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	02/22/2024

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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 Complaint IN00427985. Complaint IN00427985 - No deficiencies related to the allegations are cited. Unrelated deficiencies cited . Survey dates: February 20, 21 and 22, 2024 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 116 Residential: 10 Total: 126 Census Payor Type: Medicare: 25 Medicaid: 68 Other: 23 Total: 116 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2024.	F 0000	Allegation of Compliance 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 ensure compliance.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

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

Jesse Ray 03/04/2024

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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	and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the			

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	comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure a plan of care was in place for a resident's (Resident D) refusal of care for 1 of 3 residents reviewed for for care plans. Findings include: The clinical record for Resident D was reviewed on 2/21/24 at 10:30 a.m. The diagnoses included, but were not limited to, dementia and stage 3 (full thickness tissue loss) pressure ulcers to the coccyx, left buttock and right buttock. The progress note, dated 1/28/24 at 1:47 a.m., indicated the resident had a shearing area to the left and right buttocks. The wound note, dated 1/29/24 at 3:50 p.m., indicated the areas were noted to be Stage 3 pressure ulcers. The wound physician note, dated 2/1/24, indicated the resident had a Stage 3 to the left buttock which measured 2.3 cm (centimeters) in length, 2.4 cm in width with a depth of 0.1 cm ; Stage 3 to the coccyx which measured 1.1 cm in length, 0.5 cm in width with a depth of 0.1 cm; and the Sage 3 to the right buttock which measured 2.5 cm in length, 1.2 cm in width with a depth of 0.1 cm. During an interview on 2/21/24 at 2:20 p.m., the wound nurse indicated the resident refused to turn side to side. Every time the resident was repositioned, she would roll to her back not 30 minutes later.	F 0656	F-656 1. Unit Manager revised resident D's comprehensive care plan to include a plan of care for being resistive to patient care and wound care on 2/22/2024. ·2. Current residents have the potential to be affected by the same alleged deficient practice therefore the MDS team members and Unit Managers completed a review of resident care plans for residents that are resistive to care beginning on 2/26/2024 to verify the accuracy of care plans to reflect the resident's current needs. ·3. MDS team members and nursing administration were re-educated by the Regional Resource Nurse on 3/1/2024 regarding the importance of updating care plans to accurately reflect the resident's current plan of care for care refusal as instructed by the RAI manual. During clinical start-up (M-F), the Director of Nursing, Unit Managers and Nurse Assessment Coordinator will and update care plans as needed to reflect the resident's current needs.	03/04/2024

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	During an interview on 2/21/24 at 3:06 p.m., CNA (Certified Nursing Aide) 6 indicated she typically did not have the resident, but when she did, she was very non-compliant with turning and repositioning. During an interview on 2/22/24 at 9:50 p.m., RN (Registered Nurse) 7 indicated the resident would not let them do anything for positioning. Each time they turned her on her side, 5 to 10 minutes later, she had already turned over to her back. They continue to turn her, but she always puts herself back on her back. She had refused turning for about 2-3 months. During an interview on 2/22/24 at 10:15 a.m., CNA 8 indicated the only time the resident would turn would be when they check and changed her every 2 hours. She preferred to lay on her back. She would not let you turn her side to side and removed pillows placed for off-loading. She had been refusing to turn and reposition for about 2 months. The clinical record lacked documentation of a plan of care for refusal to turn and reposition. During an interview on 2/22/24 at 1:50 p.m., RN 7 indicated if a resident consistently refused to turn and reposition, a care plan should have been in place for the refusal of care. On 2/22/24 at 1:59 p.m., the Director of Nursing provided a current copy of the document titled "Comprehensive Care Plan" dated 1/13/2018. It included, but was not limited to, "Procedure...To ensure that the resident...is included in all aspects of person-centered care planning...Procedure...The Comprehensive Care Planning will describe the following...Any		·4. The Resident Nurse Assessment Coordinator and/or Director of Nursing Services will review care plans for accuracy and specifically audit for the presence of care plans related to refusal of care; At least five (5) resident care plans will be reviewed for four (4) weeks and continue weekly for no less than two (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 100% then on-going per routine QAPI reviews.	

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	services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment...." 3.1-35(b)(2)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §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 interview and record review, the facility failed to ensure residents' (Residents D and E) treatments were completed, as ordered by the physician, for 2 of 3 residents reviewed for pressure ulcers. Findings include: 1. The clinical record for Resident D was reviewed on 2/21/24 at 10:30 a.m., The diagnoses included, but were not limited to, stage 3 pressure ulcers (full thickness tissue loss) to the coccyx, left buttock and right buttock. The care plan, dated 8/17/23, indicated the resident was at risk for impaired skin integrity and	F 0686	F-686 1. The treatments for residents D and E are ongoing and improvements continue. An audit was conducted by the wound care nurse on 3/1/2024 to confirm that residents identified are receiving treatments as ordered and supportive documentation is reflected in the treatment administration record. 3. Licensed Nurses were re-educated by the Regional Resource Nurse starting on 2/22/2024 on the prevention of pressure injuries policy including	03/04/2024

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	to perform treatments as ordered by the physician. The February 2024 treatment administration record (TAR) indicated staff were to cleanse the resident's coccyx, left buttock and right buttock wounds with normal saline, apply calcium alginate and cover with a foam dressing daily for wound care. The February 2024 TAR lacked documentation of treatment completion on 2/3/24, 2/6/24, 2/8/24, 2/10/24 and 2/18/24 for the left and right buttocks; and 2/3/24, 2/6/24, 2/8/24 and 2/10/24 for the coccyx. The February 2024 TAR indicated, dated 2/11/24 to discontinue the previous treatment to the coccyx with a new treatment, dated 2/11/24, to cleanse the coccyx pressure ulcer with normal saline, apply calcium alginate with Santyl and cover with a foam dressing daily. The February 2024 TAR lacked documentation of the coccyx wound treatment completion on 2/18/24. During an interview on 2/22/24 at 1:50 p.m., RN (Registered Nurse) 7 indicated once a treatment was completed, it should be signed off on the treatment administration record to show it was completed. 2. The clinical record for Resident E was reviewed on 2/22/24 at 11:16 a.m. The diagnosis included, but was not limited to, Stage 3 pressure ulcer to the coccyx. The care plan, dated 1/9/20, indicated the resident was at risk for altered skin integrity and staff were to complete treatments as ordered by the		proper documentation of treatments administered in the treatment administration record. 4. The Director of Nursing and/or Unit Manager will review (5) random residents across all shifts to verify wound treatments are completed and properly documented in the treatment administration record for (4) weeks and continue weekly for no less than (2) additional months. 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.	

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	physician. The February 2024 TAR indicated staff were to clean the coccyx with normal saline, apply calcium alginate and cover with a foam dressing daily. The February 2024 TAR lacked documentation of treatment completion on 2/8/24, 2/9/24 and 2/18/24. The current policy titled "Pressure Ulcers/Skin Breakdown" dated 4/2018, included, but was not limited to, "Treatment/Management...They physician will order pertinent wound treatments...." 3.1-40(a)(2)			