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

PRINTED: 11/18/2024 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER CHARLESTOWN PLACE AT NEW ALBANY INATID SECULATION USES TO PERCEPCIA OR SUPPLIER CHARLESTOWN PLACE AT NEW ALBANY INATID SECULATION USES THE PROCEDED OF FILL REQUILATION OF THE PROCEDED OF THE PROCEDED OF FILL REQUILATION OF THE PROCEDED | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--|---------|----------------------|---|------------|------------|
| MANG OF PROVIDER OR SUPPLIER CHARLESTOWN PLACE AT NEW ALBANY (MAN) D SUMMARY STATEMENT OF DEPICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEPICIENCY 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 Albarny was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Suppart 483-90(a), Life Safety tom 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 Type V (111) construction and fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, paces 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 lack of a 2 hour fine-raided separation between the skilled care areas and the Assisted Living area. All areas where residents have customary access | | | 45550 | B WING | | | | |
| CHARLESTOWN PLACE AT NEW ALBANY A915 CHARLESTOWN RO NEW ALBANY, IN 47150 | | 20,4252.02.01221.52 | 155666 | D. WING | | | 11/14/2024 | |
| CHARLESTOWN PLACE AT NEW ALBANY NEW ALBANY, IN 47150 CALL CHARLESTOWN PLACE AT NEW ALBANY NEW ALBANY, IN 47150 CALL CHARLESTOWN PLACE AT NEW ALBANY NEW ALBANY, IN 47150 CALL CHARLESTOWN PLACE AT NEW ALBANY NEW A | NAME OF PI | ROVIDER OR SUPPLIER | | | | | | |
| CALID SUMMAY STATEMENT OF PERICENCES DEPARTMENT OF LEGACH COMPRICTOR ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | CHARLES | TOWN PLACE AT NEW | ALBANY | | | | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS.REFERENCED TO THE APPROPRIATE CROSS.REFERENCED TO THE APPROPENT CROSS.REFERENCED TO | | | | | NEW ALBANY, IN 47150 | | | |
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| | ABORATORY | | · | F | | TITI F | | (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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | IPLE CONSTRUCTION NG 01 | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|------------------------|-----------------------------------|--|-------------------------------|----------------------------|--|
| | | 155668 | B. WING _ | | | 1 | ₹ 14/2024 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREE | T ADDRESS, CITY, STATE, ZIP CODE | 11/ | 14/2024 | |
| CHARLES | TOWN PLACE AT NEW | ALBANY | | | 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| {K 000} | Continued From page | e 1 I areas providing facility ed. | {K 0 | 00} | DEFICIENCY) | | | |
| | | | | | | | | |