

Indiana 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 05/07/2025</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 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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00458172.</p> <p>Complaint IN00458172 - No deficiencies related to the allegations are cited.</p> <p>Survey date: May 7, 2025</p> <p>Facility number: 014166</p> <p>Residential Census: 121</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 Complaint IN00458172.</p> <p>Quality review completed on May 8, 2025.</p>	R 000		

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

TITLE

(X6) DATE