STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING _____ B. WING _____	R-C 04/11/2025

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
{F 000}	INITIAL COMMENTS This visit was for the PSR (Post Survey Revisit) for Nursing Home Complaint IN00454370 completed on 3/18/25. This visit was in conjunction with the Investigation of Nursing Home Complaints IN00456144, IN00457155 and IN00457176. Complaint IN00454370 - Corrected. Complaint IN00456144 - No deficiencies related to the allegations are cited. Complaint IN00457155 - Federal/State deficiency related to the allegations is cited at F620. Complaint IN00457176 - No deficiencies related to the allegations are cited. Survey dates: April 10 and 11, 2025 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 128 Residential: 8 Total: 136 Census Payor Type: Medicare: 32 Medicaid: 66 Other: 30 Total: 128	{F 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING _____ B. WING _____	R-C 04/11/2025

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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
{F 000}	Continued From page 1 Charlestown Place was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00454370. Quality review completed on April 17, 2025.	{F 000}		