| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155432 | A. Building<br>B. Wing | 01/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Albany Health Care & Rehabilitation Center | 910 W Walnut St<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, record review, and interview, the facility failed to ensure implementation of care plan interventions to prevent falls for 1 of 3 residents reviewed for falls (Resident C). Finding includes: During an observation, on 1/14/26 at 11:28 a.m., Resident C sat in her wheelchair at a table in the dining room as CNA 3 assisted her with eating. The resident wore nonskid socks and a brace on her right foot/leg. Resident C's clinical record was reviewed on 1/14/26 at 2:39 p.m. Diagnoses included age related physical disability, syncope (fainting) and collapse, difficulty walking, and vascular dementia. The current orders included melatonin 10 mg daily at bedtime for insomnia (4/10/25), metoprolol tartrate 25 mg twice a day for hypertension - hold for systolic blood pressure less than 100 or heart rate less than 60 (7/9/25), and silent pressure alarm to bed (6/2/25). A modification of the quarterly Minimum Data Set (MDS) assessment, dated 11/10/25, indicated the resident was severely cognitively impaired. She used a walker and a wheelchair for mobility. She required partial to moderate staff assistance with walking and supervision to touching staff assistance with wheelchair mobility. She had two or more falls without injury since the prior assessment. A bed alarm was used daily. A current care plan, indicating the resident was at risk for falls related to impaired balance, was initiated 9/29/23. The care plan interventions included the following: A bed alarm will be used to remind staff the resident required assistance with bed mobility and transfers (revised 6/2/25), the resident preferred her bed to be up against the wall to make her feel safe (initiated 4/10/2025), Dycem (a non-slip material used for grip and stability) in recliner to prevent sliding (initiated 12/11/25), Dycem in wheelchair (initiated 9/20/25), and a low bed with a mat on the floor to decrease the risk of injuring herself when the resident rolled out of bed (initiated 4/18/25). Fall risk assessments completed on 7/11/25, 10/11/25, and 1/11/26 each indicated the resident was a high fall risk. A progress note, dated 10/17/25 at 6:09 p.m., indicated the resident was found lying on her side on the floor in front of her wheelchair. The resident's roommate indicated the resident was trying to get up from her wheelchair. No injuries were noted. A fall interdisciplinary team (IDT) progress note, dated 10/20/25 at 11:19 a.m., indicated the resident's fall on 10/17/25 was reviewed. Interventions included continuing the restorative therapy with walking and dressing/grooming, blood work to be obtained and follow up with any abnormal results to rule out acute illness. The immediate intervention after the fall was to lay the resident down, as she requested, in a low bed with a mat in place. A progress note, dated 11/10/25 at 6:30 a.m., indicated the resident was found sitting on her buttocks on the floor in her room. No injuries were noted. A fall IDT note, dated 11/11/25 at 11:17 a.m., indicated the 11/10/25 fall was reviewed. Interventions included the resident was to be an early riser as she allowed. An interview with the resident's family had indicated the resident was an early riser. A progress note, dated 12/11/25 at 12:30 p.m., indicated the resident was found lying on her side on the floor in her room with her legs stretched out. A laceration with bleeding to her right eyebrow was sustained from hitting her head during the fall. A fall<br><br>(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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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | IDT note, dated 12/12/25 at 12:15 p.m., indicated the 12/11/25 fall was reviewed. Interventions included shoes or proper footwear in place when resident was up for the day, and the resident's recliner was to have a non-slip mat placed in it to prevent sliding. A progress note, dated 12/29/25 at 1:58 p.m., indicated the resident moved to the secured unit. A progress note, dated 1/9/26 at 11:01 p.m., indicated the staff witnessed the resident slide off her bed. No injuries were noted. A fall IDT note, dated 1/12/26, indicated the 1/9/26 fall was reviewed. Interventions included the Social Services Director calling the family and requesting cotton pajama bottoms which would not be slick and to remove other slick bottoms from the resident's room. During an observation, on 1/15/26 at 12:05 p.m., the resident sat in her wheelchair at a table in the dining room as CNA 3 assisted her with eating. The resident wore nonskid socks and a brace on her right foot/leg. During an observation, on 1/15/26 at 12:06 p.m., the resident's bed was not against the wall as per care plan, no non-slip mat was found in the recliner, and no fall mat was visible in the room. During an observation, on 1/15/26 at 12:28 p.m., the resident was lying in a low bed without a mat beside it. The bed was not up against the wall. The wheelchair and recliner lacked a non-slip mat. No fall mat was visible in the room. During an interview, on 1/15/26 at 12:36 p.m., CNA 3 indicated each resident's fall interventions were listed on the Kardex on the electronic chart. The specific fall interventions for Resident C was a bed alarm, increased supervision, and assistance with toileting. The resident did not have a fall mat since she moved from the other unit. Fall mats were not permitted on the secured unit because they were considered a fall hazard. She thought the resident did have a non-slip mat, but it was not in her room, her wheelchair, or her recliner. CNA 3 indicated the bed was not against the wall. During an interview, on 1/15/26 at 12:41 p.m., QMA 4 indicated the residents' fall interventions were listed in the Kardex. Sometimes, when a new intervention was initiated, Unit Manager 5 would tell the staff and have them sign a paper. She pulled up the Kardex on the computer screen. The Kardex indicated the resident was to have a mat beside her bed, non-slip mat in her wheelchair and her recliner, and her bed was to be up against the wall. During an interview, on 1/15/26 at 1:11 p.m., Unit Manager 6 indicated she monitored and supervised the secured unit when a QMA, and not a nurse, was on duty. The residents' specific fall interventions were listed in the care plan and in the Kardex. Resident C had been moved back to the secured unit recently. She had a fall mat on the other unit, but the fall mats were not utilized on the secured unit because they were a fall risk with the residents who wandered in and out of resident rooms. Resident C's care plan was not revised yet. She had seen a non-slip mat in the resident's room last week and was uncertain what had happened to it. During an interview, on 1/15/26 at 1:18 p.m., the DON indicated Resident C's care plan should have been updated and the appropriate interventions such as the bed against the wall and the non-slip mat placed in the wheelchair and recliner should have been in place. She indicated fall mats were not used on the secured unit as they were a trip hazard. A current facility policy, revised 8/2024, provided by the DON on 1/15/26 at 2:23 p.m., titled Fall Investigation and Risk Evaluation, indicated the following: . ‘Accident' refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. ‘Avoidable Accident' means the an accident occurred because the facility failed to:.implement interventions, including adequate supervision and assistive devices . This citation relates to Intake 2705971.3.1-45(a)(2) |