PRINTED: 04/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED 03/15/2012		
155432			B. WIN			03/15/	2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
ALBANY	HEALTH CARE &	REHABILITATION CENTER			WALNUT ST Y, IN 47320		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	1 1 1 C C C C C	1 D ('C' (' 1	K00	000	This plan of correction is		
		ode Recertification and	Kuc	<i>)</i> 00	This plan of correction is prepared and executed becau	ise	
		Survey was conducted by			it is required by the provisions		
		e Department of Health in			State & Federal law and not		
	accordance with	42 CFR 483.70(a).			because Albany Health Care		
	Survey Date: 0.	3/15/12			Rehabilitation Center agrees we the allegations and citations listed. Albany Health and		
	Facility Number	r: 000309			Rehabilitation Center maintair		
	Provider Number				that the alleged deficiencies do not individually or collectively jeopardize the health and safety		
	AIM Number:						
	Alivi Nullibel.	100288900			of the residents, nor are they		
	C D1:11	. 1. 1.6 6 6 6			such character so as to limit o	ur	
	_	ip Komsiski, Life Safety			capability to render adequate	1-4-	
	Code Specialist				care. Please accept the last of noted on this plan of correction		
					the facility's written credible	11 43	
	At this Life Safety Code survey, Albany				allegation of compliance.		
	Health & Rehab	ilitation Center was found					
	not in complian	ice with Requirements for					
	Participation in	Medicare/Medicaid, 42					
	CFR Subpart 48	3.70(a), Life Safety from					
	Fire, and the 20	00 edition of the National					
	Fire Protection	Association (NFPA) 101,					
		e (LSC), Chapter 19,					
	1	Care Occupancies and					
	410 IAC 16.2.	··· F · · · ·					
	110 1110 10.2.						
	This one story f	acility was determined to					
		11) construction and was					
	fully sprinklered. The facility has a fire alarm system with smoke detection in the						
	1						
	corridors and spaces open to the corridors with no smoke detectors in the resident						
	rooms. The fact	ility has a capacity of 101					

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.

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

PRINTED: 04/10/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155432	A. BUILDING B. WING	01	COMPI 03/15	LETED	
	ROVIDER OR SUPPLIER 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 PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	and had a census of 82 at the time of this survey.					
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/26/12.					
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6MRX21

Facility ID: 000309

If continuation sheet

Page 2 of 6

PRINTED: 04/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			· ′	DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED		
155432		B. WIN	G		03/15/	2012	
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	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0027 SS=E	NFPA 101 LIFE SAFETY C Door openings ir least a 20-minute at least 1¾-inch core. Non-rated exceed 48 inche are permitted. H comply with 7.2. or automatic clos 19.2.2.2.6. Swin to swing with egi not required.  Based on observe facility failed to smoke barrier do the appropriate h door which must closes first, so be close completely Medicare & Med requires sets of s swing in the sam with an astragal te ensure the door v always closes fir practice could af hall and 36 resid as staff and visite  Findings include  Based on observe the tour between p.m. with the Ma	ODE STANDARD  In smoke barriers have at a fire protection rating or are thick solid bonded wood protective plates that do not a from the bottom of the door dorizontal sliding doors 1.14. Doors are self-closing using in accordance with using doors are not required ress and positive latching is 19.3.7.5, 19.3.7.6, 19.3.7.7 ations and interview, the ensure 2 of 5 sets of fors were equipped with ardware to allow the close first, to always oth doors will always as a pair. Centers for dicaid Services (CMS) moke barrier doors that the direction and equipped to have a coordinator to which must close first st. This deficient fect 18 residents on 100 tents on 200 hall as well to the control of the	K00		K 027  Corrective action for affected and potentially affected residents: All residents residing on the 100 and 200 halls have the potential to be affected by the alleged deficient practice. Coordinator hardware has been installed on the affected doors.  Systemic changes: Coordinator hardware has been installed on the affected doors.  Monitoring: Fire door function will be checked by the Maintenance Supervisor weekly for 4 weeks, then checked month ongoing. Results of checks will reviewed at each Qualit Assurance Committee	e he ed ed	04/10/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6MRX21

Facility ID: 000309

If continuation sheet Page 3 of 6

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

PRINTED: 04/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION ID	DENTIFICATION NUMBER: 155432	A. BUIL B. WINC	DING	<u>01</u>	COMPL 03/15/	ETED
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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PERCEDED BY FULL  CONTROL OF THE SECTION OF THE S	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	100 hall and 200 h same direction and metal astragal, lack allow the astragal first. When tested doors closed prope door closing first. 03/15/12 at 12:33 with the Maintenan acknowledged the barrier doors lacke	all, which swung in the were equipped with a sed a coordinator to side of the door to close these sets of smoke orly with the astragal Based on interview on p.m. and 12:40 p.m. Ince Supervisor, it was aforementioned smoke d a coordinator to the the metal astragal		TAG	meeting.  Completion Date: April 10, 2012		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6MRX21

Facility ID: 000309

If continuation sheet

Page 4 of 6

PRINTED: 04/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
155432		A. BUILDING	01	03/15/2012		
		155432	B. WING		03/15/2012	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ALBANY HEALTH CARE & REHABILITATION CENTER				WALNUT ST NY, IN 47320		
			ALDAI			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
K0066	NFPA 101	LSC IDENTIFYING INFORMATION)	IAG	DETELENCT)	DATE	
SS=E		ODE STANDARD				
00-L		ions are adopted and include				
		following provisions:				
		rohibited in any room, ward,				
	•	where flammable liquids, es, or oxygen is used or				
		y other hazardous location,				
		posted with signs that read				
	NO SMOKING or with the international					
symbol for no smoking.		noking.				
	(2) Smoking by r	patients classified as not				
		ohibited, except when under				
	direct supervisio	n.				
	(2) Ashtrova of n	annombustible meterial and				
		oncombustible material and provided in all areas where				
	smoking is perm					
	` '	ners with self-closing cover				
		ch ashtrays can be emptied able to all areas where				
	smoking is permitted. 19.7.4  Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container instead of a plastic container with paper goods for 1 of 1 areas where smoking was permitted.  This deficient practice could affect 3 residents observed in the smoking hut as					
			K0066	K 066	04/10/2012	
				Corrective action for affected	ed	
				residents:		
				All residents who utilize the	)	
				smoking area have the	ha	
				potential to be affected by talleged deficient practice. A		
				self-closing metal container		
	well as visitors a	_		has been installed in the		
	211 45 (151015 4			smoking area. The plastic		
	Findings include	·		waste container has been		
	- mamps merade	•		removed from the smoking		
	Based on observation on 03/15/12 at 1:15			area.		
		aintenance Supervisor,				
	P.III. WILLI LIIC IVIC	intendice Supervisor,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6MRX21

Facility ID: 000309

If continuation sheet Page 5 of 6

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

PRINTED: 04/10/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (155432) Trovider/supplier/clia  identification number:	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	(X3) DATE SURVEY COMPLETED 03/15/2012		
	PROVIDER OR SUPPLIER 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 PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION		
	smoking was permitted just outside the 100 hall where over 100 cigarette butts as well as paper goods were in a 25 gallon plastic container. Based on review of the smoking policy on 03/15/12 at 3:45 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 03/15/12 at 1:22 p.m. with the Maintenance Supervisor, it was acknowledged extinguished cigarette butts were thrown into a plastic container with paper goods.  3.1-19(b)		Systemic changes: A self-closing metal cont has been installed in the smoking area. The plasti waste container has bee removed from the smoking area.  Monitoring: The administrator or maintenance supervisor complete weekly checks smoking area ongoing. Results of weekly checks be reviewed at each Quanta Assurance Committee meeting.  Completion Date: April 10, 2012	c n ng will of the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6MRX21

Facility ID: 000309

If continuation sheet

Page 6 of 6