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	10/05/2021

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

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F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Survey dates: October 5, 2021. Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census Bed Type: SNF/NF: 72 Total: 72 Census Payor Type: Medicare: 10 Medicaid: 52 Other: 10 Total: 72 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 7, 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 10/7/2021. Albany Health and Rehab respectfully requests paper compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection			

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

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	prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the			

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	disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to follow and maintain transmission-based precautions, for a resident with COVID-19 symptoms and to prevent the spread of COVID-19 during a pandemic, for 1 of 3 residents reviewed for infection prevention and control (Resident 13). Findings include: During an observation, on 10/5/21 at 11:45 a.m., Resident 13's room contained a yellow zone contact/droplet isolation sign on the door. The sign indicated staff was required to wear an N95 (respirator) mask in Resident 13's room. Certified Nurse's Aide (CNA) 4 wore a surgical mask, face shield, gown and gloves and entered Resident 13's room and delivered the lunch tray. The resident was sitting up in bed, ready to eat without a face covering, while CNA 4 stood at the side of the bed within 3 feet of the resident	F 0880	**F880 Infection Prevention and Control** Plan of Correction **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 13 was placed in TBP and a PCR test was obtained results were negative. CNA 4 instructed on correct usage of N95 mask when entering rooms in TBP **2. How other residents having the potential to be affected by the same deficient**	10/07/2021

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	and prepared the resident's lunch items on the over the bed table for consumption. During an observation, on 10/5/21 at 11:48 a.m., CNA 4 exited Resident 13's yellow isolation room with a surgical mask and a face shield on her face. During an interview at the time of observation, on 10/5/21 at 11:48 a.m., CNA 4 indicated she wore a surgical mask into Resident 13's contact/droplet isolation room while she delivered and prepared the resident's lunch tray. CNA 4 indicated she should have worn an N95 mask in Resident 13's room as an N95 mask was required to be worn in any yellow contact droplet isolation rooms. During an interview, on 10/5/21 at 1:07 p.m., the Director of Nursing indicated Resident 13 was in yellow isolation due to a fever but was being removed from isolation on 10/5/21 as the provider indicated the symptoms were related to a urinary tract infection. Resident 13's clinical record review was completed on 10/5/21 at 1:30 p.m. Diagnosis included, but were not limited to, personal history of COVID-19 and unspecified dementia without behavioral disturbance. Medications included, but were not limited to, ceftriaxone sodium solution reconstituted (antibiotic) 1 Gram - infuse 1 Gram intravenously at 100 milliliters per hour over 1 hour for infection for 1 day dated 10/3/21 and ceftriaxone sodium solution reconstituted (antibiotic) - use 1 Gram in the evening for urinary tract infection (UTI) for 2 days dated 10/5/21.		**practice will be identified and what corrective action(s) will be taken?** Those residents having been removed from TBP had the potential to be affected. A review of residents removed from TBP in the past 2 weeks was completed to ensure residents had been isolated in TBP according to the CDC and IP recommendations. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Root cause analysis was completed with investigative findings: CNA 4 stated while passing lunch trays had forgotten to change from her surgical mask into the N95 before entering the TBP room. Systemic change: nursing staff working assignments with any TBP rooms will wear N95 masks for the duration of their shift. IP nurse stated that she failed to obtain a PCR test prior to removal of Resident 13 from TBP once receiving confirmation that Resident 13's symptoms were from a UTI. Systemic change: PCR confirmatory tests will be obtained prior to removal from TBP rooms once an alternative diagnosis is determined. LTC Infection Control and	

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	Orders included, but were not limited to, maintain droplet isolation due to COVID-19 symptoms. This was ordered on 10/3/21 and discontinued on 10/5/21 at 1:22 p.m. A current care plan for an infection requiring IV antibiotics and fluids for hydration, dated 10/4/21, indicated Resident 13 had a mid line IV. Interventions included, but were not limited to, intravenous antibiotics medications as ordered, intravenous fluids for hydration as ordered, and observe for signs and symptoms of worsening infection. A current care plan for isolation related to COVID-19 symptoms, revised on 10/5/21, indicated Resident 13 required isolation. Interventions included, but were not limited to, I will have contact isolation procedures while symptomatic and I will have respiratory isolation precautions while I am symptomatic. A 9/22/21 COVID-19 Resident Testing document, provided by Registered Nurse (RN) 2 on 10/5/21 at 4:55 p.m., indicated the reason for the rapid testing was outbreak. A change in condition Nurse's Note, dated 10/3/21 at 7:50 a.m., indicated Resident 13's pulse was 123 and pulse oximetry was 92%. The resident's evaluation included symptoms of increased confusion, altered level of consciousness, weakness, and decreased appetite/fluid intake. A 10/3/21 COVID-19 Resident Testing document, provided by RN 2 on 10/5/21 at 4:55 p.m., indicated the reason for the negative rapid testing was symptoms of lethargy and no		Self-assessment from 4/1/2021 was reviewed and updated for accuracy. IP Nurse and Tanya Canales, State IP to review and update the COVID 19 readiness/Mitigation assessment on 10/14/21 @ 11am. RDQA reviewed the Antigen Testing Algorithm with Administrator, Nurse Managers and Environmental Supervisor. IP Nurse/CEC educated staff on use of N95 masks and PCR testing. IP Nurse created and placed additional N95 signs outside of the TBP rooms. The DON/Designee will audit all TBPs daily during department head meeting X6weeks, then weekly X6, then monthly X2, then quarterly for no less than 6 months to ensure precautions are being followed and maintained. The DON/Designee will complete daily visual rounds to include varying shifts X6 weeks, then weekly X6, then monthly X2, then quarterly for no less than 6 months to ensure staff are wearing the appropriate mask for their assignments.. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.**	

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	appetite. A 10/5/21 COVID-19 Resident Testing document, provided by RN 2 on 10/5/21 at 4:55 p.m., indicated the reason for the rapid testing were positive signs and symptoms per CDC (Center for Disease Control) Guidelines. The clinical record lacked any PCR (follow-up confirmatory) testing from 10/3/21 to 10/5/21 while Resident 13 remained symptomatic. A Nurse's Note, dated 10/5/21 at 1:18 p.m., indicated the resident's preliminary urinalysis results showed the resident had a UTI, the resident has not had any respiratory symptoms, and per the nurse practitioner, isolation was not necessary as resident had a UTI and tested negative for COVID-19. During an observation, on 10/5/21 at 2:42 p.m., Resident 13 was resting in bed with her head of bed at 30 degrees. Her eyes were closed, door was open, and the television was on. Resident 13's doorway and door did not contain any isolation signage and the personal protective canister had been removed from the left side of the doorway. During an interview, on 10/5/21 at 2:48 p.m., RN 2 indicated Resident 13 had not completed a PCR (confirmatory) test since she became symptomatic on 10/3/21. She indicated a PCR confirmatory test was necessary when a resident was symptomatic with respiratory symptoms and the symptoms continued after the rapid COVID-19 test was negative. RN 2 indicated the facility has not had any indication to do a PCR test. During an interview, on 10/5/21 at 2:52 p.m., RN		Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. Afer consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually. **5. By what date will the systematic changes be completed?** October 7, 2021	

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	2 indicated the facility had not received Resident 13's final urine culture results from 10/4/21. She indicated Resident 13 remained symptomatic with confusion and lethargy. RN 2 indicated Resident 13 was not typically a resident that remained in bed and lately had not been herself at all. She indicated the facility had recently had some staff members positive for COVID-19 and the last COVID-19 positive staff member test was 10/5/21. During an interview, on 10/5/21 at 3:31 p.m., RN 3 indicated a PCR confirmatory test was not completed for Resident 13 and the transmission based precautions should not have been discontinued. She indicated as a result, Resident 13 was just placed back into isolation. During an interview, on 10/5/21 at 3:34 p.m., RN 2 indicated any staff members who entered a room with a yellow zone transmission based precaution sign should have worn an N95 face mask. During an observation, on 10/5/21 at 3:44 p.m., the resident was resting in bed on her right side. A yellow isolation sign was back on Resident 13's doorway and the isolation canister of personal protective equipment was located to the right of the doorway. A current policy, titled "COVID-19 POLICY," provided by RN 3 on 10/5/21 at 4:38 p.m., indicated the following: "Policy: It is the policy of this facility to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to Federal and State/Local recommendations (to include, for example:			

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	Admissions, Visitation, Precautions: Standard, Contact, Droplet and/or Airborne Precautions, including the use of universal eye protection). Note: All healthcare personnel will be correctly trained and capable of implementing infection control procedures and adhere to requirements....Procedure: Resident Care: ...Ongoing, daily monitoring for potential signs/symptoms of respiratory infection (per guidance). COVID-19 testing consistent with current CDC (Center for Disease Control) recommendations as well as state and local health departments. For suspected or known cases of COVID-19 follow CDC Guidance as well as State and local health department...." 3.1-18(b)(2)			