CENTERS FOR STATEMEN	FOF HEALTH AND HUM REMEDICARE & MEDICARE REMEDICARE REM			JILDING	ONSTRUCTION 00		RM APP B NO. 09 SURVEY ETED	938-039
	PROVIDER OR SUPPLIER			4915 CI	ADDRESS, CITY, STATE, ZIP COD HARLESTOWN RD LBANY, 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 APPROPRIAT DEFICIENCY)	TE	COMP	(X5) PLETION ATE
F 0000 Bldg. 00	Licensure Survey. Residential Licensu Investigation of Con	Recertification and State This visit included a State re Survey and the nplaints IN00441570, 142755, and IN00442598.	F 00	000	Allegation of Compliance Please accept the following place correction for the annual surve that was completed on 9/12/20	ey		

Post-Survey revisit (PSR) to Complaint IN00435623 completed on June 27, 2024 and the PSR to Complaints IN00439316, IN00439663, and IN00439706 completed on August 15, 2024.

This visit was in conjunction with the

Complaint IN00441570 - No deficiencies related to the allegations are cited.

Complaint IN00441712 - No deficiencies related to

the allegations are cited.

Complaint IN00442755 - No deficiencies related to the allegations are cited.

Complaint IN00444298 - No deficiencies related to

the allegations are cited.

Complaint IN00435623 - Corrected

Complaint IN00439316 - Corrected

Complaint IN00439663 - Corrected Complaint IN00439706 - Corrected

Survey dates: September 5, 6, 9, 10, 11, and 12,

2024

Facility number: 001144 Provider number: 155668 AIM number: 200256980

Census Bed Type: SNF/NF: 118 Residential: 9 Total: 127 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.

Preparation and/or execution of

this plan of correction does not

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 09/20/2024

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/12/2024	
	PROVIDER OR SUPPLIER		4915 C	ADDRESS, CITY, STATE, ZIP COD SHARLESTOWN RD ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0558 SS=D Bldg. 00	Quality review com 483.10(e)(3) Reasonable Acco Needs/Preference Based on observative review, the facility provided a bed and accommodate his hereident beds observed. (Resident 60 Findings include: During an observative Resident 60 did not to move up, and his footboard. His head the mattress. During an observative resident's feet were the resident indication over in this bed. Resident's room and touching the footboard blisters to the reside proceeded to uncovassessed the skin. New York (1908)	reflect State Findings cited in 0 IAC 16.2-3.1. upleted on September 17, 2024. mmodations uses on, interview and record failed to ensure a resident was mattress that could eight comfortably for 1 of 69 wed for accommodation of	F 0558	1 On 9/11/24, the Maintena Director adjusted the footboar extend the bed length and prothe resident 60 with more sparand comfort. 2 Residents that are taller of 72 inches have the potential to affected by the alleged deficie practice. On 9/16/24, the Maintenance Director and Uni Manager interviewed residents were 72 inches or taller and audited their respective beds of verify that the standard 80-ince beds in each residents' room provided sufficient space at the head and footboard. Any bed adjustments needed were corrected immediately. 3 On 9/17/24, the Executive Director provided education to maintenance staff to maintain sufficient space for residents if facility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and make accommodations to lengthen of the standard sufficient space for residents if acility beds and the standard sufficient space for residents if acility beds and the standard sufficient space for residents if acility beds and the standard sufficient space for residents if acility beds and the standard sufficient space for residents if acility space for residents if ac	d to ovide ce than o be ent it s that to the ee o the ent in ee

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could be extended, but his feet definitely touched

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widen beds as needed.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155668	B. W	NG		09/12/	
				_			-
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					HARLESTOWN RD		
CHARLE	STOWN PLACE AT	Γ NEW ALBANY		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the foot board.				4 The Executive Director		
					and/or Maintenance Director v	vill	
	During an observati	ion on 9/11/24 at 10:46 a.m., the			audit at least five (5) resident l	beds	
	resident's feet were	observed touching the foot			to verify sufficient space is		
	board of the bed.				maintained for residents need	ing	
					reasonable accommodations		
	The record for Resi	dent 60 was reviewed on 9/7/24			weekly for four (4) weeks and	then	
	at 1:32 p.m. The resident's diagnoses included, but				at least weekly for no less that	n	
	were not limited to,	abnormal posture, pain in the			two (2) additional months. An	у	
	right shoulder, mus	cle weakness, low back pain,			corrective action needed will b	-	
	abnormal gait and r	nobility and paraplegia.			completed immediately. The		
					results of these audits will be		
	The Quarterly MDS (Minimum Data Set)				presented to the Quality		
	assessment, dated 3/17/24, indicated the resident				Assurance/Performance		
	was cognitively inta	act.			Improvement committee meet	ing	
					for a minimum of three months	s to	
	The nurse's note, da	ated 8/15/23 at 3:43 p.m.,			validate 100% compliance and	t	
	indicated while staf	f helped with repositioning the			then on-going per routine QAF	Pl	
	resident there was a	discolored area to the			reviews. Plan to be updated a	ıs	
	resident's outer righ	t foot. The measurements			indicated.		
	were obtained at 2 of	cm (centimeters) by 4 cm by 0					
	cm. The wound app	peared to be red and white skin					
	over the area. The v	vound had a blood blister like					
	appearance. Reside	nt 60's feet were pressed					
	against the foot boa	ard of the bed and the resident					
	was all the way up	in the bed. Immediately a foam					
	wedge was placed i	under the resident's knees and					
	lower extremities w	which raised the foot of the bed					
	to remove his feet of	off the foot board. The nurse					
	notified the immedi	ate supervisor and the NP					
	(Nurse Practitioner)).					
		0/6/04 . 0.10					
	_	v on 9/6/24 at 9:18 a.m.,					
		ed his bed was too small and					
		footboard. He had told the					
	staff, but nothing had been done.						
	During an interview	v on 9/10/24 at 9:45 a.m., the					
		tor indicated he thought the					
		be switched out for another					

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 09/12/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4915 CHARLESTOWN RD NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
F 0755 SS=E	bed. He was not aw the size of the bed. 3.1-3(v)(1) 483.45(a)(b)(1)-(3 Pharmacy	are there was a problem with			
Bldg. 00	Based on observation interview, the facility documentation on the Receipt/Record/Distriction in the Receipt/Record in the Receipt/Record in the Receipt/Record in the Record in the Re	he Controlled Drug position Form of administered 64 residents observed for in the 500, 400, and 800 Hall desidents 32, 76, 96, 45, 20, 58, 65, and 77) attion on 9/9/24 at 8:56 a.m. of attion cart, the following were dol 50 mg (milligrams) accept/Record/Disposition Form allets left. The resident's attained 5 tablets of the allose signed out on the accept/Record/Disposition Form	F 0755	1. Residents 32, 76, 96, 4 58, 219, 87, 218, 43, 15, a continue to reside at the fa and controlled medications continue to be administere ordered. There were no ne outcomes resulting from th alleged deficient practice. 2. Residents that receive controlled medications hav potential to be affected by alleged deficient practice. 9/16/24, Nursing Administr reviewed and reconciled or medication count sheets to medication administration to determine if any other re had been affected by the a deficient practice for a 30 or back period. 3. Beginning on 9/13/24, If nurses and qualified medic assistants were educated I Staff Development Coordin regarding the 9 Rights of Medication Administration, emphasis on the required documentation of controlle medications at the time of administration. 4. The Director of Nursing	and 77 acility

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administered on 9/9/24 at 8:00 a.m., by LPN

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Unit Managers will complete

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155668	B. W	ING _		09/12/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			HARLESTOWN RD		
CHARLE	STOWN PLACE AT	T NFW AI BANY			LBANY, IN 47150		
			_				T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	(Licensed Practical	Nurse) 6.			medication competencies with	ı at	
					least five (5) licensed nurses		
	-	v on 9/9/24 at 8:57 p.m., LPN 6			and/or qualified medication		
		d sign out narcotics when she			assistants to verify completion	ı of	
	pulled them.				required documentation of		
	2. During an observation on 9/9/24 at 9:09 a.m. of				controlled medications at the t		
					of administration. These audi		
		ation cart, the following was			will be completed weekly for for	our	
	observed:				(4) weeks and then at least	`	
	- D11. (70)				weekly for no less than two (2	•	
	a. Resident 76's oxy				additional months. Any correc		
		kycodone/APAP 10/325 mg eceipt/Record/Disposition Form			action needed will be complet		
	_	blets left. The resident's			immediately. The results of the		
					audits will be presented to the		
		ntained 3 tablets of the			Quality Assurance/Performan		
	-	The last dose signed out on			Improvement committee meet		
		g Receipt/Record/Disposition			for a minimum of three months		
	Form was on 9/8/24	+ at 9:00 p.m.			validate 100% compliance and		
	The record raviant	on 9/10/24 at 1:26 p.m., the			then on-going per routine QAF		
		ated 8/26/24, indicated the			reviews. Plan to be updated a indicated.	15	
		ne oxycodone/APAP 10/325 mg			ilidicated.		
	two times daily for	•					
	two times daily for	ouck puin.					
	The resident's Sente	ember MAR indicated the					
		of the oxycodone/APAP					
		ninistered on 9/9/24 at 8:00 a.m.,					
	by LPN 4.						
	Resident 76's diaze	pam 5 mg Controlled Drug					
		sposition Form had a count of 6					
	•	ident's medication card					
	contained 5 tablets	of the diazepam left. The last					
		the Controlled Drug					
	-	sposition Form was on 9/8/24 at					
	9:00 p.m.	-					
	Stoo Pinn						
	The record review of	on 9/10/24 at 1:26 p.m., the					
	physician's order, d	ated 8/26/24, indicated the					
	resident received th	ne diazepam 5 mg two times					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155668	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/12 /	ETED
	PROVIDER OR SUPPLIER		4915 CH	DDRESS, CITY, STATE, ZIP COD HARLESTOWN RD LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	b. Resident 96's hyd Controlled Drug Rehad a count of 22 to medication card coroxycodone/APAP. the Controlled Drug Form was on 9/8/24. The record review ophysician's order, d	ember MAR indicated the of the diazepam 5 mg was 0/24 at 8:00 a.m., by LPN 4. drocodone/APAP 5/325 mg exceipt/Record/Disposition Form ablets left. The resident's nationed 21 tablets of the The last dose signed out on g Receipt/Record/Disposition 4 at 9:00 p.m. on 9/10/24 at 1:29 p.m., the ated 8/30/24, indicated the e oxycodone/APAP two times				
	resident's last dose mg was administere LPN 4.	ember MAR indicated the of the oxycodone/APAP 5/325 ed on 9/9/24 at 8:00 a.m., by				
	Controlled Drug Rehad a count of 30 tamedication card conoxycodone/APAP.	sceipt/Record/Disposition Form ablets left. The resident's ntained 29 tablets of the The last dose signed out on g Receipt/Record/Disposition				
	physician's order, d	on 9/10/24 at 1:34 p.m., the ated 8/26/24, indicated the e oxycodone/APAP 5/325 mg pain.				
	resident's last dose	ember MAR indicated the of the oxycodone/APAP 5/325 ed on 9/8/24 at 9:08 a.m., by				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/12/2024		
	PROVIDER OR SUPPLIER		4915 C	ADDRESS, CITY, STATE, ZIP COD HARLESTOWN RD LBANY, 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 CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	d. Resident 20's hyd Controlled Drug Rehad a count of 26 ta medication card coroxycodone/APAP. The Controlled Drug Form was on 9/8/24 The record review of physician's order, deresident received the mg two times daily The resident's Septeresident's last dose of 7.5/325 mg was adreby LPN 4. Resident 20's lacosa Receipt/Record/Distablets left. The residents dose signed out Receipt/Record/Distablets out and the signed out Rece	on 9/10/24 at 1:37 p.m., the ated 9/6/24, indicated the e oxycodone/APAP 7.5/325				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155668	B. W	ING		09/12/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	L.			HARLESTOWN RD		
CHARLE	STOWN PLACE AT	NEW ALBANY			_BANY, IN 47150		
(V4) ID	CUMMADY	CTATEMENT OF DEFICIENCIE		1	·	1	(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` `	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG		ntained 0 tablets of the		IAG			DATE
		P. The last dose signed out on					
	the Controlled Drug Receipt/Record/Disposition Form was on 9/6/24 at 8:00 a.m. The record review on 9/10/24 at 1:37 p.m., the						
	physician's order, da	ated 8/9/24, indicated the					
	resident received the	e hydrocodone/APAP 10/325					
	mg every 6 hours as	s needed for chronic pain.					
	_	ember MAR indicated the					
		of the hydrocodone/APAP					
	_	continued on 8/9/24 and the last					
	dose given was on 9	9/7/24 at 10:30 a.m., by LPN 11.					
	Resident 58's hydro	codone/APAP 10/325 mg					
	_	ceipt/Record/Disposition Form					
		blets left. The resident's					
		ntained 24 tablets of the					
		P. The last dose signed out on					
	the Controlled Drug	g Receipt/Record/Disposition					
	Form was on 9/8/24	at 9:00 p.m.					
		on 9/10/24 at 1:40 p.m., the					
	* *	ated 8/9/24, indicated the					
		e hydrocodone/APAP 10/325					
	ing every 6 hours as	s needed for chronic pain.					
ı	The resident's Sente	ember MAR indicated the					
	_	of the hydrocodone/APAP					
		ninistered on 9/8/24 at 9:11 p.m.,					
	by LPN 12. The me	_					
	_	0/24, but continued to be					
		0/24 at 6:05 a.m., 9/11/24 at 6:00					
	a.m., and 7:46 p.m.						
		madol 50 mg (milligrams)					
	_	ceipt/Record/Disposition Form					
		blets left. The resident's					
	medication card cor	ntained 26 tablets of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155668	B. W	ING		09/12/	/2024
	PROVIDER OR SUPPLIER		•	4915 CI	ADDRESS, CITY, STATE, ZIP COD HARLESTOWN RD LBANY, IN 47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	tramadol. The last de Controlled Drug Rewas on 9/8/24 at 8:00 The record review of physician's order, da resident received the daily for pain. The review of the resident mg was administered LPN 4. g. Resident 87's trans Receipt/Record/Distablets left. The resicontained 7 tablets of signed out on the Control Receipt/Record/Distablets left. The resicontained 7 tablets of signed out on the Control Receipt/Record/Distablets left. The resicontained 7 tablets of signed out on the Control Receipt/Record/Distablets left. The resident received the daily for pain. The review of the resident received the daily for pain.	lose signed out on the ceipt/Record/Disposition Form 00 p.m. on 9/10/24 at 1:46 p.m., the ated 9/6/24, indicated the e tramadol 50 mg two times esident's September MAR ent's last dose of tramadol 50 ed on 9/9/24 at 8:00 a.m., by madol 50 mg Controlled Drug position Form had a count of 8 dent' medication card of the tramadol. The last dose			CROSS-REFERENCED TO THE APPROPRIA	TE	
	Controlled Drug Re had a count of 16 ta medication card cor oxycodone/APAP.	cycodone/APAP 7.5/325 mg ceipt/Record/Disposition Form blets left. The resident's ntained 15 tablets of the The last dose signed out on Receipt/Record/Disposition at 4:00 a.m.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 09/12/2024			ETED		
		155668	B. W	ING	_	09/12/	2024
	PROVIDER OR SUPPLIER			4915 CI	ADDRESS, CITY, STATE, ZIP COD HARLESTOWN RD LBANY, IN 47150		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	physician's order, d resident received th mg every 4 hours fo	on 9/10/24 at 1:51 p.m., the ated 9/3/24, indicated the e oxycodone/APAP 7.5/325 or pain.					
	resident's last dose of the oxycodone/APAP 7.5/325 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4.						
	Receipt/Record/Dis 10 tablets left. The contained 8 tablets signed out on the C	nadol 50 mg Controlled Drug position Form had a count of resident' medication card of the tramadol. The last dose ontrolled Drug position Form was on 9/8/24 at					
	physician's order, d	on 9/10/24 at 1:48 p.m., the ated 9/19/23, indicated the e tramadol 50 mg two tablets r pain.					
	The review of the resident's September MAR indicated the resident's last dose of two tablets of tramadol 50 mg was administered on 9/9/24 at 8:00 a.m., by LPN 4.						
	Receipt/Record/Dis 28 tablets left. The contained 26 tablets signed out on the C	nadol 50 mg Controlled Drug position Form had a count of resident' medication card s of the tramadol. The last dose ontrolled Drug position Form was on 9/8/24 at					
	physician's order, d	on 9/10/24 at 1:53 p.m., the ated 8/26/24, indicated the e tramadol 50 mg two tablets					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668		A. BU	A. BUILDING <u>00</u> COM			survey Leted /2024	
	PROVIDER OR SUPPLIE		1	4915 CI	ADDRESS, CITY, STATE, ZIP COD HARLESTOWN RD LBANY, IN 47150	<u> </u>	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION
TAG	The review of the reindicated the resident tramadol 50 mg was a.m., by LPN 4. k. Resident 77's ox Receipt/Record/Di 14 tablets left. The contained 13 tablet last dose signed our Receipt/Record/Di 8:00 p.m. The record review physician's order, or resident received the daily for back pain. The resident's Septimesident's last dose administered on 9/9. During an interview indicated he had not upon administration as he gave the med. During an interview (Qualified Medicates should sign out narrow DON (Director of 18 should sign out the medication was given of the number of narrow The Controlled Sulfied Controlled S	ember MAR indicated the of the oxycodone 5 mg was 9/24 at 8:00 a.m., by LPN 4. w on 9/9/24 at 9:30 a.m., LPN 4 ot signed out the narcotics in. He should mark the narcotics ications. w on 9/9/24 at 9:53 a.m., QMA icion Aide) 7 indicated she ecotics as she gave them. w on 9/10/24 at 11:10 a.m., the Nursing) indicated the nurse narcotic on the sheet once the identification.		TAG			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/12/2024	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 4915 CHARLESTOWN RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
F 0761 SS=E	receipt, administrat of each shift 9. A Controlled medicati each shift. The nurs						
Bldg. 00	failed to ensure disc medications were p of 7 observations of (Medication Carts 3 Room 900) Findings include: 1. During an observative 300 Hall medical naloxone hydrochlor September 2023 were boxes had no resided 2. During an observative 400 Hall medical concerns were identified as Resident 2's discondered with the drawer. b. Resident 36's Landate. There was only	vation on 9/9/24 at 9:09 a.m. of ation cart, the following tified: ontinued lubricating plus eye ration date of August 2024	F 07	761	1 1. The Director of Nursin properly discarded the medical that was identified during the survey on that was past the expiration date and the medical that was discontinued was discarded appropriately. 2 2. Residents residing in a facility have the potential to be affected by the alleged deficie practice. Medication carts and medication storage rooms were audited for proper labeling and storage by Nursing Administration 9/13/24. Any corrective accepted was completed immediately. 3 3. Beginning on 9/13/24, licensed nurses and qualified medication assistants were educated by the Staff Development Coordinator on properly storing and labeling medications and the procedure discarding improperly stored, labeled and expired supplies. education is also to be reviewed.	tion ation the ent re tion tion the for	09/18/2024

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` '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155668	B. W	ING		09/12/2024	
NAME OF F	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·	_		ADDRESS, CITY, STATE, ZIP COD		
					HARLESTOWN RD		
CHARLE	STOWN PLACE AT	I NEW ALBANY		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION Nurse) 4 indicated the nurse		TAG		DATE	
	,	mark the open date, they			during new hire job specific training.		
		te on the pen when it was			4 4. The Assistant Directo	r of	
	opened.	or on the pen when it was			Nursing and/or Unit Manager		
	1				audit medication rooms and		
		vation on 9/9/24 at 10:04 a.m. of			medication carts for proper		
		ation cart, the following			labeling and storage of		
	concerns were identified:				medications and validate the		
	D 11 . 001 . 1				removal of expired medication		
	a. Resident 80's tiotropium bromide 2.5 mcg				three (3) times a week for four	, ,	
	(micrograms) per actuation indicated to discard after 10/19/23.				weeks and continue weekly for less than two (2) additional	or no	
	and 10/17/23.				months. Any corrective action		
	b. An unlabeled via	of Spiriva 2.5 mcg was sitting			needed will be completed		
	in a drawer without				immediately. The results of th	ese	
					audits will be presented to the	:	
		l of Albuterol 2.5 mg			Quality Assurance/Performan	ce	
	(milligrams) was si	tting in a drawer without a box.			Improvement committee meet	•	
		1 60 : 25			for a minimum of three month		
	in a drawer without	of Spiriva 2.5 mcg was sitting			validate 100% compliance and		
	in a drawer without	. d 00x.			then on-going per routine QAI reviews. Plan to be updated a		
	e. Resident 86's 2 b	oxes of Symbicort had no label			indicated.		
		o indicate the expiration date.					
		pro flexpen indicated an open					
		on the bag. There was 55 units					
		e pen. The Lispro flexpen was					
	expired 28 days after	er opening.					
	4. During an observ	vation on 9/9/24 at 11:24 a.m. of					
	_	ation room, the following					
	concerns were iden	_					
		moterol inhalant, received					
		3, for 7 days of administration					
		refrigerator. The medication					
	had an expiration d	ate of July 31, 2024.					
	b. Resident 78's 2 b	ags of micafungin 150 mg per					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155668	(X2) MULTIP A. BUILDIN B. WING		nstruction 00	(X3) DATE : COMPL 09/12/	ETED
	PROVIDER OR SUPPLIER STOWN PLACE A		49 ⁻	15 CH	DDRESS, CITY, STATE, ZIP COD IARLESTOWN RD BANY, IN 47150		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OF 100 mL intravenou refrigerator. They we had a use by date of longer received this During an interview indicated expired of were usually taken picked up by the photo- During an interview indicated the nurse Medication Aide) is medications to the puring an interview of indicated she got the residents. At this	R LSC IDENTIFYING INFORMATION s medication were located in the were received on 8/30/24 and f 9/3/24. The resident no s medication. v on 9/9/24 at 9:10 a.m., LPN 4 r discontinued medications to the manager and they were harmacy company. v on 9/9/24 at 9:37 a.m., LPN 5	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE .	DATE
	indicated the expire should be sent back completion of the n (Assistant Director of Nursing) should destroy if it was export to the property of the property o	v on 9/10/24 at 10:30 a.m., the medication carts, and the frigerators were checked for nued medications two to three e need for removal.					
	DON indicated the the health department They still should have	ov on 9/10/14 at 10:45 a.m., the naloxone was dropped off by ent, so it didn't have a name. are been removed from the e to the expiration date.					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155668	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/12/2024
	ROVIDER OR SUPPLIER STOWN PLACE AT		4915 C	ADDRESS, CITY, STATE, ZIP COD CHARLESTOWN RD 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 B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
F 0812 SS=E Bldg. 00	policy, revised Aprilimited to, "Medicat accordance with fed regulations governin non-hazardous phar and controlled substance securely locked area disposed of 3 is supplied in sealed u returned to the issui" 3.1-25(k)(6) 3.1-25(o) 483.60(i)(1)(2) Food Procurement, Store Based on observation failed to ensure kite and the kitchen floo and grease build up observations. This daffect 118 residents the kitchen. Findings include: 1. During the initial and the Regional Dialests a.m., the follow on had gray substantial states of the general control of two ceiling room had gray substantial states of the general states of the	ng management of maceuticals, hazardous waste tances 1. All unused es shall be retained in a n with restricted access until individual resident medications nopened containers may be ng pharmacy for disposition e/Prepare/Serve-Sanitary on and interview, the facility hen equipment, ceiling vents r were free from food debris	F 0812	1. On 9/12/24, the equipment and vents in the kitchen ider during the survey were thore cleaned and the two items identified in the walk-in refrigwere discarded immediately identification. 2. All residents have the potential to be affected by the alleged deficient practice. A other dietary equipment and ceiling vents were reviewed Executive Director on 9/12/2 verify sanitation and cleanlin 3. On 9/16/24, the Dietary Manager provided re-educated dietary staff regarding thorous cleaning and sanitation of equipment and ceiling vents	ntified bughly gerator upon e II by the 4 to ess. y tion to ugh

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETE			
		155668	B. W	'ING		09/12/2024	
NAME OF T	DROWNER OF CURPLYEE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	C		4915 C	HARLESTOWN RD		
CHARLE	STOWN PLACE AT	Γ NEW ALBANY		NEW A	LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	DATE	
	_	gerator had a container of hot			assigned and proper discarding	ng of	
	_	ad a 9/1/24 open date with a			food after use by date.		
	l	A container of baked apples			4. The Executive Director		
	_	9/1/24 with a use by date of			and/or Dietary Manager will a		
		viches on a tray had a date of			to verify food is properly disca		
	9/1/24 when they w 9/4/24.	vere made with a use by date of			after use by date and that ceil	~	
		y build up of yellow grease			vents and kitchen equipment a sanitized and cleaned	are	
		own both sides of the fryer					
	and left side of the	-			appropriately at least (3) days		
		of both steamers and the			week for (4) weeks and then a least weekly for no less than (
	_	them had a heavy build up of			additional months. Any correct		
	yellow grease with				action needed will be complet		
		ble burnt black spots inside the			immediately. The results of the		
	bottom of both over				audits will be presented to the		
		build up of burnt black food			Quality Assurance/Performan		
	· ·	ve top burners and around			Improvement committee meet		
	them.	•			for a minimum of three month		
	- The toaster had a	heavy build up of crumbs in			validate 100% compliance and		
	the tray below the v	vire rack.			then on-going per routine QAI		
	- The wall behind th	he fryer had yellow and white			reviews. Plan to be updated a		
	streaks which ran h	alf way down the wall to the			indicated.		
	floor.						
		oor tiles against the wall by the					
		er that had a build up of white					
	and black wet subst	ance on the tiles.					
	_	vation at 11:30 a.m. with the					
		nd the Regional District					
	Manager, the follow	ving concerns were identified:					
	- the same areas of	concerns identified at 8:55 a.m.					
	were again present.						
	3. During an observ	vation on 9/9/24 at 2:00 p.m.					
	while accompanied	by the Regional Dietary					
	Manager, the follow	ving concerns were identified:					
	- One of two ceiling	g air vents in the dry storage					
		stance around the vent. The					

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155668	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMI	E SURVEY PLETED 2/2024
NAME OF I	PROVIDER OR SUPPLIEF	· !		ADDRESS, CITY, STATE, ZIP COD	•	
CHARLE	STOWN PLACE A	Γ NEW ALBANY		HARLESTOWN RD LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION grate cover of the second air	TAG	DEFICIENCY		DATE
		pating of gray dust on the				
	grate.	ating of gray dust on the				
	_	y build up of yellow grease				
		lown both sides of the fryer				
		steamer. The Regional Dietary				
		that the fryer did make a mess.				
	•	of both steamers and shelves				
	grease with food pa	d a heavy build up of yellow				
	-					
	- There were multiple burnt black spots in the bottom of both ovens.					
	- There was a heavy	y build up of burnt black food				
	particles on the stov	ve top burners and around				
	them.					
		heavy build up of crumbs in				
	the tray below the v					
		he fryer had yellow and white alf way down the wall to the				
	floor.	an way down the wan to the				
		ot dogs sitting in water in the				
	_	nat went to the dementia unit				
	for lunch.					
	During an interview	with the Regional Dietary				
	_	4 at 11:30 a.m., he indicated he				
	had been fighting t	o get those stove burners				
	1	g time. They were hard to				
		ally would eat the hot dogs for				
	lunch after the resid	lents were finished.				
	On 9/11/24 at 11:15	5 a.m., the Dietary Manager				
	presented a copy of	the cleaning schedule for				
	_	3/24 which indicated the				
	following:					
	,	boil out as needed) marked as				
	completed on 9/1/2					
		s/top/inside) a name was				
	marked on the sche	dule but was not completed.				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155668	· /	JILDING	nstruction 00	(X3) DATE : COMPL 09/12/	ETED
	PROVIDER OR SUPPLIER			4915 CH	DDRESS, CITY, STATE, ZIP COD HARLESTOWN RD BANY, IN 47150		
CHARLE (X4) ID PREFIX TAG	SUMMARY: (EACH DEFICIEN REGULATORY OR - Clean stove (stove was on the schedule - Steamer (Delime, completed on 9/1/2d Review of the facili revised 9/2017 on E not limited to, "Poli equipment will be of working order. Proc be routinely cleaned accordance with ma training materials. 2 properly trained in to of all equipment. 3. will be cleaned and non-food contact ed of debris" A second current por revised 9/2017, incl "Policy Statement: food service areas, a maintained in a clean and a san The Dining Service kitchen is maintained in dventilation. 2. T will ensure that all of in the proper procect sanitizing of all food surfaces. 3. All food cleaned and sanitize Dining Services Din cleaning schedule is	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION reyes and catch tray) a name rebut was not completed. Top and Sides) marked as 4. ty's current policy dated requipment, included, but was cy Statement: All food service redures: 1. All equipment will redured and maintenance All food contact equipment sanitized after every use. 4. All redured, but was not limited to, All food preparation areas, and dining areas will be retary condition. Procedures: 1. The bird in a clean and sanitary redured in a clean and sanitary reduced in a clean and sa				TE	(X5) COMPLETION DATE
	3.1-21(i)(3)	rage areas, and surfaces"					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155668	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION DO	c3) date survey COMPLETED 09/12/2024
	PROVIDER OR SUPPLIEF		4915 (ADDRESS, CITY, STATE, ZIP COD CHARLESTOWN RD ALBANY, IN 47150	
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
Bldg. 00	Survey. This visit in State Licensure Sur Complaints IN0044 and IN00442598. This visit was in co Post-Survey revisit IN00435623 compl PSR to Complaints IN00439706 compl Survey dates: Septe 2024 Facility number: 00 Provider number: 1 AIM number: 2002 Residential Census: These State Resider accordance with 41	(PSR) to Complaint eted on June 27, 2024 and the IN00439316, IN00439663, and eted on August 15, 2024. ember 5, 6, 9, 10, 11, and 12, 11144 55668 56980 19 Intial Findings are cited in	R 0000	Allegation of Compliance Please accept the following plar correction for the annual survey that was completed on 9/12/202 Preparation and/or execution of this plan of correction does not constitute admission or agreemed by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 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 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.	ent n nis it ne
R 0243 Bldg. 00	interview, the facili documentation on t Receipt/Record/Dis narcotics for 2 of 2	Deficiency on, record review, and ty failed to ensure	R 0243	Residents 3 and 5 continue to reside at the facility and controll medications continue to be administered as ordered. There were no negative outcomes resulting from the alleged deficience.	ed S718,232

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/12/2024	
	PROVIDER OR SUPPLIER		4915 (CHARLESTOWN RD	•
CHARLE	STOWN PLACE AT	I NEW ALBANY	NEW A	ALBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	medication cart. (Re	esidents 3 and 5)		practice.	
				2. Residents that receive	
	Findings include:			controlled medications have	
				potential to be affected by th	
		ion on 9/9/24 at 9:50 a.m., of		alleged deficient practice. C	
		ation cart the following		9/16/24, Nursing Administration	
	concerns were iden	tified:		reviewed and reconciled cor medication count sheets to t	
	1 Desident 2's tram	adol 25 mg (milligrams)			**=
		eceipt/Record/Disposition Form		medication administration re to determine if any other res	
				had been affected by the alle	
had a count of 28 tablets left. The resident's medication card contained 27 tablets of the				deficient practice for a 30 da	~
tramadol. The last dose signed out on the				back period.	ly look
	Controlled Drug Receipt/Record/Disposition Form			3. Beginning on 9/13/24, lice	ensed
	was on 9/8/24 at 8:0	-		nurses and qualified medica	
		1		assistants were educated by	
	The review on 9/10	/24 at 2:15 p.m., of the		Staff Development Coordina	
	physician's order, d	ated 6/18/24, indicated the		regarding the 9 Rights of	
	resident received th	e tramadol 25 mg three times		Medication Administration, w	vith
	daily for hip pain.			emphasis on the required	
				documentation of controlled	
	_	ember MAR (Medication		medications at the time of	
		ord) indicated the resident's		administration.	
		nadol 25 mg was administered		4. The Director of Nursing a	
		m., by QMA (Qualified		Unit Managers will complete	
	Medication Aide) 7			medication competencies wi	
	2 Dagidant 51a mar-	sabalin 200 ma Controlled Dur-		least five (5) licensed nurses	5
		abalin 200 mg Controlled Drug sposition Form had a count of 8		and/or qualified medication	on of
	_	ident's medication card		assistants to verify completion required documentation of	וס ווס
		of the oxycodone/APAP. The		controlled medications at the	a time
		on the Controlled Drug		of administration. These au	
	_	sposition Form was on 9/8/24 at		will be completed weekly for	
	8:00 p.m.	1 5: 5: = : 30		(4) weeks and then at least	
				weekly for no less than two	(2)
	The review on 9/10	/24 at 2:18 p.m., of the		additional months. Any corre	` '
		ated 8/28/24, indicated the		action needed will be comple	
		e pregabalin 200 mg two times		immediately. The results of t	
	daily for fibromyals			audits will be presented to the	
				Quality Assurance/Performa	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/12/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4915 CHARLESTOWN RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ſΕ	(X5) COMPLETION DATE
	resident's last dose of administered on 9/9 During an interview	Improvement committee meeting for a minimum of three months stered on 9/9/24 at 8:00 a.m., by QMA 7. Improvement committee meeting for a minimum of three months validate 100% compliance and then on-going per routine QAP reviews. Plan to be updated as indicated.		s to I			
	DON (Director of N should sign out the	on 9/10/24 at 11:10 a.m., the Jursing) indicated the nurse narcotic on the sheet once the en. They do that to keep track recotics remaining.					
	2019, included, but Controlled substance receipt, administration of each shift 9. A Controlled medication each shift. The nurs	stances policy, revised April was not limited to, " 5. es are reconciled upon on, disposition, and at the end t the End of Each Shift: a. ons are counted at the end of e coming on duty and the determine the count together					
R 0273 Bldg. 00	410 IAC 16.2-5-5. Food and Nutrition	1(f) nal Services - Deficiency					
	failed to ensure kite and the kitchen floo and grease build up observations. This caffect 9 of 9 Reside meal trays from the Findings include: 1. During the initial and the Regional Diagrams.	leficiency had the potential to ntial residents who received	R 02	273	1 On 9/12/24, the equipmer and vents in the kitchen identification the survey were thorough cleaned and the two items identified in the walk-in refriger were discarded immediately up identification. 2 All residents have the potential to be affected by the alleged deficient practice. All other dietary equipment and ceiling vents were reviewed by Executive Director on 9/12/24	ied ghly rator pon	09/18/2024

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668				LDING	00	COMPL 09/12/	ETED
	ROVIDER OR SUPPLIER			4915 CH	ADDRESS, CITY, STATE, ZIP COD HARLESTOWN RD		
CHARLE	STOWN PLACE AT	NEW ALBANY		NEW AL	LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	room had gray subsimiddle slats of the givent had a heavy cograte. - The walk-in refrig dogs on the shelf ha 9/3/24 use by date had an open date of 9/1/24. Two sandw 9/1/24 when they w 9/4/24. - There was a heavy streaks which ran dand left side of the service of the ser	of both steamers and the them had a heavy build up of food particles. The burnt black spots inside the ins. It build up of burnt black food the top burners and around the spots in wire rack. The fryer had yellow and white half way down the wall to the coor tiles against the wall by the er that had a build up of white			verify sanitation and cleanlines 3	n to h s g of dit rded ng ure a t (2) tive ed es e eng	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155668		A. BUILDING B. WING	00	COMPLETED 09/12/2024	
	PROVIDER OR SUPPLIER		4915 C	ADDRESS, CITY, STATE, ZIP COD CHARLESTOWN RD	
CHARLE	STOWN PLACE AT	NEW ALBANY	NEW A	ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3. During an observ while accompanied	ration on 9/9/24 at 2:00 p.m. by the Regional Dietary wing concerns were identified:			
	room had gray subsimiddle slats of the givent had a heavy congrate. - There was a heavy streaks, which rand and left side of the side of	ble burnt black spots in the cons. To build up of burnt black food the top burners and around the burners and around the avy build up of crumbs in the burners and white construction and white construction and the burners are the burners and the burners are the burners and the burners are the burners are the burners and the burners are the burners are the burners are the burners and the burners are the burners			
	_	ot dogs sitting in water in the nat went to the dementia unit			
	Manager on 9/11/24 had been fighting t clean for a very lon	with the Regional Dietary 4 at 11:30 a.m., he indicated he o get those stove burners g time. They were hard to ally would eat the hot dogs for lents were finished.			
	presented a copy of	5 a.m., the Dietary Manager The cleaning schedule for 3/24 which indicated the			

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155668	B. W	NG		09/12/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			HARLESTOWN RD		
CHARLE	STOWN PLACE AT	T NEW ALBANY			LBANY, IN 47150		
	1						<u> </u>
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCI		DATE
	following:						
	Class frage (filter	/boil out as needed) marked as					
	completed on 9/1/2						
		s/top/inside) a name was					
		dule but was not completed.					
		e eyes and catch tray) a name					
	,	e but was not completed.					
		Top and Sides) marked as					
	completed on 9/1/2	•					
	•						
	Review of the facili	ity's current policy dated					
	revised 9/2017 on Equipment, included, but was						
	not limited to, "Poli	icy Statement: All food service					
	equipment will be o	clean, sanitary, and in proper					
	working order. Prod	cedures: 1. All equipment will					
	be routinely cleaned	d and maintained in					
	accordance with ma	anufacturer's directions and					
		2 All staff members will be					
		the cleaning and maintenance					
		All food contact equipment					
		sanitized after every use. 4. All					
		quipment will be clean and free					
	of debris"						
		olicy on Equipment also dated					
		luded, but was not limited to,					
		All food preparation areas, and dining areas will be					
	maintained	and diffing areas will be					
		itary condition. Procedures: 1.					
		es Director will ensure that the					
		ed in a clean and sanitary					
		floors, walls, ceilings, lighting,					
		Γhe Dining Services Director					
		employees are knowledgeable					
		dures for cleaning and					
		d service equipment and					
		d contact surfaces will be					
	cleaned and sanitize	ed after each use. 4. The					
			1				I

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		IDENTIFICATION NUMBER 155668	A. BUILDING 00 B. WING		COMPLETED 09/12/2024				
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	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 APPROPRIAT DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE			
	cleaning schedule is	ector will ensure that a routine in place for all cooking rage areas, and surfaces"							
R 0306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance								
Bldg. 00	1271		R 0306		1. The Director of Nursing properly discarded the medical that was identified during the survey on that was past the expiration date and the medical that was discontinued was discarded appropriately. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. Medication carts and medication storage rooms were audited for proper labeling and storage by Nursing Administration 9/13/24. Any corrective actin needed was completed immediately. 3. Beginning on 9/13/24, licent nurses and qualified medication assistants were educated by the Staff Development Coordinator properly storing and labeling medications and the procedured discarding improperly stored, labeled and expired supplies. Education is also to be reviewed during new hire job specific training. 4. The Assistant Director of Nursing and/or Unit Manager views and the procedure of the procedure	ad the medication and during the as past the as past the and the medication and the medication and the medication and the medication are as a social to be a			
	During an interview on 9/9/24 at 9:50 a.m., QMA 7 indicated the resident's morphine was				audit medication rooms and medication carts for proper labeling and storage of				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED		
		155668	B. WING		09/12/2024		
			STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	L	4915 CHARLESTOWN RD				
CHARLE	STOWN PLACE AT	NEW ALBANY	NEW ALBANY, IN 47150				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	discontinued in Aug	discontinued in August 2024.		medications and validate the			
				removal of expired medication	s		
	_	on 9/9/24 at 11:29 a.m., LPN 8		three (3) times a week for four	(4)		
	_	discontinued medications		weeks and continue weekly fo	r no		
		to pharmacy at the time of		less than two (2) additional			
		nedication or the ADON		months. Any corrective action			
	(Assistant Director of Nursing) or DON (Director			needed will be completed			
	of Nursing) should be given the medication to			immediately. The results of these			
	destroy if it was expired.			audits will be presented to the			
				Quality Assurance/Performance			
	_	on 9/10/24 at 10:30 a.m., the		Improvement committee meet	ng		
	,	Jursing) indicated the		for a minimum of three months			
		nd the medication room		validate 100% compliance and	I		
refrigerators were chec		•	then on-going per routine Q				
		ations two to three times		reviews. Plan to be updated a	s		
	weekly for the need of medication removal. The Discarding and Destroying Medications			indicated.			
	_						
	policy, revised April 2019, included, but was not limited to, "Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances 1. All unused						
	controlled substances 1. All unused						
	securely locked area with restricted access until disposed of 3 individual resident medications supplied in sealed unopened containers may be returned to the issuing pharmacy for disposition						
		ng pharmacy for disposition					
	"		1		I		

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