STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 00 B. WING	08/15/2024

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CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00437974, IN00438638, IN00439105, IN00439316, IN00439663, IN00439706, IN00440360 and IN00441040. Complaint IN00437974 - No deficiencies related to the allegation is cited. Complaint IN00438638 - No deficiencies related to the allegations are cited. Complaint IN00439105 - Federal/State deficiency related to the allegation is cited at F602. Complaint IN00439316 - Federal/State deficiency related to the allegation is cited at F842. Complaint IN00439663 - Federal/State deficiency related to the allegations is cited at F842. Complaint IN00439706 - Federal/State deficiency related to the allegations is cited at F842. Complaint IN00440360 - No deficiencies related to the allegations are cited. Complaint IN00441040 - No deficiencies related to the allegations are cited. An unrelated deficiencies are cited. Survey dates: August 11, 12, 13, 14 and 15, 2024 Facility number: 001144 Provider number: 155668 AIM number: 200256980	F 0000	Allegation of Compliance Please accept the following plan of correction for the survey that was completed on August 15, 2024. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth, facts alleged, or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. We respectfully request consideration for a desk review to verify substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jesse Ray	Executive Director	09/04/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Census Bed Type: SNF/NF: 111 Residential: 7 Total: 118 Census Payor Type: Medicare: 22 Medicaid: 57 Other: 32 Total: 111 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 19, 2024.			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance			

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	services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview and record review, the facility failed to ensure residents (Residents E and H) toilets were clean and sanitary for 2 of 4 residents reviewed for resident rights. Findings include 1. The clinical record for Resident E was reviewed on 8/11/24 at 12:13 p.m. The resident's diagnoses included, but were not limited to, hypertension, anxiety and depression. The quarterly MDS (Minimum Data Set) assessment, dated 6/12/24, indicated the resident's cognition was intact. On 8/11/24 at 9:35 a.m., the resident was observed sitting up in her wheelchair in her room watching television. The resident indicated her toilet bowl	F 0584	1. On 8/13/2024, housekeeping cleaned the toilet in the bathroom of resident E and H. 2. On 8/14/2024, the housekeeping supervisor verified the cleanliness of each resident's bathroom toilet and addressed any areas needed immediately. 3. Starting on 8/16/2024, the housekeeping supervisor provided education to housekeeping staff on the daily cleaning procedures of resident's bathrooms, with return demonstration to verify competence. 4. The Executive Director and/or Regional Director of Housekeeping will audit at least ten (10) resident bathrooms, to verify proper sanitation and	09/03/2024

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	had not been cleaned in over a week. The toilet bowl was dirty and had a dark black substance in the bottom of it. On 8/11/24 at 9:41 a.m., the Resident's bathroom toilet bowl was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. On 8/12/24 at 9:05 a.m., the toilet bowl in the resident's bathroom was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. On 8/13/24 at 9:07 a.m., the Resident's bathroom toilet bowl was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. 2. The clinical record for Resident H was reviewed on 8/13/24 at 1:30 p.m. The resident's diagnoses included, but were not limited to, right sided hemiplegia and diabetes. The annual MDS assessment, dated 7/30/24, indicated the resident's cognition was intact. On 8/11/24 at 9:40 a.m., Resident H indicated the bathroom toilet had been like that for over a week because it had not been cleaned. On 8/11/24 at 9:41 a.m., the Resident's bathroom toilet bowl was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl.		cleanliness of toilets weekly for four (4) weeks, and then five (5) resident bathrooms weekly for at least two (2) months, and then ongoing monthly. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	On 8/12/24 at 9:05 a.m., the toilet bowl in the resident's bathroom was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. On 8/13/24 at 9:07 a.m., the Resident's bathroom toilet bowl was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. During an interview on 8/13/24 at 9:17 a.m., the assistant housekeeping supervisor indicated resident bathrooms were cleaned daily. At 9:18 a.m., during an observation of Resident E's toilet bowl with the assistant housekeeping supervisor, he indicated the matter in the toilet bowl looked like it had been there for a while. During an interview on 8/13/24 at 9:20 a.m., the housekeeping supervisor indicated the toilets should be cleaned daily. On 8/14/24 at 11:30 a.m., the Executive Director provided a current copy of the document titled "7-Step Daily Washroom Cleaning" dated 1/1/2000. It included, but was not limited to...Purpose...To show Housekeeping employees the proper method to sanitize a...bathroom in long-term care...Clean and Sanitize Commode - The commode includes the tank, the seat, the bowl and the base...." 3.1-19(4)(f)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to follow medication administration hold parameters related to a resident heart rate (Resident C) for 1 of 3 residents reviewed for quality of care. Findings include: The clinical record for Resident C was reviewed on 8/11/24 at 12:03 p.m. The resident's diagnoses included, but were not limited to, palpitations, orthostatic hypotension and syncope. The physician's order, dated 7/26/23, indicated the resident was to receive Digoxin 125 mcg (micrograms) daily for palpitations. The medication was to be held for a heart rate less than 60 and to notify the physician. Review of the July and August 2024 medication administration record indicated the following: On 7/08/24, the resident's HR was 47 and the resident's medication (Digoxin) was administered. On 8/11/24, the resident's HR was 55 and the resident's medication (Digoxin) was administered. The clinical record lacked documentation of the physician's notification related to the resident's heart rate less than 60. On 8/15/24 at 1:55 p.m., LPN (Licensed Practical	F 0684	**1.** The nurse practitioner was notified on 8/29/2024 of the digoxin being given outside parameters on 7/8/2024 and 8/11/2024. Resident C remains in the facility and there has been no negative outcome related to the alleged deficient practice. 2. Current residents' medication records were reviewed by the Director of Nursing on 8/16/2024 and there were no other residents on digoxin. 3. Facility Licensed nurses and QMAs were provided education by the Staff Development Coordinator starting on 8/16/2024, regarding the 9 rights of medication administration, with emphasis on following medication parameters according to physician orders. Beginning on 8/25/2024, a member of the Nursing Administration Team to include but not limited to the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Staff Development Coordinator (SDC), MDSC, or Nurse Supervisor will conduct a medication administration competency for licensed Nurses	09/03/2024

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	Nurse) 5 indicated if a resident was on a medication with hold parameters and the resident's heart rate was out of range, the medication should have been held and the physician notified for guidance. The policy titled "Administering Medications" dated April 2019 included, but was not limited to, "Policy Statement...Medications are administered in a safe...manner, and as prescribed...Medications are administered in accordance with prescriber orders...." 3.1-37		and QMA's, that includes following the 9 rights of medication pass and following physicians' orders. 4. The Nursing Administration Team will conduct medication competencies with Licensed Nurses or QMA's three (3) times a week for four (4) weeks, then weekly for no less than two (2) months. The Director of Nursing Services and/or Assistant Director of Nursing will audit the MAR for residents who receive Digoxin, five (5) times a week for four (4) weeks, then weekly for no less than two (2) months. Any corrective action needed will be completed immediately. Findings will be submitted to the monthly QAPI Committee for review and further recommendations for a minimum of three (3) months or until audit compliance is maintained at 100% then on-going per routine QAPI reviews.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records.			

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	§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or			

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	(iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure medication administration records and controlled substance records accurately reflected the administration of narcotic medication for 3 of 4 residents reviewed for medical records. (Residents C, F, and H) Findings include: 1. The clinical record for Resident C was reviewed on 8/11/24 at 12:03 p.m. The resident's diagnoses included, but were not limited to, depression and osteoporosis. The physician's order, dated 6/27/24, indicated the resident was to receive Norco (Hydrocodone-Acetaminophen) 5-325 mg (milligrams) twice daily for back pain at 8:00 a.m. and 8:00 p.m. The care plan, dated 11/13/20, indicated the resident needed pain management and staff were to administer the resident's pain medication as	F 0842	1. There were no negative outcomes experienced by residents C, F, and H related to the alleged deficient practice. Resident D successfully discharged home following short-term therapy at our facility. 2 2. Current residents receiving narcotic medications, sliding scale insulin, and surgical treatment orders have the potential to be affected by the alleged deficient practice. The Director of Nursing reviewed residents' medication administration records and controlled substance records over the last 30 days, any opportunities identified were addressed immediately. Additionally, new admissions that occurred over the last 30 days were reviewed to verify the accuracy of physician orders to include but not limited to	09/03/2024

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	ordered. Review of the July 2024 and August 2024 Medication Administration Record indicated, on 7/17/24 at 8:00 a.m., 7/22/24 at 8:00 a.m., 8/9/24 at 8:00 a.m. and 8/10/24 at 8:00 a.m., the resident received the twice daily Norco (pain medication). The July 2024 and August 2024 controlled substance record lacked documentation of the resident's medications administration on 7/17/24 at 8:00 a.m., 7/22/24 at 8:00 a.m., 8/9/24 at 8:00 a.m. and 8/10/24 at 8:00 a.m. During an interview on 8/15/24 at 1:55 p.m., LPN (Licensed Practical Nurse) 5 indicated when the resident's narcotics (Norco) were administered, the medication should have been signed off on the controlled substance record and the Medication Administration Record. On 8/14/24 at 12:10 p.m., the Director of Nursing provided a current copy of the document titled "Medication Administration" dated 6/21/17. It included, but was not limited to, "Medication will be administered...in accordance to applicable State, Local and Federal laws and consistent with accepted standards of practice...Procedure...document medication administration with initials on the Medication Administration Record (MAR) immediately after administering medication to each resident...." 2. The clinical record for Resident F was reviewed on 8/12/24 at 1:44 p.m. The resident's diagnoses included, but were not limited to, anxiety and depression. The physician's order, dated 4/3/24, indicated the resident was to receive Lorazepam (antianxiety		surgical treatments and insulin orders. 3 3. Facility Licensed nurses and QMAs were provided education by the Staff Development Coordinator starting on 8/16/2024 regarding the 9 rights of medication administration including medication administration procedures with supportive documentation in the medication administration record and the controlled substance record as required. Additionally, education was provided for licensed nurses regarding verification of new admission orders for accuracy including but not limited to surgical treatments and insulin orders. During daily clinical review M-F nursing administration will review the Medication Administration Records to validate medication administration has occurred as ordered and any opportunities identified will be addressed immediately. 4 4. The Nursing Administration Team will conduct medication competencies with Licensed Nurses or QMA's three (3) times a week for four (4) weeks, then weekly for no less than two (2) months. to verify medication administration procedures are being performed correctly and supportive documentation in the medication administration record and the	

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	medication) 0.25 ml (milliliters) every 4 hours for restlessness at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. Review of the June 2024 Medication Administration Record indicated, on 6/18/24 at 4:00 a.m., the resident's medication was not signed out as administered. Review of the August 2024 Medication Administration Record indicated, on 8/10/24 at 4:00 a.m., the resident's medication was not signed out as administered. The physician's order, dated 1/23/24, indicated the resident was to receive Clonazepam (antianxiety medication) 1 mg (milligram) every 8 hours for anxiety at 12:00 a.m., 8:00 a.m. and 4:00 p.m. Review of the July 2024 Medication Administration Record indicated the resident's medications were administered on 7/6/24 at 4:00 p.m., 7/10/24 at 4:00 p.m., 7/14/24 at 4:00 p.m. and 7/26/24 at 4:00 p.m. The July 2024 controlled substance record lacked documentation that the medications were administered on 7/6/24 at 4:00 p.m., 7/10/24 at 4:00 p.m., 7/14/24 at 4:00 p.m. and 7/26/24 at 4:00 p.m. The physician's order, dated 3/14/24, indicated the resident was to receive Morphine Sulfate Oral Solution (pain medication) 0.25 ml six times a day for pain at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m. Review of the June 2024, July 2024 and August 2024 Medication Administration Records lacked documentation that the medication was administered on the following dates and times:		controlled substance record as required. New admission orders will be reviewed M-F during morning clinical meeting to verify accuracy of physician orders for new admits and nurse practitioner will address any discrepancies. Any corrective action needed will be completed immediately. Findings will be submitted to the monthly QAPI Committee for review and further recommendations for a minimum of three (3) months or until audit compliance is maintained at 100% then on-going per routine QAPI reviews.	

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	- On 6/11/24 at 6:00 a.m. and 2:00 p.m. - On 6/13/24 at 6:00 a.m. - On 6/14/24 at 6:00 a.m. - On 6/18/24 at 6:00 a.m. - On 6/24/24 at 6:00 a.m. - On 7/09/24 at 6:00 p.m. - On 7/15/24 at 2:00 p.m. and 6:00 p.m. - On 7/16/24 at 6:00 p.m. - On 7/21/24 at 6:00 a.m. - On 7/29/24 at 6:00 a.m. - On 8/03/24 at 6:00 p.m. - On 8/10/24 at 6:00 a.m. 3. The clinical record for Resident H was reviewed on 8/12/24 at 2:07 p.m. The resident's diagnoses included, but were not limited to, neuropathy and osteoporosis. The physician's order, dated 8/3/23, indicated the resident was to receive Tramadol 50 mg twice daily at 8:00 a.m. and 4:00 p.m. The care plan, dated 4/6/23, indicated the resident had pain and staff were to administer the resident's analgesia as ordered. The July 2024 Medication Administration Record indicated the resident received the Tramadol (pain medication), on 7/9/24 at 8:00 a.m. The controlled substance record lacked documentation of the administration of the resident's Tramadol on 7/9/24 at 8:00 a.m. 2. The clinical record for Resident D was reviewed on 8/11/24 at 10:52 a.m. The resident's diagnoses included, but were not limited to, strain of the right achilles tendon and diabetes. The hospital discharge orders, dated 7/11/24,			

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	155668	A. BUILDING 00 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	indicated the resident was to receive Humalog sliding scale with meals and at bedtime. The facility admission orders, dated 7/11/24, indicated to check the resident's blood sugar before meals and at bedtime. The clinical record lacked documentation of the sliding scale insulin, refusal of the insulin upon admission or education of the risks of not taking the insulin. During an interview on 8/14/24 at 3:07 p.m., the DON (Director of Nursing) indicated she thought the resident had refused the sliding scale upon admission, but was not for certain. During an interview on 8/15/24 at 1:55 p.m., LPN 5 indicated if a resident was admitted from the hospital on sliding scale insulin and refused, the order should have been put in the system and then staff would notify the NP/MD for guidance. The orthopedic surgeon orders, dated 7/24/23, indicated the resident was to have a wet to dry treatment completed twice daily to the right ankle surgical wound and the resident was to follow up with the surgeon on 7/31/24. The July 2024 Treatment Administration Record indicated the orthopedic surgeon/'s order was discontinued on 7/25/24. The in-house would evaluation summary, dated 7/25/24, indicated staff were to complete a saline moist wet to dry dressing daily. The clinical record lacked documentation of any notification to the orthopedic wound physician prior to the discontinuation of the treatment			

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	ordered on 7/24/24. During a telephone interview on 8/14/24 at 10:55 a.m., the in-house wound physician indicated when she first spoke with the resident, there were no specific orders in place for the wound. The resident reported that he had a follow-up appointment with the surgeon. On 7/24/24, he went to his follow-up appointment with the surgeon and returned with orders of a wet to dry and those orders were followed. She indicated she thought the surgeon ordered the treatment daily so that was a mistake on her part; a miscommunication on her part. This Citation relates to Complaints IN00439316, IN00439706 and IN00439663 3.1-50(a)(1) 3.1-50(a)(2)			