

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 09/30/2014
--	---	--	---

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 visit was for the Investigation of Complaints IN00156476, IN00157021, and IN00157146.</p> <p>Complaint IN00156476-Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00157021-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00157146- Substantiated. Federal/State deficiency related to the allegation was cited at F156.</p> <p>Survey dates: September 29 & 30, 2014</p> <p>Facility number: 000366 Provider number: 155469 AIM number: 100288900</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: SNF/NF: 122 Total: 122</p> <p>Census payor type: Medicare: 14 Medicaid: 96</p>	F000000	<p>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.</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.

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 09/30/2014	
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			
F000156 SS=D	<p>Other: 12 Total: 122</p> <p>Sample: 5</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>Quality review completed on October 1, 2014, by Janelyn Kulik, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>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.</p> <p>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</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 09/30/2014
--	---	--	---

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>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.</p> <p>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.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>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.</p> <p>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;</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 09/30/2014
--	---	--	---

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>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.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>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, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure a Medicare/Medicare Advantage Plan Non-coverage Letter was given to a resident/Responsible Party in a timely manner for 1 of 2 residents reviewed for liability services of the 2 who met the criteria for liability services. (Resident #D)</p> <p>Findings include:</p> <p>During a telephone interview, Resident #D's Responsible Party indicated she had been informed by the facility Resident #D's Medicare Advantage Plan would no longer cover the resident's stay on 09/29/14. She indicated she had not been issued a letter or the opportunity to</p>	F000156	<p>1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>Resident D responsible party was contacted via phone during discharge process and was made aware of the termination of Medicare Advantage Plan Services. Resident D family member was contacted during survey and appeal rights were reviewed over the phone. The certified letter providing all appeal rights and notices was mailed to her same day. Responsible party verbalized understanding of the ending of benefits and was not interested in an appeal. Resident was discharged as planned 4 days later.</p> <p>1. How other residents having</p>	10/13/2014

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 09/30/2014	
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>appeal the decision to not cover the resident's stay.</p> <p>Resident #D's record was reviewed on 09/29/14 at 10:45 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and anxiety.</p> <p>A Progress Note, dated 09/24/14 at 1:59 p.m., indicated the Interdisciplinary Team met with the resident and the Responsible Party and discussed the last day of Medicare Advantage Plan coverage would be 09/29/14 and the facility would assist the Responsible Party in finding placement for the resident in another facility closer to the Responsible Party.</p> <p>During an interview on 09/30/14 at 11:15 a.m., the Administrator indicated a Non-coverage Letter had not been given to the Resident's Responsible Party. She indicated the Responsible Party was notified on 09/11/14 about the possible non-coverage and the Responsible Party voiced no concerns. She indicated the Responsible Party was not given the information to appeal the decision for non-coverage. She indicated the resident would have had to private pay for the stay at the facility after 09/29/14 but now the facility was aware the Non-coverage was not given, and the resident will continue</p>		<p>the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>Residents with the potential to be affected by this alleged deficient practice for advance notice to Medicare Beneficiaries within the last 30 days were reviewed for compliance.</p> <p>1. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>Social Services and Admissions were educated on the Medicare Advantage Plan Non-Coverage Letter process.</p> <p>1. How the corrective action will be monitored to ensure the deficient practice will not recur; ie QA program put into place:</p> <p>Executive Director/Designee will review Medicare Advantage Plan residents during weekly review to ensure that Non-Coverage Letters are given as required.</p> <p>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.</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 09/30/2014
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>coverage from the Medicare Advantage Plan due to Physical Therapy. She indicated a Medicare Advantage Plan Non-coverage Letter was given to the Responsible Party by telephone on 09/30/14 at 11:34 a.m. and a Certified Letter would be sent.</p> <p>This Federal Tag relates to complaint IN00157146.</p> <p>3.1-4(a)</p>				