

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

PRINTED: 09/18/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/12/2024	
NAME OF PROVIDER OR SUPPLIER CHARLESTOWN PLACE AT NEW ALBANY				STREET ADDRESS, CITY, STATE, ZIP CODE 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 a Post Survey Revisit (PSR) to Complaint IN00435623 completed on June 27, 2024. This visit was in conjunction with the Recertification and State Licensure Survey; a State Residential Licensure Survey; the Investigation of Complaints IN00441570, IN00441712, IN00442755, and IN00442598 completed on September 12, 2024; and the PSR to Complaints IN00439316, IN00439663, and IN00439706 completed on August 15, 2024. Complaint IN00435623 - Corrected Complaint IN00439316 - Corrected Complaint IN00439663 - Corrected Complaint IN00439706 - Corrected Survey dates: September 5, 6, 9, 10, 11, and 12, 2024 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 118 Residential: 9 Total: 127 Census Payor Type: Medicare: 11 Medicaid: 65 Other: 42 Total: 118 Charlestown Place at New Albany was found to			{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: 155668	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/12/2024
NAME OF PROVIDER OR SUPPLIER CHARLESTOWN PLACE AT NEW ALBANY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 N00435623. Quality review completed on September 17, 2024.	{F 000}			