PRINTED: 01/30/2025 FORM APPROVED OMB NO. 0938-039

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

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			COMPL		
		155224	B. WI	NG		12/31/	2024
	ROVIDER OR SUPPLIER			621 W (ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST VILLE, IN 47710		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AV OF CORRECTION		(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'	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· L	DATE
F 0000							
Bldg. 00	IN00449174. Complaint IN00449 related to the allegates F842.	55224 66780	F 00	000	The creation and submission the Plan of Correction does reconstitute an admission by the provider of any conclusions forth in the statement of deficiencies, or of any violatiof regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey re-visit.	not ne et on	
	accordance with 410	reflect State Findings cited in DIAC 16.2-3.1. pleted on January 8, 2025.					
F 0695 SS=D Bldg. 00	failed to follow the resident reviewed for (Resident D) The re	eostomy Care and and record review, the facility nebulizer policy for 1 of 1 or hospital discharge. sident was not assessed prior tment, facility staff did not	F 06	595	F695 Respiratory/Tracheosto Care and Suctioning It is the policy of this facility ensure respiratory care is provided consistent with		01/30/2025
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	3	TITLE		(X6) DATE
Andrea				Beran			01/17/2025

Any defiency statement 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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/31/2024	
	ROVIDER OR SUPPLIER		621 W	ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST SVILLE, 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 BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	stay at bedside during Resident D was lated no respirations or pure Finding includes: On 12/30/24 at 10:5 record was reviewed 12/6/24. A Minimulation had not been compiled to Continuous oxygen Start date 12/9/24 Albuterol sulfate somedication) for neb 1/3 mL (milliliters) indate 12/10/24 Observe pulse, respubefore each nebulized Start date 12/9/24 Observe pulse, respubefore each nebulized Start date 12/9/24 Code status full code A nursing progress A.M., indicated a Q (QMA) yelled for he found not breathing breathing treatment resuscitation (CPR)	ing the nebulizer treatment; or found by a staff member with alse. A.M., Resident D's clinical d. Resident D was admitted on am Data Set (MDS) Assessment eted. Index included, but were not at 2 liters per nasal cannula, Ilution (bronchodilator ulization; 0.63 mg (milligrams) inhalation every 4 Hours, Start irations and breath sounds er treatment, four times a day, irations and breath sounds treatment, four times a day, irations and breath sounds treatment, four times a day, irations and breath sounds treatment, four times a day, irations and breath sounds treatment, four times a day, irations and breath sounds and breath sounds treatment, four times a day, irations and breath sounds treatment, four times a day, irations and breath sounds and without a pulse during a		professional standards of practice. 1. How will corrective action accomplished for those residents found to have been affected by this deficient? Resident D is not longer residents in facility. RN#5 was in-serviced on new treatment documentation and policy for remaining with residenting the treatment unless otherwise ordered. 2. How will the facility ident other residents having the potential to be affected by the same deficient practice? All residents who receive new treatment orders will be audiensure they have orders for monitoring pulse, respiration breath sounds prior to nebuli treatment. All nurses will be in-serviced DNS/designee on following nebulizer treatment orders, completing documentation as as remaining with resident did the treatment unless otherwite ordered. 3. What measures will be purinto place or systematic changes made to ensure the	n be en ding bulizer d dent ify the bulizer is ted to s and zer by s well uring se
	Resident D was tran	nsported to the hospital.		the deficient practice will no reoccur?	

STATEMEN	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		12/31/2024	
						<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIE	R			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	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	The electronic med	lication administration record			DNS/designee will complete d	daily	
	(eMAR) on 12/11/2	24 lacked documentation for the			audit of residents with nebuliz	· ·	
	following:				treatment orders to ensure		
	10:00 A.M. albuter	ol nebulizer treatment			documentation completed per		
	Pulse, respirations,	breath sounds, oxygen			policy.		
	saturation before n	ebulizer treatment			DNS/designee will complete d	daily	
	administration				rounds to ensure nurses rema	· ·	
					with residents during nebulize		
	An SBAR physicia	in communication event, dated			treatments unless otherwise		
		2 A.M., indicated Resident D			ordered.		
	was not using oxyg				4.How will the facility monito	or	
		,			its corrective actions to ensi		
	During an interview	w on 12/31/24 at 8:31 A.M.,			that the deficient practice wi		
	_	RN) 5 indicated that on			not reoccur?		
	,	D started a breathing treatment			DNS/designee will complete		
		ell. RN 5 left the room while the			respiratory care for nebulizer		
		t was running to call the nurse			treatment QAPI tool weekly fo	or 4	
		indicated a QMA yelled for			weeks, monthly for 6 months		
	_	esident D was found			then quarterly for 2 quarters u		
		Director of Nursing (DON)			continued compliance is		
	initiated CPR.	3 ()			maintained for 2 consecutive		
					quarters. The results of these	<u>,</u>	
	During an interview	w on 12/31/24 at 9:39 A.M., the			audits will be reviewed by the		
	_	essments should be completed			QAPI committee overseen by		
		irse before, during, and after			ED. If threshold of 90% is not		
	1	tment, and indicated RN 5 was			achieved, an action plan will b		
	_	eduled to cover the nursing			developed. Deficiency in this		
	I	alls of the first floor from 6:00			practice will result in disciplina	arv	
	A.M. to 2:00 P.M.				action up to and including	,	
					termination of responsible		
	On 12/30/24 at 3:0	9 P.M., the Administrator			employee.		
		ty did not have a nebulizer			5. Date of Compliance: 1.30.2	25	
		nd indicated all nurses had a				-	
		t skills check off during					
		time, she provided a document					
		reatment" that indicated "6.					
		ment including pulse,					
	•	eath sounds 11. Stay with					
	_	ire procedure 13. During					
	_	assessment including pulse,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 12/31/2024			
NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER			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 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 0842 SS=E Bldg. 00	post-assessment incibreath sounds. 19 information on med (MAR) and nebulize. This citation relates 3.1-47(a)(6)	and record review, the facility umentation was complete and resident records reviewed. On and nebulizer treatments complete on the Medication ord. (Resident C, Resident O, ant U) 0:32 A.M., Resident C's clinical d. Diagnoses included, but diabetes mellitus. uarterly Minimum Data Set detailed to maximal assistance from the than half) for bathing, and the out of seven days during	F 0842	F842- Resident Records – Identifiable Information It is the practice of this facilit to ensure resident records at maintained in a complete, accurate, organized and accessible manor. 1. How will corrective action accomplished for those residents found to have been affected by this deficient? Resident C was assessed with ill effects noted related to miss EMAR documentation. Reside is receiving medications/treatments per organd documentation is being completed. Resident O was assessed with ill effects noted related to miss EMAR documentation. Reside is receiving medications/treatments per organd documentation is being completed. Resident M was assessed with Interest to the property of the prope	be n n no sing ent C der n no sing ent O der

I f '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155224	B. WI	B. WING)24
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER			SVILLE, IN 47710		
	T						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	D1				ill effects noted related to miss	·	
		icluded, but were not limited to:			EMAR documentation. Reside	nt	
	_	J-100 Insulin (insulin aspart) (a			M is receiving	.	
	_	n) - 100 unit/mL (units per			medications/treatments per or	der	
	1	ister subcutaneously per sliding			and documentation is being		
		gar is less than 60, call Medical			completed.		
		lood Sugar is 0 to 199, give 0			Resident U was assessed with		
		gar is 200 to 249, give 2 Units. If			ill effects noted related to miss	~	
	_	to 299, give 3 Units. If Blood			EMAR documentation. Reside	int U	
	_	9, give 4 Units. If Blood Sugar is			is receiving		
		Units. If Blood Sugar is 400 to If Blood Sugar is greater than			medications/treatments per or	der	
	500, call MD, date				and documentation is being		
	500, call MD, date	u 11/19/24.			completed.	I	
	inculin alorgina col	lution (a long-acting insulin)			2. How will the facility identif	у	
		ninister 10 units subcutaneously			other residents having the potential to be affected by the		
		11/29/24 with a stop date of			same deficient practice?	.e	
	12/23/24.	11/2//24 with a stop date of			All residents have to potential	to	
	12/23/24.				be affected by the alleged def		
	The December 202	4 Medication Administration			practice.	OICH	
		ked documentation to indicate			A 100% audit for last 30 days	of	
	` ′	d the 11:00 P.M. dose of insulin			EMAR documentation will be	°'	
		and 12/10/24 and the 8:00 P.M.			completed.		
	dose of insulin glan				DNS/designee will in-service		
		-			nurses and QMAs on complet	ina	
	On 12/31/24 at 9:3	8 A.M., the Director of Nursing			EMAR documentation and rur	-	
		nat she was unsure if Resident C			their compliance reports prior	-	
	1 1	ordered on 12/8/24, 12/10/24,			end of their shifts.		
	1 -	it was not documented as			3.What measures will be put		
	given.				into place or systematic		
	2. On 12/30/24 at 1	1:24 A.M., Resident U's clinical			changes made to ensure tha	t	
	record was reviewed. Diagnoses included, but				the deficient practice will no		
	were not limited to	, type 2 diabetes mellitus.			reoccur?		
					DNS/designee will review		
	The most recent Qu	uarterly Minimum Data Set			administration compliance rep	ort	
	(MDS) Assessmen	t, dated 10/16/24, indicated			daily in clinical meeting to ens		
	Resident U was co	gnitively intact, required partial			100% compliance. DNS/design	gnee	
	assistance from sta	ff for transfers, and received			will follow up with any staff that	at	
	insulin seven of se	ven days during the lookback			have missing documentation.		
1	period.				4. How will the facility monitor	or	

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155224	B. W	B. WING 12/31/2024			/2024
		<u>I</u>		CTPEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			COLUMBIA ST		
COLLINE	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
COLUMB	NA HEALTHOAKE	OLIVILIX		LVANS	· · · · · · · · · · · · · · · · · · ·		
(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
					its corrective actions to ensu		
		orders included, but were not			that the deficient practice wi	II	
	limited to:				not reoccur?		
	_	(a hypoglycemic injection);			DNS/designee will complete		
		ter: 60 units subcutaneous,			EMAR compliance QAPI tool		
		nsulin if blood sugar is below			weekly for 4 weeks, monthly for		
	120, at bedtime eve	ery day. Start date 10/18/24.			months and then quarterly for	2	
					quarters until continued		
		ication administration record			compliance is maintained for 2		
		cumentation for the following:			consecutive quarters. The res		
	12/16/24 8:00 P.M.	blood sugar results			of these audits will be reviewe	•	
					the QAPI committee overseer	•	
	12/16/24 8:00 P.M.	Basaglar insulin administration			the ED. If threshold of 90% is		
					achieved, an action plan will b	e	
		2:20 P.M., Resident M's clinical			developed. Deficiency in this		
		d. Diagnoses included, but			practice will result in disciplina	ary	
	were not limited to,	type 2 diabetes mellitus.			action up to and including		
					termination of responsible		
		narterly Minimum Data Set			employee.		
		, dated 9/29/24, indicated			5. Date of Compliance: 1.30.2	25	
	_	tion was too low to be					
	· ·	vas substantial assistance					
	*	half of the work) for toileting,					
	-	ers, and received insulin seven					
	of seven days durin	g the lookback period.					
	Cumont physicis -	orders included, but were not					
		orders meruded, but were not					
	limited to:	Amount to Administer: 9 units					
		e times a day, Start date					
	7/15/24.	times a day, Start date					
	//13/24.						
	inculin liento nen:	Amount to Administer					
	insulin lispro pen; Amount to Administer: If Blood Sugar is less than 60, call MD.						
	_	to 149, give 0 Units.					
	_	50 to 169, give 1 Units.					
	-	70 to 189, give 2 Units.					
	-	90 to 209, give 3 Units.					
	-	10 to 229, give 4 Units.					
	-	30 to 249, give 6 Units.					
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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 12/31/2024
	PROVIDER OR SUPPLIEI		621 W	ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST SVILLE, IN 47710	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
PREFIX TAG	REGULATORY OF IT Blood Sugar is 2 If Blood Sugar is 2 Units. If Blood Sugar is g 12 Units. If Blood Sugar is g 12 Units. If Blood Sugar is g Subcutaneous three 12/4/24. The electronic med (eMAR) lacked dod 12/28/24 12:00 P.M administration 12/28/24 12:00 P.M administration 12/28/24 12:00 P.M administration 12/29/24 12:00 P.M administration 12/29/24 12:00 P.M administration 4. On 12/30/24 at 2 record was reviewed were not limited to disease. The most recent Qu (MDS) Assessment Resident M's cogni assessed, resident v (staff did all the work staff did all the w	R LSC IDENTIFYING INFORMATION 50 to 269, give 8 Units.	PREFIX TAG		ATE COMPLETION DATE
	Current physician of	orders included, but were not			

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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 12/31/2024
	PROVIDER OR SUPPLIER BIA HEALTHCARE CENTER	621 W (ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST VILLE, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	limited to: ipratropium bromide solution 0.02% inhalation (bronchodilator nebulizer medication) four times a day, Start date 11/25/24			
	Observe pulse, respirations and breath sounds before each nebulizer treatment, Start date 10/31/24			
	Observe pulse, respirations and breath sounds after each nebulizer treatment, Start date 10/31/24			
	The electronic medication administration record (eMAR) lacked documentation for the following: 12/1/24 8:00 A.M. ipratrompium bromide administration			
	12/1/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds			
	12/2/24 8:00 A.M. ipratrompium bromide administration			
	12/2/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds			
	12/3/24 8:00 A.M. ipratrompium bromide administration			
	12/3/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds			
	12/6/24 12:00 P.M. ipratrompium bromide administration			
	12/23/24 8:00 A.M. ipratrompium bromide administration			

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Event ID:

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NAME OF PROVIDER OR SUPPLER COLUMBIA HEALTHCARE CENTER (X4)ID SIMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MOST BE PRECEDE BY PLL) TAG: REGILATORY OR SE CUPINTENTIAN MORROMATION 12/23/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds 12/25/24 4:00 P.M. ipratrompium bromide administration including pulse, respiration, and breath sounds On 12/30/24 at 3:09 P.M., the Administrator indicated the finality did not have a nebulizer restament documentation policy, and indicated all nurses had a nebulizer treatment shulting pulse, respiration, and breath sounds. On 12/30/24 at 3:09 P.M., the Administrator indicated the finality did not have a nebulizer treatment documentation policy, and indicated all nurses had a nebulizer treatment document titled. Note builtier treatment document titled indicated all nurses had a nebulizer treatment shift beach off during orientation. At that time, she provided a document titled. Note builtier treatment with indicated "C Perform pre-assessment including pulse, respiration, and breath sounds	STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		NSTRUCTION	(X3) DATE	
STREET ADDRESS. CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEPTICIENCY MUST BE PRECEDED BY PILL). TAG REQULATIONY GOES LEG IDENTIFYING INFORMATION 1223274 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds 1225524 4:00 P.M. ipratrompium bromide administration including pulse, respiration, and breath sounds On 1230-24 at 3:09 P.M., the Administrator indicated the facility did not have a nebulizer restament documentation poley, and indicated all nurses had a nebulizer treatment document titled "Nebulizer Treatment" that indicated "C. Perform pre-assessment including pulse, respiration, and breath sounds. 1. Slay with resident during entire procedure	AND PLAN					00		
E21 W COLUMBIA ST EVANSVILLE, IN 47710 (X4) D SUMMARY STATEMENT OF DEFICIENCE (GACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 12/23/24 8:00 A.M., pre and post nebulizer assessment including pulse, respiration, and breath sounds 12/25/24 4:00 P.M. ipratrompium bromide administration 12/25/24 4:00 P.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds On 12/30/24 at 3:09 P.M., the Administrator indicated the facility did not have a nebulizer restment documentation policy, and indicated all nurses had a nebulizer treatment skills check off during orientation. At that time, she provided a document titled "Nebulizer Treatment" that indicated "6. Perform pre-assessment including pulse, respiration, and breath sounds 11. Stay with resident during entire procedure 13. During procedure perform assessment including pulse, respiration, and breath sounds 16. Perform post-assessment including pulse, respiration, and breath sounds 19. Document pertinent information on medication administration record (MAR) and nebulizer treatment flow sheet". During un anonymous interview, it was indicated that the facility was often not fully staffed during the evening shift making it difficult to complete all tasks. They indicated documentation was a task that was left unfinished. On 12/31/24 at 9:53 A.M., the DON provided a current Medication Administration will be recorded on the MAREMARK or TAR					12/31/	/2024		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 12/23/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds 12/25/24 4:00 P.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds On 12/25/24 4:00 P.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds On 12/30/24 at 3:09 P.M., the Administrator indicated the facility did not have a nebulizer treatment documentation policy, and indicated all nurses had a nebulizer treatment documentation policy, and indicated all document titled "Nebulizer Treatment documentation policy, and indicated all nurses had a nebulizer treatment documentation policy, and indicated all document titled "Nebulizer Treatment" that indicated "6- Perform pre-assessment including pulse, respiration, and breath sounds 11. Stay with resident during entire procedure 13. During procedure perform assessment including pulse, respiration, and breath sounds 16. Perform post-assessment including pulse, respiration administration on medication administration record (MAR) and nebulizer treatment flow sheet". During an anonymous interview, it was indicated that the facility was often not fully staffed during the evening shift making it difficult to complete all tasks. They indicated documentation was a task that was left unfinished. On 12/31/24 at 9:53 A.M., the DON provided a current Medication Administration policy, revised 7/20/3, that indicated "Medication administration wail the recorded on the MAREMAR or TAR					621 W 0	COLUMBIA ST		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 12/23/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds 12/25/24 4:00 P.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds On 12/30/24 at 3:09 P.M., the Administrator indicated the facility did not have a nebulizer treatment documentation policy, and indicated all nurses had a nebulizer reatment documentation policy, and indicated all nurses had a nebulizer reatment document titled "Nebulizer Treatment" that indicated "6. Perform pre-assessment including pulse, respiration, and breath sounds with resident during entire procedure 13. During procedure perform assessment including pulse, respiration, and breath sounds 16. Perform post-assessment including pulse, respiration, and breath sounds 16. Perform post-assessment including pulse, respiration, and breath sounds 16. Perform post-assessment including pulse, respiration, and breath sounds 16. Puring an anonymous interview, it was indicated that the facility was often not fully staffed during the evening shift making it difficult to complete all tasks. They indicated documentation was a task that was left unfinished. On 12/31/24 at 9:53 A.M., the DON provided a current Medication administration policy, revised 7/20/3, that indicated "Mediation administration wail to be recorded on the MAREMAR or TAR	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID			(X5)
12/23/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds 12/25/24 4:00 P.M. ipratrompium bromide administration including pulse, respiration, and breath sounds On 12/30/24 at 3:09 P.M., the Administrator indicated the facility did not have a nebulizer treatment documentation policy, and indicated all nurses had a nebulizer treatment documentation policy, and indicated all nurses had a nebulizer treatment focumentation policy. At that time, she provided a document titled "Nebulizer Treatment" that indicated "A Perform pre-assessment including pulse, respiration, and breath sounds 11. Stay with resident during entire procedure 13. During procedure perform assessment including pulse, respiration, and breath sounds 16. Perform post-assessment including pulse, respiration, and breath sounds 19. Document pertinent information on medication administration record (MAR) and nebulizer treatment flow sheet". During an anonymous interview, it was indicated that the facility was often not fully staffed during the evening shift making it difficult to complete all tasks. They indicated documentation was a task that was left unfinished. On 12/31/24 at 9:53 A.M., the DON provided a current Medication Administration policy, revised 7/20/23, that indicated "Mediation administration will be recorded on the MAREMAR or TAR					PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	rc	
assessment including pulse, respiration, and breath sounds 12/25/24 4:00 P.M. ipratrompium bromide administration 12/25/24 4:00 P.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds On 12/30/24 at 3:09 P.M., the Administrator indicated the facility did not have a nebulizer treatment documentation policy, and indicated all nurses had a nebulizer treatment skills check off during orientation. At that time, she provided a document titled "Nebulizer Treatment" that indicated "6. Perform pre-assessment including pulse, respiration, and breath sounds 11. Stay with resident during entire procedure 13. During procedure perform assessment including pulse, respiration, and breath sounds 16. Perform post-assessment including pulse, respiration, and breath sounds 19. Document pertinent information on medication administration record (MAR) and nebulizer treatment flow sheet". During an anonymous interview, it was indicated that the facility was often not fully staffed during the evening shift making it difficult to complete all tasks. They indicated documentation was a task that was left unfinished. On 12/31/24 at 9:53 A.M., the DON provided a current Medication Administration redication administration will be recorded on the MAR/EMAR of TAR	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i	DATE
(Treatment Administration Record) after given".		12/23/24 8:00 A.M. assessment includin breath sounds 12/25/24 4:00 P.M. administration 12/25/24 4:00 P.M. assessment includin breath sounds On 12/30/24 at 3:09 indicated the facility treatment document nurses had a nebuliz during orientation. Adocument titled "No indicated "6. Perfor pulse, respiration, a with resident during During procedure pulse, respiration, and breath presentation and breath information administration reconstruction and perform post-assess respiration, and breath information administration reconstruction and presentation information administration reconstruction and presentation information administration reconstruction information administration reconstruction information administration reconstruction information administration reconstruction in the facility was the evening shift matasks. They indicate that was left unfinis. On 12/31/24 at 9:53 current Medication 7/2023, that indicate will be recorded on	pre and post nebulizer ag pulse, respiration, and ipratrompium bromide pre and post nebulizer ag pulse, respiration, and P.M., the Administrator y did not have a nebulizer ration policy, and indicated all zer treatment skills check off At that time, she provided a rebulizer Treatment" that m pre-assessment including nd breath sounds 11. Stay g entire procedure 13. reform assessment including nd breath sounds 16. ment including pulse, ath sounds 19. Document on on medication rd (MAR) and nebulizer t". rus interview, it was indicated often not fully staffed during aking it difficult to complete all red documentation was a task hed. 3 A.M., the DON provided a Administration policy, revised red "Mediation administration the MAR/EMAR or TAR					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

21RC11 Facility ID: 000129

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

PRINTED: 01/30/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155224	B. WING		12/31/	/2024	
NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER			621 W	ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST SVILLE, 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	
	This citation relates 3.1-50(a)(1) 3.1-50(a)(2)	to complaint IN00449174.					

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