STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to provide grooming assistance for 1 of 2 residents reviewed for activities of daily living. (Resident 16) Findings include:During an observation, on 2/16/26 at 10:33 a.m., Resident 16 sat in a wheelchair in the dining room. He was unshaven. During an observation, on 2/17/26 at 10:11 a.m., Resident 16 sat in a wheelchair in his room. He was unshaven. During an observation, on 2/18/26 at 10:55 a.m., the resident sat in a wheelchair in the dining room. He was unshaven. Resident 16's clinical record was reviewed on 2/18/26 at 3:48 p.m. Diagnoses included altered mental status, dementia, other lack of coordination, other reduced mobility, and need for assistance with personal care. A quarterly Minimum Data Set (MDS) assessment, dated 1/19/26, indicated the resident was severely cognitively impaired. He required substantial/maximal staff assistance with personal hygiene. A current care plan, created 12/17/24, indicated the resident needed assistance with his activities of daily living (ADLs) related to activity intolerance. An intervention, revised 9/12/25, indicated the resident was dependent on staff assistance for his morning and evening care. A point of care response history indicated the resident had received a shower on 2/11/26 and bed baths on 2/15/26 and 2/18/26. During an observation, on 2/19/26 at 4:50 p.m., the resident propelled himself in his wheelchair out of the dining room. He was unshaven and had facial hair the length of the diameter of a pea. At the same time, during an interview, the Corporate Nurse Consultant indicated the resident did not appear he had been shaved recently. The residents were generally shaved twice weekly with showers. CNA 8 was offering and shaving residents this week. She wondered if CNA 8 had offered to shave Resident 16. During an interview, on 2/19/26 at 4:52 p.m., CNA 8 indicated she had not shaved, nor offered to shave, Resident 16 this week. During an interview, on 2/20/26 at 2:17 p.m., CNA 6 indicated the residents were shaved on shower days and as needed. Resident 16 normally requested to have his shaving done or performed the shaving himself with set up. He did not refuse to be shaved or showered as far as she knew. During an interview, on 2/20/26 at 2:18 p.m., CNA 5 indicated she set up the resident with his electric razor yesterday to shave. She wondered if the razor was not working properly. He had a couple of electric razors and shaved himself with set up. She usually shaved men when she got them up in or when they got a shower. The resident received showers on second shift. During an interview, on 2/20/26 at 2:59 p.m., the DON indicated the residents should be shaved at least twice a week on shower days. A facility document, provided by the Administrator on 2/20/26 at 3:09 p.m., titled Resident Care Procedure #39: RCP-Electric Razor, did not include when or how often a resident should be shaved. 3.1-38(a)(3)(D)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to follow physician's wound treatment orders to promote healing of an arterial ulcer for 1 of 3 residents reviewed for skin conditions. (Resident 2)Finding includes:During an observation on 2/16/26 at 3:38 p.m., Resident 2 was in bed with a dressing on the right foot. The dressing included an orange bordered gauze, rolled gauze, and a net stocking.Resident 2's clinical record was reviewed on 2/20/26 at 1:50 p.m. Diagnoses included heart failure, type 2 diabetes mellitus, and reduced mobility.A wound treatment order, dated 12/23/25, included the following: Cleanse the pressure injury to the right dorsum foot with povidone iodine (antiseptic for wound), air dry, apply skin preparation, and place a foam dressing on day shift every day for wound healing. This order was discontinued on 2/18/26.A current wound treatment order, dated 2/12/26, included the following: Apply horseshoe pad to the right medial foot, paint area with povidone iodine (antiseptic for wound), and apply Alginate (wound dressing) between toes. Cover with ABD (absorbent wound dressing) pad, soft roll, and rolled gauze. Secure with stretch net. Change dressing three times weekly every 72 hours. A Treatment Administration Record (TAR) for February 2026 indicated the following:On 2/5/25 - the wound treatment was not completedOn 2/11/26 - the wound treatment was not completedOn 2/12/26 - both wound treatment orders were marked as completedOn 2/13/26 - the old wound treatment order was marked as completedOn 2/14/26 - the old wound treatment order was marked as completedOn 2/15/26 - both wound treatment orders were marked as completedOn 2/16/26 - the old wound treatment order was marked as completedOn 2/17/26 - the old wound treatment order was marked as completedOn 2/18/26 - both wound treatment orders were marked as completedA 12/30/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. She required maximal staff assistance with lower body dressing, repositioning, and footwear. The resident was dependent on staff assistance for transfers. Resident 2 was at risk for pressure ulcers and had one unstageable pressure ulcer. A current care plan, dated 12/22/25, indicated the resident had an unstageable pressure ulcer on the right dorsum foot. Interventions included resident wound treatments as ordered (12/22/25).A wound center progress note, dated 2/11/26, indicated the right foot wound was an arterial ulcer. A provider progress note, dated 2/12/26, indicated the resident was evaluated at the wound clinic for the right medial foot wound and had a non-pressure chronic ulcer of the right foot which was managed with wound care. Circulation was worsened and is expected to improve with bilateral lower extremity stent placement. The treatment ordered included a horseshoe pad to the right medial foot, apply Betadine (wound antiseptic) and cover with an ABD pad three times weekly. Continue the current wound care regimen. During an interview on 2/19/26 at 4:49 p.m., Unit Manager 11 indicated the resident had weekly visits to the wound clinic. Wound treatment orders were provided by the wound clinic. The facility performed the treatments based on those orders. The facility updated the wound treatment orders when the resident returned from the wound clinic. The facility had received new orders to change the resident's dressing from every day to every three days, but she did not catch the duplicate order until 2/18/26 when she completed the resident's dressing change. On 2/20/26 at 2:20 p.m., Unit Manager 11 indicated it appeared the facility continued to do daily dressing changes rather than following the new order. On 2/18/26, during wound care, she was unable to get the horseshoe pad removed so she cleansed around it and left it in place. The resident had an appointment scheduled for next week, so she intended to leave the horseshoe pad in place until the resident attended her appointment. She did not contact the wound clinic for further instructions regarding the inability to remove the horseshoe pad. On 2/20/26 at 4:43 p.m., the DON indicated staff should always follow the physician's orders. Previous wound care orders should have been discontinued when the facility received new wound care orders. Wound care performed more frequently than ordered had the potential to increase the resident's risk of infection. The provider must be notified when wound care cannot be completed according to the order to obtain clarification for further instructions.A current (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy, dated 11/29/23, titled Wound Treatment Management, provided by the Administrator on 2/20/26 at 5:07 p.m., indicated the following: Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate catheter maintenance and services to prevent potential urinary tract infections for 1 of 2 residents reviewed for indwelling catheters. (Resident 16) Finding includes: During an observation, on 2/16/26 at 3:34 p.m., Resident 16 sat in his wheelchair in his room. His urinary catheter tubing, with cloudy, yellow urine, came from the resident's waistband and went down under the resident's wheelchair into a privacy bag. The catheter tubing under the wheelchair hung within the diameter of a pencil eraser from the floor. During an observation, on 2/17/26 at 10:11 a.m., the resident sat in his wheelchair in his room. His urinary catheter tubing was coiled on his lap. During an observation, on 2/18/26 at 11:51 a.m., the resident sat in his wheelchair in the dining room. His urinary catheter tubing hung down and rested on the floor, then went into a privacy bag. During an observation, on 2/18/26 at 12:07 p.m., the resident propelled himself in his wheelchair out of the dining room. The urinary catheter tubing drug on the floor underneath his wheelchair. During an observation, on 2/18/26 at 3:28 p.m., the resident propelled himself away from the dining room. The urinary catheter tubing drug on the floor as he propelled himself out of the dining room. Resident 16's clinical record was reviewed on 2/18/26 at 3:48 p.m. Diagnoses included benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, retention or urine, neuromuscular dysfunction of bladder, altered mental status, dementia, and the need for assistance with personal care. Physician orders included doxycycline (antibiotic) 50 mg daily for chronic urinary tract infections (started 2/8/25, discontinued 2/17/26), methenamine hippurate (urinary anti-infective) 1 g (gram) twice a day for urinary tract infection prophylaxis (2/17/26), tamsulosin (for BPH) 0.4 mg daily (6/28/25), suprapubic catheter 16 French with 10 cc bulb (8/6/25), clean suprapubic site with normal saline, pat dry, and apply T sponge every shift (11/4/25), irrigate suprapubic catheter with 50 mL sterile water every day and evening shift (8/15/25), and maintain enhanced barrier precautions due to indwelling device (2/11/25). A quarterly Minimum Data Set (MDS) assessment, dated 1/19/26, indicated the resident was severely cognitively impaired. He was dependent on staff for toileting hygiene and transfers. He required substantial/maximal staff assistance with showering/bathing, upper and lower body dressing, donning and doffing footwear, personal hygiene, and wheeling 150 feet in a manual wheelchair. He required partial/moderate staff assistance with wheeling 50 feet in a manual wheelchair. A current care plan, revised 1/7/25, indicated the resident had chronic and recurring urinary tract infections. An intervention, initiated 12/24/24, indicated to administer prophylactic medications as ordered. A current care plan, revised 7/1/25, indicated the resident had a suprapubic catheter related to neurogenic bladder. Interventions included change catheter system when clinically indicated or ordered (initiated 1/8/25), give catheter care every shift (initiated 1/8/25), observe for changes in the color, consistency, and odor of urine, changes in mental status, changes in amount of urine produced, and pain in lower back or lower abdomen (initiated 1/8/25), and maintain enhanced barrier precautions (initiated 2/9/25). During an observation, on 2/18/26 at 4:01 p.m., the resident sat in his room in the doorway of his room. The urinary catheter tubing lay on the floor under his wheelchair. At 4:04 p.m., the ADON paused as she passed the resident's room. She smiled and waved at the resident. During an observation, on 2/18/26 at 4:05 p.m., the resident sat in his room in his wheelchair. His left heel rested on the urinary catheter tubing. He moved and the tubing became twisted around his left front wheelchair wheel. During an interview, on 2/18/26 at 4:06 p.m., the ADON indicated the resident's urinary tubing was currently on the floor. The resident's urinary catheter was usually placed on the back of the resident's wheelchair to keep the tubing off the floor. During an interview, on 2/18/26 at 4:09 p.m., CNA 5 indicated the resident's catheter tubing should not be on the floor. To prevent the urinary catheter tubing from dragging on the floor, she clipped the tubing to the resident's clothes. She tried to watch for when the tubing became unclipped and (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reclipped it to his clothes because the resident was very mobile in his wheelchair. During an interview, on 2/18/26 at 4:11 p.m., CNA 6 indicated the urinary catheter tubing should not be on the floor. She usually clipped the resident's tubing to his pants. The resident moved all over the place, and that was why the urinary catheter tubing was sometimes on the floor. During an observation, on 2/19/26 at 11:44 a.m., the resident sat in his wheelchair at the dining room table. His urinary catheter tubing was laying over his leg and went into a privacy bag under his wheelchair. The drainage spout from the urinary drainage bag was unsecured and hung from the privacy bag onto the floor. During an observation, on 2/19/26 at 11:52 a.m., the resident was assisted out of the dining room while sitting in his wheelchair. The urinary catheter bag spout drug on the floor. The DON secured the drainage spout so that it no longer drug on the floor. During an interview, on 2/19/26 at 3:48 p.m., the DON indicated neither the resident's urinary catheter tubing nor the urinary drainage bag spout should be dragging on the floor. A current facility policy, revised 7/1/24, titled Catheter Care, provided by the Administrator on 2/19/26 at 3:56 p.m., indicated the following: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care.Ensure tubing and catheter bag does not touch the floor.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and interview, the facility failed to provide meal assistance to maintain nutritional status for 1 of 4 residents reviewed for nutrition. (Residents 21) Finding includes:During a dining observation, on 2/18/26 at 12:04 p.m., Resident 21's meal assistance was provided by her visitor who sat on the right side of Resident 21and offered the resident several bites. The resident accepted one bite. The visitor switched seats and moved to a chair located on Resident 21's left side. After moving to Resident 21's left side, the resident consistently accepted every bite of food offered for the rest of the observation. Resident 21 drank fluids from a cup with a straw.During a continuous dining observation, on 2/19/26 at 8:20 a.m., a staff member sat on the right side of Resident 21. Resident 21's neck was bent forward, and her head was hanging downwards. The staff member offered two additional bites, which the resident did not accept. The staff member indicated Resident 21 did not eat well for breakfast and walked over to a kiosk and started charting. At 8:26 a.m., the resident allowed food and fluids to fall from her mouth. The staff member approached Resident 21 from the left side and asked her if she was okay. Resident 21 indicated she was okay. The staff member asked if she had anything else in her mouth. Resident 21 opened her mouth to show the staff member her mouth was empty. The staff member removed Resident 21 from the dining room.During a meal observation, on 2/19/26 at 11:42 a.m., Resident 21's lunch was placed in front of her. A cup of ice cream and a supplement were present. Resident 21 was not served a drink. At 11:48 a.m., a staff member sat down between Resident 21 and another resident. The staff member was on Resident 21's right side. The staff member did not acknowledge Resident 21. The staff member offered the other resident several bites of food and encouragement. At 11:50 a.m., the staff member acknowledged Resident 21. Resident 21 had her head turned to the left. The staff member, while seated on resident 21's right side, attempted to reach around the front of Resident 21and tried to angle her wrist enough to give Resident 21 a bite of food. Resident 21 did not accept the offered spoonful of food. This was the only bite of food offered at that time. At 11:52 a.m., the staff member got up and assisted another resident out of the dining room. At 11:55 a.m. the staff member returned to the dining room and sat down in her previous location between the residents. The staff reached around Resident 21 and offered a bite of food to the resident. Resident 21 attempted to accept the bite but only received the tip of the spoonful. Two bites of food were offered between 11:42 am and 11:56 a.m. Resident 21's visitor arrived at 11:56 a.m. and offered to assist the resident with her meal. The resident and her meal were moved to a different table. The resident was not provided a drink. Initially the family sat down on Resident 21's right side and then promptly moved to her left side and offered Resident 21 a bite of food. Resident 21 accepted the first bite offered. The resident occasionally held the food in her mouth for a couple of seconds before swallowing. The visitor left the dining room and returned with a foam cup in which she poured a soda, placed a lid on the cup, and placed a straw in the lid. Resident 21 immediately drank from the straw when fluids offered. Resident 21 accepted a variety of foods when offered. The resident was observed to have taken an additional 10 bites and continued eating until the end of the observation.During an observation, on 2/19/26 at 4:56 p.m., Resident 21 was lying in a low bed with the head of bed elevated approximately 30 degrees and the left side of the bed against the wall. The resident's meal sat in an opened foam container on her bedside table. The bedside table was not within reach of the resident. An applesauce container was opened about a quarter of the way and there was one spoonful divot in the pureed pizza. There were no supplements present. Resident 21 was awake and looking around. No staff member was present in the room. At 5:09 p.m., CNA 9 entered Resident 21's room with a foam cup and placed it on the bedside table. CNA 9 greeted the resident, indicated she would be back, and departed Resident 21's room. No drink or bite of food was offered while CNA 9 was in the room. At 5:12 p.m., CNA 9 and CNA 13 entered Resident 21's room and shut the door. No bites of food or fluids were offered during the observation from 4:56 p.m. to 5:12 p.m.During an observation, on 2/19/26 at 5:16 p.m. CNA 13 (continued on next page)

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	155432	A. Building B. Wing	02/20/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exited Resident 21's room, carrying a microwaveable cup of chicken noodle soup. CNA 9 remained in the room, standing in front of Resident 21. Resident 21 sat in her wheelchair with the bedside table in front of her. During an interview, at the time of the observation, CNA 9 indicated Resident 21 was dependent for all care. Resident 21 had dementia and a history of a right hip injury. Resident 21 would not accept food from her when offered earlier in the week but the CNA was able to get her to drink a homemade milkshake. Resident 21's supper remained sitting on the bedside table in front of the resident, the food appearance was unchanged from the prior observation (one spoonful divot). CNA 13 entered the room and removed the foam container and placed it in the food cart in the hall. CNA 9 indicated the resident liked chicken noodle soup and CNA 13 was warming it up at that time. Resident 21 looked at staff and stated no mashed potatoes. At 5:20 p.m., CNA 13 placed a bowl of chicken noodle soup on Resident 21's bedside table. CNA 13 indicated Resident 21 had a major stroke years ago and had steadily been declining since her admission to the facility. She did not feel that Resident 21 had right sided neglect (did not acknowledge their right side). No offer of fluids or food had been given. CNA 9 indicated the soup was hot and CNA 13 departed room. At 5:24 p.m., Resident 21 was observed reaching across the bedside table towards the soup. Resident 21 indicated she was hungry. CNA 9 handed Resident 21 a foam cup. Resident 21 immediately grasped the cup with both hands and began drinking from the straw. CNA 9 indicated Resident 21 did well if you handed her the cup to hold. She did not feel Resident 21 had right sided neglect. The resident continued to steadily drink from the cup. At 5:27 p.m. CNA 9 indicated the soup was still too hot to eat and she would give the resident a bite once it cooled down. No bites of food were offered throughout observation.Resident 21's clinical record was reviewed on 2/20/26 at 3:00 p.m. Diagnoses included dementia, age-related physical debility, cerebral infarction, cognitive communication deficit, and need for assistance with personal care.Current physician orders included regular diet with pureed texture, thin consistency, (2/10/26), 206 (supplement) juice, preferably orange, at breakfast and dinner, and ice cream with all meals and for bedtime snack.A quarterly MDS (Minimum Data Set) assessment, dated 2/6/26, indicated the resident was severely cognitively impaired. The resident required partial/moderate assistance with eating and oral hygiene. The resident did not have a loss of liquids or solids from mouth when eating or drinking. She did not hold food in her mouth or have residual food in mouth after meals. No coughing or choking occurred during meals or when swallowing medication. No complaints of difficulty or pain when swallowing. Resident 21's weight was 99 pounds and a loss of five percent or more in the last month or a loss of 10 percent or more in the last six months was identified and noted that the resident was not on a prescribed weight loss regimen. She received a mechanically altered diet that required a change in the texture of food or liquids.A current care plan, revised on 12/20/25, indicated Resident 21 was at risk for malnutrition due to dementia, reduced mobility, and a recent illness. Interventions included the following: meal intakes were to be reviewed (7/23/25), weights were to be reviewed (7/23/25), and extra food or beverage was to be received with meals or between meals to provide calories and/or protein (7/23/25).A current care plan, dated 12/20/25, indicated Resident 21 had an unplanned weight loss due to recent illness and family unable to visit as family brings in additional food items for the resident. Interventions included the following: assist the resident with eating (12/20/25).A current care plan, revised on 8/5/25, indicated Resident 21 had a communication deficit as evidenced by a cerebral vascular accident, history of transient ischemic attacks (mini-strokes), and a cognitive communication deficit related to dementia. Interventions included the following: You will ensure having my attention, face me from the front and not on the side, before speaking with me (8/5/25).A weight history in Resident 21's electronic record, indicated on 08/05/2025, the resident weighed 134 pounds. On 2/8/26, the resident weighed 93.6 pounds, which is a 30.15% loss.During an interview, on 2/20/26 at 4:38 p.m., LPN 9 indicated Resident 21 was a picky eater. Family had announced a lot of food dislikes for the resident. Resident 21's dementia was progressing. Resident 21's diet had recently changed to pureed. Varying meal intakes were noted. She was not aware if Resident 21 had one-sided neglect. Staff were to sit at her level, eye to eye, while assisting Resident (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	21 with her meals. Resident 21 would often eat ice cream when offered.During an interview, on 2/20/26 at 4:43 p.m., the DON indicated staff was to ensure Resident 21 sat upright for her meals. Staff were to offer the resident foods based on her preferences, alternate bites of food with drinks with fluids. Staff were to sit down beside her when meal assistance was offered. She was unaware if Resident 21 had neglect on one side or not.During an interview, on 2/20/26 at 4:49 p.m., the ADON indicated Resident 21 had one-sided neglect but was unsure which side.During an interview, on 2/20/26 at 4:51 p.m., CNA 15 was sitting across the table from Resident 21. A nursing aide in training sat on Resident 21's right side and was assisting Resident 21 with her meal. CNA 15 indicated Resident 21 would feed self at times and encouragement was needed. Resident 21 was able to drink from a cup without assistance. CNA 15 did not feel Resident 21 had one-sided neglect and did not feel sitting on one side versus another affected her eating. Staff were aware that Resident ate better for lunch when her representative was present. Resident 21 was not eating well for this meal.A current facility policy, dated 11/29/23, titled Serving a Meal, provided by the Nurse Consultant, on 2/20/26 at 6 p.m., indicated the following: .3. Remove dome lid from the tray, and check to be sure everything is included on the meal tray that is required by the diet card, and the residence preference. 4. Arrange the dishes in silverware so the resident can reach them easily.12. Remember that some residents take a long time to eat. Provide adequate time for the resident to consume the meal and offer to reheat foods as needed. 13. Offer additional fluids and water with the meal when there are no fluid restrictions.A current facility policy, dated 11/27/23, titled Assisted Nutrition and Hydration, , provided by the Nurse Consultant, on 2/20/26 at 6 p.m., indicated the following: Policy: Residents within the facility will maintain adequate parameters of nutritional and hydration status, to the extent possible, to ensure each resident is able to maintain the highest practicable level of well-being.Policy Explanation and Compliance Guidelines: 1. The Facility will: a. Provide nutritional and hydration care and services to each resident, consistent with the residents comprehensive assessment; b. Recognize, evaluate, and address the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration.2.the facility will ensure each resident: a. Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residence clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; . 3.1-46(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were dated when opened and medication was discarded when expired for 1 of 3 medication carts reviewed for medication storage. (100 hall) Finding includes:During a medication storage observation of the 100 hall medication cart, accompanied by QMA 10 on 2/18/26 at 3:11p.m., the following was observed: Six bottles of eye drops were open and undated. Two metered dose inhalers were open and undated. One bottle of Robitussin DM (cough medicine) was open, undated, and had an expiration date of 9/2024. One bottle of Black Seed herbal supplement was open and undated. Nine bottles of Miralax (laxative) were open and undated. Two bottles of liquid Docusate Sodium were open and undated. One bottle of cough medication liquid was open and undated. One bottle of Lactulose (laxative) was open and undated. Five bottles of Milk of Magnesia (laxative) were open and undated. One bottle of saline nasal spray was open and undated. Two bottles of Flonase (steroid) nasal spray was open and undated. During an interview at the time of the observation, QMA 10 indicated he was unsure if opened items needed labeled and dated at the time the product was opened and thought the facility went by the product expiration dates. During an interview at the time of the observation, RN 12 indicated he found the bottle of Robitussin DM in a resident's room. The resident's family had brought it to the facility. He removed the medication from the resident's room and placed it in the medication cart. He was aware the resident did not have an order for the Robitussin when he placed it in the medication cart. He did not notify the physician or request an order for the medication. He was not aware it had expired. During an interview, on 2/18/26 at 3:48 p.m., LPN 11 indicated all medications were to be labeled with an open date and all medications in the medication cart were to have a physician order. Any expired item was to be removed. During an interview, on 2/18/26 at 4:06 p.m., the DON indicated that medication items were to be dated when opened. All medications were to have a physician order and there were not to be any expired medications in the medication cart. A current facility policy, revised 4/16/24, titled Labeling of Medications and Biological's, provided by the Corporate Nurse Consultant, on 2/18/26 at 4:40 p.m., indicated the following: Policy: All medications and biological's used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. 3.1-25(j)3.1-25(k)3.1-25(o)

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(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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to utilize proper hand hygiene and avoid touching food with bare hands during meal tray distribution for 4 of 9 opportunities during room meal tray deliveries on the 200 hall. Findings include:During an observation on 2/16/26 at 12:11 p.m., CNA 8 entered room [ROOM NUMBER]-D with a meal tray. She rearranged a book and cup on the overbed table prior to setting up the meal tray. Hand hygiene was not performed. CNA 8 then removed the dinner roll bare handed and set the dinner roll on top of the wrap it came in. On 2/16/26 at 12:19 p.m., CNA 8 entered room [ROOM NUMBER]-W with a meal tray. She took the dinner roll out of a plastic bag with her bare hands and placed it in front of the resident. During an interview on 2/16/26 at 3:03 p.m., CNA 8 indicated she probably should have washed her hands before touching residents' food. She used hand sanitizer after handing out lunch trays to avoid cross contamination. Hand hygiene was utilized for infection prevention.During an observation on 2/19/26 at 4:56 p.m., CNA 9 retrieved a meal tray from the cart, and delivered the meal tray to room [ROOM NUMBER]-D. CNA 9 assisted the resident with meal set up and touched personal items on the beside table. She exited room [ROOM NUMBER]-D, poured a yellow drink from the drink cart, and placed the cup on a tray in the food cart. Then CNA 9 delivered a meal tray to room [ROOM NUMBER]-D and exited the room. Hand hygiene was not observed at any time throughout the observation. During an interview on 2/19/26 at 5:16 p.m., CNA 9 indicated she probably should have performed hand hygiene after she passed out each tray. Hand hygiene was done to prevent cross contamination.On 2/20/26 at 2:32 p.m., the Infection Preventionist indicated hand hygiene was required before picking up any meal trays.On 2/20/26 at 2:33 p.m., the DON indicated hand hygiene must be completed every time staff enter and exit resident rooms, after touching themselves, and after touching objects. Food should not be touched bare handed.A current policy, revised 10/2017, titled Hand Antiseptic for Food Service, provided by the Corporate Nurse Consultant on 2/20/26 at 2:48 p.m., indicated the following: Policy. Hand antiseptic or antimicrobial gel used by staff as a hand dip or wash will be limited to situations that involve no direct contact with food by the bare hands. Hand antiseptic may be applied between washing hands twice before full hand washing must be completed.3.1-18(l)