PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER CHARLESTOWN PLACE AT NEW ALBANY CASID SUMMARY STATEMENT OF DITICUTION: TAG RECULATORY OR ISC IDENTIFYING INFORMATION TAG This visit was for the Investigation of Complaint INOUH14596 - Federal/State deficiency related to the allegation is cited at F744. Complaint: INOUH14596 - Federal/State deficiency related to the allegation is cited at F744. Survey date: August 21, 2023 Facility number: 001144 Provider number: 155668 AlM number: 200256980 Census Bed Type: SNE/NE: 114 Total: 114 Census Payor Type: Medicare: 17 M	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2023	
CASID SUMMARY STATEMENT OF DEFICIENCIE FRIETR TAG REGULATORY OR LSC IDENTIFYING INFORMATION THIS visit was for the Investigation of Complaint IN00414596 - Federal/State deficiency related to the allegation is cited at F744. Complaint: IN00414596 - Federal/State deficiency related to the allegation is cited at F744. Survey date: August 21, 2023 Facility number: 200256980 Alm number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicare: 17 Medicaid: 67 Other: 30 Total: 114 Comit: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16-2-3.1. Quality review completed on August 28, 2023. FOR This propriete treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility well-being. Based on record review and interview, the facility Werespectfully request Complaint TILE (X6) DATE In provider structure of SUMPLIFICACION COMPLITION DATE COMPLITION TAG Allegation of Compliance Please accept the following plan of correction for the survey or completed on August 21, 2023 Preparation and/or execution of the following plan of correction for the survey or completed on August 21, 2023 Preparation and/or execution of the federal mumber: 155668 AIM number: 200256980 Allegation of Compliance Please accept the following plan of correction for the survey or completed on August 21, 2023 Preparation and/or execution for the survey and and or conclusions set forth in the statement of deficiencies. This plan of correction for the reduction of the Federal and State Laws. This 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 deak review and paper compliance. FO744 483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her h	NAME OF	PROVIDER OR SUPPLI	ER			
RECULATORY OR LSC IDENTIFYING RYGEMATION TAG RECULATORY OR LSC IDENTIFYING RYGEMATION This visit was for the Investigation of Complaint IN00414596. Federal/State deficiency related to the allegation is cited at F744. Survey date: August 21, 2023 Fucility number: 001144 Provider number: 155668 AIM number: 200256980 Consus Bed Type: SNF/NF: 114 Total: 114 Consus Payor Type: Medicare: 17	CHARLE	ESTOWN PLACE A	AT NEW ALBANY			
TAG REGULATORY OR INCIDENTIFYING INFORMATION TAG REGULATORY DIRECTORS OR PROVIDERS SUPPLIER REPRESENTATIVES SIGNATURE THE REGULATORY OR PROVIDERS SUPPLIER REPRESENTATIVES SIGNATURE TITLE		SUMMAR	Y STATEMENT OF DEFICIENCIE			
Bildg. 00 This visit was for the Investigation of Complaint N00414596 - Federal/State deficiency related to the allegation is cited at F744. Survey date: August 21, 2023 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicare: 17 Medicarid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. Laboratory Directors or provided in the right or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility Laboratory Directors or providers Supplier Representatives signature. Allegation of Compliance Allegation of Compliance Please accept the following plan of correction for the survey completed on August 21, 2023. Preparation and/or execution of this plan of correction loses not constitute admission or agreement by the provision or survey of the plan of correction in 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. Laboratory Directors or provide/scoolid well-being. Based on record review and interview, the facility F 0744 Laboratory Directors or provide/scoolid well-being. Based on record review and interview, the facility F 0744 Laboratory Directors or provide/scoolid well-being.					CROSS-REFERENCED TO THE APPROPRIA	1E
Bildg. 00 This visit was for the Investigation of Complaint IN00414596. Complaint: IN00414596 - Federal/State deficiency related to the allegation is cited at F744. Survey date: August 21, 2023 Facility number: 902144 Provider number: 90256980 AlM number: 200256980 Census Bed Type: SNFANF: 114 Total: 114 Census Payor Type: Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. For paration 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 0744 483.40(b)(3) Treatment/Service for Dementia S483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SKONATURE TILLE Allegation of Compliance Please accept the following plan of correction for does not constitute admission or agreement by the provision of the tresident by the provision of the tresident salleged or conclusions set forth in the statement of deficiencies. This plan of correction location of the Survey and deficiences. This plan of correction location of the Survey and excellent and or acceptance in the truth facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction loc		REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
This visit was for the Investigation of Complaint IN00414596. Complaint: IN00414596 - Federal/State deficiency related to the allegation is cited at F744. Survey date: August 21, 2023 Survey date: August 21, 2023 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Total: 114 Census Payor Type: Medicare: 17 Medicad: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. Total: 483.40(b)(3) Treatment/Service for Dementia S483.40(b)(3) A resident who displays or is diagnosed with demental, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility process of the Second of the	F 0000					
IN00414596. Complaint: IN00414596 - Federal/State deficiency related to the allegation is cited at F744. Survey date: August 21, 2023 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Total: 114 Census Payor Type: Medicare: 17 Medicare: 17 Medicare: 17 Medicare: 17 Medicare: 17 Medicare: 18 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. Allegation of Compliance Please accept the following plan of correction for the survey completed on August 21, 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. We respectfully request consideration for a desk review and paper compliance. LABORATORY DIRECTORS OR PROVIDERSUPPLIER REPRISENTATIVES SIGNATURE Allegation of Correction for Correction for the Surveyor completed on August 28, 2023. Allegation of Correction for the survey completed on August 21, 2023. Preparation and/or execution of the function and 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 only the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and or required by the provision of the Federal and State Laws. This facility appreciated the time and or required	Bldg. 00					
related to the allegation is cited at F744. Survey date: August 21, 2023 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Total: 114 Census Payor Type: Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16,2-3.1. Quality review completed on August 28, 2023. For 744 483.40(b)(3) Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 LABORATORY DIRECTORS OR PROVIDER:SUPPLIER REPRESENTATIVES SIGNATURE Correction for the survey ocompleted on August 21, 2023. Correction for the survey completed on August 21, 2023. Preparation and or executed on August 21, 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 conclusions on agreement by the provider of the truth facts alleged or conclusions on agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusion or agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusion or alleged or conclusion or agreement by the provider of the truth facts alleged or conclusion or alleged or conclusions of the truth facts alleged or conclusion or alleged or conclusion or alleged or conclusion or alleged or conclusion of the facts alleged or conclusion of the truth facts alleged or conclusions of the truth facts alleged or conclusion or alleged or conclus			the Investigation of Complaint	F 0000	Allegation of Compliance	
related to the allegation is cited at F744. Survey date: August 21, 2023 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Total: 114 Census Payor Type: Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16,2-3.1. Quality review completed on August 28, 2023. For 744 483.40(b)(3) Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 LABORATORY DIRECTORS OR PROVIDER:SUPPLIER REPRESENTATIVES SIGNATURE Correction for the survey ocompleted on August 21, 2023. Correction for the survey completed on August 21, 2023. Preparation and or executed on August 21, 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 conclusions on agreement by the provider of the truth facts alleged or conclusions on agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusion or agreement by the provider of the truth facts alleged or conclusions or agreement by the provider of the truth facts alleged or conclusion or alleged or conclusion or agreement by the provider of the truth facts alleged or conclusion or alleged or conclusions of the truth facts alleged or conclusion or alleged or conclusion or alleged or conclusion or alleged or conclusion of the facts alleged or conclusion of the truth facts alleged or conclusions of the truth facts alleged or conclusion or alleged or conclus		Complaint: IN004	14596 - Federal/State deficiency		Please accept the following pl	an of
Facility number: 001144 Provider number: 155668 AIM number: 200256980 AIM number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Total: 114 Census Payor Type: Medicare: 17 Medicare: 17 Medicare: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. Treatment/Service for Dementia \$483.40(b)(3) Treatment/Service for Dementia or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility LABORATORY DIRECTORS OR PROVIDER:SUPPLIER REPRESENTATIVES SIGNATURE 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 statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the statement and dedication of the Surveyor; the facility of care provided to the tresidents in our community. We respectfully request consideration for a desk review and paper compliance. We respectfully request consideration for a desk review and paper compliance.		_			correction for the survey	
Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicarid: 67 Other: 30 Total: 114 Total: 114 Quality review completed on August 28, 2023. Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE Census Payor Type: 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 0744 483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE Constitute admission or agreement by the provider of thin the statement of deficiencies. This plan of correction is alleged or conclusion set forth in the statement of deficiencies. This plan of correction is alleged or conclusion set forth in the statement of deficiencies. This plan of correction is alleged or conclusion set forth in the statement of deficiencies. This plan of correction is and/or executed solely because it is required by the provision of the Eederal and/or executed solely because it is required by the provision of the Eederal and State L		Survey date: Augi	ust 21, 2023		Preparation and/or execution	of
Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Total: 114 Census Payor Type: Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. Total: 483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE 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 plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and/or executed solely because it is required by the provision of the Evatement of correction is prepared and/or executed solely because it is required by the provision of the Evatement and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and otol for our facilit		Facility number: (001144		•	I
AIM number: 200256980 Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Census Payor Type: Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 LAC 16.2-3.1. Quality review completed on August 28, 2023. FO744 SS=D Bldg. 00 Bldg. 00 A83.40(b)(3) Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility I alleged or conclusion set forth in the statement of deficiencies. This he 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 0744 483.40(b)(3) Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTORS OR PROVIDER:SUPPLIER REPRESENTATIVES SIGNATURE IIILE (X6) DATE					_	I
Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicare:17 Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. FO744 SS=D Bldg. 00 Float: 483.40(b)(3) Treatment/Service for Dementia S483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE Title 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 appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the time and dedication of the Surveyor; the facility appreciated the surveyor; the facility appreciated the surveyor; the facility appreciated the survey					-	I
SNF/NF: 114 Total: 114 Census Payor Type: Medicare:17 Medicaid: 67 Other: 30 Total: 114 Total: 114 Total: 114 Census Payor Type: Medicare:17 Medicaid: 67 Other: 30 Total: 114 Total: 114 Customary Payor Type: Medicare:17 Medicaid: 67 Other: 30 Total: 114 Customary Payor Type: Medicare:18 Assignment Payor Type: Medicare:19 Medicaid: 67 Other: 30 Total: 114 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. For 44 483.40(b)(3) Treatment/Service for Dementia Sy483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility For 44 For 44 For 44 Mand/or executed solely because it is required by the provision of the Federal and State Laws. This facility with edication of the Surveyor; the facility will accept the survey as a tool for our facility ous ein 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. For 44 483.40(b)(3) Treatment/Service for Dementia expressional expressional expressional expressional expressional expressional expressional expressional expression for a desk review and paper compliance. For 44 483.40(b)(3) For 5744 For 744 For 744 LABORATORY DIRECTOR'S OR PROVIDER'SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						
Total: 114 Census Payor Type: Medicare: 17 Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. We respectfully request consideration for a desk review and paper compliance. FO744 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE 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.		Census Bed Type	:		plan of correction is prepared	
Census Payor Type: Medicare:17 Medicare:17 Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. F 0744 SS=D Bldg. 00 Bldg. 00 Has 3.40(b)(3) Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE F 0744 F-744 F-744 F-744 F-744 Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the surveyor; the facility will accept the surveyor; the facility on the facility on to 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 0744 483.40(b)(3) Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 O8/24/2023		SNF/NF: 114			and/or executed solely because	se it
Medicare:17 Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. We respectfully request consideration for a desk review and paper compliance. F 0744 SS=D Bldg. 00 Bldg. 00 Medicare:17 Medicaid: 67 Other: 30 Total: 114 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 0744 SS=D Bldg. 00 Headication of the Surveyor; the facility will accept the survey as a tool for our 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 0744 SS=D Bldg. 00 Headication of the Surveyor; the facility will accept the survey as a tool for our fa		Total: 114			•	the
Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings eited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. We respectfully request consideration for a desk review and paper compliance. F 0744 SS=D Bldg. 00 Bldg. 00 Bldg. 00 Bldg. 00 Bldg. 00 Medicaid: 67 Other: 30 Total: 114 This deficiency reflects State Findings eited 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.		Census Payor Typ	e:		facility appreciated the time ar	nd
Other: 30 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. We respectfully request consideration for a desk review and paper compliance. F 0744 SS=D Bldg. 00 Bldg. 00 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Title (X6) DATE		Medicare:17			dedication of the Surveyor; the	e
Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. F 0744 SS=D Bldg. 00 Bldg. 00 We respectfully request consideration for a desk review and paper compliance. F 0744 SS=D Bldg. 00 F 0744 SS=D Bldg. 00 Sy483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility E 0744 F 0744 F -744 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.					-	is a
This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. We respectfully request consideration for a desk review and paper compliance. Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 CX6) DATE					_	
This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. We respectfully request consideration for a desk review and paper compliance. F 0744 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Total: 114			-	I
accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023. We respectfully request consideration for a desk review and paper compliance. F 0744 483.40(b)(3) Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		This deficiency re	floots State Findings sited in		•	in
Quality review completed on August 28, 2023. F 0744 SS=D Bldg. 00 Bldg. 00 Guality review completed on August 28, 2023. We respectfully request consideration for a desk review and paper compliance. We respectfully request consideration for a desk review and paper compliance. F 0744 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 D8/24/2023		1	9		our community.	
Quality review completed on August 28, 2023. Consideration for a desk review and paper compliance. Fortier the facility Fortier feet and paper compliance. Consideration for a desk review and paper compliance. Fortier feet and paper compliance. Fortie		accordance with 4	10 1740 10.2-5.1.		We respectfully request	
and paper compliance. 483.40(b)(3) Treatment/Service for Dementia \$483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 08/24/2023		Ouality review co	mpleted on August 28, 2023.		_ ·	w
SS=D Bldg. 00 Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						
SS=D Bldg. 00 Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	E 0744	483 40(b)(2)				
Bldg. 00 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE			ce for Dementic			
diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						
appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	2.ag. 00	. , , ,				
or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						
physical, mental, and psychosocial well-being. Based on record review and interview, the facility F 0744 F-744 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						
Based on record review and interview, the facility F 0744 F-744 08/24/2023 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE			•			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						
· ·		Based on record re	eview and interview, the facility	F 0744	F-744	08/24/2023
· ·	LABORATO	RY DIRECTOR'S OR PR	OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNATURE	TITLE	(X6) DATE
				Ray		. ,

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: E5DO11 Facility ID: 001144 If continuation sheet Page 1 of 5

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 155668 B. WING 08/21/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4915 CHARLESTOWN RD CHARLESTOWN PLACE AT NEW ALBANY NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to implement and update a resident's plan of Social services updated the care after the resident displayed aggressive plan of care for resident D on behaviors and a resident to resident altercation for 8/21/2023. The resident continues 1 of 3 residents reviewed for Dementia Care. at his baseline and care plan is (Resident D) appropriate and effective. Findings include: Residents residing on our dementia care hall have the The record for Resident D was reviewed on potential to be affected by the 8/21/23 at 9:20 a.m. The diagnoses included, but alleged deficient practice. were not limited to, disorientation, dementia with Residents residing on our behavioral disturbance, anxiety disorder, altered dementia care hall that have mental status, depression, and injuries of the experienced aggressive behaviors head. over the last 30 days were reviewed to verify appropriate The Quarterly MDS (Minimum Data Set) interventions were in place and assessment, dated 4/17/23, indicated the resident care plans were updated as was severely cognitively impaired. indicated. The resident's care plan lacked documentation of Our social services team the resident on resident altercation that occurred was provided education from the on the dementia unit. Vice President of Clinical Operations to ensure The behavior note, dated 2/5/23 at 6:22 p.m., understanding of the need for indicated the resident was verbally abusive to social services support and care staff and other residents. He did not want them to plan revision(s) after a resident sit any where near him in the common area, talk, or experiences' aggression or an want them to watch television. Staff had tried to altercation. Social Services redirect the resident, but the resident continued to Consultant (Lacy Beyl and not want them any where around him. Company Healthcare Consulting) has been contracted to provide The nurse's note, dated 8/6/23 at 1:22 p.m., monthly social services support indicated the resident was displaying aggressive and oversight. behavior. The resident was redirected successfully. The nurse practitioner was notified The Director of Nursing 4.

FORM CMS-2567(02-99) Previous Versions Obsolete

and the resident was to be sent out to a local

The nurse's note, dated 8/6/23 at 1:37 p.m.,

indicated Resident D was seen grabbing another

behavioral health hospital.

Event ID:

E5DO11

Facility ID: 001144

and/or designee will review

progress notes for residents experiencing aggressive behaviors

to verify social services follow-up

and care plan has been updated

If continuation sheet

Page 2 of 5

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
15566		155668	B. W	B. WING		08/21/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					HARLESTOWN RD			
CHARLESTOWN PLACE AT NEW ALBANY				NEW ALBANY, IN 47150				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	resident during lund	ch.			as appropriate M-F for (4) wee			
	The	4-19/6/22 -4 6:09			and continue weekly for no les			
		ated 8/6/23 at 6:08 p.m.,			than (2) additional months. Ar	-		
		nt arrived back from the local			corrective action needed will b	е		
	_	by EMS (emergency medical ent was placed on every 15			completed immediately. The			
		-			results of these audits will be			
	minute safety check	Δ5.			presented to the Quality			
	The nurse's note, dated 8/7/23 at 12:26 p.m.,				Assurance/Performance Improvement committee meet	ina		
		D was transported to the			for a minimum of three months	•		
		-			validate 100% compliance and			
	behavioral group for evaluation and treatment related to aggressive behaviors. Resident D was				then on-going per routine QAF			
	recently sent to the local behavioral hospital for				reviews. Plan to be updated a			
	evaluation and treatment, however returned due				indicated.	15		
	to no available beds.				maicated.			
	to no avanable bear							
	The nurse's note, da	ated 8/7/23 at 2:31 p.m.,						
		D was placed on 15 minute						
	checks per on-call staff. Awaiting a hospital bed							
	at behavioral health. The resident was transported							
	to the behavioral health facility.							
		ated 8/16/23 at 3:34 p.m.,						
	indicated the resident was re-admitted from the							
	behavioral hospital.							
	During an interview	v on 8/21/23 at 10:11 a.m., LPN						
	_	Nurse) 4 indicated Resident						
		toward Resident E was the						
		en the two residents. Resident						
		behavioral hospital for						
		tment. When Resident D						
		arted on Depakote. He had not						
		ce then. The LPN indicated						
		e residents separated and						
	redirect their attention elsewhere.							
	Total of their anomalia discontinuo.							
	During an interview on 8/21/23 at 11:25 a.m., the							
	Memory Care Facilitator indicated she was not							
present during the incident between two residents								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E5DO11 Facility ID: 001144

If continuation sheet Page 3 of 5

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPL		ETED		
15566		155668	B. WING 08/2		08/21/	08/21/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					HARLESTOWN RD		
CHARLESTOWN PLACE AT NEW ALBANY					LBANY, IN 47150		
				L	,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	that involved Resid	R LSC IDENTIFYING INFORMATION		TAG	BEFELENCTI		DATE
	mat involved Resid	ent.					
	During an interview	v on 8/21/23 at 11:47 a.m., Social					
	_	d the resident's care plan					
		pdated after a resident to					
		The Social Services would be					
		ating the care plan for					
		ould talk about it in clinical and					
	then the care plan w						
	·	1					
	During an interview on 8/21/23 at 12:05 p.m. the						
	DON (Director of N	Nursing) indicated the only care					
	plan update was on	8/14/23 for the resident					
	resisting care and p	articipating in therapy. An					
	intervention was for	r staff to praise the resident.					
	She believed the car	re plan should have been					
	updated for the altercation. The care plan						
	interventions would change as the disease						
	progressed.						
	T D 1 ' 1 A						
		sessment, Intervention, and					
		last revised March 2019,					
		ot limited to, " Management nary team will evaluate					
		•					
	behavioral symptoms in residents to determine the degree of severity, distress and potential safety						
		-					
	risk to the resident, and develop a plan care accordingly. Safety strategies will be implemented						
	immediately if necessary to protect the resident						
	and others from har						
	und ourses from hom						
	The Comprehensive	e Care Plans policy, dated					
	_	ncluded, but was not limited to,					
	· ·	nning/Interdisciplinary Team is					
		review and updating of care					
	plans: a. When there has been a significant						
		ent's condition; b. When the					
	desired outcome is not met; c. When the resident						
	had been readmitted to the facility from a hospital						
	stay"						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E5DO11 Facility ID: 001144

If continuation sheet Page 4 of 5

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

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155668	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2023		
NAME OF PROVIDER OR SUPPLIER CHARLESTOWN PLACE AT NEW ALBANY			STREET ADDRESS, CITY, STATE, ZIP COD 4915 CHARLESTOWN RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
3333		ates to Complaint IN00414596.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: E5DO11 Facility ID: 001144 If continuation sheet Page 5 of 5