

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  03/07/2014
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NAME OF PROVIDER OR SUPPLIER  SEBO'S NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342
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F000000	<p>This visit was for the Investigation of Complaints IN00144553 and IN00145369.</p> <p>Complaint IN00144553- Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, and F226.</p> <p>Complaint IN00145369- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: March 6 &amp; 7, 2014</p> <p>Facility number: 000366 Provider number: 155469 AIM number: 100288900</p> <p>Survey team: Janet Adams, RN-TC Heather Hite, RN March 7, 2014</p> <p>Census bed type: SNF/NF: 122 Total: 122</p> <p>Census payor type: Medicare: 13 Medicaid: 93</p>	F000000	<p><b>Sebo's Nursing and Rehabilitation</b> 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. The facility would like to request a desk review</p>	

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.

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F000223 SS=D	<p>Other: 16 Total: 122</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on March 11, 2014, by Janelyn Kulik, RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, record review, and interview, the facility failed to ensure residents remained free of abuse related to staff responding to a resident's behavior with statements implying the resident could be sent to the hospital related to her behavior for 1 of 3 abuse allegations reviewed. (Resident #G) (QMA #1)</p> <p>Findings include:</p>	F000223	<p><b>Sebo's Nursing and Rehabilitation</b> 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. <b>F 223 (d) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> RG had no adverse</p>	03/25/2014			

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	<p>On 3/6/14 at 5:04 p.m., Resident #G was observed sitting at a table in the Daisy Lane Dining Room. The resident's dinner meal had not yet been served.</p> <p>On 3/6/14 at 5:40 p.m., the resident was observed sitting at the table in the Dining Room. The resident was eating her meal. The resident was observed telling another female resident at the table "You have a knife there, use your knife." Resident #G then moved a plate with a brownie on it closer to another female resident residing at the table. Resident #G then told the other resident to use her silverware.</p> <p>The record for Resident #G was reviewed on 3/6/14 at 7:45 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, depressive disorder, diabetes mellitus, dementia without behaviors, alcoholic liver cirrhosis, explosive personality disorder, and undifferentiated chronic schizophrenia. The resident was sent to the hospital on 2/1/14 and was re-admitted to the facility on 2/10/14.</p> <p>Review of a 2/11/14 Abuse/Neglect Risk Observation note indicated the resident's total score was (8). The note indicated a score of (4) or more required care planning.</p>		<p>effects from the alleged deficientpractice. <b>How the facility willidentify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken:</b> All facility residents have the potential be affected by thealleged deficient practices. Social Service Director completes an abuse risk observationupon admission to determine at what level residents are at risk. Residents whopresent with a risk are care planned for interventions to reduce risk. Residents who present at a greater risk perthe observation tool were reviewed to ensure care plans interventions are inplace. QMA 1 is no longer employed. Nursing Supervisor #1 is no longer employed. <b>What measures will beput in place or what systemic changes will be made to ensure that the deficientpractice does not recur:</b> The Administrator and DON conducted educational trainingwith licensed professional staff and non-nursing staff on the Abuse PreventionProgram with emphases on protecting the resident, appropriate terms to use whenredirecting residents, and immediate notification to the Administrator. The Administrator/Designee will present resident rightspertaining to abuse at the next resident council meeting to ensure theresidents are aware of our</p>		

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	<p>A Care Plan initiated on 4/18/2011 indicated the resident was at risk for abuse/neglect related to diagnoses of depression, dementia, and schizoaffective disorder. The Care Plan was lasted updated on 1/7/14 and 2/17/14. Care plan interventions included for staff to monitor the resident for changes in mood and behaviors, allow the resident to voice concerns and feelings, observe the resident for emotional distress or changes in mood. A 2/14/14 Evaluation Note on the Care Plan indicated "episode of suspected verbal abuse, resident presents with no signs of emotional distress."</p> <p>Review of the 12/26/13 MDS (Minimum Data Set) annual assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (6). A score of (6) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident had no physical or verbal behaviors during the MDS assessment period.</p> <p>Review of a 1/28/14 Behavioral Medicine Progress Note indicated the resident's mood was within normal limits, she was coherent and her thought process was scattered. The note also indicated she had no delusions or hallucinations, and her affect was within</p>		<p>Abuse Prevention Program. <b>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 in place:</b> The Administrator/Designee will make walking rounds 3 times a week to observe care and interactions between residents and staff to ensure that proper redirection is taking place. The Administrator/Designee will also review Abuse Prevention Program during walking rounds with at least 2 staff, 3 times a week on all shifts to ensure that program is understood and is being followed. The Administrator/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.</p>				

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	<p>normal limits. The note also indicated the resident engaged in conversation readily, had short and long term memory deficits, and no new behavioral disruptions or distress.</p> <p>A Progress note completed by the Nurse Practitioner on 2/11/14 indicated the resident had been readmitted from the hospital. The note indicated the resident had been treated for altered mental status, agitation and aggressive behavior, and an urinary tract infection.</p> <p>The February 2014 Social Service Progress Notes were reviewed. An entry made on 2/1/14 at 7:23 p.m., indicated the Social Service staff entered the dining room and witnessed the resident pacing, screaming obscenities at staff, and calling names. The Social Service staff members attempted to escort the resident out of the area and attempted to redirect the resident. The entry also indicated the resident displayed verbal aggression towards staff members when staff intervened when the resident has been observed to have "jerked mothers wheelchair, who is also a resident, almost causing a fall in attempts to transfer mother." The Physician was notified and orders were received to send the resident to the hospital for evaluation. An entry made on 2/14/14 at 12:34 p.m., indicated</p>			

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	<p>Social Service staff spoke with Resident #G's daughter and informed her of "suspected verbal abuse towards resident."</p> <p>The February 2014 Nursing Progress Notes were reviewed. An entry made on 2/1/14 at 6:01 p.m. indicated the resident was observed yelling and using profanity towards staff in the Activity/Dining Room at approximately 4:15 p.m. The entry also indicated the resident was attempting to push her mother's (also a resident in the facility) wheelchair and staff attempted to redirect the resident. The resident became aggressive and combative towards staff. The Physician was notified and orders were obtained to send the resident to the hospital Emergency Room.</p> <p>The 2/13/14 Nursing Progress Notes were reviewed. An entry made on 2/13/14 at 9:35 a.m. indicated the resident was alert, verbal, and orientated to self. The entry also indicated the resident denied pain or discomfort.</p> <p>An Incident Report Form dated 2/13/14 was reviewed. The form indicated Resident #G was involved. The form alleged QMA #1 spoke inappropriately to Resident #G. The report indicated no injuries were noted. The Immediate</p>			

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	<p>Action listed on the form indicated QMA #1 was suspended, the resident's Physician and family were notified, and an investigation was started. The Follow-up indicated QMA #1 stated he was attempting to redirect the resident as Resident #G was attempting to assist other residents and they were becoming agitated. The form also indicated other staff members present stated the tone QMA #1 used when speaking to the resident was inappropriate. The form also indicated QMA #1 indicated he was frustrated and could have handled the situation better.</p> <p>The facility investigation indicated interviews were obtained from staff members present at the time of the occurrence. Interview were obtained from one QMA, two CNA's and an LPN who were present at the time of the incident. The interviews of the two CNA's were obtained by and written by the LPN Supervisor on 2/13/14 at the time the Director of Nursing notified her of the incident.</p> <p>Nursing Supervisor #1 completed an interview with CNA #1 on 2/13/14 and wrote the CNA's statement down. The written report indicated CNA #1 indicated "Resident was trying to assist her mother with dinner. QMA #1 stated</p>			

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	<p>to the resident "can you go sit down and eat your dinner and we will help your Mom." The resident then stated "Why do I have to sit down?" and the QMA stated to the resident "You don't want to be sent out to the hospital like I sent you out before". The resident then stated she wanted a straw and the QMA removed all the straws from the Medication Cart and walked down the hall. The resident then called the QMA a derogatory word. The CNA indicated the Charge Nurse was there and did not intervene with the QMA and the resident.</p> <p>Nursing Supervisor #1 also completed an interview with CNA #2 on 2/13/14 and wrote the CNA's statement down. The written report indicated CNA #2 indicated the resident was trying to assist her mother with dinner and QMA #1 told the resident to "go back to your own seat." The resident replied she did not have to sit down and QMA #1 stated "You don't want me to send you back out to the hospital like I did before." CNA #2 indicated the resident asked for a straw and the QMA removed all the straws from the Medication Cart and walked down the hall. The resident then called the QMA a derogatory term as he walked down the hall. The CNA also indicated a family member asked her to remove his loved one (another resident)</p>				

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	<p>from the Dining Room at this time. CNA #2 also indicated the Charge Nurse was in Dining Room at the time of the above and did not intervene with the QMA and the resident.</p> <p>A written report of an interview done with QMA #1 on 2/17/14 was reviewed. The report indicated the Administrator and the DON (Director of Nursing) completed the interview over the phone and documented the interview. The report indicated QMA #1 stated he was trying to redirect the resident as she was getting agitated and wanting to help her mother with the meal. The QMA spoke with her several times and tried to redirect the resident and she seemed to get worse. The QMA indicated he did tell the resident that he didn't want to send her back to the hospital because he knew she didn't like to go to the hospital and he thought that would help her.</p> <p>The facility Administrator and the DON (Director of Nursing) were interviewed on 3/7/14 at 9:45 a.m. related to reported incident for Resident #G.</p> <p>The facility Administrator indicated she was not in the facility at the time of the 2/13/14 incident involving Resident #G. The Administrator indicated the DON called her at the time the incident was</p>			

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	<p>reported to her.</p> <p>The DON indicated she was not in the facility at the time of the above incident. The DON indicated she received a call from the facility on her phone and no message was left. The DON indicated she did not know who the call was from. The DON indicated she then called the facility back and talked to the Nurse on the Daisy Lane. This Nurse was LPN #1. The LPN informed her there was a behavior on the unit involving Resident #G. The LPN indicated to her that QMA #1 was trying to redirect the resident and the resident's behaviors were getting worse. The QMA then said to resident a statement such as you don't want to go back to the hospital. The DON indicated she then informed LPN#1 the QMA should not have redirected the resident in that manner and instructed the Nurse to send the QMA home at this time. The DON indicated she then spoke with the Evening Nursing Supervisor who was present in the facility at the time and instructed the Evening Supervisor to go to the Daisy Lane Unit where the above incident occurred and LPN #1 was then sent home for failure to notify the DON or the Administrator and failure to intervene in the QMA's redirection attempts. The DON indicated the Evening Supervisors began interviewing</p>				

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	<p>the staff present in the Daisy Lane Dining Room at the time of the incident with Resident #G.</p> <p>The facility Administrator indicated LPN #1 was interviewed the night of the allegation and was suspended at that time. The LPN was told not to report back to work until they spoke with her again. The Administrator indicated the QMA was spoken to on the night of the incident and indicated he was agitated when interventions did not work but he thought he was doing the right thing at the time.</p> <p>The Administrator indicated the allegation of verbal abuse was not substantiated as they felt the QMA was attempting to redirect the resident. The Administrator indicated the QMA's tone may not have been appropriate when attempting to redirect the resident.</p> <p>When interviewed on 3/7/14 at 2:45 p.m., the facility Administrator indicated the QMA's statements to the resident were not intentional. The Administrator indicated Resident #G had behaviors that escalated in the past and the resident had similar behaviors that started and had to be sent to the hospital and the QMA was trying to intervene to negate her having to go the hospital for behaviors as she had before.</p>			

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	<p>The facility policy titled "Abuse Prevention Program" was reviewed on 3/7/14 at 9:00 a.m. There was no date on the policy. The facility Administrator provided the policy. The policy indicated facility prohibited any mistreatment, neglect, or abuse. The policy indicated Employees were required to report any incident, allegation or suspicion of abuse, neglect, or misappropriation to the Administrator or an immediate supervisor, who then must immediately report it to the Administrator.</p> <p>This Federal tag relates to Complaint IN00144553.</p> <p>3.1-27(a)</p>				