

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 11/20/2014
--	---	--	---

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
F000000	<p>This survey was for the Investigation of Complaint IN00159503.</p> <p>Complaint IN00159503-Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F323.</p> <p>Survey date: November 20, 2014</p> <p>Facility number: 000366 Provider number: 155469 AIM number: 100288900</p> <p>Survey Team: Heather Tuttle, RN-TC Lara Richards, RN Yolanda Love, RN Cynthia Stramel, RN</p> <p>Census bed type: SNF/NF: 116 Total: 116</p> <p>Census payor type: Medicare: 8 Medicaid: 101 Other: 7 Total: 116</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings</p>	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 deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 11/20/2014
--	---	--	---

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
F000282 SS=E	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November 22, 2014, by Janelyn Kulik, RN.</p> <p>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.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders, as well as, the plan of care were being followed as written related to the use of bed and chair alarms and non-skid socks for 4 of 7 sampled residents. (Resident #C, #E, #F, & #G)</p> <p>Findings include:</p> <p>1. On 11/20/14 at 9:05 a.m., Resident #E was observed in her wheelchair in the Rainbow Room. The resident had a chair alarm attached to the back of her wheelchair. The alarm was checked by LPN #1 at the time and it was not functioning.</p> <p>The record for Resident #E was reviewed on 11/20/14 at 10:14 a.m. The resident's diagnoses included, but were not limited</p>	F000282	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident E was provided with a new wheelchair alarm. Resident E suffered no ill effects due to wheelchair alarm not sounding.</p> <p>Resident G was provided with a new bed alarm. Resident G suffered no ill effects due to alarm not sounding and not having non-skid socks. An interdisciplinary meeting was held to review Resident G's plan of care and non-skid socks were discontinued as a fall intervention. Resident G's care plan has been updated to reflect the change.</p> <p>Resident F's wheelchair alarm has been discontinued and care plan updated per interdisciplinary</p>	12/08/2014

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 11/20/2014	
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			
	<p>to, Alzheimer's disease, senile dementia and history of falls. A Physician's order dated 3/31/14 and listed on the 11/2014 Physician's order summary (POS), indicated the resident was to have a chair alarm while seated in the wheelchair. The alarm was to be checked for placement and function every shift.</p> <p>The plan of care dated 3/29/12, which was reviewed 9/2014, indicated the problem of "resident has history of falling related to decreased safety awareness." The approaches included, but were not limited to, chair and bed alarm.</p> <p>Interview with LPN #1 on 11/20/14 at 9:05 a.m., indicated the resident's wheelchair alarm was not functioning. 2. On 11/20/14 at 8:58 a.m., Resident #G was observed laying in her bed, there was a sensor alarm on the bed. CNA #1 and LPN #1 assisted the resident turning in her bed, but the alarm did not sound. The LPN indicated the alarm was not functioning properly.</p> <p>Another observation was made on 11/20/14 at 11:25 a.m. with CNA #1. The resident was in bed, she had regular socks on, they were not non skid socks. The CNA looked in her drawers and indicated the resident did not have any</p>		<p>review.</p> <p>Resident C's bed alarm has been discontinued and care plan updated perinterdisciplinary review.</p> <p>How the facility will identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken;</p> <p>All facilityresidents using assistive devices such as alarms- nonskid socks have thepotential to be affected by the same alleged deficient practice.</p> <p>A facility auditof bed and chair alarms has been completed to check for proper placement and functionand to identify residents who no longer require the use of a bed or chairalarm.</p> <p>A facilityaudit was completed to identify residents who have non-skid socks as a fallintervention to ensure non-skid socks are available for resident's use.</p> <p>The facilityheld an interdisciplinary meeting to identify residents who no longer requirethe use of a bed/chair alarm or non-skid socks. The orders, care plans, and care cards have been updated</p>				

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 11/20/2014	
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			
	<p>non skid socks. The care card in the resident's closet did not indicate the resident should have on non skid socks.</p> <p>The record for Resident #G was reviewed on 11/20/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, psychosis, anxiety and weakness.</p> <p>The Annual Minimum Data Set assessment dated 9/24/14 indicated the resident had a BIMS (Brief Interview for Mental Status) score of 11, which indicated moderate cognitive impairment. The resident needed limited assistance with transferring.</p> <p>A care plan dated 1/17/14 indicated the resident was at risk for falls related to weakness and decreased safety awareness. Interventions included to wear non skid socks when in bed. The care plan for falls was updated on 11/10/14 and included to assess for appropriate footwear and to have a bed alarm in place and checked every shift.</p> <p>Interview with the Administrator on 11/20/14 at 1:45 p.m., indicated a house wide audit had just been completed on the bed and chair alarms. She further indicated the alarms should be checked by staff for proper functioning prior to placing them on the residents.</p>		<p>accordingly.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Director of Nursing/ designee in-serviced nursing staff on the Following;</p> <ul style="list-style-type: none"> ·Following physician's orders and care plans related to checking for placement and function of alarms prior to placing them on the residents. ·Following physician orders and the plan of care related to checking function of bed and chair alarms to ensure they are in working order and the battery is still functional. ·Following physician's orders and plan of care related to non-skid socks and ensuring they are available for use when needed. ·How to check for proper function of an alarm and identify when the battery is running low. ·How to change the battery of an alarm. ·Where to find replacement alarms and batteries for beds and chairs when needed. <p>How the corrective action(s)</p>				

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 11/20/2014
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	
	<p>3. On 11/20/14 at 8:55 a.m., Resident #F was observed sitting in her wheelchair. There was a personal alarm on the wheelchair. When CNA #1 helped the resident stand up, the alarm did not sound. The CNA wiggled the wires around on the alarm, then the alarm started beeping. LPN #1 indicated at that time the alarm was not working properly.</p> <p>The record for Resident #F was reviewed on 11/20/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, dementia with delusions and a history of falls.</p> <p>The Quarterly Minimum Data Set assessment dated 10/22/14 indicated the resident had severe cognitive impairment and she required extensive assistance for transferring.</p> <p>A care plan dated 3/6/14 was for risk of fall related to decreased safety awareness and dementia. The approaches included to have a chair alarm, the placement and function were to be checked each shift.4. On 11/20/14 at 9:15 a.m., during a brief initial tour of the facility with the Assistant Director of Nursing (ADON), Resident #C was observed in her room. The resident was in bed, awake, and dressed in street clothes. A bed alarm</p>		<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>Five days a week, the DON/ designee will observe ten residents, auditing to include all three shifts, to ensure residents with orders for alarms have alarms placed on beds/chairs as ordered and that they are working properly.</p> <p>Five days a week, the DON/ designee will observe ten residents, auditing to include all three shifts, to ensure residents with non-skid socks as a fall intervention have them available for use and they are being used per plan of care.</p> <p>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.</p>		

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 11/20/2014
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=D	<p>was observed, it was not flashing. The ADON repositioned the resident in the bed, the bed alarm did not sound. She then pulled the alarm pad out from underneath the resident, the bed alarm did not sound. The bed alarm was then turned on, the bed alarm did not sound.</p> <p>Review of the Physician's Orders dated 9/19/14 indicated, may have bed alarm while in bed every shift.</p> <p>The plan of care dated 4/23/14 indicated, resident at risk for falling related to cognition and diagnosis of difficulty walking. The interventions included, but were not limited to, bed alarm while in bed.</p> <p>Interview with the ADON at the time of the observation indicated the bed alarm was not functioning properly and was probably in need of new batteries.</p> <p>This Federal Tag relates to Complaint IN00159503</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident</p>				

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 11/20/2014
--	---	--	---

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
	<p>hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure safety measures were in place for a resident with a history of recent falls for 1 of 7 residents reviewed for accidents. (Resident #G)</p> <p>Findings include:</p> <p>On 11/20/14 at 8:58 a.m., Resident #G was observed laying in her bed, there was a sensor alarm on the bed. CNA #1 and LPN #1 assisted the resident turning in her bed, but the alarm did not sound. The LPN indicated the alarm was not functioning properly.</p> <p>Another observation was made on 11/20/14 at 11:25 a.m. with CNA #1. The resident was in bed, she had regular socks on, they were not non skid socks. The CNA looked in her drawers and indicated the resident did not have any non skid socks. The care card in the resident's closet did not indicate the resident should have on non skid socks.</p> <p>The record for Resident #G was reviewed on 11/20/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, psychosis, anxiety and weakness.</p>	F000323	<p>F 323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident G was provided with a new bed alarm. Resident G suffered no ill effects due to alarm not sounding and not having non-skid socks. An interdisciplinary meeting was held to review Resident G's plan of care and non-skid socks were discontinued as a fall intervention. Resident G's scare plan has been updated to reflect the change.</p> <p>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 using assistive devices such as alarms- non skid socks have the potential to be affected by the same alleged deficient practice. A facility audit of bed and chair alarms has been completed to check for proper placement and function and to identify residents who no longer require the use of a bed or chair alarm. A facility audit was completed to identify residents who have non-skid socks as a fall intervention to ensure non-skid socks are available for resident's use. The facility held an interdisciplinary meeting to identify residents who no longer</p>	12/08/2014

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 11/20/2014	
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			
	<p>The Annual Minimum Data Set assessment dated 9/24/14 indicated the resident had a BIMS (brief interview for mental status) score of 11, which indicated moderate cognitive impairment. The resident needed limited assistance with transferring.</p> <p>An Event Report dated 11/9/14 at 9:00 a.m., indicated the resident was found sitting on the floor in her room, she indicated she had slid to the floor.</p> <p>An Event Report dated 11/10/14 at 12:15 p.m., indicated the resident was found laying on the floor in her room. The cause of the fall was unknown.</p> <p>A Progress note dated 11/10/14 at 10:35 a.m., indicated the Interdisciplinary Team reviewed the resident's care plan and added interventions.</p> <p>A care plan dated 1/17/14 indicated the resident was at risk for falls related to weakness and decreased safety awareness. Interventions included to wear non skid socks when in bed. The care plan for falls was updated on 11/10/14 and included to assess for appropriate footwear and to have a bed alarm in place and checked every shift.</p>		<p>require the use of a bed/chair alarm or non-skid socks. The orders, care plans, and care cards have been updated accordingly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Director of Nursing/ designee in-serviced nursing staff on the Following;</p> <ul style="list-style-type: none"> ·Following physician's orders and care plans related to checking for placement and function of alarms prior to placing them on the residents. ·Following physician orders and the plan of care related to checking function of bed and chair alarms to ensure they are in working order and the battery is still functional. ·Following physician's orders and plan of care related to non-skid socks and ensuring they are available for use when needed. ·How to check for proper function of an alarm and identify when the battery is running low. ·How to change the battery of an alarm. ·Where to find replacement alarms and batteries for beds and chairs when needed. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>Five days a week, the DON/</p>				

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 11/20/2014
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 Federal Tag relates to Complaint IN00159503 3.1-45(a)(2)		designee will observe tenresidents, auditing to include all three shifts, to ensure residents withorders for alarms have alarms placed on beds/chairs as ordered and that theyare working properly. Five days a week, the DON/ designee will observe tenresidents, auditing to include all three shifts, to ensure residents withnon-skid socks as a fall intervention have them available for use and they arebeing used per plan of care. TheDON /designee will present a summary of the audits to the Quality Assurancecommittee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditingand monitoring will be done quarterly and present quarterly at the QAmeeting. Monitoring will be on going.		