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	08/29/2025

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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review and interview, the facility failed to ensure care plan interventions and treatments were in place or completed as ordered by the physician for 5 of 7 residents reviewed for pressure wounds (Residents 2, 52, 64, 14, 73). This deficient practice resulted in a resident acquired bilateral unstageable heel wounds (Resident 2). Findings include:1.During an observation on 8/26/25 at 10:30 a.m., Resident 2 was sitting up in his wheelchair with his feet resting on the foot pedals. The resident was assisted back to bed for wound dressing changes to the right and left heels. The wound Nurse Practitioner (NP) removed the old dressings. The resident had pressure wounds to the right and left heels. The left pressure wound measured 4.1 centimeters (cm) in length and 4.2 cm in width. The peri wound tissue was pink in color. The right heel wound measured 2.7 cm in length and 2.3 cm in width. A small amount of serosanguinous drainage was on the old dressings. The record for Resident 2 was reviewed on 8/23/25 at 8:49 a.m. The resident's diagnoses included, but were not limited to, pain in the left foot, pain in the right foot pressure-induced deep tissue damage to the right heel, pressure-induced deep tissue damage to the left heel, and a Stage 3 pressure wound of the sacral region. The admission Minimum Data Set (MDS) assessment, dated 7/3/25, indicated the resident was moderately cognitively impaired. The clinical record lacked documentation to indicate the resident had a care plan and preventive interventions for the bilateral heels in place prior to the development of bilateral heel wounds on 7/8/25. The Braden Skin assessment, dated 7/3/25, for risk of pressure wounds indicated the resident was at high risk for pressure wounds. On 7/4/25, the admission assessment indicated the resident had redness to the peri area, an ulcer to coccyx area Stage 2 and no other skin areas were observed. On 7/12/25, the resident's skin was warm, dry and intact. He had a pressure wound to the coccyx, redness to peri area, and no other new skin concerns were observed. 1.a. The physician's order, dated 8/2/25, indicated staff were to cleanse the resident's left heel pat dry, apply a nonstick dressing and wrap with a gauze every day for a pressure wound. The order was discontinued on 8/5/25. The physician's order, dated 8/4/25, indicated staff were to apply skin prep to the resident's bilateral heels daily and float heels with pressure reducing boots while in bed daily. The order discontinuation (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

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	08/29/2025

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 - Actual harm Residents Affected - Few	date was 8/12/25. The physician's order, dated 8/13/25, indicated Santyl external ointment 250 units/gm (grams) was to be applied to the resident's left heel topically every day shift for a deep tissue injury to the left heel and as needed. The order discontinuation date was 8/25/25. The physician's order, dated 8/25/25, indicated staff were to cleanse the resident's left heel pressure wound with wound cleanser, pat dry, apply calcium alginate, and apply Santyl to the wound bed and wrap with gauze daily and as needed. The resident's skin assessments notes indicated the following: On 7/26/25, the resident indicated that he had redness to the left heel. On 8/2/25, a new pressure area was observed to the resident's left heel. No other skin concerns were observed. On 8/9/25, the resident's skin to the left heel was pale in color and warm to touch. Wound care was following the resident and the treatment continued. On 8/16/25, treatment continued to the bilateral heels. The review of the Wound Observation Tool indicated the following: On 8/8/25, the resident acquired an unstageable pressure wound (due to necrosis) of the left heel on 8/2/25. The wound was 100 percent necrotic tissue. The left heel wound measured 4.5 (centimeters) cm length by 4.3 cm width and 0.1cm in depth. Serous drainage and no odor. The treatment plan included, apply calcium alginate and Santyl to the wound bed, cover with a ABD pad and wrap with gauze daily and as needed. On 8/11/25, the pressure wound to the resident's left heel was unstageable. The wound had visible slough and necrotic tissue with serosanguinous drainage. The wound measured 4.7 cm in length, 4.3 cm in width, and 0.1 cm in depth. The treatment included applying calcium alginate and Santyl to the wound bed, covering with a ABD pad and wrap with gauze daily and as needed. On 8/15/25, the resident had an unstageable pressure wound to the left heel. Necrotic tissue was present with serosanguinous drainage. The wound measured 2.4 cm in length, the width measured 2.5 cm, and the depth measured 0.1 cm. The treatment included applying calcium alginate to the wound bed, once daily and as needed. On 8/22/25, the resident had an unstageable pressure wound to the left heel. The wound tissue had slough and necrotic tissue present with a moderate amount of serosanguinous drainage. The measurements included 4.4 cm in length, 4.4 cm in width, and 0.1 cm in depth. The treatment included applying calcium alginate and Santyl to the wound bed, covered with an ABD pad and wrap with gauze daily and as needed. 1.b. The physician's order, dated 8/12/25, indicated staff were to apply skin prep to the resident's right heel with pressure-reducing boots while in bed daily. The order discontinuation date was 8/19/25. (continued on next page)

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	08/29/2025

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 - Actual harm Residents Affected - Few	The physician's order, dated 8/25/25, indicated staff were to cleanse the resident's wound to the right heel with wound cleanser, apply a dime size Santyl ointment, cover with calcium alginate and wrap with gauze daily and as needed. The physician's order, dated 8/26/25, indicated staff were to cleanse the resident's right heel with wound cleanser, pat dry, apply calcium alginate and Santyl to the wound bed. Wrap with gauze once daily and as needed. The skin assessments notes indicated the following: On 8/16/25, treatment continued to the resident's bilateral heels. The review of the Wound Observation Tool indicated the following: On 8/8/25, the resident acquired an unstageable deep tissue injury to the right heel. The wound measurements for the resident's right heel was 2.3 cm in length, 2.7 cm in width, and 0 depth. On 8/11/25, the pressure wound to the resident's right heel was an unstageable deep tissue injury. The measurements included length 2.4 cm, width 2.7 cm and 0 depth. The treatment was for staff to apply skin prep once daily and as needed. On 8/22/25, the resident had an unstageable pressure wound to the right heel. Necrotic tissue was present with serosanguinous drainage. The measurements included length 2.4 cm, the width was 2.7 cm and the depth was 0.1 with serosanguinous drainage. The treatment included applying calcium alginate and Santyl to the wound bed, covering with a ABD dressing and wrapping with gauze daily and as needed. 1.c. The care plan, dated 7/7/25 and revised on 7/15/25, indicated the resident had potential for skin impairment. The interventions included, but were not limited to, apply treatment as ordered, observe the resident's skin during care and report any concerns to the nurse, a pressure-reducing mattress, skin check weekly, and a wheelchair cushion. The Braden Skin assessment, dated 7/3/25, for risk of pressure wounds indicated the resident was at high risk for pressure wounds. The physician's order, dated 7/14/25, indicated zinc oxide external cream 10 percent topical was to be applied to the resident's coccyx topically two times a day for redness. The medication was discontinued on 8/25/25. The skin assessments notes indicated the following: On 7/4/25, the admission assessment indicated the resident had redness to the peri area, an ulcer to coccyx area Stage 2 and no other skin areas were observed. On 7/12/25, the resident's skin was warm, dry and intact. He had a pressure wound to the coccyx, redness to peri area, and no other new skin concerns were observed. The review of the Wound Focus Exam indicated the following: (continued on next page)

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	08/29/2025

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 - Actual harm Residents Affected - Few	On 7/18/25, the resident had an unstageable deep tissue injury to the sacrum related to pressure. The pressure wound measured 5 by 5 and was not documented with cm. No exudated was observed. The intact skin had purple and maroon discoloration. The treatment plan indicated apply zinc ointment twice a day and as needed. On 7/25/25, the resident had a Stage 3 pressure wound to the sacrum with full thickness. The wound measured 5 cm in length by 4 cm in width and 0.1 cm in depth. No exudated was observed. The wound had 25 percent granulation, intact normal skin color, and the wound progress had evidence of improvement. The treatment plan was to apply zinc ointment twic3 a day and as needed. On 8/1/25, the resident's Stage 3 pressure wound to the sacrum had resolved. During an interview, on 8/22/25 at 10:35 a.m., the Wound Physician indicated the resident was not admitted with the unstageable bilateral heal pressure wounds. The wounds occurred related to the resident resting his heels on the foot petals. She indicated she thought the wounds were healable, but they would need to be debrided at some point. During an interview, on 8/26/25 at 11:00 a.m., the Assistant Director of Nursing (ADON) indicated to the resident's family member the heel wounds were pressure from the resident sitting up in the wheelchair with his feet resting on the foot pedals. During an interview, on 8/27/25 at 10:30 a.m., Licensed Practical Nurse 3 (LPN) indicated pressure wound interventions included, but were not limited to, off-loading, heel boots, reposition every 2 hours and before when needed, low air mattress, a cushion in the resident's wheelchair, and weekly skin assessments. The pressure reducing interventions should have begone on admission. 2. The record for Resident 52 was reviewed on 8/22/25 at 10:00 p.m. The resident's diagnoses included, but were not limited to, moderate protein malnutrition, muscle weakness, edema, open wounds to the bilateral lower extremities. The physician's order, dated 8/2/25, indicated Zinc Oxide External Cream 12 percent, was to be applied to the resident's coccyx topically every day and night shift for redness. Staff were to clean the wound well with soap and water before applying The care plan, dated 5/7/25 and revised on 8/15/25, indicated the resident had an actual skin impairment. A Stage 3 coccyx wound. The interventions included, but were not limited to, incontinence care every shift and as needed for incontinence episodes, the wound physician to assess and treat as indicated, treatment as ordered, observe skin during personal care and report any concerns to the nurse, turn and reposition to maintain the skin integrity, medications as ordered and a cushion to the wheelchair. The clinical record lacked documentation indicating accurate weekly skin assessments. The review of the weekly skin assessments indicated the following: On 7/10/25, the resident had no areas of concern observed, skin warm, dry, and intact. On 7/17/25, the resident's bilateral lower extremities had edema noted and tight yet not pitting. The resident started taking Lasix on 7/16/25 (continued on next page)

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	08/29/2025

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 - Actual harm Residents Affected - Few	On 7/18/25, the resident developed a Stage 3 pressure wound. The wound measured 0.7cm in length by 0.8 cm in width and 0.3 cm in depth. On 7/24/25, the resident had a coccyx wound, scattered wounds on the bilateral lower extremities, and staff were to continue with treatments. On 7/31/25, the resident had no new areas noted. On 8/7/25, the resident's coccyx and bilateral lower extremities wound continued. On 8/15/25, the resident's Coccyx wound was acquired on 7/11/2025. The wound was a Stage 3, worsening, with granulation 100% serous drainage. The wound measured: length 0.7 cm x (by) width 0.8 cm x depth 0.1 cm. The staff were to apply Leptospermum honey and cover with a gauze island dressing with border once daily and as needed. Not at goal due to generalized decline of patient. On 8/21/25, the resident had no new skin issues to note. On 8/28/25, the resident had no new skin issues noted. The Focused Wound Exam indicated the following: On 7/18/25, the resident had a Stage 3 pressure wound to the coccyx with full thickness. The etiology was pressure. The healing potential was fair. The wound size included length 0.7 cm by 0.8 cm width by 0.3 cm in depth. The wound had moderate serosanguinous drainage. The treatment plan included applying Alginate calcium once daily and as needed: if saturated, soiled, or dislodged. For 30 days On 7/25/25, the resident had a Stage 3 pressure wound. The etiology was pressure. The wound measurements included 0.5 cm by 0.5 cm by 0.3 cm. The wound had light serosanguinous drainage. The wound had improved evidenced by decreased surface area. The treatment plan included applying Zinc ointment twice daily and as needed if saturated, soiled, or dislodged. On 8/1/25, the resident had a Stage 3 pressure wound with full thickness. The measurements included length 0.5 cm by width 0.5 cm and 0.1 cm in depth. The wound had 100 percent granulation tissue. The treatment plan included applying Zinc ointment twice daily and as needed for saturated, soiled or dislodged. On 8/8/25, the resident had a Stage 3 pressure wound. The wound measurements included length 0.5 cm by width 0.4 cm and 0.1 cm in depth. The wound had been improved by evidence of decreased surface area. The treatment plan included applying Zinc oxide twice daily and as needed for saturation, soiled, or dislodged. On 8/11/25, the resident had a Stage 3 pressure wound to the coccyx with improvement by decreased surface area and full thickness. An ultrasound mist therapy was performed on the wound. The treatment plan included adding Zinc ointment twice a day and as needed. The goal of treatment was healing evidenced by 64 percent decrease in the surface area within the wound bed in comparison to the previous wound care visit. On 8/22/25, the resident had a Stage 3 pressure wound to the coccyx. The wound measurements (continued on next page)

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	08/29/2025

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 - Actual harm Residents Affected - Few	included the length 0.4 cm by 0.5 cm in width and 0.1 cm in depth. The wound had 20 percent slough and 80 percent granulation tissue. The wound had improved evidenced by decreased surface area. The treatment plan included applying Zinc oxide twice daily and as needed. A debridement procedure was attempted but aborted related to pain. The wound underwent treatment with non-contact, non-thermal, low frequency ultrasound. The wound was treated for the indicated time based on wound size and features. An absorbent pad was placed to protect the patient's clothing and bedding. A fresh bandage was applied. 3.During an observation, on 8/26/25 at 9:15 a.m., Resident 64 was sitting up in his wheelchair with his left foot resting on the foot pedals. The resident had a sock on his left foot, however there was no pressure relieving heel boot to offload his foot. There was no sheep skin cushion on the wheelchair. During an observation, on 8/27/25 at 8:30 a.m., the resident was lying on his left side with no protective heel boots in place. During an observation, on 8/28/25 at 10:15 a.m., the resident was lying on his left side with no protective heel boots in place During an observation, of wound care on 8/29/25 at 9:00 a.m., wound care was performed in accordance with the physician's orders. Hand hygiene completed by staff. The left heel wound measured 4 cm long by 5.26 cm wide by 0.2cm depth. A second newer left calf wound was observed on 8/28/25 and resulted from the resident supporting the left leg with a towel. The wound to the left calf measured at 2.08 cm long by 4.22 cm wide by 0.2cm depth on 8/29/25. The wound care was observed with the Wound Physician and treatment included Medi-honey to the newest wound on the left calf topically one time a day. The record for Resident 64 was reviewed on 8/26/25 at 10:16 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, pain in left lower leg, need for assistance with personal care, right below the knee amputation, and Stage 3 pressure ulcer of the left heel. The care plan, dated 11/26/24 and revised on 8/18/25, indicated the resident had actual or the potential for skin impairment. The interventions included, but were not limited to, heel boots while in bed, sheep skin to the right side of the wheelchair, pressure reducing mattress, skin check weekly, lymphedema care management via compression wraps, turning and repositioning, and a wheelchair cushion. The physician's order, dated 7/29/25, indicated staff were to cleanse the resident's left heel pressure wound with normal saline, apply Santyl and calcium alginate, abdominal (ABD) pad, and wrap one time a day every dayshift and as needed. The order discontinuation date was 8/12/25. The Braden Skin assessment, dated 7/30/25, indicated the resident was at high risk for pressure wounds. The State Optional Minimum Data Set (MDS) assessment, dated 8/13/25, indicated the resident was cognitively intact. The physician's order, dated 8/13/25, indicated staff were to cleanse the resident's left heel pressure wound with normal saline, apply Santyl and calcium alginate, abdominal (ABD) pad, and wrap one time (continued on next page)

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	08/29/2025

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 - Actual harm Residents Affected - Few	a day every dayshift and as needed. The order discontinuation date was 8/15/25. The physician's order, dated 8/16/25, indicated staff were to cleanse the resident's left heel pressure wound with normal saline, apply Leptospermum honey and calcium alginate, cover the wound with an abdominal (ABD) pad, and wrap with kerlix one time a day and as needed. The resident's skin assessment notes indicated the following: On 5/21/25, the assessment indicated the resident's skin was warm, dry, and intact. On 5/28/25, the assessment indicated the resident's skin was warm, dry, and intact. On 6/6/25, the assessment indicated the skin was intact with no skin issues. On 6/15/25, the assessment indicated the resident had redness to his bilateral buttocks, and a prevention cream in place. On 6/21/25, the assessment indicated the resident had no new skin issues noted, and the skin was warm, dry, and intact, The review of the Wound Observation Tool for the left heel wound indicated the following: On 6/19/25, the resident acquired an unstageable pressure wound of the left heel. The wound was 100 percent necrotic tissue. The left heel wound measured 3 cm length by 3 cm width and 0.1cm in depth. Serous drainage and no odor. The treatment plan included, apply calcium alginate and Santyl to the wound bed, cover with an ABD pad and wrap with gauze daily and as needed. On 7/3/25, the resident has an unstageable pressure wound of the left heel. The wound was 100 percent necrotic tissue. The left heel wound measured 3 cm length by 4 cm width and 0.1 cm in depth. Serous drainage and no odor. The treatment plan included, apply calcium alginate and Santyl to the wound bed, cover with an ABD pad and wrap with gauze daily and as needed. As a result of a surgical debridement, the nonviable tissue in the wound bed decreased from 100 percent to 20 percent. On 8/1/25, the resident had an unstageable pressure wound of the left heel. The wound was 50 percent necrotic tissue. The left heel wound measured 4 cm length by 4.5 cm width and 0.1 cm in depth. Serous drainage and no odor. No signs of infection. The treatment included applying calcium alginate and Santyl to the wound bed, covering with an ABD pad and wrap with gauze daily and as needed. Surgical debridement was completed on that date. On 8/8/25, the resident had an unstageable pressure wound of the left heel with full thickness The wound was 50 percent necrotic tissue. The left heel wound measured 4 cm length by 4.5 cm width and 0.1 cm in depth. Serous drainage and no odor. No signs of infection. The treatment included applying calcium alginate daily and for 30 days applying Santyl to the wound bed, covering the wound with an ABD pad and wrap with gauze daily and as needed. Surgical debridement was completed on this date. On 8/15/25, the resident had a Stage 3 pressure wound of the left heel with full thickness The wound was 50 percent necrotic tissue. The left heel wound measured 4 cm length by 4.5 cm width and 0.1 cm in depth. Serous drainage and no odor. No signs of infection. The treatment included applying (continued on next page)

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	08/29/2025

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 - Actual harm Residents Affected - Few	calcium alginate daily and for 30 days applying Santyl to the wound bed, covering the wound with an ABD pad and wrap with gauze daily and as needed. Surgical debridement was completed on this date. On 8/22/25, the resident had a Stage 3 pressure wound of the left heel with full thickness The wound was 50 percent necrotic tissue. The left heel wound measured 4.3 cm length by 4.5 cm width and 0.1 cm in depth. Serous drainage and no odor. No signs of infection. The treatment included, applying calcium alginate once daily and as needed. For 16 days; apply Leptospermum honey once daily, covering the wound with an ABD pad and Gauze roll 4.5 daily and as needed. On 8/25/25, the resident had a Stage 3 pressure wound of the left heel with full thickness The wound was 50 percent necrotic tissue. The left heel wound measured 4.3 cm length by 4.5 cm width and 0.2 cm in depth. Moderate Serosanguinous drainage and no odor. No signs of infection. The duration of the wound was greater than 76 days. The treatment included applying calcium alginate once daily and as needed. For 13 days; apply Leptospermum honey once daily, covering the wound with an ABD pad and Gauze roll 4.5 daily and as needed. During an interview, on 8/29/25 at 11:00 a.m., the Wound Physician indicated that there was redness on the resident's left calf and continued down to left foot. A wound culture would be ordered. A doppler was ordered and was negative for abnormalities and the residents had good pedal pulses. The resident has been compliant with interventions but needed assistance with bed mobility, transfers, and placing the boot on his left heel. The clinical record lacked documentation to indicate the resident had accurate skin assessments completed by the nursing staff and failed to ensure adequate preventive interventions to avoid the development of new wounds in the resident's care plan. 4. During an observation of Resident 14 on 8/26/25 at 1:07 p.m., the Wound Company NP and the facility Wound NP, performed hand hygiene and applied PPE (personal protective equipment). The Wound Company NP indicated the main goal of the treatment was for infection control, debridement, and odor control. The resident was on hospice care. The old dressing was dated 8/26/25 where it had been changed due to soilage. Serosanguinous drainage was visible on the dressing. The wound had clean edges with a beefy red wound bed. There was undermining and the wound measured 6.3 cm long by 2.1 cm wide by 3 cm deep. The undermining was at 12 o'clock with a depth of 4 cm. There was no odor present. The wound was cleansed with gauze soaked in Dakins. The Wound NP indicated no flagyl was needed and the Wound Company NP indicated it would be discontinued. The wound was packed in calcium alginate and no concerns with the wound appearance were observed. The Wound Company NP indicated the wound had an odor last Friday, but none was present today. The resident usually ate well, but the wound was not expected to heal. The wound would have times of reducing in size and then increasing. The wound had been the same size since the resident was admitted . The wound company started care on 7/25/25. The record for Resident 14 was reviewed on 8/26/25 at 11:10 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, multiple sclerosis, hypertension, repeated falls, osteoarthritis, vitamin B12 deficiency anemia, difficulty walking, pain in the left hip, and the need for assistance with personal care. The care plan, dated 3/4/25 and revised 7/18/25, indicated actual and/or potential skin impairment related to limited mobility, fragile skin, multiple sclerosis, medication use, anemia, pain, osteoarthritis, hypothyroidism, anxiety, and depression. Unstageable pressure ulcer to the buttocks. The (continued on next page)

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	08/29/2025

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 - Actual harm Residents Affected - Few	interventions, dated 3/4/25, included, but were not limited to, incontinence care every shift and as needed for incontinent episodes. Dated 7/18/25, notify hospice of declines in skin integrity or pressure ulcer development. Dated 3/18/25, the wound physician was to assess the wound, provide treatment as ordered, observe skin during care and report any concerns to nurse, turn and reposition to promote healing of current areas, pressure reducing mattress, skin check weekly, medications as ordered, and wheelchair cushion. The nurse's note, dated 2/22/25 at 2:45 p.m., indicated the resident arrived at the facility with family members at 2:30 p.m. by wheelchair. The resident was alert and oriented. The physician's order, dated 2/23/25, indicated to apply a pressure reducing mattress to the resident's bed. The physician's order, dated 2/23/25, indicated to apply a pressure reducing cushion to the wheelchair. The physician's order, dated 2/24/25, indicated the resident was to have their wound assessed by the wound company. The wound company's initial assessment, dated 2/27/25, indicated the resident had a Stage 2 pressure ulcer to the sacral area, that measured 1 cm long by 0.4 cm wide by 0.1 cm deep. There were open areas with exposed dermis. The primary dressing was for zinc ointment to be applied twice daily for 30 days. The recommendations were to off-load the wound and to reposition per facility protocol. The wound company's assessment, dated 3/3/25, indicated the resident's Stage 2 wound had resolved. The dietary progress note, dated 4/30/25 at 10:23 a.m., indicated the resident triggered for a significant weight loss of 7.4% of 10.4 pounds in a month. The resident's current body weight was 129.2 pounds and in March the resident weighed 139.6 pounds. The weight loss was unplanned and was due to poor oral intake. The resident tolerated a regular diet with a meal intake of 25 to 75%. The resident admitted she had never been a big eater but did enjoy the food that was served. The resident was willing to try Ensure for added nutrition support. Will continue to monitor the resident's oral intake, weight, and skin. The physician's order, dated 4/30/25, indicated the resident was to receive Ensure Plus drinks after meals for nutritional support related to poor intake. The physician's note, dated 5/17/25 at 8:03 a.m., indicated that the resident had a 1 cm long split in the intergluteal cleft, which was barely open, with no blood. There was no sign of pain or discomfort. The resident's condition was stable. This was an acute new problem. The order was to apply gentle care to avoid a deeper tear. Notify a clinician of any change in condition. The wound company's assessment, dated 5/27/25, indicated the resident had a new wound to the sacrum, which measured 1.5 cm long by 1 cm wide by 0.1 cm deep with 10% slough and 90% granulation tissue. The estimated time to heal was 1 to 4 weeks. The treatment plan was to apply alginate calcium daily and as needed for 28 days. The dressing was a gauze island with border daily and as needed. The resident refused debridement due to pain. The resident was educated. (continued on next page)

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	08/29/2025

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 - Actual harm Residents Affected - Few	The wound company's assessment, dated 6/19/25, indicated the resident's wound to the sacral area measured 2 cm long by 2 cm wide by 0.1 cm deep with 10% slough and 90% granulation tissue. The treatment was to continue the calcium alginate to the wound bed and cover with a bordered island dressing daily and as needed. The wound company's assessment, dated 6/29/25, indicated the resident's wound to the sacrum remained stable, measuring 3 cm long by 3 cm wide by 0.1 cm deep with a moderate serous drainage. The wound was progressing at goal. The treatment was to continue the calcium alginate to the wound bed and cover with a bordered island dressing daily and as needed. The nurse's note, dated 7/3/25 at 2:07 p.m., indicated to provide Ensure Plus after meals for nutritional support related to poor oral intake. The Ensure was not available. The nurse's note, dated 7/3/25 at 5:05 p.m., indicated to provide the resident with Ensure Plus after meals for nutritional support related to poor oral intake. The Ensure was not available. The nurse's note, dated 7/6/25 at 4:42 p.m., indicated the resident's sacral wound was not responding to the treatment and had a strong odor. The wound needed to be followed by the wound doctor. The nurse's note, dated 7/10/25 at 5:12 p.m., indicated to provide the resident with Ensure Plus after meals for nutritional support related to poor oral intake. The Ensure was not available. The wound company's assessment, dated 7/11/25, indicated the unstageable wound to the resident's coccyx had exacerbated due to generalized decline of patient, measuring 3 cm long by 2 cm wide by 0.3 cm deep with 70% thick adherent devitalized necrotic tissue and 30% slough present. There was a moderate amount of serous drainage. The order was to continue the calcium alginate, apply leptospermum honey to the wound bed and cover with a bordered island dressing daily and as needed. The nurse's note, dated 7/15/25 at 7:04 a.m., indicated to treat the resident's wound with Medi honey wound/burn dressing external gel. Apply to the sacrum topically one time a day and apply calcium alginate. Awaiting the delivery of the supplies. The nurse's note, dated 7/16/2025 7:16 a.m., indicated to treat the resident's wound with Medi honey wound/burn dressing external gel. Apply to the sacrum topically one time a day and apply calcium alginate. Awaiting the delivery of the supplies. The physician's order, dated 7/16/25, indicated to notify the hospice company for all resident condition changes and medication needed every shift. The nurse's note, dated 7/17/25 at 8:49 a.m., indicated to treat the resident's wound with Medi honey wound/burn dressing external gel. Apply to the sacrum topically one time a day and apply calcium alginate. Awaiting the delivery of the Medi honey. The wound company's assessment, dated 7/25/25, indicated the unstageable necrosis wound to the resident's sacrum measure 3.7 cm long by 2.5 cm wide by 1.5 cm deep with heavy serous drainage and 100% thick adherent devitalized necrotic tissue. The resident was on palliative care and debridement was not indicated at this time. The same treatment plan was in place. (continued on next page)

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	08/29/2025

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 - Actual harm Residents Affected - Few	The nurse's note, dated 7/25/25 at 5:46 p.m., indicated to provide the resident with Ensure Plus after meals for nutritional support related to poor oral intake. The Ensure drink could not be located with all storage rooms checked. The nurse's note, dated 7/30/25 at 9:34 a.m., indicated to apply Dakins (1/2 strength) External Solution 0.25 % to the coccyx topically one time a day for wound treatment. Soak the gauze with Dakins and pack the wound and cover with mepilex. The Dakins was not found on the treatment cart and was reordered. The Braden Skin assessment, dated 7/30/25, indicated the resident had a very high risk for pressure ulcers. The nurse's note, dated 7/31/25 at 9:46 a.m., indicated to apply Dakins (1/2 strength) External Solution 0.25 % to the coccyx topically one time a day for wound treatment. Soak the gauze with Dakins and pack the wound and cover with mepilex. The Dakins was not found on the treatment cart and was reordered on 7/30/25. The nurse&rs

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	08/29/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure a resident received periodic gradual dose reductions for the anti-psychotic and anti-depressant medications to determine necessity at current dosages for 1 of 5 residents reviewed for unnecessary medications. (Resident 56) Findings include: The record for Resident 56 was reviewed on 8/27/25 at 1:33 p.m., The resident's diagnoses included, but were not limited to, cognitive communication deficit, generalized anxiety disorder, major depression recurrent, insomnia and vascular dementia with other behavioral disturbance. The physician's order, dated 4/4/24 with a secondary order dated 7/22/25, indicated staff were to administer the resident 7.5 milligrams (MG) of Clorazepate Dipotassium Oral Tablet. The resident was to receive one tablet three times a day (TID) to treat anxiety disorder. An anti-depressant was ordered on 4/28/25 for the resident to receive Trazadone HCl (hydrochloriide) 50 mg. The staff were to give one and half tablets to the resident at bedtime, to treat insomnia. Dated 2/17/25, the resident was to receive escitalopram oxalate (Lexapro) 10 mg. The staff were to administer two tablets in the morning for depression.An Annual Minimum Data Set (MDS) assessment, dated 8/2/25, indicated the resident was cognitively intact, often felt depressed and had no issues with behaviors or sleep.The review of the psychiatric and physician progress notes, between 3/1/25 and 8/29/25, indicated the resident's mood and anxiety to be stable and no issues with sleep. A pharmacy review, dated 3/24/25, indicated the resident was receiving clorazepate dipotassium oral tablet 7.5 mg three times and day for anxiety. All psychotropic medications needed to be evaluated for a gradual dose reduction (GDR) twice in the first year of therapy, and annually thereafter. Consider attempting a GDR to ensure the resident was receiving the minimum effective dose. If a GDR was not appropriate, please include a statement documenting a reason a GDR was contraindicated at that time.Documentation was lacking, between 3/24/25 and 8/29/25, of a GDR or a reason why a GDR was contraindicated for the resident.During an interview with the Social Services Director, on 8/29/25 at 12:40 p.m., she indicated she was unable to find any files where the resident had received a gradual dose reduction on the resident's anti-depressant for insomnia and the anti-anxiety medications.A review of the facility's current policy on Psychotropic Medication Use, included, but was not limited to, Policy Statement: Residents will not receive medications that are not clinically indicated to treat a specific condition. Policy Interpretation and Implementation: 1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: .anti-depressants; anti-anxiety medications; and hypnotics .16. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications.Review of the facility's current policy on Tapering Medications and Gradual Dose Reduction, included, but was not limited to, Policy Statement: .2. All medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as gradual dose reductions. 3. Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Policy Interpretation and Implementation: .3. The staff and practitioner will consider tapering of medications ass one approach to finding an optimal dose or determining whether continued use of a medication is benefiting the resident .5. The physician will periodically review whether current medications are still necessary in their current doses; for example, whether an individual's conditions or risk factors are sufficiently prominent or enduring that they require medication therapy to continue in the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medications, or with a lower dose. Cross Reference F756 3.1-48(b)(2) No Notes

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	08/29/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to ensure the prevention of UTIs (Urinary Tract Infections) and proper infection control techniques for 1 of 2 residents reviewed for bowel and bladder. (Resident 2)Findings include: During an observation, on 8/22/25 at 12:41 p.m., Resident 2's indwelling catheter tubing was laying on the floor. The resident's urine was leaking onto the floor. The urine was cloudy and pink tinged in color. The resident clinical record indicated the resident currently had a Urinary Tract Infection (UTI).During an observation, on 8/26/25 at 1:30 p.m., Resident 2's indwelling catheter tubing was observed laying on the floor. Light pink urine was observed in the tubing. The record for Resident 2 was reviewed on 8/22/25 at 2:50 p.m. The resident's diagnoses included, but were not limited to, hematuria, dehydration, acute prostatitis, benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy, urinary tract infection, and urinary retention.The care plan, dated 7/15/25, indicated the resident had an indwelling urinary catheter. The interventions included, but were not limited to, positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door, observing for pain or discomfort due to the catheter, observing as needed for signs and symptoms of a UTI, observing the tubing for kinks, and obtain intake and output as per ordered.The physician's order, dated 7/20/25, indicated staff were to provide indwelling catheter care every shift and as needed every shift. The admission (MDS) Minimum Data Set assessment, dated 7/3/25, indicated the resident was moderately cognitively intact.The nurse's note, dated 8/16/25, indicated the resident was observed to have hematuria in his indwelling catheter and dysuria with urination. A new order was received to do a uranalysis reflex with culture, a Complete Blood Count (CBC), and flush the catheter until it clears for 24 hours.The urinalysis results, dated 8/19/25, indicated the resident's urine was positive for pseudomonas fluroescens/putida. The organism was known to possess inducible Beta-Lactamase. The Nurse Practitioners (NP) note, dated 8/16/25, indicated the resident had a history of hematuria and dysuria. The resident had his indwelling catheter changed at his urology appointment per nurse patient had his indwelling catheter changed at a doctor's appointment. He complained of burning and lower abdominal pain and bladder pain. The indwelling catheter was irrigated with some clearing. A uranalysis was ordered. The physician's order, dated 8/22/25, indicated staff were to administer the resident's Cefepime 1 gram (gm) intramuscular (IM) one time a day for three days related to a UTI.The Nurse Practitioner (NP) note, dated 8/22/25, indicated the resident had been to a Urology Physician for Uroflow testing. His indwelling catheter remained at the bedside related to time a failed post void residual in the Urology office. He was continued on Flomax and the Urologist added finasteride for BPH. The resident currently had a UTI and received IM Rocephin.During an interview, on 8/28/25 at 2:00 p.m., RN 8 indicated the UTI interventions included, proper peri care, proper catheter care, encourage plenty of fluids, keep the urine bag and tubing off the floor, keep the indwelling catheter bag lower than the bladder, monitor the resident for signs and symptoms of a urinary tract infection. During an interview, on 8/28/25 at 2:15 p.m., Certified Nursing Aide 9 (CNA) indicated he would wear gloves when providing personal care, provide good peri and catheter care, hydration, and keep the indwelling catheter bag lower than the bladder. The bag should be in a dignity bag. The bag and the indwelling catheter tubing should never be touching the floor.The review of the Infection Prevention and Control Policy, dated 2017, indicated .An infection and prevention program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. 3.1-41(a)(2)

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	08/29/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to ensure nutritional supplements were provided to 2 of 9 residents reviewed for skin treatments and nutrition. (Residents 14 and 92)Findings include:1. The record for Resident 14 was reviewed on 8/26/25 at 11:10 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, multiple sclerosis, and vitamin B12 deficiency anemia.The care plan, dated 2/23/25 and revised 7/11/25, indicated the resident had a nutritional problem or potential nutritional problem related to multiple sclerosis, hypertension, gastroesophageal reflux disease, anxiety, and depression, and a pressure injury. On 4/30/25, the resident had a significant unplanned weight loss of 7.4% per month. On 5/13/25, the resident had a significant planned weight gain of 7.9% per month. On 7/6/25, the resident's diet was downgraded under hospice care. The interventions, dated 7/8/25, included, but were not limited to, the resident refused to eat and appeared concerned during meals. Staff were to obtain and monitor the resident's weight monthly and as needed (PRN); dated 4/30/25, staff were to provide and serve Ensure supplements as ordered.The nurse's note, dated 2/22/25 at 2:45 p.m., indicated the resident arrived at the facility with family members by wheelchair. The resident was alert and oriented. The wound company's initial assessment, dated 2/27/25, indicated the resident had a Stage 2 pressure ulcer to the sacral area, that measured 1 cm long by 0.4 cm wide by 0.1 cm deep. There were open areas with exposed dermis. The primary dressing was for zinc ointment to be applied twice daily for 30 days. The recommendations were to off-load the wound and to reposition per facility protocol.The wound company's assessment, dated 3/3/25, indicated the Stage 2 wound had resolved.The dietary progress note, dated 4/30/25 at 10:23 a.m., indicated the resident triggered for a significant weight loss of 7.4% of 10.4 pounds in a month. The resident's current body weight was 129.2 pounds and in March the resident weighed 139.6 pounds. The weight loss was unplanned and was due to poor oral intake. The resident tolerated a regular diet with a meal intake of 25 to 75%. The resident admitted she had never been a big eater but did enjoy the food that was served. The resident was willing to try Ensure for added nutrition support. Will continue to monitor the resident's oral intake, weight, and skin. The physician's order, dated 4/30/25, indicated the resident was to receive Ensure Plus drinks after meals for nutritional support related to poor intake.The nurse's note, dated 7/3/25 at 2:07 p.m., Ensure Plus after meals for nutritional support related to poor oral intake. The Ensure was not available.The nurse's note, dated 7/3/25 at 5:05 p.m., indicated to provide the resident with Ensure Plus after meals for nutritional support related to poor oral intake. The Ensure was not available.The nurse's note, dated 7/10/25 at 5:12 p.m., indicated to provide the resident with Ensure Plus after meals for nutritional support related to poor oral intake. The Ensure was not available.The nurse's note, dated 7/12/25 at 3:41 p.m., indicated the resident was to have comfort medications only until the resident was able to tolerate oral intake. Nectar Thickened liquids. The physician's order, dated 7/13/25, indicated to provide a diet with small portions with a dysphagia pureed texture, and thickened liquid of nectar consistency.The physician's order, dated 7/16/25, indicated to notify the hospice company for all condition changes and medication needed every shift.The nurse's note, dated 7/25/25 at 5:46 p.m., indicated to provide the resident with Ensure Plus after meals for nutritional support related to poor oral intake. The Ensure drink could not be located with all storage rooms checked.The nurse's note, dated 8/1/25 at 12:25 p.m., indicated to provide the resident with Ensure Plus after meals for nutritional support related to poor oral intake. The Ensure was not available.During a confidential interview, between 8/21/25 and 8/27/25, Staff B indicated if supplies were out of stock, the Unit Manager would be notified, because the Unit Manager could get the needed supplies quickly. The supply of Ensure nutritional supplements had run out, but she would check elsewhere to get it. Staff B would check the supply room on the 400 Hall for the Ensure.During an interview, on 8/27/25 at 2:16 p.m., Licensed Practical Nurse (LPN) 5 indicated the Ensure had run out at times. She asked the Unit Manager about it. The residents received it when they didn't take in (continued on next page)

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	08/29/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enough nutrients for their wound or if they had weight loss. During an interview, on 8/27/25 at 2:25 p.m., the Unit Manager 6 indicated she was unsure where the Ensure came from. The Ensure was a nutritional drink for weight loss or was a preferred drink for the residents. It would also help with wound healing. During an interview, on 8/28/25 at 10:08 a.m., LPN 3 indicated she had not observed any issues with Ensure being out of stock. The full-time RN for the 600 Hall kept the Ensure well stocked. The 100 Hall supply room was where the stock was supplied. There was one box of Ensure on the shelf. Hospice also supplied Ensure. Otherwise, it came from the supply company and was delivered weekly. The Unit Manager observed the charting and indicated if one RN was documenting the Ensure supply being out of stock, then it meant she did not want to go get it from supply. During an interview, on 8/29/25 at 8:10 a.m., the wound physician indicated Ensure nutrition was important for wound healing. 2. The record for Resident 92 was reviewed on 8/27/25 at 2:35 p.m. The resident's diagnoses included, but were not limited to, protein calorie malnutrition, vitamin B12 deficiency anemia, and abnormality of albumin and liver function studies. The care plan, dated 2/4/25 and revised 7/9/25, indicated the resident was at risk for malnutrition as evidenced by score of 6 out of 14 on Mini Nutritional Assessment (MNA) Nutritional Screening Tool. The interventions, dated 2/4/25, included, but were not limited to, consult dietician as indicated, notify dietitian or physician for supplementation for nutritional needs as needed, and obtain weight for gain or loss as ordered, provide ordered diet. The care plan, dated 7/19/23 and revised 6/6/25, indicated the resident had a nutritional problem or potential nutritional problem related to dysphagia, dementia, malnutrition; dated 7/25/24, the resident was malnourished related to MNA score 4 out of 14; dated 3/3/25, the resident had a significant weight loss of 9.6% per month; dated 7/31/2025, administer intravenous fluids (IVF for Hydration). The interventions, dated 7/19/23 and revised 8/30/24, included, but were not limited to; dated 1/18/24 observe for signs and symptoms of dehydration and encourage fluids; dated 7/29/24 and revised 8/30/24, observe and report to the physician as needed for signs and symptoms of malnutrition; dated 3/3/24 and revised 8/4/25, provide nutrition supplement as ordered. The dietary review note, dated 5/23/25 at 10:02 a.m., indicated the resident presented with a skin tear to the left wrist. The resident was tolerating a regular dysphagia diet with meal intake of 50 to100%. She had orders for Ensure and Pro-stat. The resident's weight was obtained on 6/2/25 and was 150 pounds,The nurse's note, dated 6/26/25 at 10:28 a.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was out.The nurse's note, dated 6/26/2025 12:59 p.m., indicated to provide Ensure Plus after meals for promote weight gain. The Ensure Plus was not available.The nurse's note, dated 6/26/2025 05:27 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available. The nurse's note, dated 6/27/2025 1:49 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The nurse's note, dated 6/27/2025 05:50 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The nurse's note, dated 6/29/2025 12:05 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The nurse's note, dated 6/29/2025 05:09 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The nurse's note, dated 6/30/2025 11:35 a.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The nurse's note, dated 6/30/2025 12:16 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The nurse's note, dated 6/30/2025 05:03 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The nurse's note dated 7/1/2025 12:40 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The nurse's note, dated 7/1/2025 12:41 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The nurse's note, dated 7/1/2025 05:20 p.m., indicated to provide Ensure Plus after meals to promote weight gain. The Ensure Plus was not available.The resident's weight of 149 pounds was obtained on 7/1/25 The physician's order, dated 7/14/25, indicated to provide the resident with a (continued on next page)

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	08/29/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regular diet, dysphagia advanced texture, and thin liquid consistency.The resident's weight was obtained on 8/1/25 and was 143 pounds. The Nutrition and Hydration to Maintain Skin Integrity policy, revised in October 2010, included, but was not limited to, . General Guidelines 1. When there is a decline in a resident's appetite, nutritional intake, weight, or overall condition, caregivers should first attempt to discover the factors compromising nutritional status and offer support with eating. 2. If intake continues to be inadequate, impractical, or impossible, nutritional support must be implemented according to the plan of care. 4. Although poor nutritional status is associated with increased risk of pressure ulcer development, no specific nutritional interventions have been proven conclusively to prevent or heal pressure ulcers. 5. Healing of acute (e.g., postoperative) and chronic (e.g., pressure ulcers) wounds requires enough protein and calories so that the body will not use lean body mass for energy and wound repair.Cross Reference F6863.1-46(a)(1)

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	08/29/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to follow up on 2 of 8 Consultant Pharmacy recommendations with the physician for 1 of 5 residents reviewed for unnecessary medications (Resident 56)Finding includedThe record for Resident 56 was reviewed on 8/27/25 at 1:33 p.m. The resident's diagnoses included, but were not limited to, cognitive communication deficit, generalized anxiety disorder, major depression recurrent, insomnia and vascular dementia with other behavioral disturbance. A Pharmacy recommendation, dated 3/24/25, indicated the resident had the following pertinent medication order: Cloazepate Doptassium Oral Tablet 7.5 mg. Staff were to administer one tablet by mouth three times a day for anxiety. Please consider a gradual reduction while monitoring for re-emergence of behavioral and/or withdrawal symptoms.R Review of the physician's orders, between March and October 2025, indicated the documentation was lacking of a response to the Pharmacy recommendation.A Pharmacy recommendation, dated 5/13/25, indicated the following: The Resident had the following pertinent medication order: carBAMazepine ER (extended release) Oral Tablet Extended Release 12 Hour 200 MG. Staff were to administer one tablet by mouth two times a day for epilepsy. It was recommended to monitor a Carbamazepine level and TSH (thyroid functions) yearly with carbamazepine therapy. Please consider ordering labs on next convenient lab day, if appropriate. Review of the physician's orders, between May and October 2025, indicated the documentation was lacking of a response to the Pharmacy recommendation. During an interview with the Director of Nursing (DON) on 8/28/25 at 1:30 p.m., she indicated the pharmacy liaison emailed the recommendations to her and she then printed them out and gave them to the appropriate Physician/Nurse Practitioner (NP) to address. Once they were completed, they were returned to her and she would forward them back to the liaison. The Physicians/NP usually returned them within a week to her. The Physicians/NP wrote their own orders. She could not account as to why these two recommendations were not addressed.Review of the facility's current policy on Medication Monitoring, included, but was not limited to, Policy:.The pharmacist must report any irregularities to the Attending Physician, the facility's Medical Director and the Director of Nursing, and these reports must be acted upon in a manner that meets the needs of the resident and regulatory regulations. Procedure:.4. A written report of all irregularities and recommendations resulting from the medication regimen review are provided a facility designee for the Attending Physician, Director of Nursing and Medical Director.4b. Report will be submitted within the same day as the actual review.7. For non-urgent recommendations, the Facility and Attending Physician must address the recommendation(s) in a timely manner that meets the needs of the resident - but no later than their next routine visit to assess the resident - and the Attending Physician should document in the medical record: a. What the irregularity has been reviewed; b. What action has been taken to address the issues.9. If the Attending Physician fails to address a recommendation or document a rationale for rejecting a recommendation: a. The Director of Nursing will be notified, and a summary shall be provided to the QAPI (Quality Assurance Performance Improvement) committee on a periodic basis. b. The DON, Medical Director or designee should review the incomplete recommendation with the Attending Physician.Cross Reference F605 3.1-25(j)