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 _____	**09/10/2020**

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 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to perform immediate testing for residents with symptoms consistent with COVID-19 for 2 of 4 residents reviewed who tested positive during facility-wide COVID-19 testing (Residents 3 and 2). Findings include: 1. Review of Resident 3's clinical record was completed on 9/10/20 at 11:27 a.m. [DIAGNOSES REDACTED]. Current physician orders [REDACTED]. An 8/31/20, admission Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired and required extensive assistance for ADLs. She had a current 9/9/20 care plan problem of a positive COVID-19 test without current signs or symptoms. A 9/1/20 progress note indicated her family thought her confusion and cognitive decline was possibly related to a urinary tract infection [MEDICAL CONDITION]. Review of 9/2/20 progress note indicated she had increased confusion; a urinalysis was ordered. She was noted to have a dry hacking cough. A 9/2/20 physician's note indicated she had been experiencing a decline, and increased confusion. Blood tests and a CT of her head was ordered. There was no COVID-19 testing ordered. A 9/3/20 progress note indicated she had a dry, hacking cough. Review of 9/4/20 progress notes indicated her family had been concerned with her condition and tests had been being ran. A new order was received for a STAT chest X-ray; there were no new orders from the results. A 9/5/20 progress note indicated she had a dry hacking cough. A 9/6/20 progress note indicated she had complained of dyspnea and shortness of breath, and had a moist, non-productive cough. Review of 9/8/20 progress notes indicated she had no cough. A COVID-19 test was done due to a possible exposure. A 9/9/20 progress note indicated she tested COVID-19 positive. 2. Review of Resident 2's clinical record was completed on 9/10/20 at 10:05 a.m. [DIAGNOSES REDACTED]. Current physician orders [REDACTED]. He had a previous 8/27/20 order for droplet precautions for 14 days for possible COVID exposure/new admission. A 9/3/20, admission, MDS assessment indicated he was cognitively intact and required extensive assistance with ADLs. He had a current, 8/31/20, care plan problem of requiring isolation. There was no reason for the isolation indicated on the care plan. He had a current, 9/9/20, care plan problem of a positive COVID-19 test ,but currently without signs or symptoms. Interventions included, but were not limited to, initiation of his isolation care plan. A 9/4/20 progress note indicated he had a dry, hacky cough. A 9/4/20 Nurse Practitioner note indicated he was seen virtually for cough and diminished breath sounds. He had been coughing and .feels a little SOA Blood tests and a chest X-ray were ordered, but no COVID-19 testing was ordered. A 9/4/20 Change in Condition evaluation indicated he had a cough and diminished lung sounds bilaterally. The onset of the persistent cough was new. A STAT chest X-ray, basic metabolic panel, and completed blood count was ordered. There was no order for a COVID-19 test. A 9/8/20 progress note indicated COVID-19 testing was done per order, due to a possible exposure. Review of 9/9/20 progress notes indicated he tested COVID-19 positive. During an interview, on 9/10/20 at 1:17 p.m., the DON indicated she was not aware of why COVID testing wasn't ordered by the medical providers; they may have been trying to rule out other things. Resident 3 also had a respiratory history, and was on [MEDICAL CONDITION] and had [MEDICAL CONDITION]. The resident's daughter had a concern that maybe her [MEDICATION NAME] (opiate pain medication) was causing some confusion, so it was put on hold. Her cognition improved with the medication held, so it was discontinued on 9/9/20. Review of www.cdc.gov/coronavirus/2019, on 9/9/20 at 4:00 p.m., indicated the following: .Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0oF might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 3.1-18(a)

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