STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155765	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHERN INDIANA REHABILITATION HOSPITAL - SNF	**3104 BLACKISTON BLVD - PROGRESSIVE CARE UNIT NEW ALBANY, IN 47150**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure appropriate notification to families and responsible parties of new cases of COVID-19 positive employees for 4 of 6 staff working in the facility. (OT 4, CNA 4, PTA 6, and PTA 7) Findings include: During the review on 8/27/20 at 9:40 a.m., the LTC (Long Term Care) Respiratory Surveillance Line List identified the following staff members as being COVID-19 positive and having worked on the LTC side of the facility: - OT (Occupational Therapist) 4 worked in the LTC on August 7 and 12, 2020. He tested positive on 8/20/20 - CNA (Certified Nurse Aide) 5 worked in the LTC on August 1, 2, 6, 7, 13, 14, and 15, 2020. She tested positive on 8/20/20. - PTA (Physical Therapy Assistant) 6 worked in the LTC on August 11, 13, 14, 15, and 16, 2020. She tested positive on 8/20/20. - PTA 7 worked in the LTC on August 11, 13, 14, 15, 16, 18, 20, and 21, 2020. He tested positive on 8/26/20. The facility could not provide any documentation to show families were notified of the positive Covid 19 employees. During an interview on 8/27/20 at 9:54 a.m., the IP (Infection Preventionist) indicated they did not notify families of each of the new cases. The OT 4, PTA 6, and CNA 5 were tested on [DATE]. All of the other staff were tested on [DATE] and 21. During an interview on 8/27/20 at 10:23 a.m., The Executive Director indicated that they had not notified families of the positive employees in August, because he had believed they primarily worked the acute hospital side of the facility, and had not realized they worked the Long Term Care side. Because they worked the LTC side in the past few weeks, family should have been notified if they had worked over here.

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.