STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING **01** B. WING _____	R-C **04/14/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY NURSING AND REHABILITATION CENTER	**201 E ELM ST** **NEW ALBANY, IN 47150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the investigation of Complaint Number IN00348293 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/14/21 Facility Number: 001145 Provider Number: 155616 AIM Number: 200120200 At this PSR to a complaint investigation, New Albany Nursing and Rehabilitation Center was found 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 and 410 IAC 16.2. This two story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus, the facility has smoke detectors hard wired to the nurses call system with battery backup in all resident sleeping rooms. The facility has a total capacity of 143 licensed beds with 122 certified beds and had a total census of 65 at the time of this visit. The entire facility was surveyed due to the lack of a 2 hour fire-rated separation. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING **01** B. WING _____	R-C **04/14/2021**

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{K 000}	Continued From page 1 Quality Review completed on 04/19/21	{K 000}		