

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/07/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>HELLENIC SENIOR LIVING OF NEW ALBANY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2632 GRANT LINE ROAD</b> <b>NEW ALBANY, IN 47150</b>		
(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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00394551, IN00395835, IN00396066 and IN00396072</p> <p>Complaint IN00394551 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00395835 - Unsubstantiated due to lack of sufficient evidence.</p> <p>Complaint IN00396066 - Unsubstantiated due to lack of sufficient evidence.</p> <p>Complaint IN00396072 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 6 and 7, 2023</p> <p>Facility number: 014166</p> <p>Residential Census: 113</p> <p>Hellenic Senior Living of New Albany was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00394551, IN00395835, IN00396066 and IN00396072.</p> <p>Quality review completed on February 8, 2023.</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE