STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Provider/Supplier/CLIA Identification Number:	Multiple Construction:	Date Survey Completed:
145631 (X1)	A. Building: B. Wing: (X2)	10/11/2021 (X3)

Name of Facility Surveyed:	Facility Address (Street, City, State. Zip Code)
NEWMAN REHAB & HEALTH CARE CTR	418 SOUTH MEMORIAL PARK ROAD NEWMAN Illinois 61942

Name of Accrediting Organization Performing Survey (if applicable):

ID Prefix Tag (X4)	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency should be preceded by full regulatory or LSC identifying information)	ID Prefix Tag	PLAN OF CORRECTION (Each corrective action should be cross-referred to the appropriate deficiency)	Completion Date (X5)
F 884 SS=F	Based on record review, the facility failed to report complete information about COVID-19 to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) during a seven-day period that reporting was required by regulation. The CDC submitted data from the NHSN to the Centers for Medicare and Medicaid Services (CMS). Based on review of that data, CMS determined that between 10/04/2021 and 10/10/2021, the facility did not report complete information to NHSN about COVID-19 in the standardized			

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	format and frequency as specified by CMS and the CDC. This failure to report has the potential to cause more than minimal harm to all residents residing in the facility.			