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	12/30/2024

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 IN00447226, IN00448143 and IN00449144. Complaint IN00447226 - Federal/State deficiencies related to the allegation are cited at F690, F695 and F760. Complaint IN00448143 - No deficiencies related to the allegations are cited. Complaint IN00449144 - Federal/State deficiencies related to the allegations are cited at F580, F684, F692 and F695. Survey dates: December 27 and 30, 2024 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 123 Residential: 9 Total: 132 Census Payor Type: Medicare: 14 Medicaid: 60 Other: 49 Total: 123 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 6, 2025.	F 0000	Allegation of Compliance Please accept the following plan of correction for the annual survey that was completed on 12/30/2024. 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. 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 DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jesse Ray	Executive Director	01/18/2025

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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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to ensure the physician was notified of a resident's (Resident K) low blood pressure and continuous complaints of shortness of breath for 1 of 3 residents reviewed of notification of changes. Findings include: The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnoses included, but were not limited to, diabetes, acute respiratory failure with hypoxia, congestive heart failure and hypertension. The resident's September 2024 Medication Administration Record indicated staff were to observe the resident for shortness of breath on day shift, evening shift and night shift. The September 2024 Medication Administration Record indicated the resident was short of breath on 9/3/24 during night shift and on 9/4/24 during all three shifts. The progress note, dated 9/4/24 at 2:01 p.m., indicated the resident reported feeling weak. The resident was assessed with a blood pressure of 80/50 while lying and 93/37 while sitting (a standard blood pressure was 120/80). The resident asked to lay down, because she was cold and a bit tired. The resident was assisted by staff to a comfortable position in the bed and her call light was in reach. The progress note, dated 9/4/24 at 6:26 p.m., indicated the resident had an episode where she	F 0580	1. Resident K did not have proper documentation for change of condition to include notification to MD or family. Resident K was discharged from our facility on 9/5/24. 2. Any resident who has had a change of condition could be affected The DON reviewed residents with a change of condition over the last 30 days to verify proper notifications had occurred, any opportunities identified were addressed immediately. 3. Education provided to nursing staff to include change of condition policy, to be completed by 1/5/25. This education is to be completed by SDC, UM, ADON and DON. 4. Audits will be completed by the DON and/or Unit Managers to validate appropriate notification of MD and RP for changes of condition- 7 charts weekly for 4 weeks, 5 charts weekly for 4 weeks, 5 charts monthly till 100 % compliance is met. 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	01/20/2025

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	felt shortness of air. The residents' fan was turned on to cool her and the resident was assisted to reposition. The resident's hand fan and breathing techniques helped her to calm down. The clinical record lacked documentation of a physician's notification related to the resident's low blood pressure and shortness of breath. During an interview on 12/30/24 at 2:55 p.m., RN (Registered Nurse) 4 indicated if a resident had an abnormally low blood pressure and complained of shortness of breath, the physician should be notified immediately. On 12/30/24 at 4:13 p.m., the Director of Nursing provided a current copy of the document titled "Change in Condition: When to report to the MD/NP/PA...Vital Sign...Blood Pressure...Systolic BP <90...Symptom or Sign...Dyspnea (shortness of breath...." This Citation relates to Complaint IN00449144 3.1-5(a)(2)		reviews. Plan to be updated as indicated.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure the licensed staff accurately assessed a residents' (Resident K) vital signs for skilled charting and obtain vital signs daily for 1 of 3 resident's skilled assessments reviewed for quality of care. Findings include The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnoses	F 0684	1 Resident K had skilled assessments completed on 3 days had the same vital signs listed for each day. Resident K was discharged from our facility on 9/5/24 2 Any resident who has orders for skilled charting could be affected by the alleged deficient practice. The DON reviewed resident charting over the last 30	01/20/2025

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	included, but were not limited to, atrial fibrillation, hypertension, congestive heart failure and acute respiratory failure with hypoxia. The daily skilled note, dated 8/30/24 at 12:32 p.m., indicated the resident had the following vital signs: -blood pressure of 113/58 obtained on 8/29/24 at 8:26 p.m. -oxygen saturation of 97% on room air obtained on 8/29/24 at 8:26 p.m. -temperature of 97.9 obtained on 8/29/24 at 8:26 p.m. -heart rate of 68 obtained on 8/29/24 at 8:26 p.m. -respirations 18 obtained on 8/29/24 at 8:26 p.m. The daily skilled note, dated 8/31/24 at 4:51 p.m., indicated the resident had the following vital signs: -blood pressure of 113/58 obtained on 8/29/24 at 8:26 p.m. -oxygen saturation of 97% on room air obtained on 8/29/24 at 8:26 p.m. -temperature of 97.9 obtained on 8/29/24 at 8:26 p.m. -heart rate of 68 obtained on 8/29/24 at 8:26 p.m. -respirations 18 obtained on 8/29/24 at 8:26 p.m. The daily skilled note, dated 9/2/24 at 10:57 a.m., indicated the resident had the following vital signs: -blood pressure of 113/58 obtained on 8/29/24 at 8:26 p.m. -oxygen saturation of 97% on room air obtained on 8/29/24 at 8:26 p.m. -temperature of 97.9 obtained on 8/29/24 at 8:26 p.m. -heart rate of 68 obtained on 8/29/24 at 8:26 p.m. -respirations 18 obtained on 8/29/24 at 8:26 p.m.		days to identify similar occurrences, any opportunities identified were addressed immediately. 3 Education completed by 1/5/25, by SDC, UM, ADON and DON provided to nursing staff to include correct documentation for skilled charting, each skilled charting must have new vital signs. 4 Audits will be completed by the DON and/or Unit Managers to validate vitals being taken and recorded accurately in the EMR- 7 charts weekly for 4 weeks, 5 charts weekly for 4 weeks, 5 charts monthly till 100% compliance is met. 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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	The daily skilled note, dated 9/3/24 at 2:51 a.m., indicated the resident had the following vital signs: -blood pressure of 137/78 obtained on 9/2/24 at 12:39 p.m. -oxygen saturation of 84% on 9/2/24 at 12:40 p.m. -temperature of 97.9 obtained on 8/29/24 -heart rate of 72 obtained on 9/2/24 at 12:39 p.m. -respirations of 18 obtained on 8/29/24 at 8:26 p.m. The resident's clinical record lacked documentation of vital signs obtained for the resident on 8/30/24, 8/31/24 and 9/1/24. During an interview on 12/30/24 at 2:55 p.m., RN (Registered Nurse) 4 indicated nurses should obtain current vital signs prior to completing skilled charting and never use another nurses previous vital signs. During an interview on 12/30/24 at 4:13 p.m., the Director of Nursing indicated the nursing staff should obtain their own vital signs for the skilled charting. Upon admission, if a skilled resident, vital signs should be obtained each shift for 72 hours and then daily after that. This Citation relates to Complaint IN00449144 3.1-37			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview and record review, the facility failed to ensure staff documented urine output for residents' with indwelling catheters for 3 of 4 residents reviewed for bowel and bladder. (Residents B, F and G)	F 0690	1. Resident B lacked documentation of foley catheter output as ordered per shift. Resident B's POC charting was reviewed for further discrepancies. 2. Any resident who has a foley	01/20/2025

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	Findings include: 1. The clinical record for Resident B was reviewed on 12/27/24 at 10:07 a.m. The resident's diagnosis included, but was not limited to, obstructive and reflux uropathy. The care plan, dated 8/30/24, indicated the resident had an indwelling catheter and to monitor urine output. The physician's order, dated 9/19/24, indicated to document urine output every day shift and every night shift. Review of the October 2024, November 2024 and December 2024 medication administration records lacked documentation of the resident's urine output on the following dates and shifts: -10/04/24 on night shift -10/13/24 on night shift -10/15/24 on night shift -10/22/24 on night shift -11/16/24 on day and night shift -11/17/24 on day shift -11/20/24 on day shift -12/01/24 on night shift -12/08/24 on night shift -12/17/24 on night shift During an interview on 12/30/24 at 2:55 p.m., RN (Registered Nurse) 4 indicated residents with indwelling catheters should have the urine output documented on the treatment administration record every shift. 2. The clinical record for Resident F was reviewed on 12/27/24 at 12:30 p.m. The resident's diagnoses included, but were not limited to, stage 4 kidney disease and uropathy.		catheter has the potential to be affected by the alleged deficient practice. The DON reviewed residents with foley catheters to verify similar occurrences had not happened over the last 30 days, any opportunities identified were addressed immediately. 3. Education was completed by 1/5/25 by the SDC, UM, ADON and DON provided to the nursing staff on policy and procedures on proper documentation of foley catheter output in the EMAR per shift. 4. Audits will be completed by the DON and/or Unit Managers to verify proper documentation of foley catheter output has occurred as required- 7 charts weekly for 4 weeks, 5 charts weekly for 4 weeks, 5 charts monthly till 100% compliance is met. 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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	The care plan, dated 12/26/24, indicated the resident had an indwelling catheter and to obtain the output as ordered. The physician's order, dated 12/16/24, indicated to document the resident's urine output on day shift and night shift. Review of the December 2024 treatment administration record lacked documentation of the resident's urine output on 12/22/24 for night shift. 3. The clinical record for Resident G was reviewed on 12/27/24 at 12:45 p.m. The resident's diagnosis included, but was not limited to, obstructive and reflux neuropathy. The care plan, dated 12/4/24, indicated the resident had an indwelling catheter and to obtain the urine output as ordered. The physician's order, dated 12/5/24, indicated to document the resident's output every day and night shift. The December 2024 treatment administration record lacked documentation of the output for night shift on 12/9/24 and 12/17/24. During an interview on 12/30/24 at 5:02 p.m., the Director of Nursing indicated the facility did not have a policy regarding physician's orders. This Citation relates to Complaint IN00447226			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on interview and record review, the facility	F 0692	1. Resident K was noted by MD	01/20/2025

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	failed to ensure staff followed a resident's fluid restriction order from the physician, for 1 of 3 residents reviewed for hydration. (Resident K) Findings include: The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnosis included, but was not limited to, congestive heart failure. The physicians' note, dated 9/1/24 at 12:32 p.m., indicated the resident had gained 5 pounds in 24 hours and to limit the resident's fluid intake to 1,500 cc's (cubic centimeters) in a 24 hour period. Review of the September 2024 fluid intake record indicated the resident consumed the following fluid totals in a 24 hour period: - On 9/2/24, the resident's fluid intake was documented as 2,900 cc. - On 9/3/24, the resident's fluid intake was documented as 1,580 cc. - On 9/4/24, the resident's fluid intake was documented as 2,560 cc. The clinical record lacked documentation of the implementation of the order on 9/1/24. During an interview on 12/30/24 at 4:13 p.m., the Director of Nursing indicated she felt the physician did not relay the order to the nursing staff. On 12/30/24 at 4:13 p.m., the Director of Nursing provided a current copy of the document titled "Encouraging and Restricting Fluids" dated 10/2010. It included, but was not limited to, "Purpose...The purpose of this procedure is to		to have a 5 lb weight gain in 24 hours and ordered a fluid restrict diet. These orders were not entered into PCC. This resident was discharged on 9/5/25 2. Any resident who is admitted with CHF has the potential to be affected by the alleged deficient practice. The DON reviewed residents with CHF to verify similar occurrences had not happened over the last 30 days, any opportunities identified were addressed immediately. 3. Education was completed by 1/5/25 by the SDC, UM, ADON and DON provided to nursing staff to ensure all fluid restriction orders are entered and documented as required. 4. Audits will be completed by the DON and/or Unit Managers on residents with Fluid Restrictions to validate orders are being followed and documented correctly for 8 weeks until 100% compliance is achieved. 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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	provide the resident with the amount of fluids necessary to maintain optimum health. This may include...restricting fluids...General Guidelines...Follow specific instructions concerning fluid intake or restrictions...." This Citation relates to complaint IN00449144 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure the physician's orders were in place for weekly maintenance of the nebulizer equipment (Resident B and Resident H); failed to ensure a nebulizer face mask was stored appropriately and the tubing was dated (Resident B); and failed to ensure physician's orders were in place for routine oxygen administration (Resident K) for 3 of 4 residents reviewed for respiratory. Findings include: 1. The clinical record for Resident B was reviewed on 12/27/24 at 10:07 a.m. The resident's diagnoses included, but were not limited to, asthma and chronic obstructive pulmonary disease. During an observation on 12/30/24 at 10:34 a.m., the resident's nebulizer face mask was lying on the shelf next to the resident's bed, not bagged and undated. The physician's order, dated 9/7/24, indicated the resident was to receive Ipratropium-Albuterol, 3 ml (milliliters) via nebulizer for times a day for shortness of air.	F 0695	1 Resident B and Resident H both had orders for nebulizer treatments. Orders for proper cleaning and storing were not entered into PCC. Resident K had documentation of having oxygen on but no orders to reflect oxygen. Resident B and H both had orders entered into PCC to reflect proper cleaning and storage of nebulizer equipment. Resident K was discharged on 9/5/24. 2 Any resident who is on nebulizer treatments or has oxygen is at risk to be affected by the alleged deficient practice. The DON reviewed residents with orders for oxygen or nebulizer treatments to verify similar occurrences had not happened over the last 30 days, any opportunities identified were addressed immediately. 3 Education was completed by 1/5/25 by the SDC, UM, ADON and DON provided to nursing staff regarding respiratory policy and	01/20/2025

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	The residents clinical record lacked documentation of daily and weekly maintenance of the resident's respiratory equipment. During an interview on 12/30/24 at 2:55 p.m., RN (Registered Nurse) 4 indicated nebulizer face masks and the nebulizer cup should be rinsed after each use and left to air dry. Once dried, the face mask should be placed in a bag. All nebulizer tubing should be dated and changed out weekly. Any resident with oxygen should have a physician's order in place for the oxygen. 2. The clinical record for Resident H was reviewed on 12/27/24 at 1:34 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic respiratory failure. The physician's order, dated 6/20/23, indicated the resident was to receive budesonide inhalation suspension, 3 ml twice daily for chronic obstructive pulmonary disease. The residents clinical record lacked documentation of daily and weekly maintenance of the resident's respiratory equipment. 3. The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and acute respiratory failure with hypoxia. The hospital discharge records, dated 8/28/24, indicated on discharge the resident was not using oxygen. The progress note, dated 9/2/24 at 1:03 p.m., indicated the resident was assessed per the family request. The resident's oxygen saturation was		procedures. 4 Audit will be completed by the DON and/or Unit Managers on residents with oxygen and/or nebulizer treatments to verify staff are following respiratory policies and procedures related to cleaning and storage of equipment and proper documentation as required. 7 charts weekly for 4 weeks, 5 charts weekly for 4 weeks, then 5 charts monthly until 100% compliance is met. 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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	84% on 2 liters of oxygen. The nurse practitioner was notified with a new order to increase the oxygen to help raise the resident's oxygen saturation. The clinical record lacked documentation of any physician's orders for the resident's oxygen administration. During an interview on 12/30/24 at 4:13 p.m., the Director of Nursing indicated the resident was on oxygen and should have had an order in place for the oxygen. On 12/30/24 at 5:30 p.m., the Director of Nursing provided a current copy of the document titled "Respiratory Infection Control" dated 4/1/2012. It included, but was not limited to, "Purpose...To provide infection control guidelines to help prevent infections associated with respiratory therapy equipment and to prevent the transmission of infections to residents and staff...Medication Nebulizers/Continuous Aerosol...Remove nebulizer container...Rinse container and mask or mouth piece with sterile water...Allow to dry on a clean paper towel or gauze sponge...Store...in a plastic bag...Discard administration "set-up" weekly...Clean and disinfect the nebulizer unit weekly and as needed...." This Citation relates to Complaints IN00447226 and IN00449144. 3.1-47(a)(6)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on interview and record review, the facility	F 0760	1 Resident K had new order for	01/20/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure an order to increase a resident's Lasix (diuretic) was implemented for 1 of 3 residents reviewed for significant medication errors. (Resident K) Findings include: The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure (CHF) and edema. The admission order, dated 8/28/24, indicated the resident was to receive Lasix 20 mg (milligrams) daily for CHF. The physician's note, dated 9/1/24 at 12:32 p.m., indicated the resident had 1+(plus) pitting edema to her bilateral lower extremities and had a five-pound weight gain in a 24-hour period. New orders were given for the resident to start Lasix 20 mg twice daily for three days then return to the 20 mg daily dose on the fourth day. The September 2024 Medication Administration Record indicated the resident received the medication twice daily on 9/1/24, 9/2/24, and on the morning of 9/3/24. The nurse practitioner follow-up note, dated 9/3/24, indicated the resident reported she had been short of breath over the weekend and that her water pill had been increased. The registered dietitian reported the resident had a 13-pound weight gain and the resident had 2+ pitting edema to her lower extremities. The resident was to continue Lasix 40 mg twice daily for two days. The physician's order, dated 9/3/24 at 11:30 p.m., indicated the resident was to start Lasix 40 mg		diuretic that was marked in the EMAR as given but could not validate where medication was pulled from. Resident K was discharged on 9/5/24 2 Any resident who has a new order for diuretics could be affected by the alleged deficient practice. The DON reviewed residents with orders for diuretics to verify similar occurrences had not happened over the last 30 days, any opportunities identified were addressed immediately. 3 Education was completed by 1/5/25 by the SDC, UM, ADON and DON provided to nursing staff to ensure all medication that has been documented has been given. 4 Audits will be completed by the DON and/or Unit Managers on new diuretic orders to verify receipt from pharmacy and/or pulled from the EDK when necessary- for 8 weeks, then monthly until 100 % compliance is met. 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.	

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	12/30/2024

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	twice daily for two days beginning on 9/4/24. The September 2024 Medication Administration Record lacked documentation of the administration of the resident's increased Lasix on 9/3/24 in the evening and the administration of any Lasix on 9/4/24. During an interview on 12/30/24 at 4:13 p.m., the Director of Nursing indicated the medication should have been implemented and it was not. The facility did not have a policy on medication administration; however, the facility followed the medication administration per the state guidance. On 12/30/24 at 4:13 p.m., the Director of Nursing provided a copy of the document titled "Medication Administration Observation" dated 11/2017. It included, but was not limited to, "General Medication Administration...Medications administered as ordered...." This Citation relates to Complaint IN00447226 3.1-48(a)			