						PRIN	TED: 09/18/2020	
DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
CENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> B. WING			COMPL	ETED		
155765					08/27/2020			
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				LACKISTON BLVD - PROGRES	SSIVE CA	RE UNIT	
SOUTHE	RN INDIANA REHA	ABILITATION HOSPITAL - SNF	NEW ALBANY, IN 47150					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	<sub>.TE</sub>	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)	-	DATE	
F 0000								
Bldg. 00								
		COVID-19 Focused Infection	F 0000		The following plan of correction is intended to demonstrate the			
	Control Survey.							
					facility's commitment to			
	Survey date: August 27, 2020.			compliance with applicable s		ate		
					and federal regulations. The			
	Facility number: 005649				statements set forth below sha	all		
	Provider number: 155765				not be construed as an admiss	sion		
	AIM number: N/A				or constitute agreement with the			
					deficiencies alleged. The facili	•		
	Census Bed Type:				has taken or will take the action			
	SNF: 8				set forth in the following plan of			
	Total: 8				correction by the dates indicat	ed.		
	Census Payor Type:							
	Medicare: 4	•						
	Other: 4							
	Total: 8							
	10111.0							
	This deficiency refle	ects State Findings cited in						
	accordance with 410	C						
	accordance with 410	0 110 10.2 3.1.						

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

Quality review completed on September 2, 2020.

Reporting-Residents, Representatives & Famili

§483.80(g) COVID-19 reporting. The facility

representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—

§483.80(g)(3) Inform residents, their

483.80(g)(3)(i)-(iii)

must-

F 0885

SS=E

Bldg. 00

TITLE (X6) DATE

Any defiency statement 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 disclodays 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.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
155765		B. WI	NG		08/27/	/2020		
NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA REHABILITATION HOSPITAL - SNF			STREET ADDRESS, CITY, STATE, ZIP COD 3104 BLACKISTON BLVD - PROGRESSIVE CARE UNIT NEW ALBANY, IN 47150					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE	
	information; (ii) Include inform implemented to p transmission, incl of the facility will I (iii) Include any considerate, their reat least weekly or calendar day follow occurrence of eith infection of COVII whenever three onew onset of resp within 72 hours of Based on record refailed to ensure appand responsible parapositive employees facility. (OT 4, CN Findings include:  During the review (Long Term Care) List identified the facility in COVID-19 pthe LTC side of the LTC on August 7 aron 8/20/20  - CNA (Certified Non August 1, 2, 6, 3 tested positive on 8	umulative updates for presentatives, and families by 5 p.m. the next owing the subsequent her: each time a confirmed D-19 is identified, or remore residents or staff with piratory symptoms occur feach other. View and interview, the facility propriate notification to families raties of new cases of COVID-19 for 4 of 6 staff working in the NA 4, PTA 6, and PTA 7)  On 8/27/20 at 9:40 a.m., the LTC Respiratory Surveillance Line following staff members as positive and having worked on a facility:  I Therapist) 4 worked in the find 12, 2020. He tested positive for the land 13, 14, and 15, 2020. She	F 08	385	1. Plan of correction: (action taken) a. Notifications to inform residents, their representative and families of any new confir cases of COVID-19 or three of more residents or staff with new on-set of respiratory symptom occurring within 72 hours of eother was started on 8/31/202 The last confirmed case of COVID-19 for residents was 4/28/2020 and for staff 8/30/2 The Director of Nursing verbanotified current alert and orient residents. The Infection Preventionist notified responsing parties of current residents by telephone. Documentation of notification was placed in the of correction binder.  2. Others at risk: All current residents have potential to be	es rmed or ew is ach co. 020. Illy ible plan	09/10/2020	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155765		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/27/2020			
NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA REHABILITATION HOSPITAL - SNF			STREET ADDRESS, CITY, STATE, ZIP COD 3104 BLACKISTON BLVD - PROGRESSIVE CARE UNIT NEW ALBANY, IN 47150				
SOUTHERN INDIANA REHABILITAT  (X4) ID  PREFIX  TAG  (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENT)  She tested positive on 8/20/20  - PTA 7 worked in the LTC of 15, 16, 18, 20, and 21, 2020. If 8/26/20.  The facility could not provide to show families were notified Covid 19 employees.  During an interview on 8/27/2 (Infection Preventionist) indice notify families of each of the 14, PTA 6, and CNA 5 were tested of the other staff were tested of 21.  During an interview on 8/27/2 Executive Director indicated notified families of the positive August, because he had believe worked the acute hospital sides		ABILITATION HOSPITAL - SNF STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION on 8/20/20.  the LTC on August 11, 13, 14, 21, 2020. He tested positive on of provide any documentation ere notified of the positive s.  of on 8/27/20 at 9:54 a.m., the IP onist) indicated they did not each of the new cases. The OT ach of the new cases. The OT ach of the new cases. The OT on 8/27/20 at 10:23 a.m., The indicated that they had not the positive employees in had believed they primarily	3104 B	LACKISTON BLVD - PROGRE	COMPLETION DATE  Seem  Selults  In the contract of the contrac		
		nily should have been notified		respiratory symptoms occur was 72 hours of each other. Notifications will be made by telephone or verbally in-personant The Infection Preventionist/designee will not resident representatives and families. The Charge Nurse/designee will notify curresidents. Notification documentation will be on or attached to the census sheet track notifications  4. Ongoing audits/tools: a. The Infection	n. tify rent		

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NTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED				
	455505		00/07/0000				

B. WING 155765 08/27/2020 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3104 BLACKISTON BLVD - PROGRESSIVE CARE UNIT SOUTHERN INDIANA REHABILITATION HOSPITAL - SNF NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Preventionist/designee will monitor new onset of COVID-19 confirmed cases and new onset of respiratory symptoms whenever three or more residents or staff members with new onset of respiratory symptoms occur as an ongoing process of this facility. The Infection Preventionist/designee will make notifications to resident representatives and families by 5pm the next calendar day following occurrence. The Charge Nurse/designee will make notifications to current residents by 5pm the next calendar day following occurrence. Notifications will include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered. The Director of Nursing/designee will audit the census notification documentation weekly for twelve consecutive weeks any discrepancy in the notification documentation will be followed up on and resolved immediately with notifications or education on the documentation requirements. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance Committee. This plan of correction will be monitored at the monthly Quality Assurance meeting until

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such time consistent compliance

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

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
155765		B. WING			08/27/2020		
NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA REHABILITATION HOSPITAL - SNF				STREET ADDRESS, CITY, STATE, ZIP COD 3104 BLACKISTON BLVD - PROGRESSIVE CARE UNIT NEW ALBANY, IN 47150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
					has been met.		
					1.Date of compliance 9/10/2	020.	

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