STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING _____ B. WING _____	R-C 02/25/2019

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
{F 000}	INITIAL COMMENTS This visit was for the PSR (Post Survey Revisit) to the Investigation of Complaint IN00284331 completed on January 24, 2019. This visit was in conjunction with the PSR to the Investigation of Complaints IN00276658, IN00276840, IN00280867, IN00282905 and IN00283365 completed on January 8, 2019, and the Investigation of Complaint IN00287463. Complaint IN00284331 - Corrected Complaint IN00276658 - Corrected Complaint IN00276840 - Corrected Complaint IN00280867 - Corrected Complaint IN00282905 - Corrected Complaint IN00283365 - Corrected Complaint IN00287463 - Substantiated. No deficiencies related to the allegations are cited. Survey date: February 25, 2019 Facility number: 001145 Provider number: 155616 AIM number: 200120200 Census Bed Type: SNF/NF: 85 Residential: 9 Total: 94 Census Payor Type:	{F 000}		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING _____ B. WING _____	R-C 02/25/2019

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
{F 000}	Continued From page 1 Medicare: 7 Medicaid: 63 Other: 15 Total: 85 New Albany Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00284331. Quality review completed on February 26, 2019.	{F 000}		