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	12/11/2025

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 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 follow medication administration parameters (Resident F and Resident K) for 2 of 3 residents reviewed for quality of care.Findings include: The clinical record for Resident F was reviewed on 12/8/25 at 2:53 p.m., The resident's diagnoses included, but were not limited to, hypertension and heart failure. The care plan, dated 4/16/25, indicated the resident had altered cardiovascular status due to hypertension and to administer medications as ordered. The physician's order, dated 8/22/25, indicated the resident was to receive Metoprolol Tartrate (medication for high blood pressure) 25 mg (milligrams) twice a day at 8:00 a.m. and 8:00 p.m. The medication was to be held if the resident's systolic blood pressure was less than 110. The September 2025 medication administration record indicated the resident received the medication on the following dates and times: -9/06/25 at 8:00 with a systolic blood pressure of 104-9/12/25 at 8:00 a.m. with a systolic blood pressure of 90 During an interview on 12/10/25 at 9:28 a.m., Staff Member 8 indicated if a resident's blood pressure was out of parameter, the medication should not be given. 2. The clinical record for Resident K was reviewed on 12/9/25 at 1:52 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular disease and hypertension.The care plan, dated7/16/25, indicated the resident had altered cardiovascular status related to hypertension and to administer medications as ordered.The physician's order, dated 8/22/25, indicated the resident was to receive Metoprolol Succinate Extended Release (medication for high blood pressure) 100 mg daily in the morning for hypertension. The medication was to bed held if the resident's heart rate was less than 60.Review of the November 2025 and December 2025 medication administration indicated the resident received the medication on the following dates:-11/03/25 with a heart rate of 59-11/17/25 with a heart rate of 54-11/20/25 with a heart rate of 58-12/03/25 with a heart rate of 53 On 12/10/25 at 10:47 a.m., the Regional [NAME] President of Clinical Operations provided a current copy of the document titled Medication Administration dated 6/21/17. It included, but was not limited to, Policy.Medications will be administered.consistent with accepted standards of practice. This Citation relates to Intakes 2665096, 2670042 and 2675349 3.1-37

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on interview and record review, the facility failed to ensure a resident's (Resident B) PICC (peripherally inserted central catheter) line dressing changes were completed for 1 of 1 resident reviewed for quality of care.Findings include: The clinical record for Resident B was reviewed on 12/8/25 at 10:32 a.m. The resident's diagnosis included, but was not limited to, cellulitis of the lower right leg. The physician's order, dated 9/29/25, indicated the resident was to receive Cefepime HCl (hydrochloride), 2 GM (grams) intravenously three times a day for a total of 115 doses at 12:00 a.m., 8:00 a.m. and 4:00 p.m. The resident's last dose was administered on 11/7/25 at 12:00 a.m. The clinical record lacked documentation of PICC line dressing changes throughout the course of the antibiotic administration. During an interview on 12/10/25 at 11:13 a.m., Staff Member 9 indicated PICC line dressing changes should be completed every 7 days. On 12/11/25 at 11:10 a.m., the [NAME] President of Clinical Operation provided a current copy of the document titled Peripheral and Midline IV Dressing Changes dated October 2024. It included, but was not limited to, Purpose.This purpose of this policy is to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings.General Guidelines.Change the dressing if it becomes damp, loosened or visibly soiled and.at least every 7 days. This Citation relates to Intakes 2665096, 2670042 and 2675349 3.1-47(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 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. Based on interview and record review, the facility failed to ensure respiratory assessments were in place for residents (Resident C, Resident D and Resident H) receiving nebulizer treatments for 3 of 4 residents reviewed for respiratory care.Findings include:1.The clinical record for Resident C was reviewed on 12/8/25 at 11:09 a.m. The resident's diagnoses included, but was not limited to, dyspnea, chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease.The physician's order, dated 10/22/25, indicated the resident was to receive Budesonide Inhalation Suspension (medication administered via nebulizer to make breathing easier), 0.5 mg (milligrams)/2 ml (milliliters) one vial orally via nebulizer twice daily for shortness of breath.The physician's order, dated 10/22/25, indicated the resident was to receive Ipratropium-Albuterol Inhalation Solution (medication administered via nebulizer used to treat bronchospasms), 3 ml every 6 hours for shortness of breath.The clinical record lacked documentation of completed respiratory assessments before, during and after the administration of the medication.During an interview, on 12/10/25 at 9:28 a.m., Staff Member 8 indicated respiratory assessments should be completed on residents throughout the treatment to ensure the breathing treatment was effective. The assessment included obtaining the residents' pulse, respirations and listening to lung sounds prior to the treatment and document those on the treatment record. After treatment, the nurse should again check the residents' pulse, respirations and lung sounds which would be documented on the treatment record.2. The clinical record for Resident D was reviewed on 12/8/25 at 2:23 p.m. The residents' diagnosis included, but was not limited to, wheezing.The physician's order, dated 10/22/25, indicated the resident was to receive Ipratropium-Albuterol, 3 ml via nebulizer two times a day for wheezing. The clinical record lacked documentation of completed respiratory assessments before, during and after the administration of the medication. 3. The clinical record for Resident H was reviewed on 12/9/25 at 11:21 a.m. The residents' diagnoses included, but were not limited to, anxiety and chronic obstructive pulmonary disease. The physician's order, dated 11/15/25, indicated the resident was to receive Ipratropium-Albuterol Inhalation Solution, 3 ml via nebulizer every 6 hours. The clinical record lacked documentation of completed respiratory assessments before, during and after the administration of the medication. On 12/11/25 at 9:35 a.m., the [NAME] President of Clinical Operations provided a current copy of the document titled Administering Medications through a Small Volume (Handheld) Nebulizer dated October 2010. It included, but was not limited to, Purpose.The purpose of this procedure is to safely and asepticall administer aerosolized particles of medication into the resident's airway.Steps in the Procedure.Obtain baseline pulse, respiratory rate and lung sounds.Approximately 5 minutes after treatment begins.obtain the resident's pulse.Obtain post-treatment pulse, respiratory rate and lung sounds. This Citation relates to Intakes 2665096, 2670042 and 2675349 3.1-47(a)(6)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure monitoring was in place for a resident (Resident H) receiving hemodialysis for 1 of 1 resident reviewed for quality of care.Findings include:The clinical record for Resident H was reviewed on 12/9/25 at 11:21 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease and dependence of renal dialysis. The resident discharged to the hospitalOn 12/9/25 at 10:38 a.m., the resident was observed with a dialysis fistula to his left antecubital space.The care plan, dated 8/31/22, indicated the resident had an alteration in kidney function due to end stage renal disease and dependence on renal dialysis. Nursing interventions included, but were not limited to, check the fistula site for signs and symptoms of infection, no blood pressure or lab draws in the right arm, dialysis center only to access site, observe for post-dialysis hangover including vital signs, mental status, excessive weight gain between treatments, nausea, vomiting, weakness, headache and severe leg cramps, observe for signs and symptoms of bleeding, and observe thrill and bruit daily and document findings.The physician's order, dated 3/24/25, indicated the resident was to receive dialysis every Monday, Wednesday and Friday.The physician's order, dated 3/24/25, indicated to check vital signs post-dialysis every shift for 24 hours.The physician's order, dated 3/26/25, indicated to check vital signs prior to dialysis.The physician's order, dated 3/24/25, indicated to obtain the resident's weight three times a week on Monday, Wednesday and Friday post-dialysis.The physician's order, dated 3/24/25, indicated to auscultate Bruit and palpate thrill every shift.The physician's order, dated 3/24/25, indicated if bleeding occurs from dialysis port, apply pressure and call 911.The physician's order, dated 3/24/25, indicated to observe the fistula site for signs and symptoms of infection every shift.The progress note, dated 11/12/25 at 6:52 a.m., indicated the resident was sent to the hospital for evaluation.The progress note, dated 11/15/25 at 2:10 a.m., indicated the resident readmitted to the facility on [DATE] at 9:15 p.m.The clinical record lacked documentation of any physician dialysis orders between 11/15/25 and 12/10/25. During an interview on 12/11/25 at 9:45 a.m., the [NAME] President of Clinical Operations indicated the previous dialysis orders should have been in place upon hospital return.This Citation relates to Intakes 2665096, 2670042 and 26753493.1-37(a)