CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.09 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUM. COMPLETE NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 910 W WALNUT ST 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 PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 910 W WALNUT ST ALBANY, IN 47320 (F000} ID PREFIX TAG PROVIDER CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 000} INITIAL COMMENTS (F 000} Paper compliance to the Investigation of Complaint IN00403125 completed on March 6, 2023. Review Date: March 30, 2023 Facility number: 100288960 Albany Health Care & Rehabi			ARTMENT OF HEALTH AN	
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		5432 3960 & Rehabilitation Center was	Provider number: 155 AIM number: 100288 Albany Health Care 8	
paper compliance review to the Complaint Investigation.		AC 16.2-3.1, in regard to the	Subpart B and 410 IA paper compliance rev	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) D				

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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