| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155668 | A. Building<br>B. Wing | 08/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Charlestown Place at New Albany | 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 (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>(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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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to ensure a resident (Resident D) received showers per her preference and failed to ensure a resident (Resident H) received his mail unopened and in a timely manner for 2 of 3 residents reviewed for resident rights.Findings Include:1 The clinical record for Resident D was reviewed on 8/11/25 at 1:08 p.m. The resident's diagnoses included, but were not limited to, depression and anxiety. The annual Minimum Data Set (MDS) assessment, dated 6/3/25, indicated the resident's cognition was intact.On 8/8/25 at 2:40 p.m., the resident was observed sitting up in her wheelchair watching television. The resident's hair was observed to be flat and oily in appearance and her bilateral lower extremities were wrapped with ace wraps. The resident indicated she preferred a shower, but they were bathing her in bed due to her legs being wrapped. She had not had a shower for about a month. She feels so much better when she gets a shower. The resident's shower days were on Wednesdays and Saturdays.The annual MDS assessment, dated 6/3/25, indicated the resident's bathing preference was very important to her. The care plan, dated 8/24/24, indicated the resident required assistance with Activities of Daily Living and staff were to assist with showers twice weekly or per the resident's preference.Review of the resident's bathing record, between 7/13/25 and 8/11/25, indicated the following:-On Wednesday, 7/16/25, the resident received a bed bath-On Saturday, 7/19/25, the resident received a shower-On Wednesday, 7/23/25, the resident received a bed bath-On Saturday, 7/26/25, no bathing documentation-On Wednesday, 7/30/25, the resident received a bed bath-On Saturday, 8/02/25, the resident received a bed bath-On Wednesday, 8/06/25, the resident received a bed bathDuring an interview, on 8/12/25 at 10:30 a.m., Licensed Practical Nurse (LPN) 4 indicated the new Certified Nursing Assistants now were not taught about covering legs that were wrapped. She was unaware that the resident was not getting her showers until just recently. The resident liked to get her showers.The document titled Resident Rights was provided on 8/12/25 by the Clinical Support at 10:28 a.m. It included, but was not limited to, The resident has the right to a dignified existence .The right to receive the services .included in the plan of care 2 The clinical record for Resident H was reviewed on 8/11/25 at 1:40 p.m. The resident's diagnoses included, but were not limited to, asthma, diabetes, chronic obstructive pulmonary disease, chronic pain and depression. The quarterly MDS assessment, dated 6/22/25, indicated the resident's cognition was intact. During an interview, on 8/10/25 at 9:49 a.m., the resident indicated on 7/23/25, a staff member (name unknown) from the front office came into his room and told him his Medicaid application had been denied and provided him with a 30-day discharge notice. He had just called the Medicaid office the week before and was told his application was still pending. He asked the lady how she knew his Medicaid had been denied and it was reported to him that they had received a letter in the mail. He told them he wanted to see the letter. On Monday, 7/28/25, the lady came in and showed him the letter, which had his name on it. He asked her why they opened the letter when it was addressed to him and she told him that anything with FSSA (Family and Social Services Administration) on it, the facility was allowed to open. He asked her to show him where, in the Federal Regulations, that it said they could open someone's mail without their permission. Again, he was told that they were allowed to open any mail with FSSA on it. He was also told on 7/28/25 that he had signed for the representative to receive his information. The only thing he had signed was a form giving permission for the representative from (name of the outside company) that helps individuals navigate the Medicaid application process to assist him with the paperwork for Medicaid. At 9:55 a.m., the resident provided the letter for the surveyor to review. The mailing date was 7/18/25 and the letter was observed to be addressed to the resident only.The progress note, dated 7/23/25 at 3:15 p.m., indicated the Director of Social Services, Business Office Manager and Assistant Business Office Manager visited the resident in his room to present a discharge letter and transfer/discharge notice of and discharge date d of 8/23/25Review of the admission Packet Agreement, signed by Resident H on 11/13/24, included, but was not limited to, the following Section 1: Parties to the Agreement .This admission and Consent to Treat Agreement .is made between the Resident identified above (Resident) and/or by the Resident Representative identified above on behalf of the Resident .and the Facility listed above .Resident Mail .The Resident will receive all mail unopened unless requested otherwise as indicated below .Forward all mail unopened to the Resident Representative The admission Packet Agreement lacked documentation of a resident representative listed for Resident H.On 8/11/25 at 9:55 a.m., the State Form 55386, Authorized Representative for Health Coverage was reviewed. It included, but was not limited to, If |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>Based on interview and record review, the facility failed to ensure a blood pressure medication was held for a resident (Resident K) with out of parameter blood pressures for 1 of 3 residents reviewed for quality of care. Findings Include: The clinical record for Resident K was reviewed on 8/11/25 at 2:16 p.m. The resident's diagnosis included, but was not limited to, hypertension.The care plan, dated 6/9/25, indicated the resident had altered cardiovascular status due to hypertension and medications were to be administered as ordered by the physician.The physician's order, dated 4/5/25, indicated the resident was to receive Lisinopril (medication for high blood pressure) 10 mg (milligrams) daily in the morning. The medication was to be held if the resident's systolic blood pressure (SBP) was less than 110.Review of the July 2025 and August 2025 medication administration record indicated the resident received the medication on the following dates:-On 7/08/25, the Lisinopril was administered to the resident with a SBP of 100-On 7/11/25, the Lisinopril was administered to the resident with a SBP of 100-On 7/23/25, the Lisinopril was administered to the resident with a SBP of 106-On 7/28/25, the Lisinopril was administered to the resident with a SBP of 100-On 7/29/25, the Lisinopril was administered to the resident with a SBP of 104-On 8/04/25, the Lisinopril was administered to the resident with a SBP of 106-On 8/05/25, the Lisinopril was administered to the resident with a SBP of 103-On 8/06/25, the Lisinopril was administered to the resident with a SBP of 109During an interview, on 8/12/25 at 10:30 a.m., Registered Nurse (RN) 5 indicated if a resident's blood pressure was out of parameters, the medication should not be given. On 8/12/25 at 12:44 p.m., the Executive Director provided a current, undated copy of the document titled Medication Administration. It included, but was not limited to, Medications will be administered .in accordance to applicable State, Local and Federal laws, consistent with accepted standards of practice .Obtain and record any vital signs as necessary prior to medication administration This Citation relates to Complaint 25809923.1-37 |