| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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.<br><br>Survey dates: May 28, 29, 30, 31, and June 3, 2013<br><br>Facility number: 000309<br>Provider number: 155432<br>AIM number: 100288960<br><br>Survey team:<br>Linn Mackey, RN TC<br>Toni Maley, BSW<br>Betty Retherford, RN<br>Shelly Reed, RN<br><br>Census bed type:<br>SNF: 2<br>NF: 74<br>Total: 76<br><br>Census payor type:<br>Medicare: 7<br>Medicaid: 54<br>Other: 15<br>Total: 76<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 | F000000 | This plan of correction is prepared and executed because it is required by the provisions of State & Federal law and not because Albany Health Care & Rehabilitation Center agrees with the allegations and citations listed. Albany Health and Rehabilitation Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept the last date noted on this plan of correction as the facility's written credible allegation of compliance.<br><br>This provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial 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.

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| 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).<br><br>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.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure the physician was contacted in regards to a resident's repeated non-compliance with fluid restrictions | F000157 | **F-157** 1. Resident #19's physician was notified of resident's non-compliance with his fluid restriction.Water pitcher was removed from room. Resident's son educated on fluid | 07/03/2013 |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | for 1 of 1 dialysis resident reviewed. (Resident #19)<br><br>Findings include:<br><br>The clinical record for Resident #19 was reviewed on 5/30/13 at 10 a.m.<br><br>Diagnoses for the resident included, but were not limited to, end stage renal disease, diabetes mellitus, chronic pain, renal dialysis status, bilateral amputations of the lower extremities, and anemia.<br><br>The clinical record indicated the resident went out for dialysis services on Tuesday, Thursday, and Saturday. The clinical record indicated the resident had a 1500 milliliter (ml) daily fluid restriction.<br><br>A health care plan problem, dated 3/21/13, indicated the resident had renal failure related to end stage disease. One of the approaches for this problem was for the resident to have a 1500 ml fluid restriction in a 24 hour day.<br><br>During a review of a computer generated intake and output "Look Back Report," printed on 5/31/13 and provided by the DoN at 1:00 p.m., indicated the resident's intake was | | restriction and requested not to supply cups for the resident. 2. All residents on fluid restrictions have the potential to be affected. Two additional residents were identified on fluid restrictions and their non-compliance was addressed with their physicians. Aide assignment sheets were updated as needed for fluid restrictions. 3. In-services will be provided for all staff on Fluid Restrictions and Physician Notification. 4. DON/designee to round daily 5 times per week to ensure no water pitchers or cups have been placed in rooms of residents on fluid restrictions for 4 weeks, then weekly for 4 weeks, then monthly on going. Residents on fluid restrictions will be reviewed weekly during the Nutrition At Risk meeting for compliance. Results of these audits will be forwarded monthly to QA committee for review and any further action. 5. Completion date 07-03-13 | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | above the 1500 milliliter restriction on 20 of 30 days in April of 2013 and above the 1500 milliliter restriction on 26 of 30 days in May 2013. The amount of fluids given on these days above 1500 ml ranged from a low of 1560 ml on 5/20/13 to a high of 3,480 ml on 5/6/13.<br><br>During an observation with RN #4 on 5/31/13 at 1:30 p.m., a water pitcher and a glass were noted on the resident's over the bed table. There were also two additional large plastic glasses with lids on the table. One was empty and one was approximately 1/2 full. The resident's name was written with a black marker on the top of one of the plastic lids. The resident was resting in bed. RN #4 indicated residents on fluid restrictions were not to have a water pitcher at the bedside and she would instruct the staff to remove it from the room. She indicated she did not know why the two large plastic glasses were in the room.<br><br>During an interview on 5/31/13 at 1:44 p.m., RN #4 indicated she had talked to the CNAs in regard to the plastic glasses in Resident #19's room. They had told her that his family often brings items in when they visit and those glasses may have | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | been brought in by them. RN #4 indicated the resident was not always compliant with his fluid restrictions.<br><br>During an interview with LPN #3 (the nurse providing care to Resident #19 that day) on 5/31/13 at 1:45 p.m., additional information was requested related to physician notification of the resident's repeated non-compliance with the 1500 ml fluid restriction and how often CNA intakes were recorded in excess of the daily restriction.<br><br>During an interview on 5/31/13 at 2:00 p.m., LPN #3 indicated she had reviewed the clinical record and was unable to find any physician notification of the resident's non-compliance with the 1500 ml fluid restriction.<br><br>Review of the current facility policy, revised 1/2012, provided by the DoN on 6/3/13 at 10:00 a.m., titled "Physician notification for change in condition," included, but was not limited to, the following:<br><br>"Purpose: To ensure that medical care problems are communicated to the attending physician in a timely, efficient, and effective manner.<br><br>...Policy: | | | |

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|
| | 1. Physician notification is to include, but is not limited to:<br><br>...Repeat refusals to take prescribed medication...<br>Unusual or worsening behavior<br>Change in condition that may warrant a change in current treatment...<br><br>2. Physician notification will be documented in the progress notes...."<br><br>3.1-5(a)(2) | | | |

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|
| F000279<br>SS=D | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). | | | |
| | Based on observation, interview, and record review, the facility failed to ensure a comprehensive plan of care was developed in regards to the need for assistance with activities of daily living for 2 of 4 residents (Resident #19 and #29) reviewed of the 7 who met the criteria.<br><br>Findings include:<br><br>1.) During an observation on 5/28/13 at 10:50 a.m., Resident #29's fingernails were noted to be long and irregular in shape. | F000279 | F-279<br>1. Care plans were updated for residents #19 and #29 to include diabetic nail care.<br><br>2. All diabetic residents have the potential to be affected. All diabetic residents' care plans were reviewed and updated as needed to include diabetic nail care.<br><br>3. A nursing in-service will be held on care plans.<br><br>4. DON/designee will audit 5 diabetic resident's care plans to ensure nail care has been addressed | 07/03/2013 |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | During observations on 5/30/13 at 9:40 a.m. and 5/31/13 at 10:40 a.m., the resident was sitting up in her gerichair in her room. Her fingernails were noted to be long and irregular in shape.<br><br>The clinical record for Resident #29 was reviewed on 5/31/13 at 11:00 a.m.<br><br>Diagnoses for Resident #29 included, but were not limited to, multiple sclerosis, hemiplegia affecting dominant side, diabetes mellitus, and cerebrovascular disease.<br><br>A quarterly Minimum Data Set assessment, dated 3/18/13, indicated Resident #29 required extensive assistance from the staff for bathing and personal hygiene.<br><br>A health care plan problem, dated 3/12/13, indicated Resident #29 was at risk for health complications related to the diagnoses of diabetes mellitus. One of the approaches for this problem was "Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails." The resident's health care plan lacked any information related to care of the resident's fingernails. | | weekly for 4 weeks, then monthly on going. Results from these audits will be forwarded to QA committee monthly for review and any action.<br><br>5. Completion date 07-03-13 | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | During an observation on 6/3/13 at 9:00 a.m., the resident was up in her gerichair in her room. Her fingernails were long and irregular in shape.<br><br>During an observation and interview with the DoN on 6/3/13 at 9:50 a.m., she indicated the resident's nails were too long and should be cut. She asked an unidentified CNA who entered the room to cut the resident's nails. The CNA indicated she couldn't because the resident was a diabetic. The DoN indicated CNAs were not allowed to cut the fingernails of diabetic residents and she would inform the resident's nurse.<br><br>During an interview with the DoN and Administrator on 6/3/13 at 10:15 a.m., additional information was requested related to the lack of any comprehensive health care plan having been developed in regards to the need for diabetic fingernail care for Resident #29.<br><br>The facility failed to provide any additional information as of exit on 6/3/12.<br><br>2.) During an observation on 5/31/13 at 1:10 p.m., Resident #19 was resting in bed. His hands were | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | uncovered and his fingernails were long and irregular in shape.<br><br>During an observation on 6/3/13 at 10:00 a.m., Resident #19 was resting in bed. His hands were uncovered and his fingernails were long and irregular in shape.<br><br>The clinical record for Resident #19 was reviewed on 5/30/13 at 10 a.m.<br><br>Diagnoses for the resident included, but were not limited to, end stage renal disease, diabetes mellitus, chronic pain, and anemia.<br><br>An admission Minimum Data Set assessment, dated 4/1/13, indicated Resident #19 required extensive assistance from the staff for bathing and personal hygiene.<br><br>A health care plan problem, dated 3/21/13, indicated Resident #19 was at risk for health complications related to the diagnoses of diabetes mellitus. One of the approaches for this problem was "Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails." The resident's health care plan lacked any information related to care of the resident's fingernails. | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | During an interview with the DoN and Administrator on 6/3/13 at 10:15 a.m., additional information was requested related to the lack of any comprehensive health care plan having been developed in regards to the need for diabetic fingernail care for Resident #19.<br><br>The facility failed to provide any additional information as of exit on 6/3/12.<br><br>3.) Review of the current facility policy, dated June 2010, provided by the DoN on 6/3/13, titled "Care area Assessment (CAA) Process and Care Planning," included, but was not limited to, the following:<br><br>"...4.7... The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...."<br><br>3.1-35(a) | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| 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 nursing and dietary staff communicated with each other and monitored fluid consumption for a resident with a physician order for fluid restrictions to ensure accurate monitoring of the resident's fluid intake for 1 of 1 dialysis resident reviewed. (Resident #19)<br><br>Findings include:<br><br>1.) During an observation of Resident #19's room on 5/31/13 at 1:10 p.m., a water pitcher and glass were noted on the over-the-bed table by the resident's bed. The water pitcher contained a small amount of water. There were also two additional large plastic glasses with lids on the table. One was empty and one was approximately 1/2 full. The resident's name was written with a black marker on the top of one of the plastic lids. The resident was resting in bed. | F000309 | **F-309** 1. Nursing and dietary department were informed of the fluid restriction for resident #19 and the allotted amount to be given by nursing and by dietary. 2. All residents on fluid restrictions have the potential to be affected. Review of their restriction and the allotted amount to be given by dietary and nursing was completed. Information about resident's fluid restriction was updated to nursing. The Dietary Manager added the total amount of fluids allowed with meals to all resident's meal cards on fluid restriction. 3. An all staff in-service to be provided on the Procedure for Monitoring Intakes on Residents with Fluid Restriction. The Dietary Manager to in service all dietary staff on meal cards as they relate to residents on fluid restriction. 4. Intakes for residents on fluid restrictions will be reviewed daily 5 days per week for 2 weeks, then weekly during Nutrition At Risk meetings on-going. Results from these audits will be forwarded to QA committee monthly for review and any action | 07/03/2013 |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | The clinical record for Resident #19 was reviewed on 5/30/13 at 10 a.m.<br><br>Diagnoses for the resident included, but were not limited to, end stage renal disease, diabetes mellitus, chronic pain, renal dialysis status, bilateral amputations of the lower extremities, and anemia.<br><br>An admission Minimum Data Set assessment, dated 4/1/13, indicated Resident #19 required extensive assistance from the staff for transfers and mobility. The assessment indicated the resident needed "Supervision-oversight, encouragement, or cueing" with eating.<br><br>The clinical record indicated the resident went out for dialysis services on Tuesday, Thursday, and Saturday. The clinical record indicated the resident had a 1500 milliliter (ml) daily fluid restriction.<br><br>A health care plan problem, dated 3/21/13, indicated the resident had renal failure related to end stage disease. One of the approaches for this problem was for the resident to have a 1500 ml fluid restriction in a 24 hour day. | | needed. 5. Completion date 07-03-13 | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | Meal consumption records for April and May 2013 for Resident #19 indicated the percentage of food eaten by the resident, but did not identify the amount of fluids consumed.<br><br>During an interview with the DoN on 5/31/13 at 11:35 a.m., additional information was requested in regards to intake monitoring for Resident #19's physician order for a 1500 ml fluid restriction.<br><br>During a review of a computer generated intake and output "Look Back Report," printed on 5/31/13 and provided by the DoN at 1:00 p.m., indicated the resident's intake was above the 1500 milliliter restriction on 20 of 30 days in April of 2013 and above the 1500 milliliter restriction on 26 of 30 days in May 2013. The amount of fluids given on these days above 1500 ml ranged from a low of 1560 ml on 5/20/13 to a high of 3,480 ml on 5/6/13.<br><br>During an interview with LPN #3 on 5/31/13 at 1:25 p.m., additional information was requested related to the allotment of fluids to be given by the dietary department and nursing department when a resident was on a 1500 milliliter fluid restriction. She | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | provided a 1500 ml restriction form which indicated the dietary department would give the resident 480 ml for breakfast, 120 ml for lunch, and 240 ml for supper and 120 ml snack at bedtime for a total of 960 ml of fluid with meals. The form indicated the nursing staff would give the resident 180 ml of fluid with medication passes on all three shifts daily for a total of 540 ml of fluids given with meds. When queried if the amount of fluids given by the nursing staff would appear on the "Look Back Report", she indicated "no." She indicated only CNA entries of fluids during meals and given by them during their shift would be entered on the "Look Back Report". She indicated she was unaware of any fluid intake report that contained the dietary, nursing, and other CNA provided amounts of fluids to the resident.<br><br>During an observation with RN #4 on 5/31/13 at 1:30 p.m., the water pitcher and glasses remained at Resident #19's bedside as noted previously during the 1:10 p.m. observation. RN #4 indicated resident's on fluids restrictions are not to have a water pitcher at the bedside and she would instruct the staff to remove it from the room. She indicated she did not | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | know why the two large plastic glasses were in the room.<br><br>During an interview on 5/31/13 at 1:35 p.m., the Dietary Manager indicated Resident #19 had a 1500 ml daily fluid restriction. He provided the resident's "diet card" sent with meal trays for review. He indicated the resident was to receive 4 ounces of skim milk and 4 ounces of juice with breakfast, 4 ounces of fluid of choice at lunch, and 4 ounces of skim milk with supper for a total of 16 ounces (480 ml) to be provided by the dietary department daily. He indicated extra fluids are present in the dining room for the CNA's to give residents when they request it.<br><br>During an interview with LPN #3 on 5/31/13 at 1:40 p.m., concerns were addressed related to the discrepancy between the amount of fluids to be given on the resident's "diet card" during meals and the amount identified on 1500 ml fluid restriction form at the nursing station. LPN #3 indicated she been unable to locate one of the forms in the resident's clinical record exclusively for him and had now made one for the clinical record with a copy to be provided to the dietary department so they would know the amounts of fluids they were | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | allotted to provide with meals.<br><br>During an interview on 5/31/13 at 1:42 p.m., CNA #5 indicated she had been in the dining room during the breakfast meal that morning. She knew Resident #5 had coffee with his breakfast that morning, but another CNA had recorded fluid intakes that morning.<br><br>During an interview on 5/31/13 at 1:44 p.m., RN #4 indicated she had talked to the CNAs in regard to the plastic glasses in Resident #19's room. They had told her that his family often brings items in when they visit and those glasses may have been brought in by them. RN #4 indicated the resident was not always compliant with his fluid restrictions.<br><br>During an interview with the DoN and Administrator on 6/3/13 at 10:15 a.m., additional information was requested regarding the lack of communication between the dietary department and nursing staff, the lack of any comprehensive fluid monitoring being completed regarding the resident's 1500 ml fluid restriction, and the almost daily recording of fluid intake in excess of 1500 ml.<br><br>The facility failed to provide any | | | |

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|
| | additional information as of exit on 6/3/13.<br><br>3.1-37(a) | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| F000312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure residents received the necessary services to maintain good personal hygiene related to long facial hairs and long, irregular nails for 3 of 4 residents reviewed for activities of daily living in a sample of 7 who met the criteria. (Residents #11, #19 and #29)<br><br>Findings include:<br><br>On 5/29/13 at 1:15 p.m., Resident #11 was observed to have several long, gray facial hairs on her chin.<br><br>On 5/30/13 at 9:30 a.m., Resident #11 was observed to have several long, gray facial hairs on her chin.<br><br>On 5/31/13 at 1:30 p.m., Resident #11 was observed to be asleep in bed. Resident #11 had several long, gray facial hairs present on her chin.<br><br>During an interview on 5/31/13, CNA #1 indicated Resident #11 required | F000312 | **F-312**<br><br>1. Nail care was provided by the nurse for residents #19 and #29. Resident #11 was shaved with her permission.<br><br>2. All diabetic residents and those requiring assistance with shaving have the potential to be affected. Rounds were completed on all residents requiring assistance with shaving and nail care to ensure appropriate care performed.<br><br>3. Nursing staff will be in-serviced on Policy and Procedure for Diabetic nail Care and Personal Hygiene. During shift rounds the nurse will observe for personal hygiene needs and ensure that care is performed. During weekly skin assessment, the nurse will assess skin and nail and document on form. The nurse will provide diabetic nail care if needed.<br><br>4. DON/designee will make daily rounds 5 times per week on 10 residents observe for personal hygiene needs for 2 weeks to ensure care has been provided, then weekly | 07/03/2013 |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | assistance for bathing and hygiene care. She indicated the nurses kept razors at the nursing station for staff to use for shaving. Razors are not kept in resident rooms.<br><br>During record review on 5/31/13 at 9:00 a.m., the Minimum Data Set (MDS) assessment dated 3/18/13, indicated Resident #11 scored a 8 of 15 for the Brief Interview Mental Status (BIMS). A BIMS score of 8 indicated Resident #11 was moderately impaired. Resident #11 required the following activity of daily living assistance: bed mobility-extensive assistance with one person physical assist, transfer-limited assistance with one person physical assist, dressing-extensive assistance with one person physical assist, eating-supervision with one person physical assist, toilet use-extensive assistance with one person physical assist and personal hygiene-extensive assistance with one person physical assist.<br><br>On 5/2/13, Resident #11 refused a shower. The shower and bathing notes indicated Resident #11 received a shower on 5/17/13 with one person physical help. On 5/24/13 and 5/28/13, Resident #11 required | | for 4 weeks, and monthly on going. Results from these audits will be forwarded to QA committee monthly for review and any needed action.<br><br>5. Completion date 07-03-13 | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | total dependence during shower care. No additional documentation related to shaving was provided.<br><br>An initial care plan dated 1/18/11, indicated Resident #11 had the potential for decline in dressing/grooming skills related to her disease process. An updated care plan dated 3/12/13 indicated no change in Activity of Daily Living (ADL).<br><br>Review of a current facility policy dated 3/12 titled "Personal Hygiene," which was provided by the Director of Nursing, on 6/313 at 10:00 a.m., indicated the following:<br><br>"Policy:<br><br>1. Personal hygiene will be performed 2 times daily in the morning and before bed.<br><br>2. Personal hygiene may include, but is not limited to:<br>a. Oral care<br>b. Washing face and hands<br>c. Washing axillary area and perineum area<br>d. Applying makeup (as needed)<br>e. Combing/brushing of hair<br>f. Applying deodorant/perfume as necessary | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | g. Shaving<br>h. Dressing and undressing<br>i. Applying lotion to skin...."<br>2.) During an observation on 5/28/13 at 10:50 a.m., Resident #29's fingernails were noted to be long and irregular in shape.<br><br>During observations on 5/30/13 at 9:40 a.m. and 5/31/13 at 10:40 a.m., the resident was sitting up in her gerichair in her room. Her fingernails were noted to be long and irregular in shape. The resident indicated she was able to move her left hand, but was unable to move her right arm/hand due to a previous stroke. The fingers of her right hand were noted to curl inward towards the palm of her hand..<br><br>The clinical record for Resident #29 was reviewed on 5/31/13 at 11:00 a.m.<br><br>Diagnoses for Resident #29 included, but were not limited to, multiple sclerosis, hemiplegia affecting dominant side, diabetes mellitus, and cerebrovascular disease.<br><br>A quarterly Minimum Data Set assessment, dated 3/18/13, indicated Resident #29 required extensive assistance from the staff for bathing | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | and personal hygiene.<br><br>During an observation on 6/3/13 at 9:00 a.m., the resident was up in her gerichair in her room. Her fingernails were long and irregular in shape.<br><br>During an observation and interview with the DoN on 6/3/13 at 9:50 a.m., the DoN indicated the resident's nails were too long and should be cut. She asked an unidentified CNA who entered the room to cut the resident's nails. The CNA indicated she couldn't because the resident was a diabetic. The DoN indicated CNAs were not allowed to cut the fingernails of diabetic residents and she would inform the resident's nurse.<br><br>3.) During an observation on 5/31/13 at 1:10 p.m., Resident #19 was resting in bed. His hands were uncovered and his fingernails were long and irregular in shape.<br><br>During an observation on 6/3/13 at 10:00 a.m., Resident #19 was resting in bed. His hands were uncovered and his fingernails were long and irregular in shape.<br><br>The clinical record for Resident #19 was reviewed on 5/30/13 at 10 a.m. | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | Diagnoses for the resident included, but were not limited to, end stage renal disease, diabetes mellitus, chronic pain, and anemia.<br><br>An admission Minimum Data Set assessment, dated 4/1/13, indicated Resident #19 required extensive assistance from the staff for bathing and personal hygiene.<br><br>During an interview with the DoN and Administrator on 6/3/13 at 10:15 a.m., additional information was requested related to the lack of fingernail care for Resident #19.<br><br>During an observation with the DoN on 6/3/13 at 10:20 a.m., the resident was resting in bed. The DoN indicated his fingernails were too long and needed to be cut.<br><br>4.) Review of the current facility policy, revised 4/2005, provided by the DoN on 6/3/13 at 1:35 p.m., titled "Nail Care," included, but was not limited to, the following:<br><br>"Purpose: To safely trip fingernails and toenails to keep surrounding skin health, intact and free from infection.<br><br>...General Consideration: | | | |

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|
| | 1. Good grooming includes quality nail care...<br><br>...3. Nails that are not kept filed can easily scratch residents, visitors, and staff members.<br><br>Caution: CNAs/QMAs will not cut and file the fingernails or toenails of a resident with diabetes or with circulation impairment. This will be done by a podiatrist or the licensed nurse...."<br><br>3.1-38(a)(3)(D)<br>3.1-38(a)(3)(E) | | | |

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|
| F000329<br>SS=D | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>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.<br><br>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 observation, interview and record review, the facility failed to ensure residents who received psychoactive medication were adequately monitored for side effects, had behavioral indicators for use and did not receive an excessive dose of medication for 2 of 10 residents reviewed for unnecessary medications (Residents #84 and #54).<br><br>Findings include: | F000329 | F 329<br><br>1.Resident #84 HS dose of Zyprexa was decreased to 7.5 mg on 05-29-13. Resident #84 will be reviewed on 06-28-13 for a decrease of the noon dose of Zyprexa to 5.0 mg. Resident #54 Seroquel was reduced to 12.5 mg. on 06-13-13.<br><br>2. All residents receiving psychoactive medications have the potential to be affected. Over the next 90 days, all residents receiving antipsychotic medications will be | 07/03/2013 |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | 1.) Resident # 84's record was reviewed on 5/29/13 at 2:45 p.m.<br><br>Resident #84's current diagnoses, included but were not limited to, senile dementia with delusional features, dementia with behavioral disturbances and anxiety.<br><br>Resident #84 had current, 5/9/13, physician's orders for the following psychoactive medications:<br>a.) Zyprexa 10 mg (an anti-psychotic medication) one time daily at bedtime. This order originated 3/16/12.<br>b.) Zyprexa 5 mg one time daily at 8:00 a.m. This order originated 12/27/12.<br>c.) Zyprexa 7.5 mg one time daily at 12:00 p.m. This order originated 1/3/13.<br>d.) Xanax 0.25 mg (an anti-anxiety medication) one daily at bedtime. This order originated 1/4/12.<br><br>During a 5/29/13, 3:00 pm, interview, the Director of Nursing reviewed Resident #84's medical record and indicated the resident received a total of 22.5 mg of Zyprexa daily. She then referenced the facilities Nursing Drug Handbook for 2014 and indicated this dose was in excess of the 20 mg total daily dose recommended for the treatment of | | reviewed during the monthly GDR meetings for possible reduction.<br><br>3. The interdisciplinary team will be re-in serviced on the GDR process. Nurses will be in-serviced on side effect monitoring of psychoactive medication.<br><br>4. The DON/designee will review GDR meeting notes monthly to verify reduction or appropriate documentation is present not to reduce. Results will be reported to the QA committee monthly for any action. This is an ongoing review.<br><br>5. Completion date 07-03-13 | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | major psychiatric disorders such as schizophrenia.<br><br>Resident #84 had a current, 2/26/13, care plan problem/need regarding psychotropic medications related to dementia. This problem originated 8/9/11. An approach to this problem was to observe/record/report to the M.D. (Medical Doctor) as needed any side effects and adverse reactions of psychoactive medications. Fatigue was listed as a potential side effect. Another approach to this problem was to discuss with the doctor the ongoing need for use of medications.<br><br>Resident #84 had a current, 2/26/13, care plan problem/need regarding the need for an anti-anxiety medication related to an anxiety disorder. An approach to this problem was to monitor for side effects. Drowsiness and lack of energy were listed side effects.<br><br>Resident #84 had a current, 2/26/13, quarterly, Minimum Data Set assessment which indicated the resident was severely cognitively impaired and never or rarely made decisions and had not displayed any maladaptive behaviors during the assessment period. | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | Review of Resident #84's side effect monitoring record for March, April and May 2013 indicated the resident had displayed no potential side effects during this three month period.<br><br>Review of Resident #84's behavior sheets for March, April and May 2013 indicated the resident had displayed two behaviors during this three month period.<br><br>Resident #84's record did not indicate if the resident slept in the day time and was awake at nights.<br><br>A 4/2/13, Social Service note indicated the resident had been discontinued from the Behavior Management Program that date. During a 5/31/13, 10:30 am interview, the Social Service Designee indicated Resident # 84 had been discontinued from the Behavior Management Program in April because her behaviors were stable.<br><br>During a 5/29/13, 1:20 pm, interview, Resident #84's family member indicated the resident slept a great deal and was often groggy. She indicated the resident had experienced great difficulty in therapy because she could not stay awake to participate. The family member | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | indicated she wondered if her loved one was receiving too much medication and felt she took a lot of Zyprexa.<br><br>Resident # 84 was observed in the TV lounge in a recliner with her feet up, head back, eyes closed and softly snoring as follows: 5/28/13, 3:00 p.m., 5/29/13, 9:30 a.m., 5/29/13, 10:35 a.m., 5/29/13, 11:25 a.m., 5/31/13, 9:55 a.m., 5/31/13, 10:30 a.m., 6/3/13, 9:30 a.m. and 6/3/13, 10:30 a.m.<br><br>During a 5/31/13, 9:56 a.m., interview, CNA #7 indicated Resident #84 spent the majority of her days sleeping in the recliner in the TV lounge. She indicated the resident usually wakes to go to the bathroom and sleeps the rest of the time. CNA #7 also indicated Resident #84 displayed no negative behaviors.<br><br>During a 5/31/13, 9:58 a.m., interview, CNA #8 indicated Resident #84 spent almost every morning sleeping in the recliner in the lounge. She indicated the resident usually woke up around 2:00 p.m. to 3:00 p.m., which is her most active part of the day. CNA #8 indicated the resident did not display negative behaviors. | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | During a 5/31/13, 10:00 a.m., interview, QMA #9 indicated Resident #84 slept in her recliner most of the day and did not display any negative behaviors.<br><br>During a 6/3/13, 10:30 a.m., interview, Activity Assistant #12 indicated Resident #84 was often awake at 9:00 a.m. following breakfast. At 9:00 a.m. the resident was usually in the recliner in the TV lounge. The resident was awake when the 9:00 a.m. activity was started but would fall asleep in her recliner shortly thereafter and stayed asleep until lunch time.<br><br>During a 6/3/13, 9:00 a.m., interview, Physical Therapist #14 indicated Resident #84 was groggy during morning physical therapy and could not complete the therapy tasks. He indicated he talked with the nursing department and the resident now has therapy between 2:00 p.m. and 3:00 p.m.<br><br>2.) Resident #54' s record was reviewed on 5/29/13 at 11:20 am.<br><br>Resident #54 is current diagnoses included, but were not limited to, senile dementia, senile dementia with | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | delusional features, and hypertension.<br><br>Resident # 54 had current, 5/9/13, physician's orders for Seroquel 25 mg (an anti-psychotic medication) Two times daily. This order originated 12/6/12.<br><br>Resident #54 had a current, 2/27/13, care plan problem/need regarding the use of psychotropic medication in relation to senile dementia with delusional features. An approach to this problem was to observe/record/report to the Medical Doctor any side effects or adverse reactions of psychoactive medications. Fatigue and social isolation were listed as a potential side effects. This problem originated 6/22/12.<br><br>Resident #54 had a current, 2/27/13, quarterly, Minimum Data Set assessment which indicated the resident was severely cognitively impaired and rarely or never made decisions and had displayed both verbal aggression and physical aggression 1 to 3 times during the assessment period.<br><br>Review of Resident #54's side effect monitoring for March, April and May | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | 2013 indicated the resident had displayed no potential side effects during this three month period.<br><br>Review of Resident #54 behavior sheets for March, April and May 2013 indicated the resident had displayed one behavioral episode in the three month period.<br><br>During a 5/31/13, 8:00 am interview, the Director of Nursing indicated Resident #54 had been removed from the Behavior Management Program on 3/5/13 because her behavior was stable.<br><br>Resident #54 was observed in her room in bed with her eyes closed and softly snoring as follows: 5/28/13, 10:03 a.m., 5/28/13, 2:22 p.m., 5/29/13, 10:00 a.m., 5/29/13, 11:15 a.m., 5/31/13, 9:45 a.m. and 5/31/13, 2:00 p.m.<br><br>During a 5/31/13, 9:50 am. interview, LPN #11 indicated Resident #54 liked to lay down in her bed and usually only got up for meals. The resident did not interact with others. Resident #54 did at time resist care but did not act out at any other time.<br><br>During a 5/31/13, 9:35 am interview, CNA #10 indicated Resident #54 | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | spent all of her time in bed except for meals. Resident #54 did not interact with others. He indicated Resident #54 did at times resist care but she did not display any other behaviors.<br><br>During a 6/3/13, 11:00 a.m., interview, Activity Assistant #13 indicated Resident # 54 was in bed asleep almost all day long. The resident was placed on one to one activity visits due to being in bed the majority of her day. She additionally indicated the resident was in bed during one to one activities and did not always open her eyes even during one to one activities.<br><br>3.) A current, 4/2012, facility policy titled "Behavior Management and Psychoactive Medication Monitoring," which was provided by the Administrator on 6/3/13 at 9:20 a.m. indicated the following:<br><br>"Policy: To ensure the resident receives effective treatment and intervention for behavior and mode symptoms.<br>To ensure the resident is receiving the necessary medication at the lowest effective dose to treat their symptoms."<br><br>4.) A current, undated facility policy | | | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | titled "Gradual Dose Reductions," which was provided by the Administration 6/3/13 at 9:30 am indicated the following:<br><br>"It is the policy of this facility to conduct Gradual Dose Reductions (GDRs) per regulatory guidelines in an effort to find the least restrictive optimal dose and to determine whether continued use of the medication is benefiting the resident."<br><br>3.1-48(a)(3)<br>3.1-48(a)(4)<br>3.1-48(a)(6) | | | |

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|
| F000431<br>SS=E | 483.60(b), (d), (e)<br>DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation, interview and record review, the facility failed to ensure the tubes and bottles of topical medications were properly | F000431 | **F-431**<br><br>1. Tubes of medicated ointments and creams without labels were removed from the 200 | 07/03/2013 |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | labeled with resident names and Physician's name for 1 of 4 treatment carts reviewed, potentially affecting 32 residents living on 200 Hall. The facility also failed to properly dispose of a bottle of expired medication for 1 of 32 residents living on 200 Hall who's medications were stored in the South Medication Room. (Resident #19)<br><br>Findings include:<br><br>1. On 5/31/13 at 2:45 p.m., while observing medication storage, tubes of medicated ointments and creams were found without labels to identify which resident the medication belonged on treatment cart for Hall 200.<br><br>The treatment cart for 200 Hall contained the following opened tubes of ointments and creams without a resident specific label: Aloe Vesta Antifungal (antifungal ointment), Aloe Vesta (protective ointment), two-Duoderm Hydroactive Gel (hydrocolloid wound dressing) and Silvasorb gel (antimicrobial wound gel)<br><br>2. The medication storage closet for 200 South Hall contained the following bottle of discontinued | | Hall treatment cart. The expired medication was removed and destroyed from the 200 Hall medication room.<br><br>2. All residents have the potential to be affected.<br><br>3. Night shift cleaning schedule initiated to include weekly checks of the medication room and treatment carts. Nursing in-service to be held on Medication Storage.<br><br>4. DON/designee will audit medication room and treatment cart to ensure proper labeling is in place and no expired medications are present twice weekly for 4 weeks, then monthly on going. Results from these audits will be forwarded to QA committee monthly for review and any required action.<br><br>5. Completion date 07-03-13 | |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | medication: Gabapentin 100 mg (pain medication for neuropathy) for Resident #19. The medication expired on 9/29/12.<br><br>Review of a current facility policy dated 8/9/11 titled "LTC Facility's Pharmacy Services and Procedures Manual;" which was provided by the Director of Nursing, on 6/3/13 at 10:00 a.m., indicated the following:<br><br>"....4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier....<br><br>18. Facility should request that Pharmacy perform a routine nursing unit inspection for each nursing station in Facility to assist Facility with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medication and biologicals."<br><br>During an interview on 6/3/13 at 10:30 a.m., the DoN indicated the pharmacy technician was in the | | | |

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|
| | facility on 5/13/13 and reviewed the medication and treatment carts.<br><br>3.1-25(j)<br>3.1-25(k)<br>3.1-25(r) | | | |

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|
| F000520<br>SS=E | 483.75(o)(1)<br>QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>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.<br><br>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.<br><br>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.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>Based on interview and record review the facility failed to identify and implement a plan of action related to psychoactive medication side effect monitoring and fluid restrictions for residents with dialysis services. This deficient practice impacted 2 of 10 residents reviewed for unnecessary medication use (Residents #84 and #54) and 1 of 1 resident reviewed for fluid restrictions and dialysis services (Resident #19). | F000520 | F-520<br><br>1. The concerns with psychoactive medication monitoring and fluid restriction will be reviewed by QA committee at the next monthly meeting for review and action plan.<br><br>2. All residents have the potential to be affected.<br><br>3. All staff will be in-serviced on the role of the QA committee. | 07/03/2013 |

| 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 06/03/2013 |
|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | Findings include:<br><br>During a 6/3/13, 11:15 a.m. interview, the Administrator was queried regarding the Quality Assessment and Assurance (QAA) process and the identified concerns of side effect monitoring for residents who reviewed psychoactive medications which impacted Residents #84 and #54 and fluid restriction monitoring for residents who receive dialysis services which impacted Resident #19.<br><br>The 5/28/13, facility "Resident Census and Condition of Residents" form indicated 26 of the facility's residents receive psychoactive medications.<br><br>The 5/28/13, "Facility Entrance Conference Worksheet" indicated 2 of the facility's residents received dialysis services.<br><br>During the 6/3/13, 2:30 p.m., exit conference, the Administrator indicated the facility did not have any information to provide regarding side effect monitoring and fluid restrictions.<br><br>3.1-52(b)(2) | | 4. The QA committee will meet monthly to identify issues and develop and implement appropriate plans of action to correct identified issues. The QA committee will review the status of action plans monthly. The administrator /designee will maintain minutes of the meetings.<br><br>5. Completion date 07-03-13 | |

| 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 06/03/2013 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>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 |
|---|---|---|---|---|