

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

PRINTED: 10/08/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155432	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2020	
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
F 000	INITIAL COMMENTS This visit was for a COVID-19 Focused Infection Control Survey. Survey date: October 5, 2020 Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 11 Medicaid: 46 Other: 8 Total: 65 Albany Health Care and Rehabilitation Center was found to be in compliance with 410 IAC 16.2-3.1 in regard to the COVID-19 Focused Infection Control Survey. Quality review completed on October 7, 2020.		F 000		

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.