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	06/18/2026

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review, the facility failed to ensure a resident's (Resident C) clinical record was updated, as requested by the resident's Power of Attorney, for 1 of 3 residents reviewed for resident rights. Findings include:The clinical record for Resident C was reviewed on 6/16/26 at 1:20 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (a progressive, incurable lung disease that caused obstructed airflow and breathing difficulties), diabetes (chronic condition where the body either cannot produce enough insulin or cannot effectively use the insulin it makes) and depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities).On 6/17/26 at 10:09 a.m., the Executive Director provided, and indicated, she had just found a document requested by Resident C's son. The note, dated 9/17/25, indicated that Resident C's son was allowed to receive healthcare information on Resident C. The note was signed by Resident C's Power of Attorney (POA)During an interview, on 6/17/26 at 10:45 a.m., Resident C's POA indicated she had provided the previous Executive Director with a handwritten note in September of 2025. The note granted permission for Resident C's son to receive health care information on Resident C.The clinical record lacked documentation for the resident's son to receive healthcare information.On 6/17/26 at 10:09 a.m., the Executive Director indicated she was unaware of the handwritten note as she was not here at the time the note was provided.This citation relates to Intake 3030651410 IAC (Indiana Authorization Code) 16.2-3.1-3(d)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure a resident's (Resident B) representative was notified of an acquired venous ulcer and a gradual dose reduction in medication for 1 of 3 residents reviewed for notification of changes. Findings include:The clinical record for Resident B was reviewed on 6/16/26 at 9:41 a.m. The resident's diagnoses included, but were not limited to, depression (a serious mood disorder that causes persistent feeling of sadness, emptiness, and a loss of interest in activities) and peripheral vascular diseases (a slow, progressive circulation disorder that narrows or blocks blood vessels outside the heart and brain).The nurse practitioner wound note, dated 4/14/26, indicated the resident had a vascular wound (sore on the skin caused by poor circulation) to the right calf and a treatment was implemented.The psychiatric nurse practitioner progress note, dated 4/29/26 at 12:08 p.m., indicated to discontinue Sertraline (medication used for depression) 25 mg (milligrams) in the morning for a gradual dose reduction (GDR) and continue the Sertraline 50 mg in the evening.The clinical record lacked documentation of family notification related to the vascular wound and the discontinuation of the Sertraline.During an interview, on 6/18/26 at 11:49 a.m., the Director of Nursing indicated the family should have been notified.On 6/18/26 at 3:32 p.m., the Executive Director provided a current copy of the document titled Change in a Resident's Condition or Status dated February 2021. It included, but was not limited to, Policy Statement.Our facility promptly notifies the resident.and the resident representative of changes in the resident's medical.condition.or status.This citation relates to Intake 3018317410 AIC (Indiana Authorization Code) 16.2-3.1-5(a)(2)

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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. Based on interview and record review, the facility failed to ensure monitoring was in place for residents (Resident B and Resident C) when a gradual dose reduction (GDR) was implemented for 2 of 3 residents; and failed to ensure a resident (Resident B) was immediately assessed for injury after a witnessed fall for 1 of 3 residents reviewed for quality of care. Findings include:1. The clinical record for Resident B was reviewed on 6/16/26 at 9:41 a.m. The resident's diagnosis included, but was not limited, depression (a common but serious mood disorder which causes persistent feelings of sadness, hopelessness and a loss of interest in activities).The April 2026 medication administration record indicated the resident received sertraline (medication for depression) 25 mg (milligrams) daily in the morning and 50 mg in the evening for depression. A psychiatric progress note, dated 4/29/26 at 12:08 p.m., indicated to discontinue the resident's sertraline 25 mg in the morning for a gradual dose reduction (GDR).The clinical record lacked documentation of a 72-hour follow-up for close monitoring when the sertraline 25 mg was discontinued.A progress note, dated 5/19/26 at 11:23 a.m., indicated Resident B had a witnessed fall and that the family had been notified.The clinical record lacked documentation of an assessment for injury at the time of the fall.During an interview, during the survey period, Staff Member 5 indicated when a resident falls, the nurse should immediately assess the resident for any injuries.During an interview, on 6/18/26 at 11:49 a.m., the Director of Nursing indicated the 72-hours follow up for GDR's should be documented in the progress notes.On 6/18/26 at 3:00 p.m., the Executive Director provided a current copy of the document titled Tapering Medications and Gradual Drug Dose Reduction dated July 2022. It included, but was not limited to, Policy interpretation and implementation .When a medication is tapered or stopped, the staff will closely monitor the resident 2. The clinical record for Resident C was reviewed on 6/16/26 at 1:20 p.m. The resident's diagnoses included, but were not limited to, depression (a common but serious mood disorder which causes persistent feelings of sadness, hopelessness and a loss of interest in activities).The physician's order, dated 9/18/26, indicated the resident was to receive Paxil (medication for depression) 5 mg daily.A psychiatric progress note, dated 12/3/25 at 9:02 a.m., indicated to discontinue the Paxil for a GDR.The clinical record lacked documentation of a 72-hour follow up for close monitoring when the medication was discontinued.This citation relates to Intakes 3018317, 3024762 and 3030651410 IAC (Indiana Authorization Code) 16.2-3.1-37

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility to ensure a resident (Resident B) was transferred, via mechanical lift, with two staff members present during the transfer for 1 of 3 residents reviewed for accidents. Findings include:The clinical record for Resident B was reviewed on 6/16/26 at 9:41 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease (a slow, progressive circulation disorder characterized by narrowed or blocked blood vessels outside the heart and brain, most commonly affects the legs), polyneuropathy (damage or disease affecting multiple peripheral nerves simultaneously) and repeated falls. The quarterly MDS (Minimum Data Set) assessment, dated 3/23/26, indicated Resident B had intact cognition and limited range of motion to both of her upper arms.During an interview, on 6/16/26 at 12:50 p.m., Resident B indicated she did have a fall. CNA 7 was dressing her after her shower. She told CNA 7 that her shoulder hurt and that she could not hold on. CNA 7 told her to hold on because she was almost done. Resident B's hand came loose and she fell. A progress note, dated 5/19/26 at 11:23 a.m., indicated the resident had a witnessed fall.The IDT (interdisciplinary team) note, dated 5/20/26 at 3:27p.m., indicated the resident was lowered to the floor from the sit to stand lift when the resident's hand slipped from the handle. The resident was being transferred by one CNA (Certified Nursing Assistant) and the resident became uncomfortable in the sling and leg go of the handle.During an interview, on 6/16/26 at 2:34 p.m., the Director of Nursing indicated Resident B's fall happened in the resident's room after her shower. CNA 7 was transferring the resident when the fall started to happen. CNA 7 yelled for Licensed Practical Nurse (LPN) 8 for assistance. There should have been two staff members present when the mechanical lift was being used for the resident. On 6/18/26 at 3:00 p.m., the Executive Director provided a current copy of the document titled Safe Lifting and Movement of Residents dated July 2017. It included, but was not limited to, Policy Statement.In order to protect the safety and well-being of.residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents.This deficient practice was corrected on 5/20/26, prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan which included the following: Immediate education was provided to the staff involved with the incident related to the use of sit to stand lifts according to manufacturer guidelines and the resident level of care needs; All staff were educated on how to properly use the sit to stand lift in accordance with the manufacturers guidelines and residents level of care required for transfers.This citation relates to Intake 3018317410 IAC (Indiana Authorization Code) 16.2-3.1-45(a)(2)

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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. Based on interview and record review, the facility failed to ensure a resident's (Resident C) medication administration record accurately reflected the administration of a medication for 1 of 3 residents reviewed for medical records. Findings include:The clinical record for Resident C was reviewed on 6/16/26 at 1:20 p.m. The resident's diagnosis included, but was not limited to, inappropriate sexual behaviors (encompasses physical or verbal actions of a sexual nature that violate social norms).The Nurse Practitioner note, dated 12/17/25, indicated to start Climara TD (transdermal) patch (medication used for inappropriate sexual behavior).The physician's order, dated 12/17/26, indicated the resident was to receive the Climara Transdermal Patch Weekly, 0.1 mg/24 hour. Apply one patch transdermally one time a day for sexually inappropriate behaviors in the morning.Review of the December 2025 and January 2026 medication administration records (MAR), indicated the resident received the medication on the following dates in the morning: 12/18/25 through 12/22/25; 12/26/25 through 12/28/25; 12/31/25; and 01/01/26 through 01/05/26.During an interview on 6/18/26 at 11:26 a.m., the Director of Nursing indicated the Nurse Practitioner had put the order in the system incorrectly. Some of the staff were signing the medication out as given and some did not. The facility never received the medication because the pharmacy was waiting on clarification of the order.On 6/18/26 at 3:00 p.m., the Executive Director provided a current copy of the document titled Administering Medications dated April 2019. It included, but was not limited to, The individual administering the medication initials the resident's MAR.after giving each medication.This citation relates to Intakes 3024762 and 3030651410 IAC (Indiana Authorization Code) 16.2-3.1-50(a)(2)