

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/15/2025
NAME OF PROVIDER OR SUPPLIER Albany Health Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review and interview, the facility failed to protect a resident's right to be free from sexual abuse by another resident for 1 of 3 residents reviewed for abuse (Residents B and C) when a cognitively impaired male resident (Resident B) with a history of sexually charged behavior was observed in the lounge with his hand underneath the cognitively impaired female (Resident C) resident's shirt fondling her breast. Findings include: During an observation on 12/15/25 at 10:09 a.m., Resident B was seated in a recliner in the North Lounge with his feet elevated and his eyes closed. During an observation on 12/15/25 at 10:46 a.m., Resident C was seated in a Broda chair (high-backed wheelchair) in the hallway near the entrance to the North Lounge by the 300 Unit Nurses' station. She was awake, tracked with her eyes, but was unable to respond verbally when spoken to. Resident B's clinical record was reviewed on 12/15/25 at 1:35 p.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, unspecified dementia, sexual aversion disorder, and difficulty in walking. A 10/17/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. Resident B used a wheelchair and walker for mobility. He required partial assistance from staff for upper body dressing, substantial assistance from staff for bathing, lower body dressing, transfers, and donning footwear, partial assistance for personal hygiene, and was dependent on staff assistance for toileting. A current care plan, dated 9/10/23, for a cognitive deficit related to dementia, cognitive communication deficit, exhibited fluctuating confusion, poor safety awareness, poor judgement and poor decision making. Interventions included you will provide me with cues, prompts, and reminders as necessary (12/25/23). A current care plan, dated 12/14/23, for behavioral symptoms such as touching female staff inappropriately, removing clothes, and touching and grabbing female peers inappropriately. Interventions included explain to be that by behavior is inappropriate (12/14/23), allow me to express my feelings (12/14/23), approach me from the front and make sure you have my attention (12/14/23), facility staff will follow me with 15 minute checks until 11/21/25 (initiated 6/7/24 and revised on 11/18/25), I will refrain from saying inappropriate comments to staff and residents (12/5/25), I will report and you will observe for changes in my behaviors and determine if any alterations in care plan is needed (12/14/23), medications as ordered (11/24/25), staff will offer to place me in the recliner or bed after meals or activities (11/18/25), staff will direct me away from female residents as necessary (11/18/25), you will follow me on the Behavioral Management Program (11/18/25), and you will remove me to a quiet area away from females as necessary (11/18/25). Resident B's Behavior Sheets included sexually charged behaviors on the following dates: On 6/7/24, while in the North Lounge, Resident B attempted to grab Resident C's breast. Both residents were removed and Resident B was placed on 15-minute checks. The behavior improved after staff talked with the resident. On 7/3/25, Resident B touched a female staff member from her thigh up to her crotch during resident care. Resident B's behavior improved when he was told that inappropriate touching was not allowed. He confirmed understanding. On 8/16/25, after Resident B was placed on the toilet, he grabbed and squeezed a female CNA's breast. Behavior ceased when the CNA reminded the resident it was inappropriate behavior. On 11/17/25, following the evening meal, Resident B and Resident C were placed in the North Lounge while assisting another resident to bed. Resident B was found touching Resident C's breast. The residents were separated. Resident B was placed on 15 minutes checks. Resident B will be offered to sit in the recliner in his room or the North Lounge following meals as tolerated. The provider was considering hormone therapy for Resident B. On 11/20/25, while in the dining room, Resident B told the QMA She had something nice sticking out the front of her shirt. No further comments were made when the QMA instructed the resident it was an inappropriate statement to make. Resident C's clinical record was reviewed on 12/15/25 at 3:09 p.m. Diagnosis included dementia, need for assistance with personal care, major depressive disorder, and cognitive communication deficit. An 8/18/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was rarely or never understood. Cognitive skills for daily decision making were severely impaired. Resident C used a wheelchair for mobility. She required substantial assistance from staff for eating, oral hygiene, upper and lower body dressing, turning, footwear, and personal hygiene. She was dependent on staff assistance for toileting, bathing, and transfers. A current care plan, dated 11/17/25, indicated the resident was at risk for psychosocial concerns related to a male peer touching me inappropriately and may exhibit signs of the following: trembling, flinching, tearfulness, change in appetite, change in cooperation with care, change in sleep, anxious facial expressions, rapid breathing, or restlessness. Interventions include the</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to immediately report an allegation of sexual abuse to the Administrator for 1 of 3 residents reviewed for abuse. (Resident C) Finding includes:A facility reported incident submitted to Indiana Department of Health (IDOH), dated 11/17/25 at 6:01 p.m. and submitted on 11/18/25, indicated staff were removing residents from the dining room following evening meal and placing them in the North Lounge. Staff assisted a resident to bed and returned to the North Lounge and found Resident B touching Resident C's breast. Review of the facility investigation file included a handwritten statement of the Administrator that indicated the Administrator and DON were notified of the incident between Resident B and Resident C on 11/17/25 at 8:25 p.m. During a telephone interview on 12/15/25 at 12:28 p.m., CNA 3 indicated she found Resident B in the North Lounge with his hand inside the front of Resident C's gown fondling her breast. The residents were separated then CNA 4 reported everything to RN 5. CNA 3 was talking to RN 6 later in the shift when she learned that RN 5 had not reported the incident between Resident B and Resident C to RN 6 during shift change report. RN 6 recommended CNA 3 to report the incident to the DON. CNA 3 had not reported the incident herself to anyone prior to 11/17/25 around 8:20 p.m. when she sent a text to the DON. The alleged abuse should have been reported immediately to the nurse, Administrator, and the DON. She knew CNA 4 had reported it immediately to RN 5 when CNA 3 and CNA 4 were separating Resident B and Resident C. During an interview on 12/15/25 at 1:22 p.m., RN 5 indicated he was working on 11/17/25 and after dinner at approximately 6:00 p.m. an unidentified CNA reported to him that Resident B was seen touching Resident C's breast in the North Lounge across from the 300 Unit nurse station. It was sexual abuse when Resident B touched Resident C's breast as Resident C could not consent to sexual contact due to her severe cognitive impairment. During shift report, when RN 5 left at 7:00 p.m. on 11/17/25, RN 5 told RN 6 to inform the Administrator, DON, Social Service Director (SSD), and the Unit Manager of the abuse that happened between Resident B and Resident C on his shift because he forgot to report it. The CNAs were required to report any abuse to the nurse on the specific unit. He should have reported any abuse immediately to the Administrator, DON, SSD, Unit Supervisor, family representatives and the physician. During an interview on 12/15/25 at 2:10 p.m., CNA 4 indicated on 11/17/25 after supper CNA 3 told CNA 4 she found Resident B touching Resident C's breast in the North Lounge. CNA 4 reported the incident immediately to RN 5. Sexual abusive behavior should have been reported to the nurse and the DON immediately when it happened. Staff had access to contact the DON and Administrator after regular business hours. During a telephone interview on 12/15/25 at 4:38 p.m., RN 6 indicated she had reported the incident of sexual abuse between Resident B and Resident C to the DON on 11/17/25 after she was made aware at approximately 8:00 p.m. by CNA 3. The abuse allegation should have been reported immediately to the DON and the Administrator. During an interview 12/15/25 at 4:55 p.m., the DON indicated she was first notified on 11/17/25 just prior to 8:30 p.m. by RN 6 that Resident B had touched Resident C's breast. She believed it occurred on 11/17/25 at approximately 6:01 p.m. The DON reported this information to the Administrator on 11/17/25 at 8:30 p.m. The abuse allegation should have been reported immediately to the Administrator when the incident occurred. On 12/15/25 at 5:07 p.m., the Administrator indicated she was notified of the above incident between Resident B and Resident C on 11/17/25 at 8:25 p.m. when the DON called her. No other staff member had reported the incident to her prior. Staff, regardless of position, should have reported abuse to the Administrator immediately when it occurred. A current facility policy, revised 7/10/24, titled Abuse, Neglect and Exploitation, provided by the Administrator on 12/15/25 at 11:11 a.m., indicated the following: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies that prohibit abuse, neglect, exploitation and misappropriation of resident property. V. Investigation of Alleged Abuse, Neglect and Exploitation.A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or report of abuse, neglect or exploitation occur. VII. Reporting/Response. A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator. a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.Cross reference F600. This citation relates to Intake 2672438.3.1-28(c)</p>		