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	05/11/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility management failed to timely report an incident to the Indiana Department of Health when a resident (Resident E) acquired a second degree burn from a coffee spill for 1 of 5 residents reviewed for reportable incidents. Findings include:The clinical record for Resident E was reviewed on 5/11/26 at 8:14 a.m. The resident's diagnosis included, but was not limited to, second degree burn (damages to the top layer of skin and the second layer characterized by server pain, swelling, ad blisters) to left hip.The incident report, dated 5/11/26, indicated on 4/23/26, Resident E reported that she spilled coffee on herself during breakfast. The nurse practitioner evaluated Resident E and new orders were received. The nurse practitioner note, dated 4/23/26 at 10:48 a.m., indicated the resident reported she was having her morning coffee and spilled it on her left hip which caused a burn and blister. The assessment/plan was to apply Silvadene (prescription antibiotic cream used to treat infections in second and third-degree burns) 1% to the second degree burn every 4 hours as needed.Review of the facility reportable incidents, between 3/21/26 and 5/11/26 lacked documentation of the second-degree burn to Resident E's left hip.On 5/11/26 at 10:21 a.m., the Executive Director indicated the resident's burn had not been reported as she was unaware burns greater than first-degree needed to be reported.During an interview on 5/11/26 at 1:18 p.m., the Executive Director indicated the facility followed State guidance related to reporting incidents.The Indiana Department of Health Policies and Procedures titled Long-Term Care Abuse and Incident Reporting Policy included, but was not limited to, Purpose .To facilitate compliance with state and federal law and regulation, as applicable, related to reporting of .incidents in licensed long-term care facilities in Indiana .Types of Incidents Reportable Under Federal and State Rules.Major accidents.Burns greater than first degree.

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 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. Based on interview and record review, the facility failed to ensure blood pressure medications were not administered to residents (Resident C and Resident D) when out of the physician ordered parameter blood pressure readings for 2 of 4 residents reviewed for quality of care. Findings include:1. The clinical record for Resident C was reviewed on 5/11/26 at 7:52 a.m. The resident's diagnosis included, but was not limited to, hypotension (abnormally low blood pressure).The physician's order, dated 4/4/26, indicated the resident was to receive Midodrine (medication used to increase blood pressure) 10 mg (milligrams) three times a day at 8:00 a.m., 2:00 p.m. and 9:00 p.m. The medication was to be held if the resident's systolic blood pressure (SBP) was greater than 120.The April 2026 and May 2026 medication administration records (MAR) indicated the resident received the medication on the following dates and times:-On 4/07/26 at 9:00 p.m., the resident received the Midodrine with a SBP of 121-On 4/10/26 at 8:00 a.m., the resident received the Midodrine with a SBP of 129 and at 9:00 p.m. with a SBP of 148-On 4/11/26 at 8:00 a.m., the resident received the Midodrine with a SBP of 140-On 4/15/26 at 8:00 a.m., the resident received the Midodrine with a SBP of 138 and at 2:00 p.m. with a SBP of 124-On 4/16/26 at 2:00 p.m., the resident received the Midodrine with a SBP of 135-On 4/18/26 at 9:00 p.m., the resident received the Midodrine with a SBP of 133-On 4/20/26 at 2:00 p.m., the resident received the Midodrine with a SBP of 133 and at 9:00 p.m. with a SBP of 132-On 4/23/26 at 2:00 p.m., the resident received the Midodrine with a SBP of 122-On 4/24/26 at 2:00 p.m., the resident received the Midodrine with a SBP of 128 and at 9:00 p.m. with a SBP of 126-On 4/25/26 at 8:00 a.m., the resident received the Midodrine with a SBP of 132-On 5/03/26 at 2:00 p.m., the resident received the Midodrine with a SBP of 130-On 5/08/26 at 9:00 p.m., the resident received the Midodrine with a SBP of 132During an interview, on 5/11/26 at 12:49 p.m., Registered Nurse (RN) 5 indicated blood pressure medication should not be administered if a resident's blood pressure was out of parameters. 2. The clinical record for Resident D was reviewed on 5/11/26 at 10:14 a.m. The resident's diagnosis included, but was not limited to, heart failure.The physician's order, dated 1/31/25, indicated the resident was to receive Metoprolol Succinate (medication for high blood pressure) ER (extended release), 25 mg daily at 8:00 a.m. The medication was to be held if the systolic blood pressure was less than 120.The April 2026 and May 2026 medication administration records indicated the resident received the medication on the following dates:-On 4/24/26 at 8:00 a.m., the resident received the Metoprolol Succinate with a SBP of 109-On 5/02/26 at 8:00 a.m., the resident received the Metoprolol Succinate with a SBP of 110 On 5/12/26 at 10:44 a.m., the Executive Director provided a current copy of the document titled Medication Administration dated 6/21/17. It included, but was not limited to, Policy.Medications will be administered.in accordance.with accepted standards of practice. This Citation relates to Intake 2992467410 AIC (Indiana Authorization Code) 16.2-3.1-37

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure timely wound treatments were implemented for a resident (Resident E), upon admission, for 1 of 3 residents reviewed for pressure ulcer prevention. Findings include:The clinical record for Resident E was reviewed on 5/11/26 at 8:14 a.m. The resident's diagnoses included, but were not limited to, depression, sepsis (the body's extreme, life-threatening response to an infection) and anxiety.The progress note, dated 4/10/26 at 4:45 p.m., indicated Resident E was admitted back to the facility from the hospital.The admission evaluation, dated 4/10/26 at 8:05 p.m., indicated the following skin issues:-Blanchable redness on the buttocks-Skin tear to the upper clavicle area, left upper arm and right elbow.The skin note, dated 4/13/26 at 1:11 p.m., indicated the resident admitted with following:-Stage 3 pressure wound of the left posterior thigh-Stage 3 pressure wound of the right posterior thigh-Skin tear to the right lower shin-Skin tear to the right upper chest-Unstageable to the right heel-Unstageable to the left heel-Venous wound to the right footThe clinical record lacked documentation of the implementation of wound treatments for the wounds until 4/16/26.During an interview, on 5/11/26 at 10:23 a.m., the Director of Nursing indicated treatments should be implemented immediately, upon admission, for residents with wounds.On 5/11/26 at 10:44 a.m., the Executive Director provided a current copy of the document titled Skin Integrity and Wound Policy dated 11/7/23. It included, but was not limited to, Policy.Based on the comprehensive assessment of a resident, the facility must ensure that.A resident receives care, consistent with professional standards of practice.to promote healing, prevent infection.Examples of impaired skin integrity include, but are not limited to, pressure injuries, venous (stasis) ulcers.skin tears. This Citation relates to Intake 2992467410 IAC (Indiana Authorization Code) 16.2-3.1-40(a)(2)