STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 00 B. WING	03/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00403125. Complaint IN00403125 - Federal/state deficiencies related to the allegations are cited at F580, F607 and F656. Survey dates: March 5 and 6, 2023 Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 5 Medicaid: 65 Other: 6 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 10, 2023.	F 0000	The completion of this plan of correction does not constitute an admission or an agreement by the provider that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. Please accept this plan of correction as our credible allegation of compliance. The facility is requesting a desk review for compliance	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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

Jason Gimre | Administrator | 03/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review the facility failed to notify both the physician and responsible party when a severely cognitively impaired resident (Resident B) verbalized intent for self harm for 1 of 3 residents reviewed for notification. Findings include: The clinical record for Resident B was reviewed on 3/6/2023 at 10:47 a.m. Diagnoses included anxiety disorder, severe dementia, and depressive disorder. The most recent, quarterly, Minimum Data Set (MDS) assessment, dated 1/17/2023, indicated the resident was severely cognitively impaired. During an interview, on 3/5/2023 at 11:51 a.m., the Business Office Manager (BOM) indicated on 3/2/2023, she heard a conversation between the resident and the Director of Nursing (DON). Resident B stated she was going to slit her wrist. The DON entered the office and said Resident B had made such statements all of the time. During an interview, on 3/5/2023 at 12:22 p.m., Resident B's family member indicated they had never been notified of any behaviors related to statements of self harm. During an interview, on 3/6/2023 at 11:18 a.m., the MDS Coordinator indicated on 3/2/2023, he had heard Resident B in the hallway saying something about cutting herself. The DON entered the adjoining office, and said she was tired of hearing the resident say that. The incident was brought	F 0580	1. Immediate action taken for those residents identified: Although the complaint resident was kept as anonymous as possible, circumstances reviewed in investigation brought forth only one resident. Resident B's behavior of making repetitive negative and pessimistic comments including comment of self-harm. The resident's representative was notified of repetitive comments and ideations as well as the notification of resident clinician. No harm was incurred to Resident B by the alleged deficient practice. Psychiatric services have been added to the resident's plan of care. 2. How the Facility identified other residents: All residents with behavioral and clinical changes are at risk. See below for corrective actions moving forward. 3. Measures put into place/ System changes: The Behavioral Health Services Policy, eInteract Change in Condition Evaluation SBAR Protocol and Notification of Change in Condition Policy was reviewed, and no changes or updates were indicated. Licensed	03/27/2023

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	up in the morning meeting the following day, and the DON indicated the resident had made such comments in the past. During an interview, on 3/6/2023 at 12:35 p.m., the DON indicated the resident had made self harm comments in the past, but was unsure of when they started. The comments should have been reported to the physician and family, and documented in the clinical record. Review of the clinical record indicated a lack of documented physician or family notification of the resident's self-harm statements. A current policy, dated 2/22, titled "Physician/Clinician/Family/Responsible Party Notification for Change in Condition", provided by the DON on 3/6/2023 at 1:00 p.m., indicated the following: "...Purpose: To ensue that medical/psychological care problems are communicated to the attending physician/clinician and family/resident representative in a timely, efficient, and effective manner...Policy: 1. The facility must immediately inform the resident; consult with the resident's physician/clinician, and notify, consistent with his or her authority, the resident representative(s) when there is: ... A significant change in the resident's physical, mental, or psychosocial status (that is , a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)...." This Federal tag relates to complaint IN00403125. 3.1-5(a)(2)		and non-licensed staff were re-educated on these policies and the importance of documenting behavior and/or change of condition and MD/Family notification. The Director of Clinical Services/designee will review all behaviors and change of condition documentation 5 times weekly for 4 weeks, 2 times weekly for 8 weeks, then once weekly for 3 months for a minimum of 6 months. 4. How the corrective actions will be monitored: The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. Resident behavior that is “potentially” harmful and clinical changes that meet immediate notification of the resident clinician will be reported and documented. Behaviors or clinical changes requiring further monitoring and not an immediate concern will be documented per policy. ALL changes in resident behavior and/or clinical change will be reported to resident representative. The findings of the audits will be presented to the monthly QAPI Committee, and the plan of action adjusted accordingly. Audits will continue after 6 months if deemed necessary by QAPI Committee.	

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			5. Who will monitor compliance: DCS/Designee	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on record review and interview, the facility failed to ensure staff reported allegations of abuse	F 0607	1. Immediate actions taken for those residents identified:	03/27/2023

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	to the Administrator in a timely manner for 1 out of 2 residents reviewed for abuse (Resident C). Findings include: The clinical record for Resident C was reviewed on 3/6/2023 at 11:17 a.m. Diagnoses included Raynaud's Syndrome, dementia, type 2 diabetes, depression, chronic obstructive pulmonary disease, and hypertension. The most recent, quarterly, Minimum Data Set (MDS) assessment, dated 2/24/2023, indicated the resident was severely cognitively impaired. During an interview, on 3/5/2023 at 10:33 a.m., RN 2 indicated a CNA (Certified Nursing Aide) had reported to her a nurse's mal-treatment of residents (Resident C). RN 2 did not remember the name of the CNA. RN 2 did not report the concern to anyone, because she did not know if the CNA just did not like that nurse, or if there was a real concern. She was unable to remember when the allegation was reported to her. During an interview, on 3/6/2023 at 10:512 a.m., the DON indicated it was the expectation of the facility that RN 2 should have reported the allegation of abuse to the Administrator, or herself, immediately. During an interview, on 3/6/3032 at 11:49 a.m., the DON indicated through a facility investigation, they were able to identify the nurse accused of the allegation of mistreatment of Resident C. During an interview, on 3/6/2023 at 12:12 p.m., CNA 9 indicated she had observed RN 10 mistreat Resident C. CNA 9 had reported the concern to RN 2.		No residents were harmed by this allegation. 2. How the facility identified other residents. All residents have the potential to be affected. 3. Measures put into place/ System changes: The facility policy Freedom from Abuse, Neglect, Exploitation and Misappropriation of Property was reviewed, and no changes were required. In-servicing on abuse reporting and facility policy with all facility staff will be done. Education on abuse and reporting is done upon hire, annually and as needed. An audit will be done of random interviews with staff on varying shifts and residents of any concerns regarding allegations of staff to resident concerns. The Director of Clinical Services/designee will interview 2 staff and 2 residents weekly for 8 weeks, 1 random staff member and 1 resident once weekly for 1 month, then 1 staff and 1 resident per month for 3 months, for a minimum of 6 months. 4. How the corrective actions will be monitored: The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. Any allegations noted	

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	A current facility policy, dated 10/17/2022, titled "Freedom from Abuse, Neglect, Exploitation and Misappropriation of Property" was provided by the DON on 3/6/2023 at 10:18 a.m. The policy indicated the following: "... Staff trained to immediately reporting all alleged violations to the Administrator... Staff to Resident Abuse - All allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator and to other officials, including the State Survey Agency and adult protective services, where state law provides for jurisdiction in nursing homes ...." This Federal tag relates to complaint IN00403125. 3.1-28(c)		from either staff or residents with be investigated per policy and reported per state and federal guidance. The findings of the audits will be presented to the monthly QAPI Committee, and the plan of action adjusted accordingly. Audits will continue after 6 months if deemed necessary by QAPI Committee. 5. Who will monitor compliance: Administrator/Designee	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40			

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	but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to develop and implement a behavioral care plan for a severely cognitively impaired resident with verbalization of self-harm intent. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/6/2023 at 10:47 a.m. Diagnoses include, anxiety disorder, severe dementia, and depressive disorder.	F 0656	1. Immediate actions taken for those residents identified: Although the complaint resident was kept as anonymous as possible, circumstances reviewed in investigation brought forth only one resident. Resident B's care plan was updated on behaviors such as repetitive negative and pessimistic comments including comments of self-harm.	03/27/2023

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	The most recent, quarterly, Minimum Data Set (MDS) assessment, dated 1/17/2023, indicated the resident was severely cognitively impaired. Review of the clinical record indicated a lack of any documentation related to verbalizations of intent for self harm, and lacked a care plan or interventions for monitoring said behaviors. During an interview, on 3/6/2023 at 11:18 a.m., the MDS Coordinator indicated Resident B's behaviors had been discussed in a morning meeting on 3/3/2023. During the meeting, the DON had indicated the resident had made these types of statements in the past. He did not know who was documenting behaviors, or developing the care plans. During an interview, on 3/6/2023 at 12:35 p.m., the DON indicated she did not realize nothing had been documented in the clinical record, until 3/5/2023. She had thought Social Services had documented something in the chart. The behaviors should have been documented in the chart, and the family should have been notified of her behaviors and statements. During an interview, on 3/6/2023 at 1:09 p.m., the Administrator and the DON indicated the Social Service Director (SSD) had left facility employment on 2/22/2023. The facility had hired a new SSD and was waiting for the start date. The SSD usually developed the care plans. A current policy, dated 12/22, titled "Nursing - Documentation Procedures and Guidelines" was provided by the DON on 3/6/2023 at 1:12 p.m. The policy indicated the following: "...Purpose: 1. To reflect the quality of care provided to each		Psychiatric services have been provided to the resident and added to the resident plan of care as well. 2. How the facility identified other residents. All residents with behavior changes are at risk. Residents with behavioral issues care plans were reviewed to ensure a care plan is developed with the behavior information and applicable interventions. 3. Measures put into place/ System changes: The facility policy for care plans was reviewed and no changes necessary. The licensed nurses were educated on the policy for care plans and the proper development of them. The Director of Clinical Services/designee will audit care plans of residents with noted behaviors reviewed in daily clinical meetings. The audit will be completed 3 times weekly for 4 weeks, 2 times weekly for 8 weeks, then once weekly for 3 months for a minimum of 6 months. 4. How the corrective actions will be monitored: The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted	

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	resident. 2. To document the resident's progress towards care plan goals, interventions and responses to treatment. 3. To serve as the basis for monitoring activities, education programs, risk management, and other management statistics...Documentation: 1. Each health care professional shall be responsible for making their own prompt, factual, concise entries that are complete, appropriate, and readable...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...." This Federal tag relates to complaint IN00403125. 3.1-35(b)(1)		accordingly. The findings of the audits will be presented to the monthly QAPI Committee, and the plan of action adjusted accordingly. Audits will continue after 6 months if deemed necessary by QAPI Committee. 5. Who will monitor compliance: DCS/designee	