PRINTED: 06/20/2022 FORM APPROVED OMB NO. 0938-039

|   | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155432 |   | A. BU | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                      |   |        | (X3) DATE SURVEY COMPLETED 05/31/2022 |  |  |
|---|--|---|-------|---|---|--------|---------------------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER ALBANY HEALTH CARE & REHABILITATION CENTER |  |   |       | STREET ADDRESS, CITY, STATE, ZIP COD 910 W WALNUT ST ALBANY, IN 47320 |   |        |                                       |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION |       | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETION<br>DATE            |  |  |
| F 0000  | REGULATORT OF  | LESC IDENTIFY TING INFORMATION  |       | IAG   |   |        | DAIL                                  |  |  |
| Bldg. 00  | This visit was for the Investigation of Complaint IN00377361  Complaint IN00377361 - Substantiated.        |   | F 00  | 000   |   |        |                                       |  |  |
|   | Federal/state deficiency related to the allegation is cited at F689.  Survey date: May 31, 2022            |   |       |   |   |        |                                       |  |  |
|   | Facility number: 00<br>Provider number: 1<br>AIM number: 1002  | 00309<br>55432  |       |   |   |        |                                       |  |  |
|   | Census Bed Type:<br>SNF/NF: 68<br>Total: 68  |   |       |   |   |        |                                       |  |  |
|   | Census Payor Type<br>Medicare: 6<br>Medicaid: 49<br>Other: 13<br>Total: 68                                 | :   |       |   |   |        |                                       |  |  |
|   | This deficiency refl<br>accordance with 41   | ects State Finding cited in 0 IAC 16.2-3.1.                                       |       |   |   |        |                                       |  |  |
|   | Quality review com   | pleted on June 2, 2022.   |       |   |   |        |                                       |  |  |
| F 0689<br>SS=D<br>Bldg. 00  |  | ents.   |       |   |   |        |                                       |  |  |

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

TITLE (X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1FK711

PRINTED: 06/20/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 05/31/2022 155432 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 910 W WALNUT ST ALBANY HEALTH CARE & REHABILITATION CENTER **ALBANY. IN 47320** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility F 0689 F689 Accidents and Hazards: 06/27/2022 failed to ensure a resident's transfer device/gait 1. What corrective action(s) will belt was used to prevent an injury during a be accomplished for those transfer which resulted in a facial hematoma for 1 residents found to have been of 3 residents (Resident B) reviewed for accidents. affected by the deficient practice? 1:1 instruction and re-education on Findings include: failure to use gait belt completed with SCNA 1 The clinical record for Resident B was reviewed Skills competency "Using Gait on 5/31/22 at 9:26 a.m. Diagnoses included, but Belt to Assist with Ambulation" were not limited to, cerebral infarction, muscle completed per CEC with SCNA 1. weakness, abnormalities of gait, atrial fibrillation and hypertension. 2. How other residents having the potential to be affected by the A quarterly Minimum Data Set (MDS) same deficient practice will be assessment, dated 5/9/22, indicated the resident identified and what corrective was severely cognitively impaired. The resident action(s) will be taken. required one-person physical assistance for Residents requiring assist with transfers and used a walker for mobility. transfer/ambulation had the risk to be affected. A health care plan, dated 10/9/21, indicated the resident was at risk for falls related to weakness. 3. What measures will be put Interventions included, but were not limited to. into place and what systemic remind resident to use her assistive device and changes will be made to ensure keep personal items within reach. the deficient practice does not recur. A fall risk assessment, dated 2/21/22, indicated the resident was at high risk for falls related to Nursing staff educated on use of intermittent confusion. gait belt to assist with ambulation. Command hooks were placed on A progress note, dated 4/29/22 at 8:35 a.m., outside of closet doors for gait indicated a staff member assisted the resident to belts to be stored for quick and the shower room and asked the resident to sit easy access for use. down on the shower chair when she lost her Every room was audited to ensure balance and fell forward, hitting her head on the gait belt was in place and easily trash can. The resident developed a hematoma to available.

FORM CMS-2567(02-99) Previous Versions Obsolete

the right side of her forehead. The facility

Event ID:

1FK711

Facility ID: 000309

If continuation sheet

DON/CEC/designee will complete

Page 2 of 4

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| AND PLAN OF CORRECTION  DENTIFICATION NUMBER AND PLAN OF CORRECTION  DESTIFICATION NUMBER 155432  NAME OF PROVIDER OR SUPPLIER  ALBANY HEALTH CARE & REHABILITATION CENTER  BOUNDAMEN STATEMENT OF DEPICIENCE  (CAST)  ALBANY, IN 47320  IN WAILINET ST  ALBANY, IN 47320  ALBANY, IN 47320  TAG  TO WAILINET ST  ALBANY, IN 47320  IN WAILINET ST  ALBANY, IN 47320  TO WAILINET ST  ALBANY, IN 473 | CENTERS FOR MEDICARE & MEDICAID SERVICES |  |                                 |                            |            |                                   | OMB NO. 0938-039 |            |  |  |
|--|--|--|---------------------------------|----------------------------|------------|-----------------------------------|------------------|------------|--|--|
| NAME OF PROVIDER OR SUPPLIER  ALBANY HEALTH CARE & REHABILITATION CENTER  ALBANY HEALTH CARE & REHABILITATION CENTER  BY OW WALNUT ST  ALBANY, IN 47320  SUMMARY STATEMENT OF DEFICIENCE  BY REGULATORY OR LSC IDENTIFYING INFORMATION  Initiated neurological assessmens, notified the physician and family of the fall.  An Interdisciplinary Team (IDT) note, dated 4/29/22 at 11:22 a.m., indicated Resident B wanted to walk with the Personal Care Assistant (PCA) 1 to the shower room instead of being wheeled in her wheelchair. The resident became confused and thought she needed to get her colling and attempted to walk while the PCA had turned to get her supplies. The resident became confused and thought she needed to get her colling and attempted to walk while the PCA had turned to get her supplies. The resident the fall and hir her face on the trash can and developed a hematoma to her forchead.  During an interview with the Director of Nursing (DON) and PCA 1 on 5/31/22 at 2:17 p.m., PCA 1 indicated the received transfer education prior to the fall. Resident B wanted to walk to he shower room and the resident that the side went to look for her clothes, she fell forward into the trash can. She was not using a gait belt at the time of the fall. The DON indicated PCA 1 should of had a gait belt around the resident.  Review of PCA 1's new-hire education courses, she completed the following:  a. Using gait belt to assist with ambulation 5/3/22 b. Walking 3/3/22 c. Assist with walker 5/3/22 d. Transfer to chair 4/29/22. PCA 1 successfully completed all procedures on 5/12/22.  Review of a current facility procedure, titled  "Using Gait Belt to Assist with Ambulation." revised 4/20, and provided by the DON on   | STATEMEN                                 | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA   |                                 | (X2) MULTIPLE CONSTRUCTION |            |                                   | (X3) DATE SURVEY |            |  |  |
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| Date      | ΔΙ ΒΔΝΥ                                  | HEALTH CARE & I  | REHARII ITATION CENTER          |                            |            |                                   |                  |            |  |  |
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| "Using Gait Belt to Assist with Ambulation," revised 4/20, and provided by the DON on  |  | J114/44.   |                                 |                            |            |                                   |                  |            |  |  |
| "Using Gait Belt to Assist with Ambulation," revised 4/20, and provided by the DON on  |  | Review of a current  | t facility procedure titled     |                            |            |                                   |                  |            |  |  |
| revised 4/20, and provided by the DON on   |  |  |                                 |                            |            |                                   |                  |            |  |  |
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|  |  |  | •                               |                            |            |                                   |                  |            |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

"Procedure Steps

1. Assist resident to sit on the edge of bed....

Event ID:

1FK711

Facility ID: 000309

If continuation sheet

Page 3 of 4

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2022 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155432 | X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |   | (X3) DATE SURVEY COMPLETED 05/31/2022 |            |      |  |
|--|--|---|---|---|---------------------------------------|------------|------|--|
| NAME OF PROVIDER OR SUPPLIER  ALBANY HEALTH CARE & REHABILITATION CENTER |  |   |   | STREET ADDRESS, CITY, STATE, ZIP COD 910 W WALNUT ST ALBANY, IN 47320 |                                       |            |      |  |
| (X4) ID  | SUMMARY STATEMENT OF DEFICIENCIE   |   |   | ID  | PROVIDER'S PLAN OF CORRECTION         |            | (X5) |  |
| PREFIX   | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL                                   |   |   | ATE                                   | COMPLETION |      |  |
| TAG  | REGULATORY OF  | LSC IDENTIFYING INFORMATION                                   |   | TAG   | DEFICIENCY)                           |            | DATE |  |
|  | 2. Place belt around resident's waist with the buckle in front (on top of resident's clothes) and adjust to a snug fit ensuring that you can get your hands under the belt. Position one hand on the belt at the resident's side and the other hand at the resident's back5. Stand to side and slightly behind resident while continuing to hold onto belt"  This Federal Tag relates to complaints IN00377361.  3.1-45(a) |   |   |   |                                       |            |      |  |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1FK711 Facility ID: 000309 If continuation sheet Page 4 of 4