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	02/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/03/25 Facility Number: 000309 Provider Number: 155432 AIM Number: 100288960 At this Emergency Preparedness survey, Albany Health Care & Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 102 certified beds. At the time of the survey, the census was 85. Quality Review completed on 02/05/25	E 0000	The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/03/25 Facility Number: 000309 Provider Number: 155432 AIM Number: 100288960 At this Life Safety Code survey, Albany Health	K 0000	The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Gimre	Administrator	02/19/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 01 B. WING	02/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Care and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in the resident rooms. The facility has a capacity of 102 and had a census of 85 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except a barn for beds and wheelchairs and a garage for maintenance equipment which were not sprinklered. Quality Review completed on 02/05/25			
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 2 of 2 exit discharge paths that lead through a courtyard was readily accessible at all times and 1 of 1 procedures on how to unlock the gate in the exit discharge paths was known to all staff. This deficient practice could affect all residents in the facility. Findings include: Based on observations and interviews during a	K 0211	1. No residents were affected. The exits that were locked had their locks removed to ensure all exit discharge path gates are free from aany locks. 2. All residents have the chance to be affected. 3. Proper exit discharge path regulation was reviewed.	02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 01 B. WING	02/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tour of the facility with the Maintenance Director (MD) and Administrator (AD) on 02/03/25 between 11:35 a.m. and 1:45 p.m., the large, fenced courtyard in the rear of the facility has two gates (one on each end) that are locked with a padlock with no key in the immediate vicinity. Exit discharges from marked exits in the facility's 300, 400 and 100 halls lead into the aforementioned locked courtyard. Only the facility's 400 hall is considered a memory care area. The exit discharge from the 400 hall memory care area is not separated from the rest of the courtyard. The exit discharge from the 300 hall only has the option of traversing both aforementioned locked gates in order to arrive at the parking lot. The MD stated that he had previously thought padlocking these gates was a problem. This finding was acknowledged by the Maintenance Director and AD at the time of observation and again at the exit conference with the MD and AD present. 3.1-19(b)		Maintenance Director will be educated on the regulation. 4. Maintenance Director/Designee will perform an audit including review of the accessability of the exit discharge paths to ensure compliance with the regulation. Audit will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum of 6 months. The findings of these audits will be presented during the facility's QAPI meetings and the plan of action adjusted accordingly.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview; the facility failed to install exit signage in 2 of 2 courtyard exits in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect up to	K 0293	1. No residents were affected. Exit signange was installed at both courtyard exits. Exit signage was also installed outside of our 300 hall exit. 2. All residents have the chance to be affected. LSC 7.10.1.2.2 was 3. LSC 7.10.1.2.2 was reviewed to ensure compliance with the installed exit signage.	02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 01 B. WING	02/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	50 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) and Administrator (AD) on 02/03/25 between 11:35 a.m. and 1:45 p.m., the 100, 300 and 400 hallway exits lacked directional signage once exiting the facility. The aforementioned exit discharges each had options when exiting (right or left). There was no directional signage present to indicate which path was the desired path to a parking lot or the public way. The 300 hall exit discharge to the "right" would seem correct however this sidewalk leads to a storage garage and not to the parking lot or public way. The "left" option is a sidewalk which leads around the rear of the facility and enters a courtyard through a locked gate and exits through a second locked gate in order to arrive at the parking lot. The Maintenance Director agreed that the courtyard exits need to have directional signage. This finding was acknowledged by the Maintenance Director and AD at the time of observation and again at the exit conference with the MD and AD present. 3.1-19(b)		Maintenance Director will be educated on the regulation. 4. Maintenance Director/Designee will perform an audit including review of the properly installed exit signage at all 3 exits to ensure compliance with the regulation. Audit will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum of 6 months. The findings of these audits will be presented during the facility's QAPI meetings and the plan of action adjusted accordingly.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for	K 0324	1. No residents were affected. Tape was installed to properly indicate the approved design location for cooking appliances that are moved for cleaning.	02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 01 B. WING	02/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 6 staff, and no residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) and Administrator (AD) on 02/03/25 between 11:35 a.m. and 1:45 p.m., the gas wheeled burner range and flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Maintenance Director the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. Based on observations,		2. All residents have the chance to be affected. 3. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2 was reviewed. Maintenance Director will be educated on the regulation. 4. Maintenance Director/Designee will perform an audit including reviewing the kitchen following a cleaning of the kitchen and the placment of the tape to ensure compliance with the regulation. Audit will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum of 6 months. The findings of these audits will be presented during the facility's QAPI meetings and the plan of action adjusted accordingly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 01 B. WING	02/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	it appeared they hood suppression nozzles were not lined up appropriately over the aforementioned range. The MD agreed with the observation and that it appeared the appliance had "walked it's way to the left." This finding was acknowledged by the Maintenance Director and AD at the time of observation and again at the exit conference with the MD and AD present. 3.1-19(b)			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 1 staff in the laundry area. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) and Administrator (AD) on 02/03/25 between 11:35 a.m. and 1:45 p.m., in the laundry area a brown extension cord was in use powering electronic equipment and a fan. Based on interview at the time of observation, the Maintenance Director acknowledged an extension cord was in use as described above and removed the cord during the survey. This finding was acknowledged by the Maintenance Director and AD at the time of	K 0920	1. No residents were affected. Extension cord was immediately removed from laundry area. 2. All residents have the chance to be affected. 3. NFPA-70/2011 regulation was reviewed. Maintenance Director will be educated on the regulation. 4. Maintenance Director/Designee will perform an audit including the review of laundry area for presence of extension cords to ensure compliance with the regulation. Audit will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum of 6 months. The findings of these audits will be presented during the facility's QAPI meetings and the plan of action adjusted	02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 01 B. WING	02/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observation and again at the exit conference with the MD and AD present. 3.1-19(b)		accordingly.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents.	K 0921	1. No residents were affected. TLC Construction will complete required maintenance and building maintenance director wil maintain complete documentation of inspections for PCREE. 2. All residents have the chance to be affected. 3. NFPA 99 2012 edition, sections 10.3 and 10.5 regulation was reviewed. Maintenance Director will be educated on the regulation. 4. Maintenance Director/Designee will perform an audit including review of the completed maintenance and complete documentation for PCREE to ensure compliance with the regulation. Audit will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum of 6 months. The findings of these audits will be presented during the facility's QAPI meetings and the plan of action adjusted accordingly.	02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 01 B. WING	02/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on records review, interview and facility tour with the Maintenance Director (MD) and Administrator (AD) on 02/03/25 between 10:05 a.m. and 1:45 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The MD and AD stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. Both the AD and MD stated that the facility was not aware that the PCREE was required to be tested. This finding was acknowledged by the Maintenance Director and AD at the time of observation and again at the exit conference with the MD and AD present. 3.1-19(b)			