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	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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 IN00398549 and IN00399561. Complaint IN00398549 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00399561 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F690 and F693. Survey dates: January 26 and 27, 2023 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 72 SNF: 47 Residential: 4 Total: 123 Census Payor Type: Medicare: 14 Medicaid: 59 Other: 46 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 1, 2023.	F 0000	Allegation of Compliance Please accept the following plan of correction for the complaint survey completed on January 27, 2023. 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. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jesse Ray | Administrator | 02/13/2023

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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	§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure treatments were completed, as ordered by the physician, for 2 of 3 residents reviewed for pressure ulcers. (Residents C and D) Findings include: 1. On 1/26/23 at 11:01 a.m., Resident C was observed resting in bed with his eyes closed, heels offloaded, and positioned on his left side. The resident's wound treatments were in place and dated 1/26/23. The clinical record for Resident C was reviewed on 1/26/23 at 12:08 p.m. The diagnoses included, but were not limited to, Stage 4 pressure ulcer (deep wound that has reached the muscle, ligaments or bone) of the sacrum and unstageable (full thickness tissue loss where the depth of the wound is obscured by slough and/or eschar in the wound bed) pressure ulcer to the left and right hips. The care plan, dated 10/12/22, indicated the resident had an unstageable pressure ulcer (Stage	F 0686	1. Patient C and D continue to reside at our facility and treatments are being completed as ordered by the physician. 2. Residents with alterations in skin integrity have the potential to be affected by the alleged deficient practice. Beginning on 1/30/2023, the Director of Clinical Services reviewed the medical records of patients/residents currently identified with wounds to validate adherence to ordered interventions and documentation of prescribed treatments. Results of audit revealed adherence to established guidelines for management on skin integrity. 3. Beginning on 1/30/2023, the Director of Clinical Education provided education to licensed nursing staff regarding the established guidelines for management of Skin Integrity. Licensed Nurse will perform prescribed treatments and	01/31/2023

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	4 as of 11/30/22) to the coccyx and an unstageable pressure ulcer to the right hip (as of 1/18/23). Treatments were to be completed as ordered. The physician's order, dated 10/12/22 and discontinued on 11/3/22, indicated staff were to cleanse the resident's wound with normal saline, apply medihoney, apply calcium alginate and cover with a sacral silicone foam border dressing daily. The October 2022 treatment administration record indicated the resident's wound treatment was not completed on 10/17/22, The physician's order, dated 11/3/22 and discontinued on 11/16/22, indicated staff were to cleanse the resident's coccyx wound with normal saline, apply santyl, apply calcium alginate and cover with a sacral silicone foam border dressing daily. The November 2022 treatment administration record lacked documentation the resident's wound treatment was completed on 11/5/22. The physician's order, dated 11/16/22 and discontinued on 11/30/22, indicated staff were to cleanse the resident's wound with normal saline, apply santyl anasept mix to outward tissue, pack with mesalt rope and cover with a silicone foam border dressing daily. The November 2022 treatment administration record lacked documentation the resident's wound treatment was completed on 11/17/22, 11/22/22, 11/24/22 and 11/25/22. The physician's order, dated 11/30/22, indicated staff were to cleanse the resident's wound with		document completion of treatments in the resident's medical record. The Unit Managers and/or HIMC will review scheduled User Defined Assessments and the Treatment Administration Record during The Morning Clinical Meeting (M-F) to validate completion and documentation of ordered treatments/interventions. Corrections will be made immediately as applicable. 4. The Director of Nursing, Unit Managers and/or Wound Care Nurse will audit at least 10 treatment records of residents with wounds and validate through direct observation for 4 weeks, then at least 5 weekly for at least two additional months to visually confirm treatment completion and validate documentation of prescribed treatments and adherence to the Skin Integrity Guidelines. Findings will be submitted to the monthly QAPI Committee for review and further recommendations for a minimum of 3 months or until audit compliance is maintained at 95% then on-going per routine QAPI reviews.	

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	normal saline, apply Dakins' soaked gauze, apply dry gauze and cover with silicone foam border dressing every day and night shift. The December 2022 and January 2023 treatment administration record lacked documentation the resident's wound treatment was not completed on the following dates and shifts: -12/12/22 on day shift -12/14/22 on day shift -12/15/22 on day shift -12/17/22 on night shift -12/21/22 on day shift -12/22/22 on day shift -12/27/22 on day shift -01/09/23 on day shift -01/13/23 on day shift -01/18/23 on day shift -01/20/23 on night shift The physician's order, dated 1/5/23, indicated staff were to apply alginate to the resident's right hip ruptured blister and cover with a silicone foam border dressing daily. The January 2023 treatment administration record lacked documentation the resident's treatment was completed on 1/7/23, 1/9/23, 1/13/23 and 1/18/23. During an interview on 1/27/23 at 10:35 a.m., LPN (Licensed Practical Nurse) 5 indicated resident's wound treatments should be signed as completed on the treatment administration record. 2. The clinical record for Resident D was reviewed on 1/26/23 at 3:49 p.m. The diagnosis included, but was not limited to, Stage 4 pressure ulcer to the coccyx.			

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	The care plan, dated 4/15/22, indicated the resident had a Stage 4 to the coccyx and to complete treatments as ordered. The December 2022 TAR (treatment administration record) indicated staff were to cleanse the resident's wound area with normal saline, apply medihoney and cover with a sterile border gauze daily. The December 2022 TAR lacked documentation of the resident's wound treatment completion on 12/10/22, 12/14/22 and 12/26/22. The January 2023 TAR indicated staff were to cleanse the resident's wound area with normal saline, apply medihoney and cover with a sterile border gauze daily. The January 2023 TAR lacked documentation of the resident's wound treatment completion on 1/8/23, 1/14/23, 1/19/23 and 1/22/23. On 1/27/23 at 2:35 p.m., the Director of Nursing provided a current copy of the document titled "Skin Care Guidelines" dated July 2018. It included, but was not limited to, "Purpose...To provide a system for evaluation of skin risk and identify individual interventions...Pressure Ulcer Flow Diagram...Implement resident specific interventions...Treatment as ordered...." This Federal tag relates to Complaint IN00399561 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview and record review, the facility failed to ensure catheter care was provided for 2 of 3 residents (Residents C and F) and failed to ensure a resident's (Resident E) catheter was changed per the physician's order for 1 of 3 residents reviewed for Indwelling catheters.	F 0690	1. 1. Resident E's catheter was changed; Resident C and F were provided catheter care per physician orders. 1.Residents with indwelling Foley catheters have the potential to be affected by the alleged	01/31/2023

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	Findings include: 1. The clinical record for Resident C was reviewed on 1/26/23 at 12:08 p.m. The diagnoses included, but were not limited to, Stage 4 sacral wound (deep wound that has reached the muscle, ligaments or bone) and neuromuscular dysfunction of the bladder. On 1/26/23 at 11:01 a.m., the resident was observed with an Indwelling catheter with catheter bag hooked on the bed side. The resident's clinical record lacked documentation of any Indwelling catheter care. During an interview on 1/27/23 at 10:35 a.m., LPN (Licensed Practical Nurse) 5 indicated the resident's catheter care should have been completed every shift. The physician's orders should have been followed as well as the resident care plan. 2. The clinical record for Resident E was reviewed on 1/26/23 at 4:35 p.m. The diagnosis included, but was not limited to, obstructive and reflux uropathy. On 1/26/23 at 3:12 p.m., the resident was observed with an Indwelling catheter with the catheter bag hooked on the bed side. The care plan, dated 7/23/21, indicated the resident had an Indwelling catheter and staff were to change the Foley catheter as ordered. The December 2022 treatment administration record (TAR) indicated staff were to change the resident's Foley catheter on the 18th of every month on day shift.		deficient practice. The Director of Nursing Services reviewed residents with indwelling Foley catheters to validate that catheters are changed and catheter care is being completed and documented appropriately as ordered. 2.Beginning on 1/30/2023, licensed nurses were re-educated by the Director of Clinical Education on completing and documenting indwelling Foley catheter care as ordered. During clinical start-up (M-F), the Health Information Management Coordinator will review nursing documentation to validate the completion of indwelling Foley catheter care as ordered. Any found to be incomplete will be investigated with applicable corrections. 4. 4. The Director of Nursing Services and/or Unit Managers will review at least 5 residents with indwelling Foley catheters to validate the completion of catheter care through direct observation with supportive documentation weekly for 4 weeks and continue weekly for no less than 2 additional 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 3 months or until audit compliance is maintained at 95% then on-going per routine QAPI	

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	The December 2022 TAR lacked documentation the resident's catheter was changed on 12/18/22. 3. The clinical record for Resident F was reviewed on 1/26/23 at 4:43 p.m. The diagnosis included, but was not limited to, Stage 4 pressure ulcer of the sacral region. The care plan, dated 1/17/23, indicated the resident had an alteration in bladder elimination and staff were to provide catheter care every shift. The physician's order, dated 1/6/23, indicated staff were to provide catheter care every shift. The January 2023 treatment administration lacked documentation the resident's catheter care was completed on the following dates and shifts: -1/06/23 on night shift -1/08/23 on night shift -1/11/23 on day shift and night shift -1/12/23 on day shift -1/17/23 on night shift -1/18/23 on evening shift and night shift -1/19/23 on night shift -1/21/23 on day shift -1/22/23 on night shift -1/23/23 on evening shift and night shift 1/25/23 on night shift On 1/27/23 at 3:09 p.m., the Director of Nursing provided a current copy of the document titled "Skill 34.2 Care and Removal of an Indwelling Catheter" and undated. It included, but was not limited to, "Providing regular perineal hygiene...are important interventions to reduce the risk of catheter-associated urinary tract infection...."		reviews.	

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	This Federal tag relates to Complaint IN00399561 3.1-41(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on interview and record review, the facility failed to ensure care was provided to a resident's (Resident C) gastrostomy tube site for 1 of 2 residents reviewed for enteral feeding. Findings include: The clinical record for Resident C was reviewed on 1/26/23 at 12:08 p.m. The diagnosis included, but was not limited to, gastrostomy status	F 0693	1. Resident C continues to reside at our facility and care is being provided to their gastrostomy tube site per physician orders. 2. 2. Residents with gastrostomy tubes have the potential to be affected by the alleged deficient practice. The Director of Nursing Services	01/31/2023

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	(g-tube). The care plan, dated 10/12/22, indicated the resident required tube feedings related to dysphagia and staff were to provide local care to the g-tube. The clinical record lacked documentation of any care provided to the resident's g-tube. During an interview on 1/27/23 at 10:35 a.m., LPN (Licensed Practical Nurse) 5 indicated when treatments were completed, they should be signed off on the treatment administration record and resident care plans should have been followed. This Federal tag relates to Complaint IN00399561 3.1-44(a)(2)		reviewed residents with gastrostomy tubes to validate care is being completed and documented appropriately as ordered. 1.Beginning on 1/30/2023, licensed nurses were re-educated by the Director of Clinical Education on completing and documenting gastrostomy care as ordered. During clinical start-up (M-F), the Health Information Management Coordinator will review nursing documentation to validate the completion of gastrostomy care as ordered. Any found to be incomplete will be investigated with applicable corrections. 4. The Director of Nursing Services and/or Unit Managers will review at least 3 residents with gastrostomy tubes to validate the completion of gastrostomy care through direct observation with supportive documentation weekly for 4 weeks and continue weekly for no less than 2 additional 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 3 months or until audit compliance is maintained at 95% then on-going per routine QAPI reviews.	