

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  06/04/2015
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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
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F 0000  Bldg. 00	<p>This survey was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 31, June 1, 2, 3, &amp; 4, 2015</p> <p>Facility number: 000309 Provider number: 155432 AIM number: 100288960</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 9 Medicaid: 53 Other: 2 Total: 64</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p>	F 0000	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.	
F 0158 SS=D Bldg. 00	<p>483.10(c)(1) RIGHT TO MANAGE OWN FINANCIAL AFFAIRS</p> <p>The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.</p> <p>Based on record review and interview,</p>	F 0158	1. The facility withdrew our	07/04/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>the facility failed to allow a resident or her representative to manage her finances for 1 of 1 resident reviewed for Social Security representative payee status (Resident #101).</p> <p>Findings include:</p> <p>During a 6/3/15, 1:49 p.m., interview, Resident #101's family member/POA (power of attorney) indicated he was his family member's POA. He had not given the facility authorization nor requested the facility to become the representative payee for the resident's Social Security benefits. He indicated the facility had requested to become Resident #101's Social Security representative payee without his consent. He indicated he was not informed of this request by the facility but inadvertently found out when conversing with the Social Security office.</p> <p>Resident #101's clinical record was reviewed on 6/3/15 at 1:49 p.m. Resident #101's diagnoses included, but were not limited to, chronic pain and cognitive communication deficit. Resident #101 was admitted to the facility within the past 60 days of this record review. Resident #101 was admitted to the facility for therapy services.</p>		<p>request to be representative payee for resident #101.2. All residents have the potential to be affected.3. Going forward, the Advance Notification of Representative Payment form will be signed by the resident or family member indicating their consent for the facility to be representative payee. The Business Office Manager will be inserviced on completing the Advance Notification of Representative Payment form.4. The Administrator will review all future Advance Notification of Representative Payment forms to ensure the appropriate signatures are present. Results/findings will be reviewed monthly by the QA committee X 3 months, then quarterly X 3.</p>				

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	<p>During a 6/04/15, 9:15 a.m., interview, Business Office Manager #1 (BOM #1) indicated she was the individual in change of establishing financial information and payment status for each resident. She indicated she would apply for the facility to become the Social Security representative payee for one of the 3 following reasons: 1. family request, 2. payments were not being made, or 3. an individual was misusing the resident's money. BOM #1 indicated she had believed Resident #101's family had desired the facility to become the resident's representative payee for Social Security. She indicated the facility did not have any forms or systems in place for families to indicate when they made this request. She indicated following this mistake, the facility had not developed a system to ensure errors did not occur again. BOM #1 also indicated she had no paperwork to verify Resident #101's family had made this request. BOM #1 indicated she believed the request had been made to her verbally. She indicated a miscommunication must have occurred. She additionally indicated she did not confirm with the nursing department if Resident #101 would become a long term resident. Lastly, she indicated after Resident #101's family told her they did not want the facility to manage the resident's Social Security and finances,</p>			

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F 0279 SS=D	<p>the facility corrected its error and withdrew its request to become payee.</p> <p>A 5/27/15, fax transmittal to the Social Security Administration Office indicated the facility had withdrawn its request to be Resident #101's representative payee for Social Security.</p> <p>A current, 8/1/14, facility form titled "Facility Admission Agreement", which was provided by BOM #1 on 6/4/15 at 11:15 a.m., indicated:</p> <p>"Personal Funds and Possessions. Deposits. The Resident is not required to deposit his or her personal funds with the Facility...."</p> <p>A current, 8/1/14, facility policy titled "Resident Rights", which was provided by the Admissions Coordinator on 6/4/15 at 11:15 a.m., indicated:</p> <p>"(1) The resident has the right to manage his or her financial affairs and the facility may not require residents to deposit their personal funds with the facility."</p> <p>3.1-6(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE</p>			

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Bldg. 00	<p><b>PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>Based on record review and interview, the facility failed to ensure care plans were initiated when new problems were identified by the Minimum Data Set assessment (Resident #92) and failed to have specific target behaviors for medications for 2 of 5 residents reviewed for unnecessary medications. (Resident #'s 82, 16)</p> <p>Findings include:</p> <p>1. Resident #92's clinical record was reviewed on 6/3/15 at 10:07 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease,</p>	F 0279	<p>1. A voiding diary was completed and reviewed for resident #92 and a toileting program was written. Resident #92's care plan was updated. Care plans for residents #82 and #16 were updated to include specific targeted behaviors for the use of antipsychotics, anti-depressants, and anti-anxiety medications. 2. All residents have the potential to be affected. A 100% audit was completed to identify residents with a decrease in their level of continence for the last quarter. A 100% audit was completed on all residents receiving anti-psychotics, anti-depressants and anti-anxiety medications to ensure specific targeted</p>	07/04/2015			

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	<p>anxiety disorder, dementia with behavioral disturbance, and Down's Syndrome.</p> <p>The resident had a 2/18/15, admission Minimum Data Set (MDS) assessment. The assessment indicated the resident had moderate cognitive impairment, was continent of urine and required the assistance of one for supervision or cueing for toileting.</p> <p>The resident had a 5/18/15, significant change Minimum Data Set assessment. The assessment indicated the resident had moderate cognitive impairment, had occasional incontinence of urine and required extensive assistance of one with toileting.</p> <p>Review of the care plan lacked a problem of incontinence having been identified or addressed.</p> <p>The MDS/Care Plan Coordinator was interviewed on 6/3/15 at 1:50 p.m. She indicated Resident #92 had been incontinent of urine 4 times in the past week after lunch. She indicated she could see the resident had a problem with urine incontinence at lunch. She indicated the resident was continent during the 72 hour voiding pattern review completed on 5/8/15. She indicated the</p>		<p>behaviors were addressed in their care plans. 3 The Regional MDS Coordinator presented an inservice to the MDS Coordinator on Section H of the MDS. The Regional Director of Quality Assurance presented an inservice to the MDS Coordinator and Social Service Director on writing care plans for those residents receiving psychoactive medications. Upon review of new orders during morning meeting, the Social Service Director will be notified of all psychoactive medication orders. 4. Upon completion of the MDS, the MDS Coordinator will complete an audit comparing Section H from the previously completed MDS to ensure there has not been any significant change in continence. During morning meeting, the Social Service Director/MDS Coordinator will complete an audit to ensure all psychoactive medication care plans have specific targeted behaviors addressed as needed. All audits/findings will be reviewed monthly by the QA committee X 3 months then quarterly X 3.</p>		

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	<p>MDS information was taken from the CNA documentation on the electronic record and was obtained after the 72 hour voiding pattern review. She indicated she had not developed a care plan problem related to the resident's occasional incontinence.</p> <p>2. The clinical record for Resident #82 was reviewed on 6/2/15 at 1:14 p.m. Diagnoses for Resident #82 included, but were not limited to, depression, dementia, and anxiety.</p> <p>Current physician orders for Resident #82 included, but were not limited to the following:</p> <p>a. Abilify (an anti-psychotic medication) 5 milligrams (mg) by mouth one time a day. The original date of this order was 4/27/15.</p> <p>b. Cymbalta (an anti-depressant medication) 60 mg by mouth at bed time. The original date of this order was 4/27/15.</p> <p>c. Alprazolam (an anti-anxiety medication) 0.25 mg by mouth "as needed" for anxiety three times daily. The original date of this order was 3/10/15.</p> <p>Resident #82 had an admission Minimum</p>			

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	<p>Data Set (MDS) assessment dated 3/17/15. The assessment indicated the resident had moderate cognitive impairment.</p> <p>Resident #82 lacked health care plans with specific targeted behaviors for the use of his anti-psychotic, anti-depressant, and anti-anxiety medications before 6/4/15.</p> <p>During an interview on 6/4/15 at 11:01 a.m., the RN Consultant and the Assistant Director of Nursing indicated they did not have any health care plans with specific targeted behaviors for Resident #124 regarding his use of anti-psychotic, anti-depressant, and anti-anxiety medications.3. The clinical record for Resident #16 was reviewed on 6/3/2015 at 9:45 a.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, chronic kidney disease, muscle weakness, dysphagia, depressive disorder, anxiety, chronic pain, asthma, hypertension, esophageal reflux and congestive heart failure.</p> <p>Current physician's orders for Resident #16 included, but were not limited to, the following:</p> <p>a. Buspirone tablet 15 mg give 0.5 tablet by mouth 2 times a day related to</p>			

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	<p>Anxiety. The original date of this order was 4/17/15.</p> <p>b. Citalopram tablet 20 mg one time a day related to Depressive Disorder. The original date of this order was 2/7/15.</p> <p>Resident #16 had a care plan, dated 1/27/15, for depression: " I have Depression as evidenced by long history of depression or other mental illness. Goal: My depressive symptoms will be managed through my care plan interventions. Interventions: Allow me to express my feelings. I will receive my medications as ordered. I will report and you will observe for changes in my depression symptoms. I will report and you will observe for signs and symptoms such as N/V [nausea and vomiting], dry mouth, weight gain/loss. Implement my pain care plan."</p> <p>Resident #16's depression care plan lacked specific behaviors related to her diagnosis of depressive disorder and use of an antidepressant medication.</p> <p>Resident #16 lacked a care plan with specific behaviors related to her diagnosis of anxiety and use of an anti-anxiety medication.</p>			

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	<p>During an interview on 6/4/15 at 1:16 p.m., the Minimal Data Set (MDS) Coordinator indicated the facility did not have specific signs and symptoms targeted in the resident's care plans.</p> <p>Review of the current, 1/2012, policy, titled "CARE PLANS Refer to RAI [Resident Assessment Instrument] Manual Chapter 4," provided by the DON on 6/4/15 at 12:39 p.m., included, but was not limited to,</p> <p>"4.7 The RAI and Care Planning...</p> <p>...the comprehensive care plan is 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...</p> <p>...Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks. Identify specific symptomatic and cause-specific interventions [physical, functional and psychosocial]...</p> <p>...Clarify how specific treatments and services will be evaluated for their</p>			

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F 0315 SS=D Bldg. 00	<p>effectiveness and possible adverse consequences..."</p> <p>3.1-35(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident with a decline in urinary continence was identified and had a health care plan put into place to restore or maintain bladder continence for 1 of 3 residents reviewed for a decline in urinary continence. (Resident #92)</p> <p>Findings include:</p> <p>Resident #92 was observed toileting herself without assistance on 6/4/15 at 12:38 p.m.</p> <p>Resident #92's clinical record was</p>	F 0315	<p>1. A toileting program and incontinence care plan has been completed for resident #92.2. All residents have the potential to be affected. A 100% audit was completed to identify residents with a decrease in their level of continence over the last quarter.3. The Regional MDS Coordinator presented an inservice to the MDS Coordinator on Section H of the MDS.4. Upon completion of the MDS, the MDS Coordinator will complete an audit comparing Section H from the previously completed MDS to ensure there has not been any significant change in continence.All audits/findings will be reviewed monthly by the QA</p>	07/04/2015

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	<p>reviewed on 6/3/15 at 10:07 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, anxiety disorder, dementia with behavioral disturbance, and Down's Syndrome.</p> <p>The resident had a 2/18/15, admission Minimum Data Set [MDS] assessment. The assessment indicated the resident had moderate cognitive impairment, was continent of urine and required the assistance of one for supervision or cueing for toileting.</p> <p>The resident had a 5/18/15 significant change Minimum Data Set assessment. The assessment indicated the resident had moderate cognitive impairment, had occasional incontinence of urine and required extensive assistance of one with toileting.</p> <p>Resident #92's voiding record was reviewed for 5/6/15 to 6/4/15. The record indicated the resident was incontinent of urine between the hours of 12:00 p.m. and 1:00 p.m., 14 times. The resident was incontinent of urine between 1:00 p.m. and 2:00 p.m., 3 times. The resident was incontinent of urine once at 5:59 a.m. and once at 7:31 p.m.</p> <p>The resident did not have a care plan</p>		committee X 3 months, then quarterly X 3.	

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	<p>addressing the resident's incontinence.</p> <p>The MDS/Care Plan Coordinator was interviewed on 6/3/15 at 1:50 p.m. She indicated Resident #92 had been incontinent of urine 4 times in the past week after lunch. She indicated she could see the resident had a problem with urine incontinence at lunch. She indicated the resident was continent during the 72 hour voiding pattern review completed on 5/8/15. She indicated the MDS information was taken from the CNA documentation on the electronic record and was obtained after the 72 hour voiding pattern review. She indicated she had not developed a care plan problem related to the resident's occasional incontinence.</p> <p>LPN #2 was interviewed on 6/3/15 at 2:40 p.m. LPN #2 indicated Resident #92 was occasionally incontinent at night due to sleeping hard and not waking up to go the bathroom. She indicated the resident toileted herself without assist during the day. She indicated the resident was occasionally incontinent during the day because the resident got involved in an activity and would wait too long before going to the bathroom.</p> <p>During a 6/4/15, 12:40 p.m., interview with CNA #3, she indicated Resident #92</p>			

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F 0323 SS=D Bldg. 00	<p>had some days when she needed more assistance with toileting and some days when she didn't need assistance.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident identified at risk for falls had fall interventions in place in accordance with his plan of care for 1 of 3 residents reviewed for accidents. (Resident #97)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #97 was reviewed on 6/3/15 at 11:56 a.m. Diagnoses for Resident #97 included, but were not limited to, dementia and muscle weakness.</p> <p>A fall risk evaluation, dated 4/14/15, prior to a 5/18/15 fall, indicated the Resident #97 was at risk for falls.</p>	F 0323	<p>1. The facility is unable to correct for resident #97 as this resident is no longer in the facility.2. All residents with personal alarms have the potential to be affected. An audit was completed on all residents with falls since 05-18-15 to ensure falls were examined for personal alarms in place.3. Nursing staff will be inserviced on alarm placement.4. The Director of Nursing/Licensed Designee will complete audits to ensure that alarms are in place and functioning 3 times per week X 4 weeks, then weekly X 4 weeks, then monthly.All audits/findings will be reviewed monthly by the QA committee X 3 months, then quarterly X 3.</p>	07/04/2015

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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
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	<p>Resident #97 had an admission Minimum Data Set (MDS) assessment, prior to the event, dated 4/21/15. The assessment indicated Resident #97 was severely cognitively impaired and never or rarely made decisions.</p> <p>A health care plan focus, dated 4/15/15, indicated Resident #97 was at risk for falls. One of the interventions for this focus was to use an alarm in the bed and in the chair "to remind me to ask for staff assistance with mobility and transfers."</p> <p>A nurse's note, dated 5/8/15, indicated Resident #97 was in his wheelchair in the dining room. Resident #97 stood up from the wheelchair and fell. A "Fall IDT [Interdisciplinary Team] Note", dated 5/11/15, indicated Resident #97 was sitting in his wheelchair in the dining room, stood up by himself and fell to the ground on 5/8/15. Neither the nurses's note nor the Fall IDT note indicated an alarm sounded when Resident #97 stood up from his wheelchair.</p> <p>During an interview on 6/4/15, at 10:33 a.m., the Director of Nursing (DON) indicated the CNA had not put the alarm in Resident #97's wheelchair on 5/8/15.</p> <p>Review of the current, revised 8/2013, policy, titled "FALL EVALUATION and</p>			

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F 0514 SS=D Bldg. 00	<p>INVESTIGATION", provided by the DON on 6/4/15 at 12:39 p.m., included, but was not limited to,</p> <p>"Purpose:...</p> <p>...2. To identify high-risk residents and implement interventions to reduce falls and the consequences of falls...."</p> <p>3.1-45(a)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on clinical record review and interview, the facility failed to ensure complete and accurate clinical record documentation regarding daily weights for 1 of 5 residents reviewed for unnecessary medications. (Resident #16)</p> <p>Findings include:</p>	F 0514	1. The events for resident #16 happened in the past so the facility is unable to complete the missing documentation. 2. All residents with orders for daily weights have the potential to be affected. A 100% audit was completed for those residents on daily weights to ensure no further records were lacking	07/04/2015

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	<p>The clinical record for Resident #16 was reviewed on 6/3/2015 at 9:45:01 a.m. Diagnoses for Resident #16 included, but were not limited to, chronic kidney disease, muscle weakness, dysphagia, depressive disorder, anxiety, chronic pain, asthma, hypertension, esophageal reflux and congestive heart failure.</p> <p>A physician's order, dated 2/27/15 and discontinued on 5/19/15, indicated Resident #16 was to be weighed daily. The physician was to be notified if the resident had a weight gain of more than two pounds in 24 hours, or 5 pounds in 7 days.</p> <p>The record lacked documented weights for the following dates: 4/5/15, 4/6/15, 4/13/15, 4/14/15, 4/15/15, 4/28/15, 4/29/15, 5/10/15 and 5/13/15.</p> <p>A hypertension care plan, dated 1/27/15, for Resident #16 indicated: "I have essential hypertension of unknown origin and angina pectoris. Goal: My blood pressure will be managed with my care plan interventions. Interventions...I will report and you will observe for edema and unexplained weight gain...."</p> <p>A congestive heart failure care plan, dated 2/23/15, for Resident #35</p>		documentation. 3. Nursing staff will be inserviced on completion and documentation of daily weights. 4. The Director of Nursing/Assistant Director of Nursing will audit daily weights during morning meeting to ensure there is complete and accurate clinical record documentation. All audits/findings will be reviewed monthly by the QA committee X 3 months, then quarterly X 3.	

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	<p>indicated: "I have congestive heart failure as evidenced by edema, weight fluctuations Goal: I will have decreased edema and my weight will be stabilized. Interventions...I will allow myself to be weighed as the physician ordered...."</p> <p>During an interview on 6/4/15 2:04 p.m., the Director of Nursing indicated there was no further information regarding the missing weights and physician/family notification. The Director of Nursing indicated the weights and physician notification of weight gain should have been documented in the resident's clinical record.</p> <p>A current facility policy titled "Documentation Procedure and Guidelines", dated 4/2015, provided by the RN Consultant on 6/4/15 at 2:48 p.m., indicated the following:</p> <p>"...Nursing Documentation... 3. Entries will be made whenever there is a change in the resident's condition. The entry will include interventions and appropriate notifications made in a timely manner...."</p> <p>3.1-50(a)(1)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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