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	06/17/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00355720. Complaint IN00355720 - Substantiated. Federal/state deficiency related to the allegation is cited at F600. Survey date: June 17, 2021 Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 8 Medicaid: 46 Other: 12 Total: 66 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 23, 2021.	F 0000	This plan of correction is prepared and executed because it is required by the provisions of state and federal law, and not because Albany Health and Rehab agrees with the allegations contained therein. Albany Health and Rehab maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. Please let this Plan of Correction serve as the facility's credible allegation of compliance for the date of 7/17/2021. Albany Health and Rehab respectfully requests paper compliance.	
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,			

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 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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	involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on, interview and record review, the facility failed to prevent staff to resident abuse for 1 of 3 residents reviewed for abuse (Resident B). The facility also failed to protect a resident from abuse by a visitor for 1 of 3 residents reviewed for abuse (Resident C). This deficient practice resulted in Resident B being slapped and pinched by CNA 1 during care and Resident C receiving a black eye after an argument with a visitor. Findings include: 1. The clinical record for Resident B was reviewed on 6/17/21 at 8:41 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, history of Covid-19, bipolar disorder, chronic pain syndrome, delusional disorder and psychosis. The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/18/21, indicated the resident was severely cognitively impaired. During the assessment period, she had both verbal and physical behavioral symptoms directed towards others 1 to 3 days. She required two-person assistance for bed mobility, transfer, dressing, toileting and hygiene. A current health care plan, dated 7/13/11, indicated the resident had dementia with behavioral disorder, as evidenced by, pulling of	F 0600	***(A) Resident B will no longer receive care from CNA 1 as she is no longer in employment with facility.*** ***17 residents on the CNA's assignment had the potential to be affected by the same deficient practice. (CNA 1 only worked one assignment, never changing to other halls or assignments.)*** ***Social services conducted interviews with all residents with BIMS greater than 9 on same assignment/hall as resident B with no negative findings.*** ***Staff interviews performed with no negative findings against any CNA's inclusive of former employee, CNA 1.*** ***Topic of abuse, burnout, and caring for combative residents will be covered at monthly in-person staff inservice. Staff continue to be encouraged to notify any management staff or scheduler of feelings of***	07/17/2021

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	peer's hair, frequent health complaints, she believed she was not liked by others, cursing, hitting, slapping and pinching staff. Interventions included, but were not limited to, approach in calm manner, identify self, establish eye contact, call by name, explain what you are going to do and cease interaction and reapproach when inappropriate. An Indiana Department of Health (IDOH) reportable, dated 6/10/21 at 6:01 a.m., indicated CNA 2 and CNA 3 reported while during resident care, CNA 1 slapped Resident B on the chest and pinched her in response to the resident pinching and twisting the CNA's skin repeatedly. A head-to-toe assessment was completed on Resident B and no redness or bruising was noted. CNA 1 was suspended pending an investigation. The incident was reported to all parties and a shift to shift in-service was initiated. An in-service, dated 6/10/21, titled "Abuse" indicated staff who reviewed and signed the in-service indicated they understood the content of the abuse policy. A statement dated, 6/10/21, indicated the Director of Nursing (DON) spoke to both CNA 2 and CNA 3. When they arrived to work, they were asked by night shift CNA 1 to assist with peri care and changing Resident B. CNA 3 went in to assist with care and the resident was repeatedly pinching CNA 1 who responded "Don't pinch me" and then smacked the resident on her chest. CNA 2 walked into the room and heard CNA 1 say to the resident "if you pinch me, I am going to pinch your [derogatory term for female genitalia]" CNA 1 then proceeded to grab the resident in the pubic area. The care was completed and CNA 1 clocked out and left the facility. The CNAs reported the incident to their supervisor, DON and		***burnout or requests to have respite from assignment, or work respite. They are reminded that they can safely discuss any frustration, feelings of being overwhelmed, or difficult residents with management staff with no concern for disclosure or reprimand.*** ***SSW will interview one resident with a BIMS of greater than 9 on each hall weekly, alternating residents, times 6 weeks, monthly times 3 months, and then quarterly.*** ***(B) Resident denies incident, recanting original allegation stating, "There was no foul play." He chooses to continue visitation from said visitor. Facility will ensure that all visits are held in the common area, or if they choose to be in the resident's room the door will remain open and the privacy curtain will be pulled back at all times during visit.*** ***SSW completed resident interviews with other residents who receive visitors to ensure no concern.*** ***Signage will be placed at the screening table stating, "Please note that we take our resident's safety very seriously. While visiting with our residents, you are expected to refrain from speaking in***	

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	Administrator. A written statement by CNA 3, dated 6/10/21, indicated she was asked by the third shift CNA to help with Resident B. During care, the resident was trying to pinch CNA 1 and she responded by saying "don't pinch me" and smacked the resident twice on the chest. CNA 2 entered the room to see if they needed help and they both heard the CNA say "if you pinch me, I'm going to pinch your [derogatory term for female genitalia]." CNA 3 then helped put the resident's shirt on and left the room. CNA 2 and CNA 3 then talked and both reported the incident to the nurse and then to the DON. A written statement by CNA 2, dated 6/10/21, indicated when she arrived to work, the third shift CNA asked for help to change the resident. CNA 3 went into the room and she went in about 5 minutes later. She observed CNA 1 say "If you pinch me, I'm gonna pinch your [derogatory term for female genitalia]." CNA 1 then proceeded to grab her in the pubic area and squeeze. CNA 3 left the room and waited for CNA 2 and then they both reported the incident to the nurse and the DON. When CNA 1 was done with care, she clocked out and left the building. A statement, dated 6/14/21, indicated the DON and Human Resource spoke with CNA 1. She was asked if she knew why she was suspended and denied knowing why. She was informed of an allegation of abuse in which 2 people witnessed and had nearly identical statements related to her behavior. CNA 1 stated the resident's name and was asked how she knew who they were talking about and CNA 1 stated "because she is mean." CNA 1 stated the resident was pinching her face and cheek and she responded by pushing her		***harsh tones, threatening, or arguing with them. We are required to report any abuse findings or suspicion to local law enforcement and Indiana Department of Health."*** ***A copy of the signage will be mailed to each resident's representative. Department managers/designee will complete rounds during visitation hours two times weekly for 2 weeks and then monthly times six months to observe for any concerns with visitation involving a resident.*** ***DPOC will be reviewed, updated, and changes made through facility QAPI program as needed to sustain substantial compliance for no less than 6 months.*** ***Date of completion will be 07/17/2021***	

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	hand away and did not intend to slap her. She was asked about pinching her in the pubic area and she stated she did not pinch her, but was simply cleaning her with a washcloth as she had been incontinent. CNA 1 stated maybe she was "showing off" in front of the other CNAs'. She was tearful and notified of her termination. During an interview on 6/17/21 at 9:51 a.m., CNA 2 indicated when she arrived to work and clocked in at 6:00 a.m., CNA 1 was still at the facility. She asked both herself and CNA 3 to help change the resident. She stated she went in the room approximately 5 minutes later to see if they needed any help. She was standing at the end of the bed when CNA 1 told the resident if she pinched her, she would pinch her [derogatory term for female genitalia]. With a gloved hand, CNA 1 reach down and grabbed the resident and squeezed her peri area. The resident did not flinch and she immediately left the room. She waited outside the room for CNA 3. CNA 1 and CNA 3 were still in the room with the resident. When they exited the room, CNA 1 went across to the break room and clocked out. They then went and reported the incident to the nurse and then the DON. During an interview on 6/17/21 at 10:00 a.m., CNA 3 indicated she clocked in at 6:00 a.m. and was asked to help assist with the resident. She was on the resident's right side and CNA 1 was on the left side. When you start to change and roll the resident, she will pinch. CNA 1 said "don't pinch me" and slapped the resident's chest twice. CNA 1 then stated she would pinch the resident in her private area if she pinched her. CNA 1 then grabbed the resident and squeezed her private area with a gloved hand. The resident did not flinch and CNA 1 did not say anything. She then looked at CNA 2 who then left the room. She			

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	exited the room with CNA 1 who went across the hall and clocked out. The aide was never alone with the resident or any other resident after that. Both herself and CNA 2 told their nurse and then reported it to the DON. During a telephone interview on 6/17/21 at 10:18 a.m., CNA 1 indicated it was about 6:30 a.m. and she was about to get off of work. She asked 2 aides to help her clean and change the resident. The resident would hit, pinch and was hateful. When she was cleaning her up, the resident pinched her and with her bent arms, pushed the resident's arms away and she thought the resident hit her own chest with her own hands. She did use foul language and told the resident if she pinched her she was going to pinch her [derogatory term for female genitalia]. She denied hitting or pinching the resident. Review of CNA 3's continuing education courses, she completed Abuse & Neglect on 1/14/21 and the Elder Justice Act on 3/2/21. During an interview on 6/17/21 at 1:50 p.m., the DON indicated they were unable to reach CNA 1 on 6/10/21. They finally spoke to her on 6/11/21 and told her she was suspended and to not come to work until someone talked to her. They set up a meeting for Monday 11, 2021 at 2:00 p.m. and they spoke to her at that time and she was then terminated. 2. During an interview 6/17/21 at 11:00 a.m., Resident B stated he had fallen while coming into his room. When asked about discharge, the resident was tearful and indicated he may not have a home to go to. He indicated he talked to his girlfriend and she felt the facility was blaming her for his fall and she may not be able to visit.			

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	The clinical record for Resident C was reviewed on 6/17/21 at 10:49 a.m. Diagnoses included, but were not limited to, orthopedic aftercare, femur fracture, bradycardia and cognitive communication deficit. The most recent admission MDS assessment, dated 5/12/21, indicated the resident was cognitively intact. He required two-person assistance for bed mobility, transfer, dressing, toileting and hygiene and used a walker or wheelchair for mobility. A health care plan, dated 5/5/21, indicated the resident was at risk for falls related to history of falls. Interventions included, but were not limited to, wear proper footwear or non-slip footwear up and have personal items in reach. A progress note, dated 6/16/2021 at 1:54 p.m., indicated the resident fell in his room. A nurse was called to the room by a CNA who was notified by the resident's wife he had fallen to the floor while attempting to ambulate alone without a walker or staff assistance. The resident was found in his room, sitting upright next to bed by the door. A small hematoma was noted to the left eyelid and neurological assessments were initiated. An immediate intervention included to educate the resident and his wife of the importance of staff assistance and usage of a walker for ambulation. A statement by the Assistant Director of Nursing (ADON), dated 6/16/21, indicated she entered the resident's room around 3:00 p.m. to install a bed alarm due to a recent fall. She noted bruising around his left eyelid and ask if that happened when he fell. The resident stated "Well I guess			

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	you could say that I fell into a fist." He was asked if he was joking or being serious and he stated he was serious. The resident stated his girlfriend hit him because she had a bad temper. The resident stated he did not want to cause anymore problems. The incident was immediately reported to the Administrator. On 6/16/21, the Administrator and ADON spoke to Resident C. The resident stated his girlfriend had a temper and they were arguing. The resident said she swung at his face and that is had happened, as well as, before being admitted to the facility. The resident stated he did not want to get anyone in trouble because he loved her. An investigation statement by the DON, dated 6/16/21, indicated a family member had asked the girlfriend if he hit his head and she stated he did not hit his head, but hit his face. Video surveillance was reviewed and the girlfriend was heard with a raised voice possibly arguing about moving an item. Two CNAs were outside the door after the fall and they were not alerted by the girlfriend. A few moments later, the girlfriend came out of the room and asked therapy to assist. The girlfriend denied any arguing and stated the resident had independently used the toilet and then returned to room with his walker. She placed his wheelchair and locked the brakes for him and then took the walker to place near his bed. The resident reached back missing the wheelchair arm and fell between the wheelchair and the unoccupied bed in his room. The resident was again interviewed and stated "I don't want to cause any more problems" but he did not deny or confirm the incident. A current facility policy, dated 4/15 and revised 4/21, titled "Abuse, Neglect and Misappropriation			

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	of Resident Property," provided by the DON on 6/17/21 at 8:51 a.m., indicated the following: "Policy: This facility's policy is the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of property in accordance with all state and federal regulations. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians friends or other individuals. ...Verbal Abuse: The use or oral, written or gestured language that is willfully includes disparaging and derogatory terms.... ...Physical Abuse: Included hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Policy Interpretation and Implementation ...7. The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with federal/state law...." This Federal tag relates to Complaint IN00355720. 3.1-27(a)(1)			