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

PRINTED: 12/22/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155616	B. WING			R	
NAME OF PROVIDER OR SUPPLIER					ET ADDRESS, CITY, STATE, ZIP CODE	12/	21/2020
INAME OF FROMIDER OR SUFFLIER					ELM ST		
NEW ALBANY NURSING AND REHABILITATION CENTER					W ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 000}				
	Paper compliance to Infection Control Sur 22, 2020.	the Focus Covid 19 vey Completed on October					
	Review Date: December 21, 2020						
	Facility Number: 00 Provider Number: AIM Number: 20	1145 155616 0120200					
	was found to be in co 483, Subpart B and 4	and Rehabilitation Center ompliance with 42 CFR Part 10 IAC 16.2-3.1, in regard to e review to a Covid 19 wey.					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	  E		TITLE		(X6) DATE

(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.