STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155432	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY HEALTH CARE & REHABILITATION CENTER	910 W WALNUT ST ALBANY, IN 47320

(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. Survey dates: April 28, 29, 30, May 1, 2, 2014 Facility number: 000309 Provider number: 155432 AIM number: 100288960 Survey team: Ginger McNamee, RN, TC Karen Lewis, RN Tina Smith-Staats, RN Toni Maley, BSW (April 28, 30, May 1, 2, 2014) Karen Koeberlein, RN (May 1, and 2, 2014 Census bed type: SNF: 3 SNF/NF: 69 Total: 72 Census payor type: Medicare: 4 Medicaid: 49 Other: 19 Total: 72 These deficiencies also reflect state findings in accordance with 410 IAC	F000000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by Albany Health & Rehab Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This Plan of Correction is Albany Health & Rehab Center's credible allegation of compliance. This facility respectfully requests paper compliance.	

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.

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	16.2. Quality review completed by Debora Barth, RN.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or			

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	interested family member. Based on record review and interview, the facility failed to ensure the physician was notified of a significant change of condition for 1 of 1 resident reviewed for significant change (Resident #17), and failed to notify the physician of laboratory results for 1 of 5 residents reviewed for unnecessary medications (Resident #21). Findings include: 1. The clinical record for Resident #17 was reviewed on 4/30/14 at 3:29 p.m. Diagnoses for the resident included, but were not limited to, renal failure, diabetes mellitus, and hypertension. A nursing note entry, dated 4/30/14 at 6:25 a.m., indicated "At approximately 0400 [4:00 a.m.] resident was only responsive to painful stimuli, found pulse ox [oximetry] to be 70%. Resident skin was ashen and clammy. Immediately placed on oxygen at 3l [liters] per N/C [nasal cannula]. O2 [oxygen] sat [saturation] up to 78% after 20 minutes. Notified resident son [name] and made aware of condition. At 0440 [4:40 a.m.] change resident to mask and O2 sat increased to 88%. At time of leaving for dialysis O2 sat was 89%."	F000157	1.Event for Resident #17 happened in the past so the facility is unable to correct. The physician was notified of labs from 3/11/14 and 3/13/14 for Resident #21. 2.Audits will be completed of all resident documentation and lab results since 4/14/14 to identify any other residents affected and physicians to be notified as appropriate. 3.DON/designee will review lab results at least 2X/week to ensure physician notification occurred. DON/designee will review the 24 hour report 5X/week to ensure physician notification is completed with any resident change of condition. 1:1 re-education will be provided to nurses who do not complete physician notification as necessary. Licensed staff in-services will be held May 21st-May 23rd, 2014 on Policy for Physician notification. 4.Results of the audits will be forwarded to QA monthly for review x 3 months, then quarterly for a total of 6 months. 5.Date of compliance: June 1, 2014.	06/01/2014

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	During an interview with the RN Consultant on 5/1/14 at 2:03 p.m., additional information was requested related to physician notification of the significant change for Resident #17 on 4/30/14. The facility failed to provide any additional information as of exit on 5/2/14. 2. The clinical record for Resident #21 was reviewed on 4/29/14 at 2:42 p.m. Diagnosis for the resident included, but were not limited to, hyperlipidemia, congestive heart failure, diabetes, hypertension, anemia, and hypothyroidism. Complete Blood Count (CBC), Comprehensive Metabolic Profile (CMP), lipid panel, Thyroid Stimulating Hormone (TSH), HemaglobinA1C, and digoxin level laboratory (lab) results completed on 3/11/14 and 3/13/14 were contained in the resident's clinical record. The lab results had multiple items flagged as high and/or low by the testing facility. The clinical record lacked any documentation related to the lab results and physician notification. During an interview with the RN Consultant on 4/30/14 at 3:28 p.m.,			

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	additional information was requested related to physician notification of lab results from 3/13/14 for Resident #21. During an interview with the RN Consultant on 4/30/14 at 4:19 p.m., she indicated the physician had not been notified of the lab results from 3/13/14 for Resident #21. During an interview with the Director of Nursing on 5/2/14 at 10:36 a.m., additional information was requested related to physician notification of lab results from 3/11/14 for Resident #21. During an interview with the Director of Nursing on 5/2/14 at 1:08 p.m., she indicated the physician had not been notified of the lab results from 3/11/14 for Resident #21. 3. Review of the current facility policy, dated 8/2013, titled "PHYSICIAN/FAMILY/RESPONSIBLE PARTY NOTIFICATION FOR CHANGE IN CONDITION," provided by the Director of Nursing on 5/1/14 at 2:56 p.m., included, but was not limited to, the following: "PURPOSE: To ensure that medical care problems are communicated to the attending physician...in a timely,			

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	efficient, and effective manner... ...POLICY: 1. Physician...notification is to include, but is not limited to:... ...Significant change in/or unstable vital signs.... ...Abnormal Lab and Diagnostic findings.... ...Change in level of consciousness.... ...Change in condition that may warrant a change in current treatment.... ...2. Physician...notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained." 3.1-5(a)(2)			
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 record review and interview, the facility failed to ensure a resident with a significant change of condition was assessed in a timely manner for 1 of 1 resident reviewed for assessment with a	F000309	1.The event for Resident #17 happened in the past so the facility was unable to correct. 2.All residents have the potential to be affected. Facility is unable to correct events happening in the past for lacking	06/01/2014

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	significant change (Resident #17). Findings include: 1. The clinical record for Resident #17 was reviewed on 4/30/14 at 3:29 p.m. Diagnoses for the resident included, but were not limited to, renal failure, diabetes mellitus, and hypertension. A health care plan problem, initiated on 4/8/11, indicated Resident #17 had diabetes mellitus. Interventions for this problem included, but were not limited to, observe, document, and report any signs or symptoms of hyperglycemia or hypoglycemia (sweating, pallor) to the physician. A health care plan problem, initiated on 4/8/11, indicated Resident #17 required hemodialysis due to renal failure. Interventions for this problem included, but were not limited to, observe, document, and report any signs or symptoms of renal insufficiency (changes in level of consciousness), and report significant changes in pulse, respirations and blood pressure immediately. A health care plan problem, initiated on 8/10/12, indicated Resident #17 had hypotension. Interventions for this problem included, but were not limited		timely assessments of significant change in condition. 3.DON/designee will review the 24 hour report 5X/week to ensure the residents with a significant change of condition are assessed in a timely manner. 1:1 re-education will be provided to nurses found to not complete a timely assessment. 4.Licensed staff in-services will be held May 21st-May 23rd, 2014 on the SBAR (Situation Background Assessment Recommendation) tool. 5.Results of the audits will be forwarded to QA monthly for review X3 months, then quarterly for a total of 6 months. 6.Date of compliance: June 1, 2014.	

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	to, observe, document, and report any sign and symptoms of hypotension (cold clammy pale skin) to the physician. A nursing note entry, dated 4/30/14 at 6:25 a.m., indicated "At approximately 0400 [4:00 a.m.] resident was only responsive to painful stimuli, found pulse ox [oximetry] to be 70%. Resident skin was ashen and clammy. Immediately placed on oxygen at 3l [liters] per N/C [nasal cannula]. O2 [oxygen] sat [saturation] up to 78% after 20 minutes. Notified resident son [name] and made aware of condition. At 0440 [4:40 a.m.] change resident to mask and O2 sat increased to 88%. At time of leaving for dialysis O2 sat was 89%." The next nursing note entry, dated 4/30/14 at 7:29 a.m., indicated "Call received from Americare transport that resident was taken to BMH [Ball Memorial Hospital] instead of dialysis due to unable to keep O2 sat above 70%. Resident's son [name] was notified." A nursing note entry, dated 4/30/14 at 1:21 p.m., indicated "Resident was admitted to BMH with diagnosis of Hypoxia, Hyperkalemia, Dyspnea... Family is aware and is at bedside at BMH."			

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	The April 2014 Medication Administration Record (MAR) indicated the resident's blood sugar was 176 at 6:00 a.m. on 4/30/14. A "TLC PRE DIALYSIS DATA" form, dated 4/30/14 at 6:29 a.m., included, but was not limited to, vital signs (blood pressure, pulse, respirations, temperature), and O2 saturation. During an interview with the RN Consultant on 5/1/14 at 2:03 p.m., additional information was requested related to the lack of assessment on 4/30/14 at 4:00 a.m. for Resident #17. The facility failed to provide any additional information as of exit on 5/2/14. 3.1-37(a)			
F000323 SS=D	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 interview and record review, the facility failed to ensure a fall was examined for root cause analysis to include the use of an as needed	F000323	1.Events for Resident #12 happened in the past so the facility was unable to correct. 2.An audit to be completed on all residents with falls since	06/01/2014

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	psychoactive medication and urinary continence on the fall for 1 of 3 residents reviewed who met the criteria for falls (Resident #12). Findings include: Resident #12's record was reviewed on 4/30/13 at 9:30 a.m. Resident #12's current diagnoses included, but were not limited to, delusional disorder, depression, Alzheimer's disease and post femur fracture with repair. Resident #12 had a current, 3/27/14, physician's order for ABH Gel (a psychoactive medication which combines an anti-anxiety, anti-psychotic and antihistamine/sleeper) apply topically to wrist every 4 hours as needed for agitation related to senile dementia with delusional features. Resident #12 had a fall on 4/15/14 at 2:56 p.m. The resident was found seated on the floor by her bed. Resident #12 sustained no injury from the fall. Prior to the fall on 4/15/14 at 12:32 p.m., Resident #12 received "as needed" ABH gel (psychoactive medication). A, 4/15/14, "Behavior Sheet" which described the residents behavior prior to the administration of the as needed psychoactive medication indicated Resident #12 was walking down the		4/14/14 to ensure falls were examined for root cause analysis. 3.DON/designee will review fall documentation 5X/week to ensure fall investigations are complete. DON/designee will review all voiding diaries for accuracy 5X/week to ensure accuracy of documentation. Licensed staff in-services will be held May 21st – May 23rd, 2014 on Fall Evaluation/Investigation Policy. QMAs/CNAs to be re-educated on ensuring the times on the voiding diary are entered correctly. Completed voiding diaries will then be reviewed by the Restorative Nurse. 4.Results of the audits will be forwarded to QA monthly for review X3 months, then quarterly for a total of 6 months. 5.Date of compliance: June 1, 2014.	

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	hallway and resisted help from staff. A 4/16/14, Fall Intra Disciplinary Team (IDT) Note indicated Resident #12 had a past history of falls, she walked around unassisted, and had unsafe behaviors of taking herself to the bathroom. The IDT note did not address the use of the as needed psychoactive medication and its possible impact on balance and motor skills. The IDT note indicated a voiding diary would be completed to evaluate toileting needs. A "Bowel and Bladder Diary" completed for, 4/16/14 through 4/18/14, had multiple entries for the same time as follows: a.) On 4/16/14 at 4:17 p.m., the resident was both continent and urinated and did not urinate during the same event. b.) On 4/17/14 at 5:06 a.m., the resident did not urinate. At 5:07 a.m., (one minute later) the resident was incontinent of urine and continent of urine during the same event. c.) On 4/17/14 at 9:08 a.m., the resident did not urinate, was incontinent or urine and continent of urine during the same event. d.) On 4/17/14 at 3:18 p.m., the resident did not urinate and was incontinent of urine during the same event. e.) On 4/18/14 at 5:26 a.m., the resident			

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	did not urinate and was incontinent of urine twice during the same event. f.) On 4/18/14 at 8:27 a.m., the resident did not urinate and was incontinent of urine during the same event. During a 5/1/14, 2:00 p.m., interview, the RN Consultant indicated the "Bowel and Bladder Diary" was completed on the computer and if a person entered all the information from their shift it showed the time it was entered not the time the resident was toileted. She also indicated the staff members must remember to manually enter the time of the toileting in order to collect accurate information to use for evaluation. Resident #12's bladder record was entered in a manner that would not allow for an evaluation. When questioned, the RN Consultant indicated a second voiding diary should have been completed in order to have accurate information for a root cause analysis evaluation. A current, 8/2013, facility policy titled "Fall Evaluation and Investigation", which was provided by the RN Consultant on 5/1/14 at 3:15 p.m., indicated the following: "1. To detect root cause of falls to extent possible and to identify supportive aides to prevent falls. 2. To identify high-risk residents and			

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	implement interventions to reduce falls and the consequences of falls. ...g. Initiate investigations to determine the cause of the fall." 3.1-45(a)(2)			
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			

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	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 interview and record review, the facility failed to ensure the use of "as needed" psychoactive medication was utilized to allow for prevention and root cause analysis of behaviors and/or behavioral intervention listed on the care plan. In addition, the facility failed to assure care plan interventions were attempted prior to the use of "as needed" psychoactive medication for 1 of 5 residents who met the criteria for unnecessary medication (Resident #12). Findings include: Resident #12's record was reviewed on 4/30/13 at 9:30 a.m. Resident #12's current diagnoses included, but were not limited to, delusional disorder, depression, Alzheimer's disease and post femur fracture with repair. Resident #12 had a current, 3/27/14, physician's order for ABH Gel (a psychoactive medication which combines an anti-anxiety, anti-psychotic and antihistamine/sleeper)	F000329	1.Events for Resident #12 happened in the past so the facility was unable to correct. 2.All residents receiving as needed psychoactive medications have the potential to be affected. 3.DON/SSD will review behavior sheets 5X/week to ensure the use of the as needed psychoactive medication was utilized to allow for prevention and root cause analysis of behaviors and/or behavioral intervention listed on the care plan and that care plan interventions were utilized prior to their use. 1:1 re-education will be provided as necessary. Licensed staff in-services will be held May 21st – May 23rd, 2014 on Behavior Management Policy and Behavior Sheet documentation. 4.Results of the audits will be forwarded to QA monthly for review X3 months, then quarterly for a total of 6 months. 5.Date of compliance: June 1, 2014.	06/01/2014

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NAME OF PROVIDER OR SUPPLIER ALBANY HEALTH CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 910 W WALNUT ST ALBANY, IN 47320	

(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
	apply topically to wrist every 4 hours as needed for agitation related to senile dementia with delusional features. Resident #12 had a current, 1/11/14, care plan problem/need regarding inappropriate and disruptive behaviors. Approaches to this problem included, but were not limited to, "cease interaction as needed/remove resident from situation if able, do NOT argue with resident, cease interaction and re-approach as needed, remove stressor if known, leave resident alone and re-approach later and take resident for a walk as tolerated or needed." Review of the Medication Administration Record for April 2014 (1-29) indicated Resident #12 had received 3 doses of as needed ABH gel (a psychoactive medication) in the month of April: Saturday, April 5, 12:17 p.m.; Sunday April 6, 11:05 a.m. and Tuesday, April 15, 12:32 p.m. The 4/5/14, 1:28 p.m., "Behavior Sheet" indicated Resident #12 was displaying the behaviors of hitting, spitting, and grabbing at a moderate level of intensity. The area of the form for precipitating factors was checked as "unknown." The "Comments" section had the guidance "Document any comments that explains			

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	behaviors (location where behaviors occurred, other persons involved in the behavior), interventions and outcomes." The "Comments" indicated "very agitated as evidenced by resident attempting to hit this writer, spit and pinch." The form did not indicate where the behavioral episode took place, what activity was occurring in the area, what staff wanted the resident to do or how staff were interacting with the resident or why the resident could not be left alone to calm down and be re-approached later. The "Behavior Sheet" and the clinical record lacked documentation of a descriptive scenario of the event to allow for the assessment of precipitating factors and future prevention of said behaviors. The 4/6/14, 1:31 p.m.,"Behavior Sheet" indicated Resident #12 was displaying the behaviors of moderately resisting care, hitting others and severely spitting and grabbing others. The area of the form for precipitating factors was checked as "unknown." The "Comments" section had the guidance "Document any comments that explains behaviors (location where behaviors occurred, other persons involved in the behavior), interventions and outcomes." The "Comments" indicated "At lunch when the dining room became busier, resident became more anxious, slapping			

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	at staff and spitting." The form did not indicate what staff wanted the resident to do or how staff were interacting with the resident, why the resident could not be left alone to calm down and be re-approached later or why the resident could not have been removed from the area to a calming location. The 4/15/14,1:33 p.m.,"Behavior Sheet" indicated Resident #12 was displaying the behaviors of wandering, resisting care, hitting others, yelling, grabbing and cursing at a severe level. The area of the form for precipitating factors was checked as "unknown." The "Comments" section had the guidance "Document any comments that explains behaviors (location where behaviors occurred, other persons involved in the behavior), interventions and outcomes." The "Comments" indicated "Resident was walking down the hall when the nursing assistant went to help her. The resident hit, grabbed, yelled and cursed at them. I tried to help but she yelled at me. We tried several things to redirect her but it didn't help. She calmed down after I gave her some medication." The form did not indicate why the resident could not walk with staff standing by which was a care plan approach to redirect behaviors.			

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	During a 5/1/14, 2:30 p.m., interview, the Social Services Director indicated there were not detailed descriptive scenarios documented in association with the three doses of ABH gel administered as needed in April 2014. A current, 6/2013, facility policy titled " Psychoactive Mediation/Gradual Dose Reduction", which was provided by the Director of Nursing on 5/1/14 at 3:00 p.m., indicated the following: "It is the policy of this facility that a resident will receive psychoactive medication only when it is necessary to improved the resident's overall psychosocial health status." 3.1-37(a)			