink shower room was discolored. There was a hole in the wall behind the door in the bathroom. Seventy-three residents resided on this unit. m. The grout throughout the floor tile was discolored in the Blue shower room. Two towel racks were loose across from shower stall 2. There were cracked ceramic tiles located on the outside of the bathroom door. Seventy-three residents resided on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342	

(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
	this unit. n. The edge of the wall at the Main Nurses' station located across from the Blue shower room was marred. o. Six floor tiles located next to the clean linen storage door were cracked. p. Sections of floor tile located in the Therapy and Restorative rooms were cracked. Interview with the Maintenance and Housekeeping supervisors at the time, indicated all of the above areas were in need of cleaning and/or repair. 3.1-52(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(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