STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING **01** B. WING _____	R **11/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTOWN PLACE AT NEW ALBANY	**4915 CHARLESTOWN RD** **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}	INITIAL COMMENTS	{K 000}		

A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey that exited on 10/08/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).

Survey Dates: 11/14/24

Facility Number: 001144
Provider Number: 155668
AIM Number: 200256980

At this PSR Life Safety Code survey, Charlestown Place at New Albany was found in compliance with Requirements for Participation in Medicare/Medicaid, 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.

This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, plus hard wired smoke detectors with battery back up in all resident sleeping rooms and several staff offices connected to a panel at the Nurses' Station (not the main fire alarm control panel). The facility has a total capacity of 172 with 158 certified beds and had a census of 20 at the time of this visit. The Assisted Living area was surveyed due to the lack of a 2 hour fire-rated separation between the skilled care areas and the Assisted Living area.

All areas where residents have customary access

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING **01** B. WING _____	R **11/14/2024**

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{K 000}	Continued From page 1 were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 11/15/24	{K 000}		