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	12/30/2024

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 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. 34231 Based on interview and record review, the facility failed to ensure the physician was notified of a resident's (Resident K) low blood pressure and continuous complaints of shortness of breath for 1 of 3 residents reviewed of notification of changes. Findings include: The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnoses included, but were not limited to, diabetes, acute respiratory failure with hypoxia, congestive heart failure and hypertension. The resident's September 2024 Medication Administration Record indicated staff were to observe the resident for shortness of breath on day shift, evening shift and night shift. The September 2024 Medication Administration Record indicated the resident was short of breath on 9/3/24 during night shift and on 9/4/24 during all three shifts. The progress note, dated 9/4/24 at 2:01 p.m., indicated the resident reported feeling weak. The resident was assessed with a blood pressure of 80/50 while lying and 93/37 while sitting (a standard blood pressure was 120/80). The resident asked to lay down, because she was cold and a bit tired. The resident was assisted by staff to a comfortable position in the bed and her call light was in reach. The progress note, dated 9/4/24 at 6:26 p.m., indicated the resident had an episode where she felt shortness of air. The residents' fan was turned on to cool her and the resident was assisted to reposition. The resident's hand fan and breathing techniques helped her to calm down. The clinical record lacked documentation of a physician's notification related to the resident's low blood pressure and shortness of breath. During an interview on 12/30/24 at 2:55 p.m., RN (Registered Nurse) 4 indicated if a resident had an abnormally low blood pressure and complained of shortness of breath, the physician should be notified immediately. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/24 at 4:13 p.m., the Director of Nursing provided a current copy of the document titled Change in Condition: When to report to the MD/NP/PA .Vital Sign .Blood Pressure .Systolic BP <90 .Symptom or Sign . Dyspnea (shortness of breath This Citation relates to Complaint IN00449144 3.1-5(a)(2)

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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. 34231 Based on interview and record review, the facility failed to ensure the licensed staff accurately assessed a residents' (Resident K) vital signs for skilled charting and obtain vital signs daily for 1 of 3 resident's skilled assessments reviewed for quality of care. Findings include The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, congestive heart failure and acute respiratory failure with hypoxia. The daily skilled note, dated 8/30/24 at 12:32 p.m., indicated the resident had the following vital signs: -blood pressure of 113/58 obtained on 8/29/24 at 8:26 p.m. -oxygen saturation of 97% on room air obtained on 8/29/24 at 8:26 p.m. -temperature of 97.9 obtained on 8/29/24 at 8:26 p.m. -heart rate of 68 obtained on 8/29/24 at 8:26 p.m. -respirations 18 obtained on 8/29/24 at 8:26 p.m. The daily skilled note, dated 8/31/24 at 4:51 p.m., indicated the resident had the following vital signs: -blood pressure of 113/58 obtained on 8/29/24 at 8:26 p.m. -oxygen saturation of 97% on room air obtained on 8/29/24 at 8:26 p.m. -temperature of 97.9 obtained on 8/29/24 at 8:26 p.m. -heart rate of 68 obtained on 8/29/24 at 8:26 p.m. -respirations 18 obtained on 8/29/24 at 8:26 p.m. The daily skilled note, dated 9/2/24 at 10:57 a.m., indicated the resident had the following vital signs: -blood pressure of 113/58 obtained on 8/29/24 at 8:26 p.m. -oxygen saturation of 97% on room air obtained on 8/29/24 at 8:26 p.m. -temperature of 97.9 obtained on 8/29/24 at 8:26 p.m. (continued on next page)

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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	-heart rate of 68 obtained on 8/29/24 at 8:26 p.m. -respirations 18 obtained on 8/29/24 at 8:26 p.m. The daily skilled note, dated 9/3/24 at 2:51 a.m., indicated the resident had the following vital signs: -blood pressure of 137/78 obtained on 9/2/24 at 12:39 p.m. -oxygen saturation of 84% on 9/2/24 at 12:40 p.m. -temperature of 97.9 obtained on 8/29/24 -heart rate of 72 obtained on 9/2/24 at 12:39 p.m. -respirations of 18 obtained on 8/29/24 at 8:26 p.m. The resident's clinical record lacked documentation of vital signs obtained for the resident on 8/30/24, 8/31/24 and 9/1/24. During an interview on 12/30/24 at 2:55 p.m., RN (Registered Nurse) 4 indicated nurses should obtain current vital signs prior to completing skilled charting and never use another nurses previous vital signs. During an interview on 12/30/24 at 4:13 p.m., the Director of Nursing indicated the nursing staff should obtain their own vital signs for the skilled charting. Upon admission, if a skilled resident, vital signs should be obtained each shift for 72 hours and then daily after that. This Citation relates to Complaint IN00449144 3.1-37

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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 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. 34231 Based on observation, interview and record review, the facility failed to ensure staff documented urine output for residents' with indwelling catheters for 3 of 4 residents reviewed for bowel and bladder. (Residents B, F and G) Findings include: 1. The clinical record for Resident B was reviewed on 12/27/24 at 10:07 a.m. The resident's diagnosis included, but was not limited to, obstructive and reflux uropathy. The care plan, dated 8/30/24, indicated the resident had an indwelling catheter and to monitor urine output. The physician's order, dated 9/19/24, indicated to document urine output every day shift and every night shift. Review of the October 2024, November 2024 and December 2024 medication administration records lacked documentation of the resident's urine output on the following dates and shifts: -10/04/24 on night shift -10/13/24 on night shift -10/15/24 on night shift-10/22/24 on night shift -11/16/24 on day and night shift -11/17/24 on day shift -11/20/24 on day shift -12/01/24 on night shift -12/08/24 on night shift -12/17/24 on night shift During an interview on 12/30/24 at 2:55 p.m., RN (Registered Nurse) 4 indicated residents with indwelling catheters should have the urine output documented on the treatment administration record every shift. 2. The clinical record for Resident F was reviewed on 12/27/24 at 12:30 p.m. The resident's diagnoses included, but were not limited to, stage 4 kidney disease and uropathy. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan, dated 12/26/24, indicated the resident had an indwelling catheter and to obtain the output as ordered. The physician's order, dated 12/16/24, indicated to document the resident's urine output on day shift and night shift. Review of the December 2024 treatment administration record lacked documentation of the resident's urine output on 12/22/24 for night shift. 3. The clinical record for Resident G was reviewed on 12/27/24 at 12:45 p.m. The resident's diagnosis included, but was not limited to, obstructive and reflux neuropathy. The care plan, dated 12/4/24, indicated the resident had an indwelling catheter and to obtain the urine output as ordered. The physician's order, dated 12/5/24, indicated to document the resident's output every day and night shift. The December 2024 treatment administration record lacked documentation of the output for night shift on 12/9/24 and 12/17/24. During an interview on 12/30/24 at 5:02 p.m., the Director of Nursing indicated the facility did not have a policy regarding physician's orders. This Citation relates to Complaint IN00447226

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 34231 Based on interview and record review, the facility failed to ensure staff followed a resident's fluid restriction order from the physician, for 1 of 3 residents reviewed for hydration. (Resident K) Findings include: The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnosis included, but was not limited to, congestive heart failure. The physicians' note, dated 9/1/24 at 12:32 p.m., indicated the resident had gained 5 pounds in 24 hours and to limit the resident's fluid intake to 1,500 cc's (cubic centimeters) in a 24 hour period. Review of the September 2024 fluid intake record indicated the resident consumed the following fluid totals in a 24 hour period: - On 9/2/24, the resident's fluid intake was documented as 2,900 cc. - On 9/3/24, the resident's fluid intake was documented as 1,580 cc. - On 9/4/24, the resident's fluid intake was documented as 2,560 cc. The clinical record lacked documentation of the implementation of the order on 9/1/24. During an interview on 12/30/24 at 4:13 p.m., the Director of Nursing indicated she felt the physician did not relay the order to the nursing staff. On 12/30/24 at 4:13 p.m., the Director of Nursing provided a current copy of the document titled Encouraging and Restricting Fluids dated 10/2010. It included, but was not limited to, Purpose .The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include .restricting fluids .General Guidelines .Follow specific instructions concerning fluid intake or restrictions This Citation relates to complaint IN00449144 3.1-46(a)(1)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34231 Based on observation, interview and record review, the facility failed to ensure the physician's orders were in place for weekly maintenance of the nebulizer equipment (Resident B and Resident H); failed to ensure a nebulizer face mask was stored appropriately and the tubing was dated (Resident B); and failed to ensure physician's orders were in place for routine oxygen administration (Resident K) for 3 of 4 residents reviewed for respiratory. Findings include: 1. The clinical record for Resident B was reviewed on 12/27/24 at 10:07 a.m. The resident's diagnoses included, but were not limited to, asthma and chronic obstructive pulmonary disease. During an observation on 12/30/24 at 10:34 a.m., the resident's nebulizer face mask was lying on the shelf next to the resident's bed, not bagged and undated. The physician's order, dated 9/7/24, indicated the resident was to receive Ipratropium-Albuterol, 3 ml (milliliters) via nebulizer for times a day for shortness of air. The residents clinical record lacked documentation of daily and weekly maintenance of the resident's respiratory equipment. During an interview on 12/30/24 at 2:55 p.m., RN (Registered Nurse) 4 indicated nebulizer face masks and the nebulizer cup should be rinsed after each use and left to air dry. Once dried, the face mask should be placed in a bag. All nebulizer tubing should be dated and changed out weekly. Any resident with oxygen should have a physician's order in place for the oxygen. 2. The clinical record for Resident H was reviewed on 12/27/24 at 1:34 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic respiratory failure. The physician's order, dated 6/20/23, indicated the resident was to receive budesonide inhalation suspension, 3 ml twice daily for chronic obstructive pulmonary disease. The residents clinical record lacked documentation of daily and weekly maintenance of the resident's respiratory equipment. 3. The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and acute respiratory failure with hypoxia. The hospital discharge records, dated 8/28/24, indicated on discharge the resident was not using oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress note, dated 9/2/24 at 1:03 p.m., indicated the resident was assessed per the family request. The resident's oxygen saturation was 84% on 2 liters of oxygen. The nurse practitioner was notified with a new order to increase the oxygen to help raise the resident's oxygen saturation. The clinical record lacked documentation of any physician's orders for the resident's oxygen administration. During an interview on 12/30/24 at 4:13 p.m., the Director of Nursing indicated the resident was on oxygen and should have had an order in place for the oxygen. On 12/30/24 at 5:30 p.m., the Director of Nursing provided a current copy of the document titled Respiratory Infection Control dated 4/1/2012. It included, but was not limited to, Purpose .To provide infection control guidelines to help prevent infections associated with respiratory therapy equipment and to prevent the transmission of infections to residents and staff .Medication Nebulizers/Continuous Aerosol .Remove nebulizer container .Rinse container and mask or mouth piece with sterile water .Allow to dry on a clean paper towel or gauze sponge .Store .in a plastic bag .Discard administration set-up weekly .Clean and disinfect the nebulizer unit weekly and as needed This Citation relates to Complaints IN00447226 and IN00449144. 3.1-47(a)(6)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 34231 Based on interview and record review, the facility failed to ensure an order to increase a resident's Lasix (diuretic) was implemented for 1 of 3 residents reviewed for significant medication errors. (Resident K) Findings include: The clinical record for Resident K was reviewed on 12/27/24 at 9:30 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure (CHF) and edema. The admission order, dated 8/28/24, indicated the resident was to receive Lasix 20 mg (milligrams) daily for CHF. The physician's note, dated 9/1/24 at 12:32 p.m., indicated the resident had 1+(plus) pitting edema to her bilateral lower extremities and had a five-pound weight gain in a 24-hour period. New orders were given for the resident to start Lasix 20 mg twice daily for three days then return to the 20 mg daily dose on the fourth day. The September 2024 Medication Administration Record indicated the resident received the medication twice daily on 9/1/24, 9/2/24, and on the morning of 9/3/24. The nurse practitioner follow-up note, dated 9/3/24, indicated the resident reported she had been short of breath over the weekend and that her water pill had been increased. The registered dietitian reported the resident had a 13-pound weight gain and the resident had 2+ pitting edema to her lower extremities. The resident was to continue Lasix 40 mg twice daily for two days. The physician's order, dated 9/3/24 at 11:30 p.m., indicated the resident was to start Lasix 40 mg twice daily for two days beginning on 9/4/24. The September 2024 Medication Administration Record lacked documentation of the administration of the resident's increased Lasix on 9/3/24 in the evening and the administration of any Lasix on 9/4/24. During an interview on 12/30/24 at 4:13 p.m., the Director of Nursing indicated the medication should have been implemented and it was not. The facility did not have a policy on medication administration; however, the facility followed the medication administration per the state guidance. On 12/30/24 at 4:13 p.m., the Director of Nursing provided a copy of the document titled Medication Administration Observation dated 11/2017. It included, but was not limited to, General Medication Administration .Medications administered as ordered This Citation relates to Complaint IN00447226 3.1-48(a)