STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. Building B. Wing	03/20/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to prevent a Stage 4 pressure ulcer development (a severe, full-thickness wound extending to muscle, tendon, or bone, featuring deep tissue loss, often with slough, tunneling, and high infection risk) for a resident who was admitted without a skin impairment to the bilateral buttocks and sacrum, was identified by the facility to be at risk for the development of a pressure ulcer, who had co-morbidities, frequent moisture, and total dependence on staff for repositioning. The facility failed to ensure services were provided to the sacral wound and facility acquired full thickness skin tears on the bilateral buttocks obtained during a fall to prevent the wounds from deteriorating to a stage four pressure injury that required surgical debridement, and hospitalization for sepsis with in 3 weeks of admission. (Resident B) The Immediate Jeopardy began on 3/10/26 when an area to the buttocks/sacrum was identified by staff, and the facility had failed to prevent the development of a Stage 4 pressure ulcer within 3 weeks of admission. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 3/19/26 at 3:30 p.m. Findings include:The clinical record for Resident B was reviewed on 03/18/26 at 10:00 a.m. The resident's diagnoses included, but were not limited to, displaced intertrochanteric fracture of left femur (severe break in the thigh bone), difficulty in walking, morbid (severe) obesity, and bilateral primary osteoarthritis of hip (a degenerative condition where cartilage in both hips wears down). A nurse's note, dated 2/18/26, indicated the resident arrived by wheelchair. She was stable and had a surgical wound on her left leg. The Braden Scale for Predicting Pressure Sore Risk (evidence-based tool used to assess a resident's risk of developing pressure ulcers), dated 2/18/26, indicated Resident B was at an increased risk of developing skin impairment. The Scale indicated the resident had limited cognition; resident was chairfast; had limited mobility; friction and sheer were a potential problem. The admission Nursing Evaluation, dated 2/18/26, indicated that the resident's skin was normal in color, the skin was warm to touch temperature, and was moist. Areas noted on the admission skin assessment were the chest, right iliac crest (groin), left iliac crest (groin) all with excoriation (superficial skin abrasion of chafing, raw, irritated lesions characterized by damage from scratching, picking, or rubbing). A surgical dressing was on the resident's thigh area of the left extremity. No pressure injuries were documented. The care plan, dated 2/19/26 and revised on 2/26/26, indicated the resident had potential for skin impairment related to decreased mobility. The interventions, dated 2/19/26, included, but were not limited to, incontinence care every shift and as needed for incontinence episodes, treatments as ordered, observe skin during care and report any concerns to the nurse, turn and reposition to maintain skin integrity, pressure reducing mattress, skin check weekly and wheelchair cushion. No new interventions were documented after the 2/19/26 Care Plan listed interventions for the revision on 2/26/26. A physician's order, dated 02/19/26, indicated the resident was to have a pressure-reducing cushion on her wheelchair and pressure-reducing mattress on her bed. A wound note, dated 2/27/26, indicated the resident had a left proximal and left distal post-surgical wound. A facility document, titled Skin Check, dated 2/27/2026, indicated the skin was warm and dry with normal limits of skin color and no external devises on the skin. The resident's left and right inguinal region (groin area located in the lower portion of the abdomen wall where meets the (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	thigh) had a rash, buttocks generalized with a stage one pressure ulcer/injury to the medial buttocks without undermining or tunneling. This pressure ulcer/injury was present on admission (documented as excoriation on the 2/18/26 admission assessment). A facility document, titled Skin Check, dated 3/6/26, indicated the skin was warm and dry with skin color within normal limits and no external devises on the skin. The left and right breast had redness, the left and right inguinal region had a rash, buttocks with a stage one pressure injury (localized injury to intact skin, characterized by non-blanchable redness that does not turn white when pressed) to the medial buttocks without undermining or tunneling. This pressure injury was present on admission. The resident was admitted on [DATE] and the admission skin assessment lacked a documented stage one pressure injury as documented on admission on the resident's Skin Checks, dated 2/27/2026 and 3/6/26, of the resident's medial buttocks. The 2/18/26 admission assessment indicated the resident had redden areas of excoriation. A Minimum Data set (MDS), dated [DATE], indicated the resident was cognitively intact. The resident was totally dependent on staff for toileting, hygiene, showering, and used a sit to stand for transfers. The resident needed substantial assistance with upper body dressing, rolling/turning in bed, sitting to lying, and lying to sitting. A wound note, dated 3/10/26, indicated the resident still had the left proximal and left distal post-surgical wounds. The resident had skin tears full thickness to the right and left buttocks and the sacrum. The Physician's order for a non-pressure wound of the resident's coccyx, left buttocks, and right buttocks, dated 3/10/26, indicated the resident was to have the wound cleansed with normal saline, pat dry, apply calcium alginate (a water insoluble, gelatinous, substance highly absorbent) and covered with a wound dressing as needed. A nurse's note, dated 3/10/26, indicated the resident was seen and examined by the wound nurse via video call with the assistant director of nursing. The assessment included the review of the resident's pressure sores on the buttocks area. The area was to have a wound dressing change twice daily: apply Dakin's solution (mild, diluted antiseptic solution used in wound care to clean, disinfect, and treat infected wounds), then put calcium alginate dressing on top and cover with abdominal gauze. A wound note, dated 3/11/26, indicated the resident had a selective debridement (precise removal of only necrotic, devitalized, or infected tissue) procedure on the right buttock and a surgical excisional debridement (use of a sharp instrument to cut away devitalized, necrotic, or contaminated tissue along with healthy tissue to promote healing) on the sacrum area. An alert note, dated 3/13/26, indicated the resident's buttock treatment was for staff to clean and flush the residents pressure injury (buttock/sacrum) with Dakin's and normal saline. The wound was tunneling and had a foul odor. Santyl (ointment to remove dead tissue from skin ulcers to promote healing) was applied with calcium alginate and border gauze. A nurse's note, dated 3/13/26, indicated the resident was sent to a local hospital for elevated temperature of 99.5 Fahrenheit and altered mental status (a sudden or gradual change in a person's baseline cognitive function, consciousness, or awareness). The Local Hospital emergency room noted, indicated on admission, that the resident was diagnosed with sepsis (a life-threatening medical emergency caused by the body's extreme, overactive response to an infection, which damages its own tissues and organs). The note indicated the resident's diagnosis of sepsis was likely due to the resident's infected sacral wound. As of 3/20/26, the resident remained in the acute hospital setting. During an interview, on 3/18/26 at 1:00 p.m., the wound care nurse practitioner (NP) indicated the resident had discoloration/abrasion on her buttocks on admission listed as excoriation. She saw the resident via telehealth medicine on 3/10/26 and did a conservative debridement on 3/11/26. The resident's wound was unstageable still after debridement. She could not answer if the wound was avoidable because the resident was overweight and did not move easily. She was supposed to see the resident on 3/6/26 but had to reschedule her time and had not seen the resident as planned. She indicated that the wound doctor had seen the resident on 2/27/26. During an interview, on 3/18/26 at 2:50 p.m., the Director of Nursing (DON) indicated that if an abnormal finding was found during a skin assessment check that the MD would be notified and if it was a stageable wound then the wound care company would be notified. A change of condition would (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	then be completed in the electronic medical record. On 3/19/26 at 3:00 p.m., the DON indicated Resident B had slipped from the bed on 3/2/26 and later there was sheering noticed. The resident was admitted to the facility with redness on the coccyx. The sheering (a mechanical force that occurred when skin and underlying tissues are pulled in opposite directions) was the resident's noted skin tears. During an interview, on 3/18/26 at 1:15 p.m., CNA 4 indicated the most important way to prevent infection was to perform hand hygiene; and turning and repositioning a resident was one of the best ways to prevent pressure ulcers. During an interview, on 3/19/26 at 11:20 a.m., LPN 5 indicated that she was working on 3/13/26. At shift change, the daytime nurse (LPN 6) assessed the resident to find her lethargic, and only responding to pain. The doctor and family were notified, and the resident was sent to the emergency room. The LPN indicated that if she found a new skin area during a skin check she would notify the DON, notify the physician/nurse practitioner and family. A skin issue document would be completed, a change of condition form completed, and management would inform the wound care providers. The current policy, titled Skin Integrity and Wound Policy was provided by the Executive Director on 3/19/26. The policy indicated, Policy: Based on the comprehensive assessment.a resident receives care, consistent with professional standards of practice. The past non-compliance Immediate Jeopardy that began on 3/10/2026. The Immediate Jeopardy was removed and corrected by 3/17/26 after the facility implemented a systemic plan that included the following actions: staff education/in-services on daily wound monitoring; all residents were assessed for identifying skin impairments; all resident care plans, regarding skin issues, were reviewed; all residential pressure injury preventions were in place for at risk residents; and a wound team consisting of but not limited to the DON, ADON, Unit Manager, Wound Nurse will completed a risk management assessment of physician notification, obtaining new orders, transcribed new orders and contacting families of new order, updated care plans with new interventions and provide therapy referrals as needed. This citation relates to Intake 2805974. 410 IAC (Indiana Administrative Code) 3.1-40(a)(1)410 IAC 3.1-40(a)(2)