STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlestown Place at New Albany	4915 Charlestown Rd 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34231 Based on observation, interview and record review, the facility failed to ensure residents (Residents E and H) toilets were clean and sanitary for 2 of 4 residents reviewed for resident rights. Findings include 1. The clinical record for Resident E was reviewed on 8/11/24 at 12:13 p.m. The resident's diagnoses included, but were not limited to, hypertension, anxiety and depression. The quarterly MDS (Minimum Data Set) assessment, dated 6/12/24, indicated the resident's cognition was intact. On 8/11/24 at 9:35 a.m., the resident was observed sitting up in her wheelchair in her room watching television. The resident indicated her toilet bowl had not been cleaned in over a week. The toilet bowl was dirty and had a dark black substance in the bottom of it. On 8/11/24 at 9:41 a.m., the Resident's bathroom toilet bowl was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. On 8/12/24 at 9:05 a.m., the toilet bowl in the resident's bathroom was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. On 8/13/24 at 9:07 a.m., the Resident's bathroom toilet bowl was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. 2. The clinical record for Resident H was reviewed on 8/13/24 at 1:30 p.m. The resident's diagnoses included, but were not limited to, right sided hemiplegia and diabetes. The annual MDS assessment, dated 7/30/24, indicated the resident's cognition was intact. On 8/11/24 at 9:40 a.m., Resident H indicated the bathroom toilet had been like that for over a week because it had not been cleaned. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/11/24 at 9:41 a.m., the Resident's bathroom toilet bowl was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. On 8/12/24 at 9:05 a.m., the toilet bowl in the resident's bathroom was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. On 8/13/24 at 9:07 a.m., the Resident's bathroom toilet bowl was observed with a brown splattered substance to the right side of the upper toilet bowl and a dark gray/black substance covered the bottom of the toilet bowl. During an interview on 8/13/24 at 9:17 a.m., the assistant housekeeping supervisor indicated resident bathrooms were cleaned daily. At 9:18 a.m., during an observation of Resident E's toilet bowl with the assistant housekeeping supervisor, he indicated the matter in the toilet bowl looked like it had been there for a while. During an interview on 8/13/24 at 9:20 a.m., the housekeeping supervisor indicated the toilets should be cleaned daily. On 8/14/24 at 11:30 a.m., the Executive Director provided a current copy of the document titled 7-Step Daily Washroom Cleaning dated 1/1/2000. It included, but was not limited to .Purpose .To show Housekeeping employees the proper method to sanitize a .bathroom in long-term care .Clean and Sanitize Commode - The commode includes the tank, the seat, the bowl and the base 3.1-19(4)(f)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 34231 Based on interview and record review, the facility failed to ensure misappropriation of resident property did not occur for 1 of 3 residents reviewed for misappropriation. (Resident C) Findings include: The clinical record for Resident C was reviewed on 8/11/24 at 12:03 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia with agitation, anxiety and depression. The incident report, dated 7/20/24 at 7:01 p.m., indicated upon shift change, the off going night shift nurse, LPN (Licensed Practical Nurse) 9, counted with the oncoming day shift nurse, LPN 10 with a correct narcotic count. On shift change from day shift, LPN 10 counted off with the oncoming night shift nurse, LPN 11 and found the narcotic count for Resident C was missing 5 tablets out of the card. The physician's order, dated 6/27/24, indicated the resident was to receive Norco (Hydrocodone-acetaminophen) 5-325 mg (milligrams) twice daily for pain at 8:00 a.m. and 8:00 p.m. On 8/13/24 at 7:30 a.m., review of Resident C's July 2024 controlled drug record indicated on 7/20/24 at 8:00 a.m., LPN 10 signed out the medication for administration as ordered. On 7/20/24 at 8:00 p.m., the drug count was changed to 17 and signed by LPN 11 and RN (Registered Nurse) 13. On 8/13/24 at 7:40 a.m., review of the July 2024 controlled medication shift change log indicated on 7/20/24 at 6:30 a.m., there were no discrepancies. The controlled shift change log was signed by both the off going nurse (LPN 9) and the oncoming nurse (LPN 10). The written statement from LPN 10, dated 7/20/24 and untimed, indicated she went to the bathroom around 3:00 p.m. and was in there around 10 minutes. She did not realize she left the medication cart keys on top of the medication cart until she came out of the bathroom. She would never pop 5 narcotics out knowing her count would be off when the next nurse arrived. On 8/14/24 at 11:33 a.m., during a telephone interview, LPN 9 indicated that when she counted the narcotics with LPN 10, the count was correct. She always, always counts the cart prior to shift start and end with the other nurses. There were no narcotics missing when she and LPN 10 counted on the morning of 7/20/24. During a telephone interview on 8/14/24 at 2:06 p.m., LPN 11 indicated when she got to work the evening on 7/20/24, LPN 10 had given her report on the patients. After giving her report, LPN 10 said, I'll see you later. LPN 11 told her no, that they needed to count the cart. When they got to Resident C, LPN 10 reported a count of 22. LPN 11 told her that was incorrect, there were only 17 in the card. She then told LPN 10 she needed to call the unit manager. LPN 11 called the unit manager who instructed her to check all the cards. LPN 11 and LPN 10 checked and there were no other discrepancies. The unit manager notified the DON (Director of Nursing) who then came in for follow up. (continued on next page)

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	155668	A. Building B. Wing	08/15/2024

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Charlestown Place at New Albany	4915 Charlestown Rd New Albany, IN 47150

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 at 2:55 p.m., the Director of Nursing indicated she was notified of the missing narcotics and came to the facility. She had spoken to LPN 10 who told her they were just missing. She admitted that she had left her cart key on top of the cart when she went to the restroom and was gone for approximately 10 minutes. The facility paid for the pharmacy to replace the missing medication. They could not prove LPN 10 took the medication. On 8/11/24 at 11:11 a.m., the DON provided a current, undated copy of the document titled Freedom from Abuse and Neglect. It included, but was not limited to, Misappropriation of resident property .deliberate misplacement .wrongful .permanent use of a resident's belongings or money without the residents consent The Past noncompliance began on 7/20/24. The deficient practice was corrected by 7/22/24 after the facility implemented a systemic plan that included the following actions: A 100% audit was completed on all prescribed narcotic medication on all units (7/20/24); Nurses and medication aides were educated on Medication, Administration, medication cart security and narcotic diversion (7/20/24); Medication was re-ordered from the pharmacy and billed to the facility to cover the cost (7/22/24). This Citation relates to Complaint IN00439105 3.1-28(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 34231 Based on interview and record review, the facility failed to follow medication administration hold parameters related to a resident heart rate (Resident C) for 1 of 3 residents reviewed for quality of care. Findings include: The clinical record for Resident C was reviewed on 8/11/24 at 12:03 p.m. The resident's diagnoses included, but were not limited to, palpitations, orthostatic hypotension and syncope. The physician's order, dated 7/26/23, indicated the resident was to receive Digoxin 125 mcg (micrograms) daily for palpitations. The medication was to be held for a heart rate less than 60 and to notify the physician. Review of the July and August 2024 medication administration record indicated the following: On 7/08/24, the resident's HR was 47 and the resident's medication (Digoxin) was administered. On 8/11/24, the resident's HR was 55 and the resident's medication (Digoxin) was administered. The clinical record lacked documentation of the physician's notification related to the resident's heart rate less than 60. On 8/15/24 at 1:55 p.m., LPN (Licensed Practical Nurse) 5 indicated if a resident was on a medication with hold parameters and the resident's heart rate was out of range, the medication should have been held and the physician notified for guidance. The policy titled Administering Medications dated April 2019 included, but was not limited to, Policy Statement .Medications are administered in a safe .manner, and as prescribed .Medications are administered in accordance with prescriber orders 3.1-37

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34231 Based on interview and record review, the facility failed to ensure medication administration records and controlled substance records accurately reflected the administration of narcotic medication for 3 of 4 residents reviewed for medical records. (Residents C, F, and H) Findings include: 1. The clinical record for Resident C was reviewed on 8/11/24 at 12:03 p.m. The resident's diagnoses included, but were not limited to, depression and osteoporosis. The physician's order, dated 6/27/24, indicated the resident was to receive Norco (Hydrocodone-Acetaminophen) 5-325 mg (milligrams) twice daily for back pain at 8:00 a.m. and 8:00 p.m. The care plan, dated 11/13/20, indicated the resident needed pain management and staff were to administer the resident's pain medication as ordered. Review of the July 2024 and August 2024 Medication Administration Record indicated, on 7/17/24 at 8:00 a.m., 7/22/24 at 8:00 a.m., 8/9/24 at 8:00 a.m. and 8/10/24 at 8:00 a.m., the resident received the twice daily Norco (pain medication). The July 2024 and August 2024 controlled substance record lacked documentation of the resident's medications administration on 7/17/24 at 8:00 a.m., 7/22/24 at 8:00 a.m., 8/9/24 at 8:00 a.m. and 8/10/24 at 8:00 a.m. During an interview on 8/15/24 at 1:55 p.m., LPN (Licensed Practical Nurse) 5 indicated when the resident's narcotics (Norco) were administered, the medication should have been signed off on the controlled substance record and the Medication Administration Record. On 8/14/24 at 12:10 p.m., the Director of Nursing provided a current copy of the document titled Medication Administration dated 6/21/17. It included, but was not limited to, Medication will be administered .in accordance to applicable State, Local and Federal laws and consistent with accepted standards of practice . Procedure .document medication administration with initials on the Medication Administration Record (MAR) immediately after administering medication to each resident 2. The clinical record for Resident F was reviewed on 8/12/24 at 1:44 p.m. The resident's diagnoses included, but were not limited to, anxiety and depression. The physician's order, dated 4/3/24, indicated the resident was to receive Lorazepam (antianxiety medication) 0.25 ml (milliliters) every 4 hours for restlessness at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. Review of the June 2024 Medication Administration Record indicated, on 6/18/24 at 4:00 a.m., the resident's medication was not signed out as administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the August 2024 Medication Administration Record indicated, on 8/10/24 at 4:00 a.m., the resident's medication was not signed out as administered. The physician's order, dated 1/23/24, indicated the resident was to receive Clonazepam (antianxiety medication) 1 mg (milligram) every 8 hours for anxiety at 12:00 a.m., 8:00 a.m. and 4:00 p.m. Review of the July 2024 Medication Administration Record indicated the resident's medications were administered on 7/6/24 at 4:00 p.m., 7/10/24 at 4:00 p.m., 7/14/24 at 4:00 p.m. and 7/26/24 at 4:00 p.m. The July 2024 controlled substance record lacked documentation that the medications were administered on 7/6/24 at 4:00 p.m., 7/10/24 at 4:00 p.m., 7/14/24 at 4:00 p.m. and 7/26/24 at 4:00 p.m. The physician's order, dated 3/14/24, indicated the resident was to receive Morphine Sulfate Oral Solution (pain medication) 0.25 ml six times a day for pain at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m. Review of the June 2024, July 2024 and August 2024 Medication Administration Records lacked documentation that the medication was administered on the following dates and times: - On 6/11/24 at 6:00 a.m. and 2:00 p.m. - On 6/13/24 at 6:00 a.m. - On 6/14/24 at 6:00 a.m. - On 6/18/24 at 6:00 a.m. - On 6/24/24 at 6:00 a.m. - On 7/09/24 at 6:00 p.m. - On 7/15/24 at 2:00 p.m. and 6:00 p.m. - On 7/16/24 at 6:00 p.m. - On 7/21/24 at 6:00 a.m. - On 7/29/24 at 6:00 a.m. - On 8/03/24 at 6:00 p.m. - On 8/10/24 at 6:00 a.m. 3. The clinical record for Resident H was reviewed on 8/12/24 at 2:07 p.m. The resident's diagnoses included, but were not limited to, neuropathy and osteoporosis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order, dated 8/3/23, indicated the resident was to receive Tramadol 50 mg twice daily at 8:00 a.m. and 4:00 p.m. The care plan, dated 4/6/23, indicated the resident had pain and staff were to administer the resident's analgesia as ordered. The July 2024 Medication Administration Record indicated the resident received the Tramadol (pain medication), on 7/9/24 at 8:00 a.m. The controlled substance record lacked documentation of the administration of the resident's Tramadol on 7/9/24 at 8:00 a.m. 2. The clinical record for Resident D was reviewed on 8/11/24 at 10:52 a.m. The resident's diagnoses included, but were not limited to, strain of the right achilles tendon and diabetes. The hospital discharge orders, dated 7/11/24, indicated the resident was to receive Humalog sliding scale with meals and at bedtime. The facility admission orders, dated 7/11/24, indicated to check the resident's blood sugar before meals and at bedtime. The clinical record lacked documentation of the sliding scale insulin, refusal of the insulin upon admission or education of the risks of not taking the insulin. During an interview on 8/14/24 at 3:07 p.m., the DON (Director of Nursing) indicated she thought the resident had refused the sliding scale upon admission, but was not for certain. During an interview on 8/15/24 at 1:55 p.m., LPN 5 indicated if a resident was admitted from the hospital on sliding scale insulin and refused, the order should have been put in the system and then staff would notify the NP/MD for guidance. The orthopedic surgeon orders, dated 7/24/23, indicated the resident was to have a wet to dry treatment completed twice daily to the right ankle surgical wound and the resident was to follow up with the surgeon on 7/31/24. The July 2024 Treatment Administration Record indicated the orthopedic surgeon/'s order was discontinued on 7/25/24. The in-house would evaluation summary, dated 7/25/24, indicated staff were to complete a saline moist wet to dry dressing daily. The clinical record lacked documentation of any notification to the orthopedic wound physician prior to the discontinuation of the treatment ordered on 7/24/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 8/14/24 at 10:55 a.m., the in-house wound physician indicated when she first spoke with the resident, there were no specific orders in place for the wound. The resident reported that he had a follow-up appointment with the surgeon. On 7/24/24, he went to his follow-up appointment with the surgeon and returned with orders of a wet to dry and those orders were followed. She indicated she thought the surgeon ordered the treatment daily so that was a mistake on her part; a miscommunication on her part. This Citation relates to Complaints IN00439316, IN00439706 and IN00439663 3.1-50(a)(1) 3.1-50(a)(2)