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	05/03/2024

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 Complaint IN00430915. Complaint IN00430915 - Federal/State deficiency related to the allegations is cited at F580. An unrelated deficiency is cited Survey dates: May 2 and 3, 2024 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 123 Residential: 5 Total: 128 Census Payor Type: Medicare: 30 Medicaid: 66 Other: 27 Total: 123 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 9, 2024.	F 0000	Allegation of Compliance Please accept the following plan of correction for the survey completed on May 3, 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.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s)			

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

Jesse Ray 05/23/2024

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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	when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical			

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	configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure the physician was notified of a resident's (Resident B) loose stool for 1 of 3 residents reviewed for change of condition. Findings include: The clinical record for Resident B was reviewed on 5/2/24 at 9:26 a.m. The diagnoses included, but were not limited to, dementia and cognitive communication deficit. Review of the October 2023 bowel record for Resident B indicated the resident did not have any loose stools. Review of the November 2023 bowel record for Resident B indicated the following: - On 11/19/23 at 2:03 p.m., the resident was incontinent with a medium loose/diarrhea stool - On 11/19/23 at 8:52 p.m., the resident was incontinent with a large loose/diarrhea stool - On 11/20/23 at 3:50 p.m., resident was incontinent with a large loose/diarrhea stool - On 11/21/23 - the resident did not have a bowel movement - On 11/22/23 at 2:08 p.m., the resident was continent with a large loose/diarrhea stool The clinical record lacked nursing documentation or any follow up or physician notification on the resident due to Resident B's multiple loose stools. During an interview on 5/3/24 at 10:40 a.m., the	F 0580	1 1. Resident B was discharged from facility on 11/25/2023. 2 2. Residents experiencing 3 or more consecutive loose stools have potential to be affected by the same alleged deficient practice. A review of POC charting was initiated on 5/15/2024 over the last 30 days to confirm proper physician notification for residents experiencing 3 or more loose stools consecutively, any opportunities identified were addressed immediately. 3 3. On 5/15/2024, the Staff Development Coordinator initiated education for nursing staff regarding physician notification when residents' experience 3 or more loose stools consecutively or when there is a change of a resident's condition. Notifications have been configured in the facility's EMR software to provide alerts to nursing staff when a resident is experiencing consecutive loose stools. 4 4. The Director of Nursing and/or designee will review POC charting daily to verify proper physician notification has occurred when residents experience 3 or more consecutive loose stools for	05/21/2024

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	Director of Nursing indicated the POC (point of care) system did not flag documented loose stools. The aides should be reporting loose stools to the nurse so they can follow up. During an interview on 5/3/24 at 2:04 p.m., LPN (Licensed Practical Nurse) 3 indicated if a resident had consistent formed stools and then presented with multiple loose stools, it would be a change of condition and the physician should have been notified. On 5/3/24 at 2:10 p.m., the Director of Nursing provided a current copy of the document titled "Change in a Resident's Condition or Status" dated 2/2021. It included, but was not limited to, "Policy Statement...Our facility promptly notifies the...attending physician...of changes in the resident's medical...condition...." This Citation relates to Complaint IN00430915 3.1-5(a)(2)		(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. Plan to be updated as indicated.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident's (Resident D) room was free of potential hazards and education was provided to the resident	F 0689	1 1. On 5/3/2024, Maintenance unplugged the unapproved power strip in Resident D's room and connected	05/21/2024

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	(Resident D) on the risks of negative outcomes secondary to potential hazards for 1 of 3 residents reviewed for accidents. Findings include: The clinical record for Resident D was reviewed on 5/2/24 at 2:04 p.m. The diagnoses included, but were not limited to, diabetes, major depressive disorder and paraplegia. The quarterly MDS (Minimum Data Set) assessment, dated 3/17/24, indicated the resident's cognition was intact. The nurse's note, dated 5/1/24 at 11:04 p.m., indicated Resident D turned his call light on for assistance. The off-going nurse, RN (Registered Nurse) 5 stopped by his room to see what the resident needed. The resident was lying on his phone charger cord, in the bed, which was plugged into an extension cord. The resident stated "All I did was move over in the bed and it just stated to burn me. It felt like a bee sting." The resident had a blister formed on his right upper back side. The physician was notified and suggested Silvadene ointment to the area daily. During an interview on 5/2/24 at 11:40 a.m., RN 5 indicated she had clocked out and was walking back down the hall towards the nurses' station when she heard Resident D yelling that something was biting him. She went in the resident's room and could smell something had burned. She moved the resident over and pulled the phone charger cord out from behind him. The end of the phone charger cord was burned and melted. The resident liked to keep things behind him so he could reach them. During an interview on 5/2/24 at 1:29 p.m., the resident was observed resting in bed with his		the resident's refrigerator and medical device directly into the outlet receptacle. Resident D's blister area to upper back continues to improve and is nearly resolved. 2 2. On 5/6/2024, Maintenance completed an electrical safety audit in resident rooms to verify proper connection of medical devices and refrigerators directly into the electrical outlets, and removal of unapproved power strips and extension cords. 3 3. On 5/2/2024, the Maintenance Director provided education to the resident council on electrical safety. Education was provided to facility staff on 5/6/2024 by the Maintenance Director related to electrical safety and proper connection of medical devices and refrigerators directly into the electrical outlets, and unapproved power strips and extension cords are not permitted. On 5/8/2024, a letter was mailed to residents' families related to electrical safety and proper connection of medical devices and refrigerators directly into the electrical outlets, and unapproved power strips and extension cords are not permissible. 4 4. The Executive Director and/or Maintenace Director will audit resident rooms for electrical safety at least weekly, to verify	

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	eyes open and his call light in reach. He was well groomed. He indicated he had his phone charger plugged into his heavy duty white extension cord in the electrical socket to his right behind his bed side table. He had the charger under his right side. All of the sudden it felt like bees were stinging him. The nurse came in and took it out from behind him and it had melted. The other nurse came in and told him he could not use his extension cord any more. On 5/2/24 at 1:40 p.m., with the Unit Manager, Resident D's phone charger cord was observed. The cord was approximately 24 inches in length. The plastic around the USB-C connecter (part that inserts into the phone charging port) was observed to be melted and the metal connector was blackened. On 5/2/24 at 1:46 p.m., with the Unit Manager, the residents' burns to his back were observed. There were 3 small areas, grayish in color with redness to all 3 the peri-wound areas. The top wound was dime sized. the middle and bottom wounds were oblong and measured 2 cm (centimeters) in length and 3 cm in width. The clinical record lacked documentation of education provided to the resident related to the risks or danger of the resident lying on his cell phone charger cord, while plugged into an extension cord, and not in use prior to 5/3/24. On 5/3/24 at 10:39 a.m., the Director of Nursing indicated there was documentation of education provided to the resident in April 2024. Upon record review on 5/3/24 at 10:40 a.m., a note was placed in Resident D's record on 5/3/24 at 9:34 a.m., dated 4/24/24 at 9:30 a.m., by RN 5. The note		proper connection of medical devices and refrigerators directly into the electrical outlets, and removal of unapproved power strips and extension cords at least weekly for (4) weeks, every other week for (2) months, and then ongoing monthly. 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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	indicated RN 5 noticed the resident, while lying in bed, had the television remote control, cellphone and oxygen tubing behind his back. RN 5 educated the resident that he should not have items tucked into bed with him and that he was obstructing his oxygen by lying on it. The resident acknowledged and understood. A second note was placed in Resident D's record on 5/3/24 at 9:37 a.m., dated 4/25/24 at 12:30 p.m., by the Unit Manager. The note indicated that the Unit Manager had spoken with the resident about his conversation with RN 5 related to possible skin breakdown related to the pressure of lying on tubing and other items. The resident stated that he understood and would put items on his bedside table. During an observation on 5/3/24 at 9:58 a.m., Resident D's refrigerator, Bluetooth system and nebulizer machine were observed to be plugged into a power strip. On 5/3/24 at 10:04 a.m., the Maintenance Director indicated refrigerators and medical devices should not be plugged into a power strip. He had been removing power strips from rooms and missed the one in Resident D's room. They check the rooms once a month and had been removing the power strips that the families had brought in. The power strip in the Resident D's room was not hospital grade. During an interview on 5/3/24 at 10:07 a.m., Resident D indicated he had not ever been educated by the staff on the risk or dangers of him lying on his phone charger cord or other items. On 5/3/24 at 9:18 a.m., the Director of Nursing provided a current copy of the document titled			

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	"Electrical Safety for Residents", dated 1/2011. It included, but was not limited to, "Policy Statement...The resident will be protected from injury associated with the use of electrical devices, including electrocution, burns and fire...Policy Interpretation and Implementation...Power strips may be used for a computer, monitor, and printer...Power strips shall not be used with medical devices in resident-care areas...." 3.1-45(a)(1)			