

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

PRINTED: 09/10/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155765	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 09/09/2020
NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA REHABILITATION HOSPITAL - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD - PROGRESSIVE CARE UNIT 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}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/04/20 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 09/09/20</p> <p>Facility Number: 005649 Provider Number: 155765 AIM Number: NA</p> <p>At this PSR survey, Southern Indiana Rehab Hospital-PCU was found in compliance with Requirements for Participation in Medicare, 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.</p> <p>This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility does not have a two hour fire separation between the certified portion of the facility and other portions of the building so the entire facility was surveyed. The facility has a capacity of 22 with a census of 14 in the certified area, furthermore, the entire facility has a total capacity of 60 with a census of 39 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility</p>	{K 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.

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{K 000}	Continued From page 1 services were sprinklered except one metal building building used for facility storage. Quality Review completed on 09/09/20	{K 000}			