STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING _____ B. WING _____	**09/30/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices for COVID-19 were followed for 3 of 4 residents reviewed for infection control (Resident B, Resident C, Resident D) Findings include: During an interview, on 9/28/20 at 8:40 a.m., the DON indicated the 300 and 400 hallways were the facility green zones. The red zone (COVID-19 unit) consisted of the 100 hallway and part of the 200 hallway to the fire doors. The yellow zone was the remainder of the 200 hallway. On 9/28/20 at 9:21 a.m. Resident C was observed sitting in her recliner in her room on the 300 hall. The door to her room was open. A notice on her door indicated she was in droplet precautions and a PPE (personal protective equipment) shelf was on her door. On 9/28/20 at 9:40 a.m., CNA 7 donned PPE and entered Resident C's room to answer her call light. She refilled the resident's water, removed her gloves and gown, performed hand hygiene, and proceeded down the hallway. On 9/28/20 at 9:45 a.m., LPN 5 donned PPE and entered Resident C's room to administer medications. During an interview, on 9/28/20 at 10:07 a.m., the DON indicated Resident C had a COVID-19 positive roommate, so she was tested and placed in isolation. She was in droplet precautions due to a positive POC (point of care/rapid) [MEDICATION NAME] test, and was awaiting PCR results, due to being asymptomatic. Resident C shared a bathroom with Residents D and E, so they were also in droplet precautions. Resident C toileted herself independently. Resident D used the bathroom with assistance, and Resident E did not toilet. When residents had a positive POC test, but were asymptomatic, they were placed in droplet precautions until the PCR test returned. If the resident was symptomatic with positive POC, then they went to the COVID-19 unit. On 9/28/20 at 11:42 a.m., LPN 5 indicated she used disinfectant wipes for the vital signs cart after assessing Residents C, D, and E before using the cart for assessing the other residents on the 300 hallway. Review of a current facility alphabetical census sheet, dated 9/28/20, provided by the DON on 9/28/20 at 10:00 a.m., indicated there were a total of 18 residents on the 300 hall. On 9/29/20 at 12:03 p.m., LPN 5 indicated the 300 hall was staffed with one nurse and usually two CNAs, so the CNAs generally share the entire hallway, instead of having sections, so they can work together. Review of Resident C's clinical record was completed on 9/28/20 at 9:21 a.m. [DIAGNOSES REDACTED]. Her current physician orders [REDACTED]. Review of a 9/27/20 progress note indicated she had a positive COVID-19 PCR (polymerase chain reaction) test. She had been tested because her roommate had tested positive for COVID-19. She was placed in isolation with education provided. The facility updated the clinical record to indicate the test on 9/27/20 was a positive [MEDICATION NAME] POC test, and struck out the PCR note. During an interview, on 9/28/20 at 10:25 a.m., the DON and ADON/IP (Assistant Director of Nursing/Infection Preventionist) indicated Resident C had a PCR collected due to the facility having had negative POC tests with symptomatic staff and residents, but positive PCRs. During an interview, on 9/28/20 at 12:18 p.m., with the Nurse Consultant, Administrator, DON, and ADON/IP, the Nurse Consultant indicated there had been many false positives with the POC machines, so the guidance from Indiana Department of Health (IDOH) phone calls was to perform a PCR prior to placing the resident in the red zone, if asymptomatic, to prevent placing falsely positive residents in the COVID-19 unit. Resident C had a positive POC test on 9/18/20, and a negative PCR resulted 9/22/20 which had been collected on 9/18/20. She then had a positive POC on 9/25, with a PCR pending since she was asymptomatic. The Administrator indicated new guidance came out the previous Friday from IDOH, due to false positives with POC machines. Review of the IDOH guidance, from the Long Term Care Newsletter, dated 9/25/20, indicated the following: .If you have a resident or staff who tests positive on an [MEDICATION NAME] test and meets ANY of the below criteria, then the positive is considered a TRUE POSITIVE and no confirmatory testing (PCR) is recommended or needed: .Person being tested is a close contact .The facility is undergoing outbreak testing .In this circumstance of a TRUE POSITIVE: If it is an employee, the person should be sent home for isolation . If it is a resident, the person should be placed in transmission-based precautions . Outbreak testing should be initiated (if it is not already occurring) as previously directed Review of CDC guidance, Considerations for Use of [DIAGNOSES REDACTED]-CoV-2 [MEDICATION NAME] Testing in Nursing Homes, dated as last updated 8/27/20, indicated the following: Testing of asymptomatic residents or HCP in nursing homes as part of an outbreak response* If an [MEDICATION NAME] test is positive, no confirmatory test is necessary. Residents should be placed in transmission-based precautions, and HCP should be excluded from work. Review of CDC guidance, Responding to Coronavirus (COVID-19) in Nursing Homes, dated as updated 4/30/20, indicated the following: Resident with new-onset suspected or confirmed COVID-19 - If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). 3.1-18(a)

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.