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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY COMPLETED<br><br>05/03/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Charlestown Place at New Albany |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 Charlestown Rd<br>New Albany, IN 47150 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>34231</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>Review of the October 2023 bowel record for Resident B indicated the resident did not have any loose stools.</p> <p>Review of the November 2023 bowel record for Resident B indicated the following:</p> <ul style="list-style-type: none"> <li>- On 11/19/23 at 2:03 p.m., the resident was incontinent with a medium loose/diarrhea stool</li> <li>- On 11/19/23 at 8:52 p.m., the resident was incontinent with a large loose/diarrhea stool</li> <li>- On 11/20/23 at 3:50 p.m., resident was incontinent with a large loose/diarrhea stool</li> <li>- On 11/21/23 - the resident did not have a bowel movement</li> <li>- On 11/22/23 at 2:08 p.m., the resident was continent with a large loose/diarrhea stool</li> </ul> <p>The clinical record lacked nursing documentation or any follow up or physician notification on the resident due to Resident B's multiple loose stools.</p> <p>During an interview on 5/3/24 at 10:40 a.m., the 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.</p> <p>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.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>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</p> <p>This Citation relates to Complaint IN00430915</p> <p>3.1-5(a)(2)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34231</p> <p>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 (Resident D) on the risks of negative outcomes secondary to potential hazards for 1 of 3 residents reviewed for accidents.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During an interview on 5/2/24 at 1:29 p.m., the resident was observed resting in bed with his 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.</p> <p>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 connector (part that inserts into the phone charging port) was observed to be melted and the metal connector was blackened.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>On 5/3/24 at 9:18 a.m., the Director of Nursing provided a current copy of the document titled 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</p> <p>3.1-45(a)(1)</p> |  |  |