STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 01 B. WING	03/15/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/15/12 Facility Number: 000309 Provider Number: 155432 AIM Number: 100288960 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Albany Health & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with no smoke detectors in the resident rooms. The facility has a capacity of 101	K0000	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	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:			

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K0027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observations and interview, the facility failed to ensure 2 of 5 sets of smoke barrier doors were equipped with the appropriate hardware to allow the door which must close first, to always closes first, so both doors will always close completely as a pair. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors that swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 18 residents on 100 hall and 36 residents on 200 hall as well as staff and visitors. Findings include: Based on observation on 03/15/12 during the tour between 12:30 p.m. and 12:55 p.m. with the Maintenance Supervisor, the set of smoke barrier doors leading into	K0027	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 monthly ongoing. Results of checks will reviewed at each Quality Assurance Committee	04/10/2012

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	100 hall and 200 hall, which swung in the same direction and were equipped with a metal astragal, lacked a coordinator to allow the astragal side of the door to close first. When tested these sets of smoke doors closed properly with the astragal door closing first. Based on interview on 03/15/12 at 12:33 p.m. and 12:40 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier doors lacked a coordinator to ensure the door with the metal astragal always closed first. 3.1-19(b)		meeting. Completion Date: April 10, 2012	

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K0066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available 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 well as visitors and residents. Findings include: Based on observation on 03/15/12 at 1:15 p.m. with the Maintenance Supervisor,	K0066	K 066 Corrective action for affected residents: All residents who utilize the smoking area have the potential to be affected by the alleged deficient practice. A self-closing metal container has been installed in the smoking area. The plastic waste container has been removed from the smoking area.	04/10/2012

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	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 container has been installed in the smoking area. The plastic waste container has been removed from the smoking area. Monitoring: The administrator or maintenance supervisor will complete weekly checks of the smoking area ongoing. Results of weekly checks will be reviewed at each Quality Assurance Committee meeting. Completion Date: April 10, 2012	