STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155224	B. WI	NG		11/01/2024	
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANSVILLE, IN 47710			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
F 0000							
Bldg. 00	This visit was for a	Recertification and State	F 00	000	This Plan of Correction constit	utes	
	Licensure Survey.	This visit included the			the written allegation of		
	Investigation of Co	omplaints IN00440519,			compliance for the deficiencies	S	
	IN00440582, IN00	441713, and IN00445070.			cited. However, submission of Plan of Correction is not an	this	
	Complaint IN0044	0519 - No deficiencies related to			admission that a deficiency ex	ists	
	the allegations are				or that one was cited correctly		
	C				The Plan of Correction is		
	Complaint IN0044	0582 - No deficiencies related to			submitted to meet requiremen	ts	
	the allegations are	cited.			established by state and feder		
					law. Columbia Healthcare des		
	Complaint IN00441713 - No deficiencies related to the allegations are cited.				this Plan of Correction to be		
					considered the facility's Allega	tion	
					of Compliance.		
	Complaint IN0044	5070 - No deficiencies related to					
	the allegations are	cited.					
		ber 24, 25, 28, 29, 30, 31 and					
	November 1, 2024.	•					
	E:1:10(20120					
	Facility number: 00 Provider number: 1						
	AIM number: 1002						
	Anvi number: 1002	200780					
	Census Bed Type:						
	SNF/NF: 111						
	Total: 111						
	10						
	Census Payor Type	e:					
	Medicaid: 93						
	Other: 18						
	Total: 111						
	These deficiencies	reflect State Findings cited in					
	accordance with 41	0 IAC 16.2-3.1.					
	Quality review con	npleted on November 13, 2024.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

Event ID: 0STT11 Facility ID: If continuation sheet Page 1 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155224	B. W	NG		11/01/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER			SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
			1110			Bille	
F 0580 SS=D	483.10(g)(14)(i)-(i						
Bldg. 00	Notify of Changes (Injury/Decline/Room, etc.)						
Diug. 00	Raced on interview	and record review, the facility	F 05	500	What corrective action(s) wil		11/20/2024
		physician of blood glucose	F 0.	980	What corrective action(s) will be accomplished for those	1	11/29/2024
		rameters for 1 of 2 residents			residents found to have been	•	
	_	n administration. (Resident 59)			affected by the deficient	Ī	
	Teviewed for insum	radiffinistration. (resident 37)			practice?		
	Finding includes:						
	S				Resident #59 was treated	for	
	On 10/29/24 at 12:5	59 P.M., Resident 59's clinical			infection. Blood sugar is now		
		d. Diagnoses included, but			within normal range. No other	r	
	were not limited to,	diabetes mellitus.			residents affected by alleged		
					deficient practice. Resident is		
	The most recent Qu	arterly Minimum Data Set			receiving appropriate care per	MD	
	(MDS) Assessment	, dated 9/29/24, indicated			order for elevated blood gluco	se	
	Resident 59 was no	t assessed for cognitive			levels		
	1 -	e the resident was rarely or					
		nd the resident received			How will the facility identify		
	insulin 7 days durin	g the 7-day lookback period.			other residents having the		
					potential to be affected by th	е	
	1	cluded, but were not limited to:			same deficient practice?		
	,	d glucose monitoring system)			All residents with daily		
		physician if Accu-check is			glucose monitoring have the		
	than 400 mg/dL, da	per deciliter (mg/dL) or greater			potential to be affected by the		
	man 400 mg/aL, da	ied 4/22/20			alleged deficient practice. An audit for all residents w	ıith.	
	A risk for adverse e	ffects of hyperglycemia or			orders for daily glucose monitor		
		ed to use of glucose lowering			was completed to ensure	Jilly	
		liagnosis of diabetes mellitus			physician orders were followed	d	
		/20 and reviewed 9/25/24,			Nurses were in-serviced of		
	_	ntion to document abnormal			change of condition and when		
	findings and notify				to report by the DNS/Designer		
					, ,g		
	A vital sign report,	dated 7/6/24 at 10:06 A.M.,			What measures will be put in	ito	
	indicated the blood	glucometer read "HI" (blood			place or systematic changes		
	glucose level greate	er than 600 mg/dL).			made to ensure that the		
					deficient practice will not		
		R indicated the physician was			reoccur?		
	not notified of Resi	dent 59's elevated blood					

PRINTED: 01/02/2025

DEPARTMENT	OF HEALTH AND HUM	MAN SERVICES				FOR	RM APPROVED
CENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPL	ETED
		155224	B. WING			11/01/2024	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST				
COLUMBIA HEALTHCARE CENTER				EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDENCE NAME CORRECTION			(X5)

	BIA HEALTHCARE CENTER		VANSVILLE, IN 47710		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG		DATE	
	glucose level on 7/6/24.		Inservice for nursing staff on		
	1 17/6/24 11 01		Change of Condition, Head to Toe		
	A Nursing progress note, dated 7/6/24 at 11:01		Assessments with Documentation		
	P.M., indicated the lab called the facility at 6:00		Guidelines, and Procedures for		
	P.M. to report Resident 59 had a critical blood		Out-of-Range Blood Sugars.		
	glucose level of 526 mg/dL. The NP was texted		DNS/Designee will review		
	and called by Licensed Practical Nurse (LPN) 6		facility activity report daily to		
	about critical lab value. A response was not received.		monitor for out-of-range blood		
			sugars and to ensure MD is		
			notified per parameters.		
	The clinical record lacked documentation of follow				
	up with the physician about Resident 59's critical		How will the facility monitor its		
	blood glucose level between 7/6/24 at 11:01 P.M.		corrective actions to ensure		
	and 7/7/24 at 8:54 A.M.		that the deficient practice will		
			not recur?		
	A Nursing progress note, dated 7/7/24 at 8:54				
	A.M., indicated the nurse attempted to contact		The DNS/Designee will be		
	the NP again for the critical blood glucose level.		responsible for the completion of		
			the Timely Notification and		
	During an interview with the Nurse Practitioner		Documentation When Blood Sugar		
	(NP) on 11/1/24 at 9:00 A.M., the NP indicated		Out of Range QA tools weekly x 4		
	staff texted her and if there was no response after		weeks, monthly x 6, then quarterly		
	15 to 30 minutes, they would call her. If she still		x 2 until continued compliance is		
	didn't respond, they were to call the on-call		maintained for 2 consecutive		
	physician.		quarters. The results of the audits		
			will be reviewed by the QAPI		
	On 11/1/24 at 11:33 A.M., the Administrator		committee overseen by the ED. If		
	provided a current Blood Glucose Monitoring		a threshold of 100% is not		
	policy, dated 2/2015, that indicated "The		achieved, an action plan will be		
	physician will be notified when the resident's		developed.		
	blood glucose is outside the physician stated				
	parameters or if the resident is experiencing signs				
	or symptoms of high or low blood sugars".				
	On 11/1/24 at 2:06 P.M., the Administrator				
	provided a current Resident Change of Condition				
	policy, dated 12/17, that indicated "It is the policy				
	of this Community that changes in resident				
	condition will be communicated to the physician				
	and family/responsible party, and that				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULT A. BUILD B. WING	IPLE CONSTRUCTION DING <u>00</u>	COMPL	(X3) DATE SURVEY COMPLETED 11/01/2024	
	PROVIDER OR SUPPLIER		6	TREET ADDRESS, CITY, STATE, ZIP COD 21 W COLUMBIA ST VANSVILLE, IN 47710	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRE	D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODUCTION OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODUCTION OF CORRECTIVE ACTION OF CORRECTIV	BE	(X5) COMPLETION DATE
F 0656 SS=D Bldg. 00	occurs All nursin and resident assessed documented in the I or serious change in manifested by a manifested by a manifested by a manifested by and/or act to contact attending will be transferred ff Documentation will family/physician residually/physician re		F 0656	How will the corrective ac be accomplished for resident to be affected by deficient practice? Resident #85 current or plans were reviewed and use to include a care plan for frourinary Tract Infections. How will the facility identionate other residents having the potential to be affected by same deficient practice? All residents have the potential to be affected An audit of residents will more UTI's have been reviand care plans have been IDT will review orders deficient or residents designed.	are updated requent ify e y the th 2 or ewed added.	11/29/2024

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Event ID:

0STT11

Facility ID: 000129

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED	
MUDILAN	or condition	155224	B. W			11/01/2	
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
COLUME	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	-	I to maximum assistance with al hygiene, was incontinent of			Morning Meeting that require		
		had a primary diagnosis of			or updated care plans related	1 10	
		structive pulmonary disease),			frequent UTIs.		
	· ·	infection within the last 30			What measures will be put i	nto	
	-	enous catheter, had been on			place and what systemic	iilo	
	intravenous medications, required isolation				changes will be made to		
	precautions, and was on antibiotics.				ensure that the deficient		
	precautions, and was on antibiotics.				practice does not recur?		
	Current physician orders included but was not				product account recall		
		colonized with ESBL			In-service include IDT Care	Plan	
		n beta-lactamase, causes			Pathways and Care Plan Libr	aries	
	problems in efficacy of antibiotics making				related to UTIs.		
	infection resistant to treatment) dated, 9/6/22.				All care plans of residents	with	
					1 or more urinary tract infection		
	On 11/1/24 at 9:45	A.M., the DON (Director of			will be audited to ensure a care		
	Nursing) indicated	that she would have expected		plan has been developed to meet			
	Resident 85 to have	e an ongoing careplan related		the medical needs of the resident			
	to recurrent urinary	tract infections and			by the DNS/Designee.		
	colonization of ESI	BL in the resident's urine.					
					How will the facility monitor	its	
		by the Administrator on			corrective actions to ensure	•	
		M., titled IDT Comprehensive			that the deficient practice w	ill	
	•	ndicated "it is the policy of this			not recur?		
	facility that each re						
		omprehensive person-centered			The MDS/Designee will be		
		d and implemented based on			responsible for the completion		
		sment Instrument process.			the Comprehensive Care Pla	~	
		include measurable goals and			in Place for Chronic UTI QA t		
	_	terventions based on the			weekly x 4 weeks, monthly x		
		preferences to promote the			then quarterly x 2 until contin		
		evel of functioning including			compliance is maintained for		
	medical, nursing, n	nental, and psychosocial			consecutive quarters. The res		
	wen-benig.				of the audits will be reviewed	- 1	
	3.1-35(a)				the QAPI committee oversee the ED. If a 100% is not achie	-	
	3.1-35(a) 3.1-35(b)(1)				an action plan will be develop		
	3.1-33(0)(1)				i an action plan will be develop	cu.	
F 0684	483.25						
SS=G	Quality of Care						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/01/2024 155224 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 621 W COLUMBIA ST COLUMBIA HEALTHCARE CENTER **EVANSVILLE, IN 47710** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 00 Based on interview and record review, the facility F 0684 How will the corrective action 11/29/2024 failed to ensure effective services to treat elevated be accomplished for residents blood glucose levels were provided in accordance found to be affected by with the physician and Nurse Practitioner (NP) deficient practice? orders for 1 of 2 residents reviewed for insulin administration. (Resident 59) This deficient Resident 59 was treated for practice resulted in the resident requiring infection. Blood glucose level is emergent transport to an acute care hospital now within normal range. No other intensive care unit for the treatment of diabetic residents affected by alleged ketoacidosis (DKA) (a life-threatening deficient practice. Resident is complication of diabetes that occurs when the receiving appropriate care per MD body doesn't have enough insulin to use blood order for elevated blood glucose sugar for energy.) levels Finding includes: How will the facility identify On 10/29/24 at 12:59 P.M., Resident 59's clinical other residents having the record was reviewed. Diagnoses included, but potential to be affected by the were not limited to, diabetes mellitus. same deficient practice? The most recent comprehensive Significant All Residents with daily glucose Change Minimum Data Set (MDS) Assessment, monitoring have the potential to be dated 3/21/24, indicated Resident 59 was not affected. assessed for cognitive impairment because the An audit for all residents with resident was rarely or never understood and the orders for daily glucose monitoring resident received insulin 6 days during the 7-day was completed to ensure lookback period. physician orders were followed by DNS/Designee. The most recent Quarterly Minimum Data Set Nursing staff educated on (MDS) Assessment, dated 9/29/24, indicated Resident Change of Condition Resident 59 was not assessed for cognitive Policy, Change of Condition-When impairment because the resident was rarely or to Report, and Head to Toe never understood and the resident received Assessment protocol by insulin 7 days during the 7-day lookback period. DNS/Designee. A risk for adverse effects of hyperglycemia or What measures will be put into hypoglycemia related to use of glucose lowering place and what systemic medication and/or diagnosis of diabetes mellitus changes will be made to care plan, dated 4/7/20 and reviewed 9/25/24, ensure that the deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPL	ETED
		155224	B. W	ING		11/01/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			COLUMBIA ST		
COLLIME	BIA HEALTHCARE	CENTER			SVILLE, IN 47710		
OOLOWL		<u> </u>		LVANO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ention to document abnormal			practice does not recur?		
	findings and notify	the physician.					
					Nursing Staff will be in-servi		
		sician's order recapitulation			on Resident Change of Condi		
	· ·	not limited to, orders for staff to			Policy, Change of Condition-V	Vhen	
	administer 20 units of insulin glargine (a				to Report, and Head to Toe		
) once daily at bedtime,			Assessment protocol.		
		nt's blood glucose once daily,			Daily audit by DNS/Desig		
		sician if Accu-check result is			for all residents with physiciar		
	1	n per deciliter (mg/dL) or greater			orders for insulin/daily glucose)	
	than 400 mg/dL.				monitoring are followed.		
					DNS/Designee will review	/	
	A vital sign report, dated 7/2/24 at 10:14 A.M.,				facility activity report daily to		
	indicated Resident 59's blood glucose level was				monitor for out of range blood		
	490 mg/dL.				sugars and to ensure MD is		
					notified per parameters.		
	-	dication Administration Record					
	1 1	ne physician was notified of the					
	elevated blood glud	cose level on 7/2/24.			How will the facility monitor		
					corrective actions to ensure		
	_	, medication administration			that the deficient practice wi	II	
		rms, dated 7/2/24, lacked			not recur?		
		letermine the physician			TI DNG/D : :::		
	_	facility staff made attempts to			The DNS/Designee will be		
	_	physician to address the			responsible for the completion	ı ot	
	elevated blood glud	cose ievei.			the Quality of Care and	- 4-	
	The presence and	aggaggments			Documentation of Notification		
	The progress notes				include medication administra		
	_	ion tools, physician orders, ninistration notes lacked			observation during medication		
					pass with immediate notification		
		ndicate a physician response			for out of range blood sugar C		
		e facility staff followed up with			tool weekly x 4 weeks, month	-	
	7/6/24 at 1:55 P.M.	een 7/2/24 at 10:14 P.M. and			6, then quarterly until continue		
	1/0/24 at 1:33 P.M.	•			compliance is maintained for 2		
	A vital sion manage	dated 7/6/24 at 10:06 A.M.,			consecutive quarters. The res		
		glucometer read "HI" (blood			of the audits will be reviewed	-	
		er than 600 mg/dL).			the QAPI committee overseer	-	
	glucose level great	er man 000 mg/aL).			the ED. If threshold of 100% is		
	The July 2024 MA	D indicated the physician was			achieved, an action plan will b	e	
	I THE JULY 2024 MA	R indicated the physician was			developed.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155224	B. W	ING		11/01	/2024	
N	NOVEMBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹			COLUMBIA ST			
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE	
	glucose level on 7/6	dent 59's elevated blood			This facility requires to IDD for the	nio.		
	glucose level on //6	<i>)/ 上</i> 午.			This facility requests IDR for the citation due to evidence provide			
	The progress notes, assessments, monitoring/evaluation tools, physician orders, and medication administration notes lacked				not included in 2567 and	ieu		
					admission to the hospital was due			
					to infection resulting in DKA.	440		
	documentation to indicate the physician was		1					
	contacted between 7/6/24 at 10:06 A.M. and 7/6/24							
	at 1:55 P.M.							
	A Physician Communication note, dated 7/6/24 at							
	1:55 P.M., indicated the physician was notified the							
	resident was not acting like herself. The resident did not want to eat, refused to drink her fluids,							
		cording to her baseline, and						
	_	ge amount. The note indicated						
		increased heart rate of 119						
		pm) and respirations of 24						
	respirations per mir							
	1	der, dated, 7/6/24 at 2:09 P.M.,	1					
		ere received for staff to						
		Γ) obtain blood draws for a int (CBC) (a laboratory test to						
		r and type of cells in blood and						
		etabolic panel (CMP) (a						
	1 -	measures 14 substances in						
	1	de information about your						
	metabolism and che							
	A Nursing progress	note, dated 7/6/24 at 11:01						
		lab called the facility at 6:00						
		dent 59 had a critical blood						
	_	6 mg/dL. The NP was texted						
	1 -	sed Practical Nurse (LPN) 6						
	1	lue. A response was not						
	received.	-						
	A magga	oot dated 7/6/04 at 6:50 D.M.						
	_	not, dated 7/6/24 at 6:50 P.M.,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155224	B. WI	NG		11/01	/2024
				STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			COLUMBIA ST		
COLLIME	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
COLUNI		CLIVILIX		LVANO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		requested orders, but did not					
	receive a response.						
	111111111111111111111111111111111111111						
	A laboratory report, dated 7/6/24 at 4:53 P.M.,						
		59 had a blood glucose level of					
	_	imed handwritten note on the					
		ne Director of Nursing (DON)					
	indicated the NP w	as notified on 7/7/24.					
	The report did not	inaluda sufficient					
	The report did not i	letermine the facility notified					
		_					
	the physician or the NP, between 7/6/24 at 4:54 P.M. and 7/7/24 at 8:53 A.M., of the elevated						
	blood glucose level.						
	blood glucose level						
	A Nursing progress	s note, dated 7/7/24 at 8:54					
		e nurse attempted to contact					
		e critical blood glucose level.					
		5					
	The July 2024 Phys	sician's recapitulation dated					
	7/7/24 at 9:39 A.M	., indicated the following order					
	was received:						
	Humalog (insulin l	ispro) KwikPen - insulin lispro					
	(a short-acting insu	ilin) - Give per Sliding Scale					
	subcutaneous, three	e times a day,					
	If Blood Sugar is le	ess than 60 mg/dL, call					
	physician.						
	_	to 199, give 0 Units.					
	_	00 to 249, give 1 Units.					
	_	50 to 299, give 2 Units.					
	_	00 to 349, give 3 Units.					
	_	50 to 399, give 4 Units.					
	If Blood Sugar is 400 to 499, give 5 Units.						
	If Blood Sugar is g	reater than 500, call physician.					
	A 1/1 1	1 . 17/7/04 . 10.04 5.35					
		dated 7/7/24 at 12:24 P.M.,					
		59's blood glucose level was					
	548 mg/dL.						
	The July 2024 Mass	lication Administration Record					
	I THE JULY 2024 MICC	ncanon Aummistration Record					I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155224	B. W	ING		11/01	/2024
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			COLUMBIA ST		
COLLIME	BIA HEALTHCARE	CENTER			SVILLE, IN 47710		
COLONIL		CENTER		LVANO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(MAR) indicated no	-					
		sident 59, on 07/07/24, to treat					
	the blood glucose level of 548 mg/dL. A vital sign report, dated 7/7/24 at 4:25 P.M., indicated Resident 59's blood glucose level was						
	582 mg/dL.						
		, medication administration					
		evaluation tools, and physician					
	orders, dated 7/7/24						
		ndicate the physician was					
		ated blood glucose levels or					
	new orders were received to treat the blood						
	glucose levels of 54	48 mg/dL or 582 mg/dL.					
	The July 2024 MAI	R indicated Resident 59's 8:00					
	I -	n lispro on 7/8/24 was given					
		e (RN) 15, but did not indicate					
		vas measured prior to					
	_	v much insulin was given, or					
		the insulin was given.					
	the body site where	the mann was given.					
	Progress notes and	the vital sign report, dated					
		1:25 P.M. and 7/8/24 at 11:25					
		mentation to indicate a blood					
	glucose level was o						
	A nursing progress	note, dated 7/9/24 at 9:04					
		sident 59 became unresponsive					
		performed a sternal rub, and a					
	blood glucose check	k was conducted. The					
	Accu-check measur	red the blood glucose as, "HI",					
		23 bpm the respirations were					
		ident was panting. The					
	1 -	ated the resident had no recent					
		ote indicated the NP was					
	notified and orders	were received to send the					
	resident to the Eme	ergency Room (ER) for					
	evaluation and treat						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/01/2024	
	PROVIDER OR SUPPLIER		621 W	ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST SVILLE, IN 47710	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	at 9:54 A.M., identitract infection (UTI but was not limited results: The blood g with a reference ran blood cell count me microliter (THOUS 4.0 - 10.3 THOUS/positive for greater a reference range of indicated Resident (Intensive Care Unit ketoacidosis (DKA). Hospital discharge particular A.M., indicated Resident for acute metabolic condition that occur oxygen, glucose, or During an interview 11:59 A.M., she indiphysician was documentation systematical properties and the progress of the maximum documentation systematics. She did not done in a progress administration notes time, the DON was	papers, dated 7/15/24 at 10:14 sident 59 was discharged back being admitted to the hospital encephalopathy (ME) (a swhen the body lacks vitamins), DKA, and UTI. With the DON on 10/30/24 at licated all notifications to the mented as a progress note. With the Director of Nursing at 1:44 P.M., she indicated the for the blood sugars over 500 he NP said to give five units units on the sliding scale. The em would not let her input its, so she put she gave zero occument the notification to the or the insulin administration is note or as a medication, but she should have. At that			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155224	B. W	ING		11/01	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			COLUMBIA ST		
COLUMB	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of insulin.						
	During on intervious	w with the DON on 10/30/24 at					
	-						
	1:59 P.M., she indicated Licensed Practical Nurse (LPN) 6 did not remember if she gave the 8 A.M.						
		o or not. The DON was unsure					
	-	blood glucose was at 8:00					
		3:00 A.M., or how many units of					
	insulin lispro were	•					
	modific fishio were	5. · 11 wing ·					
	During an interview	v, on 11/1/24 at 8:15 A.M., the					
	_	ated text messages were not					
	part of the clinical record.						
	During an interview	with the Administrator on					
	11/1/24 at 8:51 A.N	1., she indicated staff texted the					
	NP and didn't need	to document all					
	communication in t	he progress notes.					
	During an interview	with the Nurse Practitioner					
	-	9:00 A.M., the NP indicated					
		if there was no response after					
		ney would call her. If she still					
		were to call the on-call					
		not have a record of being					
		in relation to Resident 59's					
	elevated blood gluc	ose level. She indicated she					
	would have advised	staff to recheck the blood					
	sugar in an hour and	d call back if it was still high.					
	The NP indicated sl	he was unable to find a recheck					
	of blood glucose le	vels for Resident 59 on 7/2/24.					
	The NP indicated the	ne sliding scale insulin order					
		n a trial basis and then the					
		e-evaluated. At that time, the					
	-	rovide documentation that the					
		n a trial basis and when the					
		e-evaluated. The NP indicated					
		cumentation of being					
		in relation to Resident 59's					
	l elevated blood aluc	ose level. She indicated she	ı		1		1

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/01/2024	
	ROVIDER OR SUPPLIER		621 W	ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST SVILLE, IN 47710	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG	would have ordered	four units of insulin above on the sliding scale to be	TAG	DEFICIENCY)	DATE
	given, making the to administration time	otal insulin nine units for that . She indicated four units of			
	scale for a blood gli	ghest number on the sliding acose level over 400 mg/dL standing order from that point			
	on. The NP indicate	ad that she was not contacted 4 about Resident 59's blood			
	was unsure what Re	in, or a missed dose. The NP esident 59's blood glucose was			
	insulin lispro were	/24 or how many units of given.			
	provided a current l	3 A.M., the Administrator Blood Glucose Monitoring			
	physician will be no	5, that indicated, "The of tified when the resident's tside the physician stated			
	parameters or if the	resident is experiencing signs h or low blood sugars".			
		P.M., the Administrator Resident Change of Condition			
	policy of this Comr	17, that indicated, "It is the nunity that changes in resident			
	and family/responsi	ommunicated to the physician ble party, and that and effective intervention			
	and resident assessr	ng actions, physician contacts, ment information will be Progress Notes Any			
	sudden or serious cl	hange in a resident's condition rked change in physical or			
	physician with a rec	Il be communicated to the quest for physician visit			
	to contact attending will be transferred f	physician timely, the resident or emergency services			
	Documentation will	include time and			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			LETED	
		155224	B. W	'ING		11/01	/2024
				CTDEET A	DDRESS SITV STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
00111145	NA LIEAL THOADE	OFNITED			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	family/physician re	sponse"					
	On 11/1/24 at 2:06 P.M., the Administrator						
	provided a current (General Dose Preparation and					
	Medication Admini	stration policy, dated 4/30/24,					
	that indicated "D	ocument necessary medication					
	administration/treat	ment information (e.g. when					
	medications are ope	ened, when medications are					
		of a medication, if medications					
	are refused, PRN m	edications, application site) on					
	appropriate forms	."					
	On 11/1/24 at 2:06 P.M., the Administrator						
	provided a current A						
		Orders policy, dated 6/1/24,					
		acility should ensure that the					
	_	eceiving a verbal order					
		s it in the resident's chart or					
	I -	tem, including the date and					
	time of the order, th						
		r, the signature of the person					
		and other information as					
		accordance with applicable					
	law"						
		Diabetic Ketoacidosis," dated					
		yed on 11/5/24 from the Center					
	for Disease Control	and Prevention (CDC) website					
	at						
		v/diabetes/about/diabetic-ket					
		ext=also%20develop%20DKA.					
		s%20when%20your%20body					
		re%20enough%20insulin,dang					
		0in%20your%20body. The					
	_	"DKA is a serious					
	complication of dia						
		XA is most common among					
		diabetes. People with type 2					
	diabetes can also de	-					
	DKA develops whe	n your body doesn't have					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155224	B. Wl	ING		11/01/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUDEDIG DI ANI GE CORRECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	low blood sugar into your					
		gy. Instead, your liver breaks					
	down fat for fuel, a process that produces acids called ketones. When too many ketones are						
		ney can build up to dangerous					
	levels in your body						
	levels in your body	•••					
The article, "Metabolic Encephalopathy", dated 7/10/24, was retrieved on 11/5/24 from the Cleveland Clinic website at https://my.clevelandclinic.org/health/diseases/met abolic-encephalopathy. The guidance included: "Metabolic encephalopathy is a brain		olic Encephalopathy", dated					
		by an underlying condition.					
		litions can cause metabolic these mainly target your					
		netabolism is the chemical					
		s the things you eat and					
	-	Brain dysfunction can affect					
		g and memory or cause a loss					
	of consciousness (co	-					
	encephalopathies re	quire medical attention. If left					
		be life-threatening or cause					
	permanent brain das	mage"					
	3.1-37(a)						
F 0686	483.25(b)(1)(i)(ii)						
SS=D		Prevent/Heal Pressure					
Bldg. 00	Ulcer	or revenue reasone					
5	_	and record review, the facility	F 06	686	How will the corrective actio	n	11/29/2024
	failed to ensure a re	sident did not develop an			be accomplished for residen		
	-	alcer by monitoring skin for 1			found to be affected by		
		wed for facility acquired			deficient practice?		
	pressure ulcers. (Re	sident 89)					
	F. 1				Resident #89 no longer ha		
	Finding includes:				knee immobilizer. The pressu		
	During on interni	on 10/24/24 at 2:22 D.M.			ulcer was healed on 10/30/24.		
	-	on 10/24/24 at 2:22 P.M., ed she had pressure injuries on			How will the feetite identify		
	Resident 69 marcal	on one had pressure injuries on	ı		How will the facility identify	Ų.	

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01/02/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/01/2024 155224 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 621 W COLUMBIA ST COLUMBIA HEALTHCARE CENTER **EVANSVILLE, IN 47710** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE her right leg from her knee immobilizer not being other residents having the monitored. potential to be affected by the same deficient practice? On 10/28/24 at 2:40 P.M., Resident 89's clinical record was reviewed. Diagnoses included, but All Residents with external were not limited to congestive heart failure and device have the potential to be affected by the alleged deficient diabetes mellitus. practice. The most recent Significant Change Minimum An audit was completed to Data Set (MDS) Assessment, dated 8/7/24, identify any resident with orders indicated resident 89 was cognitively intact, was for an external device and to fully dependent on staff for transfers, required ensure physician orders were substantial assistance from staff (staff do more followed and that appropriate care than half the work) for toileting and bathing, and plans are established to include did not have any unhealed pressure ulcers. routine skin assessments. Current physician orders included, but were not What measures will be put into limited to: place and what systemic changes will be made to Right calf: cleanse wound with wound cleanser, ensure that the deficient pat dry; wound to be packed by wound NP (nurse practice does not recur? practitioner) with skin sub, cover with silicone dressing, then steri-strips, then cover with a dry DNS/Designee to educate and dressing. Change 1x weekly by Wound NP. Outer in-service all Nurses on splinting dressing to be changed PRN if soiled/dislodged. device application and Weekly Once a day on Wednesday, Start date 10/2/24. Skin Assessments Daily audits will be completed Current care plans included, but were not limited by DNS/designee to ensure physician orders for all devices Impaired mobility related to: right nondisplaced and skin assessments are fracture medial tibial plateau; Assess and followed for any resident with order document skin condition weekly and as needed. for external device. Date initiated 6/12/24. The care plan did not specify to remove the How will the facility monitor its immobilizer and check skin under the immobilizer. corrective actions to ensure that the deficient practice will A nursing progress note, dated 6/12/24 at 10:14 not recur? P.M. indicated Resident 89 returned from a hospital stay, from 6/8/24 through 6/12/24 due to The DNS/Designee will be

fall with fracture in facility that occurred on 6/8/24,

0STT11

responsible for the completion of

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155224	B. WI	NG		11/01/	
				_			-
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	with a knee immob	ilizer to the right leg.			the Weekly Skin Assessment		
					Summary, Weekly Skin		
		note, dated 7/23/24 at 2:33			Assessments Reflect Alteratio	ns	
	P.M., indicated Resident 89 had returned from an				in Skin Integrity and IDT		
	orthopedic appointment with orders to				Documentation reflects the Ris		
	discontinue the knee immobilizer on Resident 89's				Factors Present Prior to Wour		
	right leg.				Development.QA tool weekly :		
					weeks, monthly x 6, then quar	terly	
	An IDT (interdisciplinary team) note, dated				until continued compliance is		
	7/26/24 at 9:48 A.M., indicated Resident 89's right				maintained for 2 consecutive		
	lateral calf noted to have two unstageable				quarters. The results of the au	dits	
	pressure wounds related to the knee immobilizer.				will be reviewed by the QAPI		
					committee overseen by the EI	D. If	
	A skin and wound note, dated 7/31/24 at 6:45				a threshold of 100% is not		
		sident was assessed by the			achieved, an action plan will b	е	
		deep tissue injury to the right			developed.		
	posterior leg caused						
		4.8 centimeters (cm) by 1.3 cm					
	by 0.1 cm.						
	The clinical record.	including assessments,					
		s, progress notes, and					
		skin assessments completed					
		g weeks while Resident 89 had					
	a right knee immob						
	6/12/24-6/18/24	•					
	6/20/24-7/2/24						
	7/4/24-7/23/24						
	.	11/1/04 + 0.00 P.3.5 - 1					
	_	v on 11/1/24 at 2:09 P.M., the					
	_	g indicated there were not skin					
	1	eted during the missing weeks					
	in June and July.						
	On 11/1/24 at 11:36	6 A.M., the Administrator					
		tled Skin Management					
	Program, revised 5/22, that indicated the purpose						
		Γο promote the prevention of					
		ry development. Avoidable					
	1 -	y: means that the resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/01/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0697 SS=D Bldg. 00	facility did not do of evaluate the resident factors; define and are consistent with and professional state and evaluate the immunous and evaluate the facility non-pharmalogical for pain prior to per residents observed to prior to per residents observed to a significant change of head, face carcinoma of skin of the evaluate the work assistance from staff the work) for toiletine eded pain medical had not received no pain in the past five	failed to administer or pharmalogical interventions forming wound care for 1 of 2 for wound care. (Resident 104) 6 A.M., Resident 104's clinical d. Diagnoses included, but malignant neoplasm of lymph , and neck and squamous cell of scalp and neck. ge MDS (Minimum Data Set) 9/3/24, indicated Resident 104 net, was completely dependent as required substantial of (staff does more than half ng and bathing, received as attion in the last five days and n-medication intervention for	F 0697	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Audit of resident 104's Management and that a per providers orders are that per providers orders and that a per providers orders are that per providers orders orders are that per providers orders	n AR I red any as 12		

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wounds have adequate pain

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155224	B. W	NG		11/01/	
				_			
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	hydrocodone-acetaminophen schedule II tablet				control.		
	5-325 mg; oral ever	ry four hours as needed, start			Daily audit will be comple	ted	
	date 9/10/24.				by DNS/designee to ensure pa		
					medication administration is be		
	Betadine (povidone	e-iodine) solution; 10%; 1			completed as ordered for routi	ine	
	application; topical. Special Instructions: Betadine				and PRN pain medication per		
	wash to left heel once a day, start date 8/28/24.				resident request for all resider	nts	
					with pain medication orders		
	Care plans included	d, but were not limited to:			receiving wound care.		
	Resident is at risk f	or pain. Offer non			What measures will be put in	ito	
	pharmacological interventions such as quiet				place or systematic changes		
	environment, rest, shower, back rub, reposition.				made to ensure that the		
	Administer medications as ordered. Start date				deficient practice will not		
	8/5/24.				reoccur?		
					All Nurses in-serviced on		
	During an observat	ion on 10/30/24 at 10:56 A.M.,			Pain Management Policy.		
	RN 12 entered Resi	ident 104's room and told		Daily audit will be completed			
	Resident 102 she w	ras going to start the wound		by DNS/designee to ensure pain			
	treatment on his foo	ot. Resident 104 requested pain			medication administration is be	eing	
	medication before I	RN 12 started the wound			completed as ordered for routi	ine	
	treatment. RN 12 st	tarted to perform wound care			and PRN pain medication per		
		egan grimacing and stating he		resident request for all residents			
	_	uld like pain medication before		with pain medication orders			
		yelled into the hall for another			receiving wound care.		
	· ·	ed Resident 104's room and RN					
		he medication cart keys and			How will the facility monitor	its	
	_	arcotic pain medication for			corrective actions to ensure		
		2 continued cleaning Resident			that the deficient practice wi	II	
	-	ainted the left heel with			not recur?		
		104 continued to grimace and			The DNS/Designee will be		
		ation. RN 10 returned to			responsible for the completion	of	
		n and handed RN 12 a			the Pain Assessed Prior to		
	-	N 12 spoon the medication and			Wound Care and Wound Care		
		nto Resident 104's mouth. RN			Held Until Pain Manageable C		
		reposition Resident 104 or to			tools weekly x 4 weeks, month	nly x	
	postpone the wound treatment.				6, then quarterly until continue		
					compliance is maintained for 2	2	
		v on 11/1/24 at 1:42 P.M.,			consecutive quarters. The res	ults	
	Resident 104 indica	ated he does not receive routine			of the audits will be reviewed I	оу	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155224	B. W	NG		11/01/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			COLUMBIA ST		
COLUME	BIA HEALTHCARE (CENTER			VILLE, IN 47710		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*	nd that staff never give the			the QAPI committee overseen	•	
	_	e to take effect before			the ED. If threshold of 100% is		
	beginning wound tre	eatments.			achieved, an action plan will b developed.	е	
	On 11/1/24 at 11:36	A.M., the Administrator			22,212,221		
		tled Pain Management, revised					
		"It is the policy to provide the					
		services to attain or maintain					
	-	ble physical, mental, and					
	psychosocial wellbe						
	management. A plan	n of care will be written with					
the initiation of pain medication and individualization to the resident and alternative							
	pain relief technique	es."					
	3.1-37(a)						
F 0759	483.45(f)(1)						
SS=D		n Error Rts 5 Prcnt or More					
Bldg. 00	1 100 of Wiodiodio	TENOTING OF TOTAL OF MOTO					
Ŭ	Based on observation	on, interview, and record	F 0'	759	What corrective action(s) wil	I	11/29/2024
	review, the facility	failed to ensure medications			be accomplished for those		
	were administered a	according to manufacture and			residents found to have beer	1	
	professional standar	rd for 1 of 5 residents			affected by the deficient		
	observed during me	edication pass. (Resident 89)			practice?		
	Two medication err	ors were observed during 26			Resident 89 received the		
	opportunities for err	ror in medication			correct insulin dosage as orde	red	
	administration. This	s resulted in a 7.69% error rate.			during the medication pass. T	here	
	(Resident 89)				were no negative effects for		
					resident 89 by the deficient		
	Findings include:				practice.		
					How will the facility identify		
	_	n administration on 10/25/24 at			other residents having the		
	, ,	icensed Practical Nurse) 13			potential to be affected by th	е	
	prepared Glargine I				same deficient practice?		
	` ′	(two times a day) and Lispro			All residents receiving insu		
		ee times a day) and did not			by injection pen have the pote	ntial	
	-	in injection pens with two units			to be affected by this alleged		
	prior to administerii	ng.			deficient practice.		
					DNS/ designee conducted		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155224	B. WI	NG		11/01/	2024
				CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
00111145		OFNITED			COLUMBIA ST		
COLUMB	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	On 10/25/24 at 1:45	5 P.M., Resident 89's clinical			insulin injection pen skills		
	record was reviewe	d. Diagnoses included, but			validations with all licensed		
	were not limited to,	diabetes mellitus and Systemic		nursing staff.			
	Lupus erythematosi			Education provided to Nurse 13			
	1 3				on proper technique of priming		
	Physician orders in	cluded, but were not limited to,		insulin injection pens.			
	-	sulin pen; 100 unit/mL		What measures will be put into			
	_	; amt (amount): 30 units;			place or systematic changes		
	, , , , ,	ial Instructions: Give half			made to ensure that the		
	•	S (Blood Sugar) < (Less			deficient practice will not		
		Day, 8:00 A.M. and 8:00 P.M,			reoccur?		
	dated 10/24/24.	3 ,		DNS/Designee will conduct			
	-				in-service with licensed nursin	a	
	Lispro Insulin pen; 100 unit/mL; amt: 10 units;				staff on Insulin Pen Administra	•	
	subcutaneous. Special Instructions: Do not				DNS/Designee will round to		
	_	below 100. Give Three Times A			ensure insulin pen administration		
		:00 P.M., and 5:00 P.M. dated			is completed per protocol		
	9/10/24.				How will the facility monitor	its	
					corrective actions to ensure		
	During an interview	on 10/25/24 at 8:00 A.M., LPN			that the deficient practice will	II	
	_	s unaware of priming the			not recur?	·-	
	insulin prior to adm				The DNS/Designee will be	!	
	1				responsible for the completion		
	On 10/25/24 at 12:5	59 P.M., the Administrator			the Insulin Administration	•	
	provided a current,				Observation During Med Pass	with	
	_	or Humalog Kwik Pen". The			No Procedure Error. QA tool		
	insert indicated "t	_			weekly x 4 weeks, monthly x 6	.	
		res the Pen is ready and			then quarterly until continued	,	
		y collect in the cartridge			compliance is maintained for 2)	
		If you do not prime before			consecutive quarters. The resi		
	_	may get too much or too little			of the audits will be reviewed by		
	insulin"	, 8			the QAPI committee overseen	-	
					the ED. If the threshold of 100	-	
	3.1-48(c)(1)				not achieved, an action plan w		
	'~(-)(*)				be developed.		
F 0761	483.45(g)(h)(1)(2)						
SS=E	Label/Store Drugs						
Bldg. 00		2.0.09.00.0					
	Based on observation	on, interview and record	F 07	61	How will corrective action be)	11/29/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/01/2024	
NAME OF F	PROVIDER OR SUPPLIER		STREE	ET ADDRESS, CITY, STATE, ZIP COD	•
			621 \	W COLUMBIA ST	
COLUME	BIA HEALTHCARE	CENTER	EVA	NSVILLE, IN 47710	_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		failed to ensure medications		accomplished for those	
		l, labeled, and not expired in 5		residents found to have be	en
		ts and 2 of 2 treatment carts.		affected by the deficient	
	,	ion Cart, 1400 Hall Medication		practice?	
		Medication Cart, 2300/2400		All opened items with no o	pen
		rt, 2500 Hall Medication Cart,		date, loose medications,	
		nt Cart, Second Floor		medications with no label ar	
	Treatment Cart)			expired items were destroye	d and
	F' 1' ' 1 1	Findings include:		replaced.	
	1. On 10/24/24 at 8:45 A.M., 1500 Hall Medication			Resident 106 Humulin a	and
				Glargine insulin pen were	
				discarded	
	Cart was observed to with the following:			Other Glargine insulin p	en
				was discarded	
	RN (Registered Nurse) 12 indicated each resident had their own glucometer (Instrument to measure			Nasal saline which was	
		nsulin is kept in the pouches.		expired is discarded	
	blood sugars) and n	isum is kept in the pouches.		1400 hall med cart the	
	[Resident Name]10	6's insulin pouch had the		expired sterile water was discarded,	
	following:	o's msum pouch had the		First floor treatment car	
	_	mulin R (Regular) insulin with		Betadine was discarded	•
	no open date	mann it (itegalar) msann with		Memory Care medication of	eart _
	2 Glargine Insulin I	Pen with no label		Clonidine pill and Miralax wa	
				discarded. Non medication i	
	[Resident Namel in	sulin pouch had the following:	1	were removed from the cart.	
	Glargine Insulin per			2400/2300 hall medication	
		•		– orange pill, white pill and N	
	1 bottle of Nasal Sa	line for [Resident Name]		was discarded	
	expired 7/24			2nd floor treatment cart –	
	1 bottle of Liquid P	rotein no label		Nystatin antifungal cream,	
				Ketoconazole shampoo,	
	During an interview	on 10/24/24 at 8:45 A.M., RN	1	hydrophile, bag balm, were	
		ation bottles should have an		discarded. The cart was clea	aned.
	*	. There should not be		2200 hall undated Miral	ax
	anything expired in	the carts.		was discarded	
				Medication Refrigerator -	
		:02 A.M., the 1400 Hall		Mary's Magic Cream with no	open
	Medication cart was	s observed with the following:		date was discarded	
				No residents had any nega	
	1 bottle of Sterile Water with an expiration of			effects due to the alleged de	ficient

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155224	A. BUILDING B. WING	00	COMPLETED 11/01/2024
		133224	D. WING		1 1/0 1/2024
NAME OF	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD	
				COLUMBIA ST	
COLUMI	BIA HEALTHCARE	CENTER	EVANS	SVILLE, IN 47710	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	10/6/24			practice.	
				How will the facility identify	
		:08 A.M., the Treatment Cart for		other residents having the	
	the First Floor was			potential to be affected by th	e
	_	Betadine (Antiseptic Cleaner)		same deficient practice?	
	_	lent Name] in black Sharpee		All residents have the	
	without and open d	ate.		potential to be affected by this	
				practice.	
	_	v on 10/24/24 at 9:10 A.M., RN		An audit was completed on	
12 indicated when a resident is discharged the medication will be returned or destroyed.			carts and medication rooms to		
			ensure proper storage of		
				medications and treatment	
	4. On 10/24/24 at 9:20 A.M., the Medication Cart for the Memory Care Unit was observed with the following:			supplies to ensure meds were	
				properly dated, labeled and no	ot
				expired and clean, and	
				non-medication items were	
	_	f the medication cart:		removed	
	1 silver colored ned			What measures will be put in	
	1 silver colored ring	_		place or systematic changes	
		th blue stones watch		made to ensure that the	
		(Milligrams) Clonidine pill		deficient practice will not	
	package			reoccur?	
	1 Bottle of MiraLA	X (laxative) with no label		The DNS/Designee will a	
				the medication and treatment	
	_	v on 10/24/24 at 9:25 A.M., RN		daily. Results of the audits will	be
		should not be any jewelry in the		taken to the morning clinical	
	medication drawer	and it should be labeled		meeting and discussed with th	e
				IDT.	
		2:30 A.M., the 2400/2300 Hall		DNS/Designee to in-service	
		as observed with the following:		licensed nursing staff and QM	
	1 small white oblor			on Medication Storage and the	
		Nitroglycerin (Antianginal) for		importance of proper labeling	and
	[Resident name] wi	ith no date		storage.	
				How will the facility monitor i	its
	6. On 10/24/24 at 9:49 A.M., the 2500 Medication			corrective actions to ensure	
	Cart was observed			that the deficient practice wil	I
	1/2 small round ora	~ ·		not recur?	
	1 small round white	-		The DNS/Designee will be	
	3 opened bottles of	MiraLAX with no open date		responsible for the completion	of

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the Medication Storage QA tool

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/01/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	Treatment Cart was 1 bottle of Nystatin no open date 1 bottle of antifung 1 bottle of Ketocon 4/24 3 tubes of open hyd no open date 9 bottles of Ketocon	0:15 A.M., the Second Floor sobserved with the following: Powder for [Resident Name] all cream no label or date open azole shampoo that expired in drophile for [Resident Name] mazole shampoo with that were not dated when			weekly x 4 weeks, monthly x 6 then quarterly until continued compliance is maintained for 2 consecutive quarters. The resi of the audits will be reviewed to the QAPI committee overseen the ED. If a threshold of 100% not achieved, an action plan wibe developed.	ults by by is		
	had no label or ope	of Bag Balm (ointment) that n date white substance on a drawer of						
	LPN (Licensed Pra Bag Balm should b	v on 10/24/24 at 10:20 A.M., etical Nurse) 13 indicated the e labeled and dated. LPN 13 she would date any tubes that						
	DON (Director of Name were stock medicat	v on 11/1/24 at 12:29 P.M., the Nursing) indicated antifungals ions until they were opened at ould be assigned to a resident						
	Medication Cart wa	0:27 A.M., the 2200 Hall as observed with the following: 'MiraLAX for [Resident the						
		0:40 A.M., the Medication Medication Storage room was following:						
	1 container of Mary	s's Magic cream for [Resident						

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Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 1 of 2 residents reviewed for insulin use. (Resident 59) Finding includes: On 10/29/24 at 12:59 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/24, indicated Resident 59 was not assessed for cognitive impairment because the resident received insulin 7 days during the 7-day lookback period. The July 2024 Physician's recapitulation orders F 0842 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Provider Notification Documentation for Resident #59 is being completed and accurately documented. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this practice. All Nursing staff were in-serviced on Documentation Guidelines by DNS/Designee	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTII A. BUILDII B. WING	PLE CONSTRUCTION NG 00	COM	(X3) DATE SURVEY COMPLETED 11/01/2024	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION On 10/25/24 at 12:59 P.M., the Administrator provided a current policy " Storage and Expiration Dating of Medications and Biologicals" revised on 8/1/24. The policy indicated "", ficility should ensure that medications and biologicals that: have an expired dated on the label and have been retained longer than the recommended manufacturer or supplier guidelines, unfill destroyedOnce any medication on biological is opened on the primary container" 3.1-25(j) 3.1-25(j) 3.1-25(j) 3.1-25(j) Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 1 of 2 residents reviewed for insulin use. (Resident 59) Finding includes: On 10/29/24 at 12:59 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/24, indicated Residnt 59 was not assessed for cognitive impairment because the resident twas rarely or never understood and the resident received insulin 7 days during the 7-day lookback period. The July 2024 Physician's recapitulation orders Provider Notification Documentation of Documentation of Documentation of Resident #Point to be affected by the same deficient practice? All residents have the potential to be affected by this practice. All Nursing staff were in-serviced on Documentation Guidelines by DNS/Designee				62	621 W COLUMBIA ST		
On 10/25/24 at 12:59 P.M., the Administrator provided a current policy "Storage and Expiration Dating of Medications and Biologicals that: have an expired dated on the label and have been retained longer than the recommended manufacturer or supplier guidelines until destroyedOnce any medication or biological is openedfiscility staff should record the date opened on the primary container" 3.1-25(j) 3.1-25(o) Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 1 of 2 residents reviewed for insulin use. (Resident 59) Finding includes: On 10/29/24 at 12:59 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/4, indicated Resident 59 was not assessed for cognitive impairment because the resident was rarely or never understood and the resident received insulin 7 days during the 7-day lookback period. The July 2024 Physician's recapitulation orders On 10/29/24 physician's recapitulation orders Finding includes: Finding includes:	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T	ON SHOULD BE THE APPROPRIATE	COMPLETION
dated 7/7/24 at 9:39 A.M., indicated the following	F 0842 SS=D	Name] with no oper On 10/25/24 at 12:5 provided a current p Dating of Medication on 8/1/24. The policensure that medicatian expired dated on retained longer than manufacturer or supdestroyedOnce an openedfacility staropened on the prima 3.1-25(j) 3.1-25(o) 483.20(f)(5), 483.7 Resident Records Based on interview failed to ensure docaccurate for 1 of 2 ruse. (Resident 59) Finding includes: On 10/29/24 at 12:5 record was reviewed were not limited to, The most recent Qu (MDS) Assessment, Resident 59 was not impairment because never understood arinsulin 7 days durin The July 2024 Phys	olicy "Storage and Expiration ons and Biologicals" revised by indicated "facility should ions and biologicals that: have the label and have been at the recommended oplier guidelines until y medication or biological is ff should record the date ary container" TO(i)(1)-(5) - Identifiable Information and record review, the facility umentation was complete and esidents reviewed for insulin 19 P.M., Resident 59's clinical d. Diagnoses included, but diabetes mellitus. arterly Minimum Data Set assessed for cognitive the resident was rarely or and the resident received gethe 7-day lookback period. ician's recapitulation orders		What corrective active accomplished for residents found to affected by the defipractice? Provider Notifith Documentation for Fibeing completed an documented. How will the facility other residents have potential to be affected and potential to be	or those have been icient cation Resident #59 is d accurately identify ving the cted by the ctice? eave the ted by this aff were ementation Designee	

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155224	B. WING 11/01/2024			/2024	
				CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
COLLINAT		CENTER		621 W COLUMBIA ST EVANSVILLE, IN 47710			
COLUME	BIA HEALTHCARE	CENTER		EVAINS	OVILLE, IN 477 IU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	order was received:				place or systematic changes	;	
		spro) KwikPen - insulin lispro			made to ensure that the		
		lin) - Give per Sliding Scale			deficient practice will not		
	subcutaneous, three				reoccur?		
	_	ss than 60 mg/dL, call			The Nursing staff was		
	physician.				in-serviced and educated on		
	_	to 199, give 0 Units.			Documentation Guidelines		
		00 to 249, give 1 Units.			All resident MAR's have bee		
	_	50 to 299, give 2 Units.			audited to ensure documentat	tion	
		00 to 349, give 3 Units.			has been completed.		
		50 to 399, give 4 Units.			The DNS/Designee will		
	_	00 to 499, give 5 Units.			complete daily audits for all		
	If Blood Sugar is gr	reater than 500, call physician.			residents receiving insulin to		
					ensure that documentation is		
		effects of hyperglycemia or			accurate and complete		
		ed to use of glucose lowering			How will the facility monitor	its	
		liagnosis of diabetes mellitus			corrective actions to ensure		
		/20 and reviewed 9/25/24,			that the deficient practice wi	II	
		ntion to document abnormal			not recur?		
	findings and notify	the physician.			The DNS/Designee will be		
					responsible for the completion	n of	
		dated 7/2/24 at 10:14 A.M.,			the Provider Notification		
		59's blood glucose level was			Documentation QA tool weekl	ух	
	490 mg/dL.				4 weeks, monthly x 6, then		
	m				quarterly until continued	_	
		ication Administration Record			compliance is maintained for 2		
	, ,	e physician was notified of the			consecutive quarters. The results		
	elevated blood gluc	ose level on 7/2/24.			of the audits will be reviewed l	-	
	TI D	te de la transferior	1		the QAPI committee overseen	-	
	_	medication administration			the ED. If a threshold of 100% is		
	· ·	rms, dated 7/2/24, lacked			not achieved, an action plan w	VIII	
		etermine the physician			be developed.		
	_	facility staff made attempts to					
		physician to address the	1				
	elevated blood gluc	ose level.					
	Δ Physician/ND and	der, dated, 7/6/24 at 2:09 P.M.,					
	1	re received for staff to	1				
		F) obtain blood draws for a					
		ant (CBC) (a laboratory test to					
l .	i combiere proou con	in (CDC) (a laboratory test to	1		I		1

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		X3) DATE SURVEY			
AND PLAN OF CORRECTION ID:		IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>00</u>			COMPLETED	
		155224	B. W	ING		11/01	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R	621 W COLUMBIA ST					
COLUME	BIA HEALTHCARE	CENTER	EVANSVILLE, IN 47710					
OOLOWE	·	<u> </u>			VIELE, III 477 10			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION OF CORRECTION OF CORRECTION ACTION SHOULD BE SEEN AS THE PROVIDER OF THE PROV			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE	
		r and type of cells in blood and						
	_	etabolic panel (CMP) (a						
	-	measures 14 substances in						
		de information about your						
	metabolism and che	emical balance).						
	A Nureina progress	note, dated 7/6/24 at 11:01						
		lab called the facility at 6:00						
		dent 59 had a critical blood						
	•	6 mg/dL. The NP was texted						
		sed Practical Nurse (LPN) 6						
	about critical lab value. A response was not							
	received.							
	A message screensh	not, dated 7/6/24 at 6:50 P.M.,						
	_	ed the critical blood glucose						
		requested orders, but did not						
	receive a response.	•						
	_							
	A vital sign report,	dated 7/7/24 at 12:24 P.M.,						
	indicated Resident	59's blood glucose level was						
	548 mg/dL.							
	-	ication Administration Record						
	(MAR) indicated no	-						
		sident 59, on 07/07/24, to treat						
	the blood glucose le	evel of 548 mg/dL.						
		1 . 1 = /= /2						
		dated 7/7/24 at 4:25 P.M.,						
		59's blood glucose level was						
	582 mg/dL.							
	The July 2024 Med	igation Administration Decord						
	The July 2024 Medication Administration Record							
	(MAR) indicated no insulin lispro was administered to Resident 59, on 07/07/24, to treat							
	the blood glucose le							
	me blood glucose is	.voi of 302 mg/dL.						
	The July 2024 MAI	R indicated Resident 59's 8:00						
	-	n lispro on 7/8/24 was given						
		-						
by Registered Nurse (RN) 15, but did not indicate								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	CON	(X3) DATE SURVEY COMPLETED 11/01/2024		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APF		(X5) COMPLETION	
TAG	 	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	administration, hov	vas measured prior to v much insulin was given, or the insulin was given.					
	(DON) on 10/30/24 nurse called the NP mg/dL on 7/7/24. Tover the maximum documentation syst that she gave 10 un units. She did not d NP, the new order, amount in a progres administration note time, the DON was documentation to it of insulin.	ndicate the nurse gave 10 units					
	1:59 P.M., she indi (LPN) 6 did not rer dose of insulin lisps was unsure what Ro at 8:00 A.M. on 7/8 units of insulin lisp	with the DON on 10/30/24 at cated Licensed Practical Nurse member if she gave the 8 A.M. ro on 7/8/24 or not. The DON esident 59's blood glucose was 8/24 at 8:00 A.M., or how many ro were given if any.					
	_	v, on 11/1/24 at 8:15 A.M., the cated text messages were not record.					
	1						
	(NP) on 11/1/24 at	with the Nurse Practitioner 9:00 A.M., the NP indicated that record of being contacted on					

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7/2/24 in relation to Resident 59's elevated blood

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/01/2024		
	PROVIDER OR SUPPLIER BIA HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	glucose level. She indicated she would have advised staff to recheck the blood sugar in an hour and call back if it was still high. The NP indicated she was unable to find a recheck of blood glucose levels for Resident 59 on 7/2/24. The NP indicated the sliding scale insulin order was for one week on a trial basis and then the resident would be re-evaluated. At that time, the NP was unable to provide documentation that the insulin order was on a trial basis and when the resident was to be re-evaluated. The NP indicated she was not contacted by a nurse on 7/8/24 about Resident 59's blood glucose level, insulin, or a missed dose. The NP was unsure what Resident 59's blood glucose was at 8:00 A.M. on 7/8/24 or how many units of insulin lispro were given. On 11/1/24 at 2:06 P.M., the Administrator provided a current General Dose Preparation and Medication Administration policy, dated 4/30/24, that indicated "Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application site) on appropriate forms". On 11/1/24 at 2:06 P.M., the Administrator provided a current Authorization and Communication of Orders policy, dated 6/1/24, that indicated "Facility should ensure that the authorized person receiving a verbal order immediately records it in the resident's chart or electronic order system, including the date and time of the order, the name of physician/prescriber, the signature of the person recording the order and other information as permitted by and in accordance with applicable law".					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
		155224	B. WING 11/01/2024				/2024	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	•		
					COLUMBIA ST			
COLUMB	SIA HEALTHCARE	CENTER		EVANS	SVILLE, IN 47710			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	3.1-50(a)(1)							
	3.1-50(a)(2)							
F 0880	483.80(a)(1)(2)(4)	(e)(f)						
SS=D	Infection Prevention							
Bldg. 00	iniconon i revenue	on a control						
	Based on observation	on and interview, the facility	F 08	880	How will corrective action be)	11/29/2024	
		ection control practices were in			accomplished for those			
	place for 2 of 2 resi	dents during incontinence care			residents found to have been	1		
	_	during wound care. Staff failed			affected by the deficient			
	to sanitize hands an	d change gloves between			practice?			
	soiled to clean tasks	s, as well as failed to use			Residents 64, 85, and 86 h	ad		
	enhanced barrier pr	ecautions during wound care.			no negative effects by the alle	ged		
	(Resident 64, Resid	ent 85, and Resident 86)			deficient practice.			
					Residnet 64 and 85 are			
	Findings included:				receiving incontinent care per			
					infection control protocol			
	1. On 10/24/24 at 1	0:43 A.M., CNA (Certified			Resident 86 is receiving			
	· ·	t into Resident 64's room.			wound care per infection conti	rol		
		ves, checked the resident's			protocol			
	_	were incontinent, started to act			How will the facility identify			
		soiled brief but then indicated			other residents having the			
		nother staff member to assist.			potential to be affected by th	е		
		resident's remote to their bed,			same deficient practice?			
		rith soiled gloves before			All residents have the			
	_	n did not sanitize or wash			potential to be affected by this	i		
	hands.				practice.			
	0.10/00/01				CNA's 3/7, QMA 5 and LPI			
		44 A.M., Resident 64's clinical			all educated on the proper dor	_		
		d. The Annual MDS (Minimum			and doffing PPE and Enhance			
	,	ent on 8/5/24 indicated the			Barrier Precaution Procedures			
		gnitively intact, required			WWhat measures will be put			
		num assistance with toileting			into place or systematic			
		ne, was always incontinent of			changes made to ensure tha			
		and had a diagnosis that			the deficient practice will not	Į.		
	menuded but was no	ot limited to dementia.			reoccur?	اله ه		
					DNS/Designee to in-service			
	2 On 10/25/24 of 10	0:58 A.M. Resident 85 indicated			nursing staff on Infection Cont	.i UI		
		nt urinary tract infections			Policy and Enhanced Barrier Precautions to include glove			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS		NSTRUCTION (X3) DATE SU		URVEY	
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
		155224	B. WING 11/01/2024			2024		
				CTD FET A	ADDRESS OF A STATE TIP COD			
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD			
00111145	NA LIEAL TUGADE	OFNITED	621 W COLUMBIA ST					
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	because staff did no	ot clean her properly.			change, proper PPE and hand	t		
					washing/sanitizing.			
	The clinical record	was reviewed on 10/28/24 at			Observational rounds will be			
	2:49 P.M. A Quarte	erly MDS (Minimum Data Set)			completed by DNS/Designee	1		
		9/24/24, indicated the resident			ensure proper PPE and			
		act, used a wheel chair,			handwashing/sanitizing			
		to maximum assistance with			techniques are being used pri	or to		
	-	al hygiene, was incontinent of			and during resident care.			
		had a primary diagnosis of			How will the facility monitor	its		
	· ·	tructive pulmonary disease),			corrective actions to ensure	-		
	· ·	nfection within the last 30			that the deficient practice wi	II I		
		enous catheter, had been on			not recur?			
	-	tions, required isolation			The DNS/Designee will be	;		
	precautions, and wa	-			responsible for the completion			
	•				the Proper PPE, Hand			
	On 10/31/24, at 9:2	2 A.M., while peri care and linen			Washing/Sanitizing and Enhai	nced		
	change was perform	ned for Resident 85 CNA			Barrier Procedures QA tool we			
	(Certified Nurses A	ide) 7 stopped QMA (Qualified			x 4 weeks, monthly x 6, then	,		
	Medication Aide) 5	to remind them to change their			quarterly until continued			
	gloves before proce	eding after the resident's			compliance is maintained for 2	2		
	soiled incontinence	brief was removed and skin			consecutive quarters. The res			
	was cleansed. QMA	5 took off soiled gloves and			of the audits will be reviewed l			
	put on clean gloves.	, did not wash or sanitize			the QAPI committee overseen	-		
	hands. CNA 7 did n	ot change their gloves, wash			the ED. If a threshold of 100%	is		
	or sanitize hands, at	fter removing soiled bed pan			not achieved, an action plan w	vill		
	from underneath the	e resident before continuing			be developed.			
	with care, including	assisting the resident with			-			
	washing their face.	3. On 10/29/24 at 10:15 A.M.,						
	Resident 86's clinic	al record was reviewed.						
	Diagnoses included	, but were not limited to, stage						
	4 pressure ulcer of s	sacral region.						
	The most recent Sig	gnificant Change Minimum						
	Data Set (MDS) As	sessment, dated 10/11/24,						
	indicated Resident	86 had no cognitive						
	impairment, require	ed substantial to maximal						
	assistance of staff (s	staff does more than half) for						
	all Activities of Dai	lly Living (ADLs), and had one						
	stage 4 pressure ulc	er on admission to the facility.						
		-						

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
TAG	The most current w 10/23/24, indicated ulcer on the sacrum (cm) in length, 8 cm Care plans included Resident is at risk of colonized with an Morganism) and requiprecautions due to a and a chronic wound dated 9/16/24. Internot limited to, enhal wear gown and glover resident care activite. The clinical record EBP. On 10/30/24 at 9:40 (LPN) 4 was observed Resident 86. LPN 4 performing the wound Resident 86 was on (EBP) was observed gloves in the room. On 10/31/24 at 10:4 Preventionist (IP) in wounds automatical should wear gown a any major care for the provided a current to the provided and the provide	A.M., Licensed Practical Nurse red performing wound care for was not wearing a gown while and care. A sign indicating Enhanced Barrier Precautions I hanging on the wall by the A.M., the Infection adicated that residents with ally got placed on EBP. Staff and gloves while performing	TAG	DEFICIENCY	DATE			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155224	` ′	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 11/01	ETED
NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	ARY STATEMENT OF DEFICIENCIE CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)		TE	(X5) COMPLETION DATE
	activities that provid MDROs to staff har barrier precautions a chronic wounds and	igh-contact resident care de opportunities for transfer of ands and clothing. Enhanced are used for: Resident(s) with d/or indwelling medical of their MDRO status".					

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