PRINTED: 09/22/2023
FORM APPROVED

CENTERS FO	R MEDICARE & MED	ICAID SERVICES				ON	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155224	B. W	ING		08/14	/2023
				CED FEE	ADDRESS OF A STATE SID SOD		
NAME OF	PROVIDER OR SUPPLI	ER			ADDRESS, CITY, STATE, ZIP COD		
00111141		COENTED			COLUMBIA ST		
COLUM	BIA HEALTHCARI	ECENTER		EVAINS	SVILLE, IN 47710		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CO		·N	(X5)
PREFIX	(EACH DEFICII	ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPERTY OF T	BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for	a Recertification and State	F 00	000	Plan of Correction for		
	Licensure Survey	Survey.			Columbia Healthcare Center.		
					F000 Initial Comments		
	Survey dates: Au	gust 7, 8, 9, 10, 11, 14, 2023			The creation and submission	n of	
					this Plan of Correction does	s not	
	Facility number:				constitute an admission by	this	
	Provider number:				provider of any conclusion set forth		
	AIM number: 100	0266780			in the statement of deficien	cies, or	
					of any violation of regulation		
	Census Bed Type	:			This provider respectfully re		
	SNF/NF: 116			that this 2567 Plan of Corre			
	Total: 116				be considered the Letter of		
		·					
	Census Payor Typ			in lieu			
	Medicare: 1				of a post survey review.		
	Medicaid: 99						
	Other: 16						
	Total: 116						
		G . G . F II					
		s reflect State Findings cited in					
	accordance with	+10 IAC 10.2-3.1.					
	Ouglinty ravious	was completed on August 24,					
	2023.	was completed on August 24,					
	2023.						
F 0558	483.10(e)(3)						
SS=D	Reasonable Acc	commodations					
Bldg. 00	Needs/Preferen						
2.49.00	*	he right to reside and receive					
	- , , , ,	acility with reasonable					
		of resident needs and					
		ept when to do so would					
	-	ealth or safety of the resident					
	or other resident	•					
	or other resident	io.	F 0:	550	F558		09/14/2023
l	1		T U,	JJ0	. 555		U2/14/2U23

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

Based on observation and interview the facility

failed to accommodate each resident with the use

TITLE

Needs/Preferences.

Reasonable Accommodations

(X6) DATE

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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155224	B. W	ING		08/14/	2023
				CTREET	ADDRESS CITY STATE 7ID COD		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
COLLIME	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
	, TILALITIOANE	OLIVILIX		LVANO	VILLE, IIN 777 IV		
(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 APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	nmon help from staff for 4 of 4			What corrective action(s) w	ill be	
	residents reviewed for assistance. (Resident 26, Resident 117, Resident 29, Resident 114)				accomplished for those		
					residents found to have bee	en	
					affected by the deficient		
					practice?	_	
	Findings include:				Residents 26,29,114, and 11	7	
	1 0 0/0/22	2.1.1. D. 11. 12.2			have been assessed and no		
		3 A.M., Resident 26's call device			adverse effects noted from the		
		of reach at the top of the bed. It			alleged deficient practice and		
	_	type of device. During an			call lights in reach at all times		
	interview at that time, the resident indicated she				How other residents having		
	had to go to the bathroom and could not find the				potential to be affected by t		
	call device. The call device was activated for the				same deficient practice will		
	resident at 9:44 A.I				identified and what correcti	ve	
		A.M., the resident's clinical			action(s)will be taken?		
		ed. Diagnoses included, but			All residents have the potenti		
		, dementia and COPD.			be affected by the alleged de		
	_	/20/23 indicated resident has			practice. Observational round		
	_	npairment and requires			were completed to ensure all		
	extensive assist of				lights were in reach. Clinical		
	_	an, dated 6/15/23, included or falls. Interventions included,			educated by DNS/designee of		
		*			ensuring call lights within rea		
	reach.	d to, touch pad call light in			What measures will be put i	nto	
		ot provided a touch pad type			place and what systemic changes will be made to en	ouro	
	call light for use.	or provided a toden pad type			that the deficient practice d		
	can fight for use.				not recur?	063	
	2. On 8/8/23 during	g a tour of the 1400 and 1500			As a measure of ongoing		
	1	residents were observed with			compliance and systemic cha	ange	
	call devices out of				the DNS and/or designee will	•	
		sident 117's call device was			complete daily audits of resid		
		ich at the foot of the bed.			rooms to ensure call lights ar		
		dent 114's call devices was			within reach.		
		ich at the foot of the bed.			All staff were inserviced by		
		dent 29's call device was			DNS/designee related to ens	uring	
		ich on the floor under the bed.			call lights within reach at all ti	-	
					How the corrective action(s		
	Policy for call light	ts was not provided.			be monitored to ensure the	•	
		•			deficient practice will not		
	On 8/11/23 at 11:19 A.M., a current Resident				recure, IE: what quality		

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEPLAY OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/14/2023
	ROVIDER 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	reviewed. It indicates the rights of resident assume their response.	as 7/23 was provided and ed "all staff members recognize ts at all times and residents sibilities to enable personal and proper delivery of care."		assurance program will be p into place? The DNS/designee will be responsible for the completion the Accommodation of Needs Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The resof these audits will be reviewed the QAPI committee overseen the ED. If threshold of 100% is achieved, an action plan will be developed. Deficiency in this practice will result in disciplina action up to and including termination of responsible employee. By what date the systemic changes for each deficiency be completed? September 14, 2023.	of QA Sults d by by s not e
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene; Based on observation review, the facility who are unable to coliving received the regood grooming, and	d for Dependent Residents esident who is unable to of daily living receives the set to maintain good go, and personal and oral on, interview, and record failed to ensure that residents earry out activities of daily necessary services to maintain a personal and oral hygiene for ewed. (Resident 26, Resident	F 0677	F677 ADL Care Provided for Dependent Residents What corrective action(s) win accomplished for those residents found to have been	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 08/14/2023 155224 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 621 W COLUMBIA ST EVANSVILLE, IN 47710 COLUMBIA HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 72, Resident 88) affected by the deficient practice? Findings include: Residents 26, 72, and 88were reviewed for their preferences in 1. During an interview and observation with bathing, and are receiving Resident 26 on 8/8/23 at 9:43 A.M., her hair was assistance necessary to maintain observed to be very disheveled. She indicated the adequate grooming and hygiene. facility has staff but some of the people don't How other residents having the bother to work. Resident indicated she had to go potential to be affected by the to the bathroom now. She called for help at 9:44 same deficient practice will be A.M. No help arrived, no one was in the hall. At identified and what corrective 9:55 A.M., the resident got to her feet and refused action(s)will be taken? to sit back down. She begged to go to the All residents have the potential to bathroom. A clinical instructor, who indicated she be affected by this alleged was employed by the facility, came to the door to deficient practice. An audit of all see what was going on. She left to get help. residents to note current bathing Resident continued to try and walk to the preferences will be completed by bathroom and cried out "I'm pooping on myself". Social Services and reviewed by At 9:58 A.M., QMA (Qualified Medication Aide) 9 nursing administration for and CNA (Certified Nursing Assistant) 6 arrived implementation. to assist resident. They helped her to sit on the All Residents will have their toilet, and cleaned up the bowel movement. When preferences met and offered finished, QMA 9 assisted the resident into her bathing as requested; with chair and put her oxygen tubing back on her and refusals for care documented handed her the call device, wearing the same appropriately by staff. gloves she used to clean up the bowel movement. What measures will be put into place and what systemic During an interview with Resident 26 on 8/8/23 at changes will be made to ensure 10:11 A.M., her hair was observed to be very that the deficient practice does disheveled and greasy-looking. Resident not recur? An in-service will be completed

indicated she needs help because it's long. She indicated she gets a shower once a week, and washes herself in between showers.

On 8/9/23 at 11:12 A.M., the resident was observed sleeping in her wheelchair in the hallway. Her hair was still very disheveled and greasy-looking.

On 8/14/23 at 8:55 A.M., the resident's clinical

with all nursing staff by DNS

refusals and the systemic practice

and/or designee related to appropriate documentation of

of returning to help/ask the

Observational rounds will be completed daily to ensure that

residents are receiving adequate

resident more than once.

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 08/14/2023 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 record was reviewed. Diagnoses included, but assistance to maintain grooming were not limited to, chronic pulmonary obstructive and hygiene. disease (COPD), dementia, epilepsy, anxiety, How the corrective action(s) will depression, and heart failure. be monitored to ensure the The Admission MDS (Minimum Data Set) deficient practice will not Assessment, dated 6/20/23, indicated the resident recure, IE: what quality had severe cognitive impairment and requires assurance program will be put extensive assistance of 2 for bed mobility, into place? The DNS/designee will be transfers, and toileting, limited assistance of 1 for eating, and total dependence for bathing. responsible for the completion of the ADL Care for Dependent Care plan date 6/15/23 Resident requires Residents QA Tool weekly times 4 assistance with ADL's...provide ADL assistance, weeks, bi-monthly times 2 including oral care, to maintain comfort and months, monthly times 4 and then dignity. Assist with bathing, as needed per quarterly until continued resident preference. Offer showers two times per compliance is maintained for 2 week. partial bath in between. consecutive quarters. The results Shower schedule reviewed at that time the of these audits will be reviewed by resident was scheduled for showers on Monday the QAPI committee overseen by and Thursday. No record of showers completed the ED. If threshold of 100% is not was available. achieved, an action plan will be developed. Deficiency in this 2. During an observation and interview with practice will result in disciplinary Resident 72 on 8/8/23 at 10:59 A.M., she was action up to and including observed to have hair that was grossly disheveled termination of responsible and greasy-looking. The resident indicated she employee. gets a bed bath about once a week. By what date the systemic changes for each deficiency will During observation and interview on 8/8/23 at be completed? 10:59 A.M., resident's hair was observed to be September 14, 2023. grossly disheveled and greasy-looking. Resident indicated she gets a bed bath about once a week. F689 On 8/9/23 at 10:00 A.M., Resident 72 was observed asleep in bed with grossly disheveled and greasy-looking hair. During an interview with resident on 8/10/23 at 9:35 A.M., resident indicated she gets bed baths, not showers, because she can't get her surgical

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLE	
		155224	B. W.	ING		08/14/2	2023
	PROVIDER OR SUPPLIER		-	621 W 0	DDRESS, CITY, STATE, ZIP COD COLUMBIA ST VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOWIDED'S DI AN OF CODDECTION	Ī	(X5)
PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
		nair was disheveled and					
		sident indicated that today the					
		r on it and called it a day".					
		ho was on the speaker phone					
	weeks ago.	d the last hair wash was 2					
	weeks ago.						
	During an interview	on 8/11/23 at 9:41 A.M. with					
	_	ed that CNA's wash under the					
	· ·	k, and genital area. She added					
		paste and mouthwash, but					
		like the mouthwash and won't					
		eeth. She indicated they do					
		every time they give her a never refused a bed bath or					
	shower.	lever refused a bed bath or					
	SHOWEI.						
	During an observati	ion and interview with resident					
	_	P.M., her hair was observed to					
	again be grossly dis	sheveled and greasy-looking.					
	She indicated she h	ad no bath today because she					
	is tired and has been	n sleeping all day.					
	On 8/11/23 at 2:07	P.M., the resident's clinical					
		d. The record indicated the					
		artial bed baths on 8/10/23,					
		23, 8/2/23, 7/28/23, 7/26/23,					
	7/25/23.						
	During interview as	n 8/14/23 at 10:00 A.M. with					
	_	ted a partial bed bath includes					
	1	it's face, hands, arm pits, under					
	_	en, and genital area.					
		-					
		A.M., the resident was					
	•	bed. Hair was observed to be					
	disheveled and grea	sy-looking.					
	On 8/14/23 at 8·27	A.M., the resident's clinical					
		d. Diagnoses included, but					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		155224	B. WI	NG	_	08/14/	/2023
NAME OF T	DOMDED OF CURRY TER			STREET A	DDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER				COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ACH DEFICIENCY 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
		cerebral palsy, neuromuscular					
	anxiety, and depress	der, urostomy, colostomy,					
		OS (Minimum Data Set)					
		7/11/23, indicated resident is					
		nd requires extensive					
		ped mobility, complete					
		sfers, extensive assistance of					
	-	ssistance of 1 for toileting, and					
	total dependence fo	r bathing.					
	Current physician orders included, but were not limited to: Up Ad Lib Wheel Chair Assist 2 with						
	mechanical lift 7/5/2	23.					
	Care Plan included:	resident requires assistance					
		ily living (ADL's), including					
		Fers, eating, and toileting					
	_	s of neurogenic bladder,					
	_	deficiency anemia, depression,					
	mood disorder, inso	-					
		flux (GERD), allergies. Has					
	urostomy and colos	tomy.					
	Interventions include	led:					
	a. assist with ambul						
		ig as needed per resident					
	-	nowers 2 times per week, partial					
	bath in between	1.00					
	c. assist with bed m	-					
		ng/grooming/hygiene as					
	_	resident to do as much for self					
	as possible	and drinking as needed					
		g appliance as needed					
	·	are at least 2 times daily					
	-	ng and/or incontinent care as					
	needed	<u> </u>					
		A.M., Resident 88 indicated					
		nen she last had a shower, and					
		t showers as often as she					
							İ

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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	COM	E SURVEY PLETED 4/2023	
	PROVIDER OR SUPPLIEF		621 W	ADDRESS, CITY, STATE, ZIP CO COLUMBIA ST SVILLE, IN 47710	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	On 8/10/23 at 10:28 she preferred show washed in the show staff does not wash On 8/10/23 at 8:53 the past 6 months washower report sheet At that time, the AI Nursing) indicated others. She further refused her shower progress notes or in On 8/10/23 at 8:44 record was reviewed included, but was not disease. The most recent quested sextensive assistance of 2 decirity as	History indicated that in the				
	past 6 months, Resi	dent 88 received showers on				

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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	(X3) DATE SURVEY COMPLETED 08/14/2023		
	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR 5/4/23, 5/5/23, 6/10 Point of Care Histor refusal. On 8/11/23 at 11:19 Rights policy dated reviewed. It indicate the rights of residen assume their respondignity, well being at 3.1-38(a)(3)(B) 3.1-38(b)(2) 3.1-38(b)(3) 483.25(d)(1)(2) Free of Accident Hazards/Supervisis §483.25(d) Accided The facility must estable §483.25(d)(1) The remains as free of possible; and §483.25(d)(2)Each adequate supervisito prevent accident Based on interview, observation, the fact supervision, assistator reduce the risk of reviewed for falls we and Resident 39) Findings include: 1. Resident 94's climater in the state of the supervision in the supervision. 1. Resident 94's climater in the supervision in the supervision.	LISC IDENTIFYING INFORMATION /23, 7/8/23, and 8/3/23. The ry lacked documentation of a A.M., a current Resident as 7/23 was provided and ed "all staff members recognize its at all times and residents sibilities to enable personal and proper delivery of care." ion/Devices ents. ensure that - eresident environment accident hazards as is n resident receives sion and assistance devices ats. erecord review, and fility failed to provide adequate ence devices, or interventions and fall for 2 of 3 residents with major injuries. (Resident 94)		F689 Free of Accident Hazards/Supervision Device What corrective action(s) wi accomplished for those residents found to have bee affected by the deficient practice? It is the practice of this facility implement interventions to pre	09/14/2023 s be n to
		Diagnoses included, but were 2 diabetes mellitus, dysphagia, degeneration.		accidents. Resident 94 and resident 39 fall care plans well reviewed and updated as	re

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155224	B. W	NG		08/14/	
				_			
NAME OF F	ROVIDER 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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					appropriately needed.		
	Resident 94's most	recent Annual Minimum Data			How other residents having	the	
	Set (MDS) Assessn	nent, dated 7/7/23, indicated			potential to be affected by th		
		verely cognitively impaired,			same deficient practice will be		
		assistance of two people for			identified and what correctiv		
	-	ers, and required extensive			action(s)will be taken?		
	-	erson for toileting and bathing.			All residents have the potentia	ıl to	
	•	2 2			be affected by the deficiency.		
	Resident 94's care r	plan included, but were not			Residents with fall intervention	ns l	
	•	ith toileting and/or incontinent			were reviewed to ensure		
		one with transfers, dated			appropriateness of intervention	ns.	
	08/24/2021.				What measures will be put in		
	002,2021				place and what systemic		
	A fall event report was created on 7/20/23 at 2:43				changes will be made to ens	ure	
	_	t indicated an unwitnessed fall			that the deficient practice do		
		wer room bathroom, and the			not recur?		
		lying on the floor with severe			Nursing staff will be educated	in I	
		d/wrist accompanied by	implementing care planned fall				
	-	note indicated a Nurse			interventions. The Clinical		
	-	lled regarding the fall, and an			Education nurse and/or Design	nee	
		vas placed. The x-ray indicated			will train/teach the implementa		
	-	ver left radius and required a			process starting during specifi		
		ne left wrist. The fall event			orientation and on-going learn		
	•	ention put in place related to			DNS/designee will review all fa	-	
		educated on staying with the			documentation to determine ro		
	patient when using				cause of fall and develop		
					appropriate intervention to add	d to	
	During an interview	v on 8/11/23 at 8:20 A.M., the			care plan.		
	-	g (DON) indicated staff had			Observational rounds will be		
		4 in to the shower room			completed daily to ensure that	fall	
	bathroom, transferr	ed Resident 94 to the toilet,			interventions are in place per t		
		4 unattended in the bathroom.			plan of care for interventions a		
	When staff returned	d to the bathroom, Resident 94			to fall care plans.		
		oor. The DON confirmed the			How the corrective action(s)	will	
	resident was to be a	assisted with transfers and			be monitored to ensure the		
	toileting, and indica	ated the intervention put in			deficient practice will not		
	place related to this fall was to educate staff to				recure, IE: what quality		
	stay with resident while toileting.				assurance program will be p	ut	
	•	:01 A.M., Resident 39's clinical			into place?		
		d. Resident 39 was admitted on			The DNS/designee will be		

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155224	B. W	ING		08/14/	2023
				CTD FFT A	DDDFGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
00111145	NA LIEAL TUGADE	OFNITED			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN 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	TC .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	8/31/22. Diagnoses	included, but were not limited			responsible for the completion	of	
		hemiparesis following cerebral			the Fall Management QA Tool		
		left nondominant side and			weekly times 4 weeks, bi-mon		
	maxillary fracture, l				times 2 months, monthly times		
	11.00.11.10.1				and then quarterly until continu		
	The most recent Ou	arterly MDS (Minimum Data			compliance is maintained for 2		
		ated 7/13/23, indicated			consecutive quarters. The res		
	1	oderately impaired cognition, 1			of these audits will be reviewe		
		since the prior assessment on			the QAPI committee overseen	•	
		ed extensive assistance of 2			the ED. If threshold of 100% is	-	
	staff for transfers ar				achieved, an action plan will b		
	starr for transfers ar	id tolleting.			developed. Deficiency in this	-	
	A current care nlan	, revised 8/9/23, indicated			practice will result in disciplina	ırı /	
	_	risk for falls due to weakness,			action up to and including	1 y	
		id impaired cognition with an					
		· ·			termination of responsible		
	intervention of car	l light in reach" dated 9/1/22.			employee.		
	The clinical record	indicated that Resident 39 fell			By what date the systemic	:	
					changes for each deficiency	WIII	
	13 (thirteen) times s	since admission.			be completed?		
	0 0/7/22 40 27 4	M D '1 420 4 ' 1			September 14, 2023.		
		.M., Resident 39 sustained an					
		nile attempting to transfer to					
	the bedside commo						
		rage resident to use call light					
	-	vas added to the care plan on					
	9/7/22.						
	0 11/0/22 - 7 12						
		A.M., Resident 39 sustained an					
		n IDT note dated 11/8/22					
		nt rolled out of her bed onto					
		bed and went to sleep. The					
	care plan lacked an	updated intervention.					
		A.M., Resident 39 sustained					
		while attempting to pick up a					
	-	e floor while sitting in her					
	wheelchair. The inte	ervention "remind resident to					
	use call light for ass	sistance retrieving objects from					
	floor" was added to	the care plan on 12/23/22.					

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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	(X3) DATE SURVEY COMPLETED 08/14/2023		
	ROVIDER OR SUPPLIER		621 W	ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION
	unwitnessed fall whethe bedside common intervention "visual to the care plan on a common of the care plan of the care pla	P.M., Resident 39 sustained an nile attempting to transfer from the bed unassisted. At that time, at to the emergency room. An			
	wall of the left antro (fractured cheek bo	um with dense opacification ne). The intervention "offer to fter lunch" was added to the 3.			
	and 8/9/23 all inclu	ned three falls, 9/7/22, 3/15/23 ded the only intervention was f the call light, no other ded.			
	Nursing) indicated	A.M., the DON (Director of that the IDT (Interdisciplinary te the care plan with a new and n after every fall.			
	Comprehensive Car was provided and in goals, and intervent	A.M., a current IDT re Plan Policy, revised 10/2019, adicated "care plan problems, ions will be updated based on assessment/condition".			
	current fall manage revision date of 8/2 "ensure residents re	4 A.M., the DON provided a ment policy with a most recent 022. The policy indicated siding within the facility pervision and or assistance to ed falls".			
	3.1-45(a)(2)				

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CENTERS FOR	MEDICARE & MEDIC.	AID SERVICES			OM	IB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	onstruction 00	(X3) DATE COMPI	
		155224	B. WING		08/14	/2023
	ROVIDER 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 BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 0690 SS=D Bldg. 00	§483.25(e) Inconti §483.25(e)(1) The resident who is co bowel on admissic assistance to mair or her clinical cond that continence is §483.25(e)(2)For a incontinence, base comprehensive as ensure that- (i) A resident who an indwelling cath unless the residen demonstrates that necessary; (ii) A resident who indwelling cathete one is assessed for as soon as possib clinical condition of catheterization is in (iii) A resident who receives appropriate to prevent urinary restore continence. §483.25(e)(3) For incontinence, base comprehensive as ensure that a resid bowel receives ap	efacility must ensure that intinent of bladder and on receives services and intain continence unless his dition is or becomes such not possible to maintain. The resident with urinary ed on the resident's issessment, the facility must enters the facility without eter is not catheterized it's clinical condition in catheterization was enters the facility with an or or subsequently receives for removal of the catheter le unless the resident's elemonstrates that the essary; and is incontinent of bladder atte treatment and services tract infections and to eat the extent possible. The resident with fecal end on the resident's essessment, the facility must dent who is incontinent of propriate treatment and eas much normal bowel				
		on, interview, and record failed to ensure residents	F 0690	F690 Bowl/Bladder Incontinence	,	09/14/2023

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received appropriate treatment to prevent urinary

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Catheter

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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. B	UILDING	00	COMPLETED
		155224	B. W	ING _		08/14/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	R			COLUMBIA ST	
COLLIME	BIA HEALTHCARE	CENTER			SVILLE, IN 47710	
	,, , , i i i i i i i i i i i i i i i i			LVANO	, , , , , , , , , , , , , , , , , , ,	<u>, </u>
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	1	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
	tract infections (UTIs) for 1 of 1 residents				What corrective action(s) will	II be
		er use and history of UTIs. A			accomplished for those	
	catheter bag was observed on the floor. (Resident 49)				residents found to have been	n
					affected by the deficient	
					practice?	
	Finding includes:				Resident # 49 foley catheter	
	O 0/0/22 (0.00 A.M. P. 11 (40) 41 (1.1				tubing was secured to prevent	t it
		A.M., Resident 49's catheter bag			from touching the floor.	
	1	g on the floor next to the			How other residents having	
	resident's bed.				potential to be affected by th	
					same deficient practice will	
	On 8/9/23 at 8:57 A.M., Resident 49's catheter bag				identified and what corrective	re
	was observed laying on the floor next to the				action(s)will be taken?	
	resident's bed.				All residents who have cathete	
					have the potential to be affect	
		A.M., RN (Registered Nurse) 12			DNS/designee completed a fa	cility
	_	ng around Resident 49's supra			wide audit to ensure no other	
	1 ~	hat time, the catheter bag was			tubing was on the floor. No	
		tubing touched the floor. RN			findings noted.	
		and left the catheter bag on the			What measures will be put in	nto
	floor.				place and what systemic	
	0.000				changes will be made to ens	
		A.M., RN 12 indicated that			that the deficient practice do	es
		nistory of throwing the catheter			not recur?	
	1 -	ne further indicated that staff			The DNS/designee will provid	
		n to where the catheter bag is			re-education to nursing staff o	
		e room and pick it up if it is on			ensuring bag and or tubing do	
	the floor.				not touch the floor. DNS/design	gnee
	On 9/10/22 -+ 09 20	A.M. Danidant 40 in direct du			education to nursing staff will	
		9 A.M., Resident 49 indicated no			include how to use the plastic	
	1	ned to him why the catheter			tubing attachment, leg adhesi	
	bag shouldn't be on	the hoof.			securement device to ensure	
	On 8/0/22 at 0.25 A	A.M., Resident 49's clinical			tubing to prevent bag and/or to	uping
		A.M., Resident 49's clinical ed. Resident was admitted on			from touching the floor. Observational rounds will be	
	6/13/22. Diagnoses included, but were not limited to, chronic kidney disease and obstructive and				completed daily to ensure that	
	1	iisease and obstructive and			catheter equipment is maintain	
	reflux uropathy.				appropriately and not touching	}
	TEI .	A LANDS (MCC D)			floor.	
	The most recent qua	The most recent quarterly MDS (Minimum Data			How the corrective action(s)	WIII

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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 00 COMPLETED B. WING 08/14/2023 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 Set) Assessment, dated 6/20/23, indicated the be monitored to ensure the resident had no cognitive impairment, no deficient practice will not behaviors, had an indwelling catheter, and recure, IE: what quality required supervision of 1 staff for transfers and assurance program will be put bed mobility and extensive assistance of 1 staff into place? for toileting. The DNS/designee will be responsible for the completion of Current Physician Orders included, but were not the Catheter QA Tool weekly times 4 weeks, bi-monthly times 2 Change dressing around supra pubic catheter QD months, monthly times 4 and then (every day) et (and) PRN (as needed), dated quarterly until continued 2/25/23. compliance is maintained for 2 consecutive quarters. The results A current care plan, dated 2/25/19, indicated of these audits will be reviewed by resident required a supra pubic urinary catheter the QAPI committee overseen by with an intervention of "encourage tubing or any the ED. If threshold of 100% is not part of the drainage system not to touch the achieved, an action plan will be floor". developed. Deficiency in this practice will result in disciplinary Infection Control Event Reports indicated action up to and including Resident 49 had UTIs with onset dates of 9/13/22, termination of responsible 10/1/22, 3/10/23, and 5/4/23. employee. On 8/11/23 at 10:37 A.M., the Infection By what date the systemic Preventionist indicated that the catheter bag changes for each deficiency will should be hung on the frame of the bed or the be completed? side of the wheelchair and should not be touching September 14, 2023. the floor. On 8/14/23 at 12:00 P.M., a current Nursing policy, revised 6/2023, was provided and indicated that nursing staff should "prevent catheter bag or tubing from touching the ground". 3.1-41(a)(2) F 0691 483.25(f) SS=D Colostomy, Urostomy, or Ileostomy Care

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ileostomy care.

§483.25(f) Colostomy, urostomy,, or

Bldg. 00

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STATEM	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER	A. B				COMPLETED	
		155224	B. W	ING		08/14	/2023	
		<u> </u>		CTREET	ADDRESS CITY STATE ZIR COD			
NAME O	F PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD			
00111	ADIA LICAL TUCADE	CENTED			COLUMBIA ST			
COLUI	MBIA 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	
	The facility must e	ensure that residents who						
	require colostomy	, urostomy, or ileostomy						
	services, receive	such care consistent with						
	professional stand	dards of practice, the						
	comprehensive pe	erson-centered care plan,						
	and the resident's	goals and preferences.						
	Based on observation	on, interview, and record	F 0	691			09/14/2023	
	review, the facility	failed to provide a resident with			F691			
	a urostomy care con	nsistent with professional			Colostomy, Urostomy, or			
	standards of practic	ce and the comprehensive			Ileostomy Care			
	person-centered car	re plan for 1 of 1 residents with			What corrective action(s) will	ll be		
	a urostomy. (Reside	ent 72)			accomplished for those			
					residents found to have been	n		
	Finding includes:				affected by the deficient			
	On 8/10/23 at 9:07 A.M., LPN (Licensed Practical Nurse) 5 was observed changing the urostomy				practice?			
					Resident # 72 urostomy care	nas		
					been completed and will be			
	dressing for Reside	ent 72. The resident had been			continued with professional			
	on contact precaution	ons beginning 8/9/23 at 10:30			standards of practice and with	1		
	A.M. due to the pre	esence of an			comprehensive person-center	ed		
	antibiotic-resistant	urinary tract infection (UTI).			care plan completed- including	g the		
	LPN 11, who identi	ified herself as the wound			measuring of urine output.			
		procedure but did not assist.			How other residents having	the		
		cc's of rust-colored urine were			potential to be affected by th	16		
	observed in the cath	heter bag.			same deficient practice will	be		
					identified and what corrective	re e		
		g the catheter bag, LPN 5			action(s)will be taken?			
	_	te basket next to resident's			All residents who have urosto	-		
		he old urostomy bag and			have the potential to be affect			
		astic bag on the bed. There			DNS/designee completed a fa	cility		
	were 2 stents, about 8" long, protruding from the				wide audit to ensure no other			
		illed with a dark red substance			issues. No findings noted.			
		ng. When applying the new			What measures will be put in	ıto	1	
		5 discussed with the resident			place and what systemic			
		had been using to adhere the			changes will be made to ens		1	
		been burning the resident's			that the deficient practice do	es		
		indicated there were other			not recur?			
		se and would check into it.			The DNS/designee will provid			
	_	nurses removed their			re-education to nursing staff o			
	personal protective	equipment (PPE) and used			ensuring professional standar	ds of		
	1		1		I		1	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155224	B. W	ING		08/14/	2023
		l	1	CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			COLUMBIA ST		
COLLINAE	BIA HEALTHCARE	CENTER			SVILLE, IN 47710		
COLUMB	DIA NEALTHUARE	CENTER		EVANS			
(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		R LSC IDENTIFYING INFORMATION	\perp	TAG	DEFICIENCY)		DATE
	· · · · · · · · · · · · · · · · · · ·	started towards the door.			practice, comprehensive		
		the catheter bag in the waste			person-centered care plans, a	nd	
		cated it needed to be thrown			resident's goals and preference	es-	
		n gloves and bagged all the			to include measuring of urine		
		ncluding the catheter bag, and			output.		
	_	oiled utility room. Neither			Observational rounds will be		
	nurse measured the	urine output.			completed daily to ensure		
					professional standards are me	et for	
	_	v on 8/10/23 at 10:45 A.M. with			ostomy care.		
		sing (DON) and LPN 5, LPN 5			How the corrective action(s)	will	
		ot know anything about the			be monitored to ensure the		
		resident was supposed to			deficient practice will not		
		ppointment with her surgeon in			recure, IE: what quality		
		ischarge instructions from the			assurance program will be p	ut	
	surgeon indicated the resident had an				into place?		
	appointment in Indianapolis on 7/20/23.				The DNS/designee will be		
		I the doctor in Indianapolis had			responsible for the completion		
		nd made arrangements for the			an Ostomy QA Tool weekly tir	nes	
		by a urologist in Evansville			4 weeks, bi-monthly times 2		
		o weak to tolerate the 6-hour			months, monthly times 4 and t	then	
	_	apolis and back. On 7/27/23,			quarterly until continued		
	_	ansville refused to see the			compliance is maintained for 2		
		day, the facility sent the			consecutive quarters. The res		
		rgency room at 9:48 A.M.,			of these audits will be reviewe	-	
		s surgical staples were			the QAPI committee overseen	•	
	· · · · · · · · · · · · · · · · · · ·	ne stents. The DON indicated			the ED. If threshold of 100% is		
		posed to follow up with the			achieved, an action plan will b	е	
	surgeon in Indianap	polis and had failed to do so.			developed. Deficiency in this		
	0:: 0/14/22 + 0.27	A.M. 41 - C1141			practice will result in disciplina	ıry	
		A.M., the facility in-services			action up to and including		
		l indicated a urostomy care			termination of responsible		
		n conducted on 5/9/23. LPN 5 and LPN 11.			employee.		
	Auenaees included	LEIN 3 and LEIN 11.			By what data the accetance:		
	On 8/14/22 at 0.20	A.M., the resident's clinical			By what date the systemic	will	
		d. Diagnoses included, but			changes for each deficiency	WIII	
		, cerebral palsy and urostomy.			be completed?		
	were not innited to,	, cereorar parsy and urostomy.			September 14, 2023.		
	The Minimum Date	e Set (MDS) Assessment, dated					
	//11/25, indicated t	he resident was cognitively					

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09/22/2023

	OF HEALTH AND HU						RM APPROVED B NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155224	r í	JILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/14/2023	
	ROVIDER OR SUPPLIE			621 W (ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	тЕ	(X5) COMPLETION DATE
	bathing. Current Physician Climited to, change to Wednesdays, chang nurse to record uro 8 hours, contact isc infection (UTI). The order for stent care The resident dischasurgeon were revie indicated the ureter removed at the possurgeon, which was not occur. The resident's care the resident has a unincluded:	arge instructions from the wed. The instructions all stents were to have been toperative visit with the secheduled on 7/20/23 and did plan, dated 7/6/23, included rostomy. Interventions					

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483.25(i)

Suctioning

Respiratory/Tracheostomy Care and

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who

tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the

needs respiratory care, including

F 0695

SS=D

Bldg. 00

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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 08/14/2023 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 comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record F 0695 09/14/2023 review, the facility failed to ensure that a resident F695 who needed respiratory care was provided such Respiratory/Tracheostomy Care care consistent with professional standards of and Suctioning practice for 1 of 1 residents reviewed for What corrective action(s) will be respiratory care (Resident 26). accomplished for those residents found to have been Findings include: affected by the deficient practice? Resident # 26 was not affected by During an interview with Resident 26 on 8/8/23 at 9:43 A.M., she indicated how she needed her the alleged deficient practice. oxygen. Resident # 26 tubing dated correctly, portable tank functioning During an observation on 8/8/23 at 9:34 A.M., the and adjusted to reflect use of 2 tubing on Resident 26's oxygen concentrator was liters per nasal cannula as not dated. There was a 2-inch strip of brown ordered. sticky substance on top of concentrator. The How other residents having the oxygen was on at 1.5 liters per minute (lpm) per potential to be affected by the nasal cannula (nc). same deficient practice will be identified and what corrective During an observation on 8/9/23 at 11:00 A.M., action(s)will be taken? the resident was observed in the hallway, asleep All residents on oxygen have the in her wheelchair, with a portable oxygen tank potential to be affected by the hanging from the wheelchair. The tubing was not alleged deficient practice. An dated, and was connected to the portable oxygen audit was completed by tank which was empty, as indicated by the DNS/designee to identify all contents indicator being in the red and the arrow residents with oxygen orders and resting at zero (0). The oxygen concentrator in the accuracy and all equipment resident's room was observed to be on at 1.5 lpm. functioning properly. The brown sticky substance on top of the What measures will be put into concentrator was still there. place and what systemic changes will be made to ensure On 8/11/23 at 1:34 P.M., the resident was observed that the deficient practice does in the hallway, asleep in her wheelchair with not recur? oxygen tubing that was not dated. The tubing was DNS/designee will re-educate attached to a portable oxygen tank, which was nursing staff related to oxygen empty as indicated by the contents indicator therapy and the application and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/14/2023	
VIDER OR SUPPLIER		621 W	COLUMBIA ST		
SUMMARY S	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S DI AN OF CORRECTION		(X5)
(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CODDECTIVE ACTION SHOULD DE	CON	MPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)]	DATE
eing in the red and on 8/14/23 at 8:55 accord was reviewed the red in the Admission Minus expression, and hearth he Admission Minus expression, and hearth he Admission Minus expression, and hearth he Admission Minus expression, and hearth the Admission Minus expression, and hearth the Admission Minus expression, and hearth total dependence for a dependence for	the arrow resting at zero (0). A.M., the resident's clinical d. Diagnoses included, but chronic obstructive pulmonary mentia, epilepsy, anxiety, rt failure. imum Data set (MDS) 6/20/23, indicated the resident e impairment and required for bed mobility, transfers, d assist of 1 for eating, and e bathing, oxygen was orders included, but were not at 2 liters per nasal cannula, in bed to alleviate shortness g flat related to diagnosis of Resident has symptoms of ion. Utilizes 2L nasal cannula. ed: d as tolerated dered nued or worsening symptoms nation naturations as ordered en as ordered A.M. a current facility oxygen policy was reviewed. The ed guidelines for labeling er bottles, cleaning oxygen nistering oxygen according to	TAG	care of this therapy. Observation rounds will be completed daily by DNS/design to ensure oxygen use is appropriate for identified residn and that physician orders are followed. How the corrective action(s) be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be pinto place? The DNS/designee will be responsible for the completion an Oxygen Therapy QA Tool weekly times 4 weeks, bi-mon times 2 months, monthly times and then quarterly until continicompliance is maintained for 2 consecutive quarters. The residithese audits will be reviewed the QAPI committee overseen the ED. If threshold of 100% is achieved, an action plan will be developed. Deficiency in this practice will result in disciplinal action up to and including termination of responsible employee. By what date the systemic	ents will ut of thly s 4 ued 2 sults d by by s not e	DATE
C = V = C Devise Track	VIDER OR SUPPLIER HEALTHCARE O SUMMARY S (EACH DEFICIENCE REGULATORY OR eing in the red and on 8/14/23 at 8:55 A coord was reviewed tere not limited to, isease (COPD), deserved to the company of	VIDER OR SUPPLIER HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION eing in the red and the arrow resting at zero (0). In 8/14/23 at 8:55 A.M., the resident's clinical cord was reviewed. Diagnoses included, but ere not limited to, chronic obstructive pulmonary isease (COPD), dementia, epilepsy, anxiety, epression, and heart failure. The Admission Minimum Data set (MDS) ssessment, dated 6/20/23, indicated the resident and severe cognitive impairment and required tetensive assist of 2 for bed mobility, transfers, and toileting, limited assist of 1 for eating, and tetal dependence for bathing, oxygen was lentified in use. The Physician Orders included, but were not mitted to: Oxygen at 2 liters per nasal cannula, ead elevated while in bed to alleviate shortness for breath while lying flat related to diagnosis of OPD every shift. The plan included: Resident has symptoms of ecreased oxygenation. Utilizes 2L nasal cannula. Interventions included: Elevate had of bed as tolerated Labs/x rays as ordered Observe for continued or worsening symptoms of decreased oxygenation Monitor oxygen saturations as ordered Administer oxygen as ordered The M14/23 at 8:55 A.M. a current facility oxygen terapy and devices policy was reviewed. The modated policy, lacked guidelines for labeling to the property of the property o	VIDER OR SUPPLIER ### HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION eing in the red and the arrow resting at zero (0). ### 14/23 at 8:55 A.M., the resident's clinical ford was reviewed. Diagnoses included, but fere not limited to, chronic obstructive pulmonary fisease (COPD), dementia, epilepsy, anxiety, epression, and heart failure. ### to a ditient of the resident and required factorise assist of 2 for bed mobility, transfers, and toileting, limited assist of 1 for eating, and fatal dependence for bathing, oxygen was for itself in use. ### urrent Physician Orders included, but were not mitted to: Oxygen at 2 liters per nasal cannula, ead elevated while in bed to alleviate shortness for breath while lying flat related to diagnosis of OPD every shift. ### are plan included: Resident has symptoms of fecreased oxygenation. Utilizes 2L nasal cannula. ### the plan included: Resident has symptoms of fecreased oxygenation. Utilizes 2L nasal cannula. ### the plan included: Resident has symptoms of fecreased oxygenation. Utilizes 2L nasal cannula. ### the plan included: Resident has symptoms of fecreased oxygenation. Utilizes 2L nasal cannula. ### the plan included: Resident has symptoms of fecreased oxygenation. Utilizes 2L nasal cannula. ### the plan included: Resident has symptoms of fecreased oxygenation. Utilizes 2L nasal cannula. ### the plan included: Resident has symptoms of fecreased oxygenation. Utilizes 2L nasal cannula. ### the plan included: Resident has symptoms of fecreased oxygenation. Utilizes 2L nasal cannula. ### the plan included: Resident has symptoms of fecreased oxygenation. Utilizes 2L nasal cannula. ### the plan included: Resident has symptoms of fecreased oxygenation or worsening symptoms of fecreased oxygenation or worsening symptoms or decreased oxygenation or	TORRECTION DENTIFICATION NUMBER 155224 STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 SUMMARY STATEMENT OF DEFICIENCIE ID PREFEIX COSESSETTE ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 SUMMARY STATEMENT OF DEFICIENCIE ID PREFEIX COSESSETTE ACTION SHOULD BE PRECEDED BY FULL. PREFIX TAG STATE ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 TO COMMITTE ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 TO COLUMBIA ST EVANSVILLE, IN 47710 TO COSESSET STATE ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 TO COSESSET STATE ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 TO COSESSET STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 TO COSESSET STATE ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 TO COLUMBIA ST EVANSVILLE, IN 47710 TO COSESSET STATE ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 TO COSESSET STATE ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 TO COSESSET STATE AND CORRECTION CALL CORRECTION ADDRESS AND STATE AND CORRECTION ADDRESS AND STATE AD	DENTIFICATION NUMBER 155224 A BUILDING 00 COMPLETED 08/14/2021 STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 SUMMARY STATEMENT OF DEFICIENCIE CEACH DEFICIENCY MUST BE PROCEDED BY FULL REGULATORY ON Excellency AND OF CARREST AND OF CORRECTION OF COMPANIES CERCULATORY OF COMPANIES CORRECTION OF COMPANIES CORRECTION OF COMPANIES A BUILDING CORRECTION OF COMPANIES CORRECTION OF COMPANIES CARD SUMMARY STATE ZUP COD CORRECTION OF COMPANIES CORRECTION OF COMPANIES A BUILDING CORRECTION OF COMPANIES CORRECTION OF COMPANIES CARD SUMMARY AND OF COMPANIES CORRECTION OF COMPANIES CARD SUMMARY AND OF COMPANIES CORRECTION OF COMP

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155224	B. WI	NG		08/14/	2023
	ROVIDER OR SUPPLIER			621 W C	DDRESS, CITY, STATE, ZIP COD COLUMBIA ST VILLE, IN 47710		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DE CAMPANIA DE LA CORRESCIONA		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
	3.1-47(a)(6)						
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staf §483.35(g) Nurse §483.35(g)(1) Data must post the follo basis: (i) Facility name. (ii) The current dat (iii) The total numb worked by the follo licensed and unlic responsible for res (A) Registered nur (B) Licensed pract vocational nurses law). (C) Certified nurses (iv) Resident cens §483.35(g)(2) Pos (i) The facility must data specified in p section on a daily each shift. (ii) Data must be p (A) Clear and reac (B) In a prominent residents and visit §483.35(g)(3) Pub staffing data. The written request, m available to the put to exceed the com §483.35(g)(4) Fac requirements. The	Staffing Information. a requirements. The facility owing information on a daily te. ber and the actual hours owing categories of ensed nursing staff directly sident care per shift: rses. tical nurses or licensed (as defined under State e aides. sus. sting requirements. st post the nurse staffing paragraph (g)(1) of this basis at the beginning of costed as follows: dable format. t place readily accessible to tors. plic access to posted nurse a facility must, upon oral or ake nurse staffing data ablic for review at a cost not numunity standard. cility data retention e facility must maintain the					
	-	e staffing data for a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155224		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING 00 COMPLE B. WING 08/14/2			LETED		
	PROVIDER OR SUPPLIER		6	21 W (ADDRESS, CITY, STATE, ZIP COD		
COLUME	BIA HEALTHCARE	CENTER	E	:VANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
		onths, or as required by					
	State law, whiche	on, interview, and record	F 0732	,			09/14/2023
		failed to post accurate total	F 0/32	,	F732		09/14/2023
		actual hours worked for			Posted Nurse Staffing		
		nsed nursing staff directly			Information		
		dent care per shift daily for 6 of			What corrective action(s) wi	II be	
	6 days during the ar	nnual survey period.			accomplished for those		
					residents found to have bee	n	
	Finding includes:				affected by the deficient		
		0.7.100			practice?		
	_	ion on 8/7/23 at 9:30 A.M. a			No residents were affected by	the	
		ing data sheet was observed			alleged deficient practice.	46.	
		eception desk, dated 8/7/23 and			How other residents having		
	indicated the census was 116. The sheet included, but was not limited to, the following				potential to be affected by the same deficient practice will		
	information:	or innited to, the following			identified and what corrective		
		umber of staff for each shift,			action(s)will be taken?		
		ach shift for RN (Registered			All residents have the potential	al to	
		sed Practical Nurse), and CNA			be affected by the alleged def		
	(Certified Nurse Ai	de).			practice. Daily staffing hours		
		there were 11.5 members of			correct and will be updated as	3	
	_	staff working during the			needed.		
	evening shift.				Scheduler, Clinical Education		
		becify which actual hours were			Nurse, and nursing administra	ation	
		cipline during the specified hours were not equal to the			will be in-service concerning scheduled posted form by		
	number of staff.	nours were not equal to the			DNS/designee.		
	namoor or starr.				What measures will be put in	nto	
	During an observati	ion on 8/11/23, a posted			place and what systemic		
	_	a sheet was observed on the			changes will be made to ens	ure	
	side of the reception	n desk, dated 8/11/23 and			that the deficient practice do		
	indicated the census	s was 115. The sheet			not recur?		
		ot limited to, the following			Scheduler/Staffing coordinato		
	information:				be re-educated on daily staffing	ng	
		imber of staff for each shift,			sheets by DNS/designee.		
		ach shift for RN, LPN, and			Observation rounds will be		
	CNA.	.1 12.5 1 6			completed daily by DNS/design		
		there were 13.5 members of			daily to ensure that the nursin	_	
I	unlicensed nursing	staff working during the			hours are posted and correct	with	I

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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 08/14/2023 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 evening shift. any changes made. The sheet did not specify which actual hours were How the corrective action(s) will worked by each discipline during the specified be monitored to ensure the shift when the total hours were not equal to the deficient practice will not number of staff. recure, IE: what quality assurance program will be put During an interview on 8/14/23 at 10:25 A.M., the into place? Director of Nursing (DON) reviewed the posted The DNS/designee will be nurse staffing sheets and indicated the staffing responsible for the completion of a sheets did not reflect the exact times of staff on Daily Staffing Therapy QA Tool the floor for partial shifts, and would find a place weekly times 4 weeks, bi-monthly to add that in to the sheet. times 2 months, monthly times 4 and then quarterly until continued On 8/14/23 at 11:34 A.M., the DON provided a compliance is maintained for 2 copy of posted nurse staffing sheets for dates consecutive quarters. The results 8/7/23, 8/8/23, 8/9/23, 8/10/23, 8/11/23, and 8/14/23, of these audits will be reviewed by each of these dates did not reflect actual hours the QAPI committee overseen by worked. A copy of posted nurse staffing policy the ED. If threshold of 100% is not dated 7/2019 was also provided at this time. achieved, an action plan will be The posted nurse staffing policy indicated "total developed. Deficiency in this hours should include the total actual hours practice will result in disciplinary worked on each shift including partial shifts" and action up to and including "the nurse staffing data should be in a clear and termination of responsible readable format". employee. By what date the systemic changes for each deficiency will be completed? September 14, 2023. F 0759 483.45(f)(1) SS=D Free of Medication Error Rts 5 Prcnt or More Bldg. 00 §483.45(f) Medication Errors. The facility must ensure that its-§483.45(f)(1) Medication error rates are not 5

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	COMPLETED	
		155224	B. W	ING		08/14/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	COLUMBIA ST	
COLLIME	BIA HEALTHCARE	CENTER			SVILLE, IN 47710	
OOLOWL		<u> </u>		LVAINC		
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	DATE
	percent or greater	•				
		on, record review, and	F 0'	759	F759	09/14/2023
		ty failed to ensure it was free of			Free of Medication Error Rat	es
		greater than 5 percent for 1 of 4			5 percent or more	
		during medication pass. Three			What corrective action(s) wi	II be
		vere observed during 35			accomplished for those	
	opportunities for er				residents found to have bee	n
		s resulted in an 8.57% error			affected by the deficient	
	rate. (Resident 1)				practice?	
					Resident #1 was assessed, n	
	Findings include:				adverse effects noted from all	eged
					deficient practice.	
	_	nedication administration, on			How other residents having	I
	8/9/23 at 8:51 A.M., QMA (Qualified Medication				potential to be affected by the	
	Aide)10 administered 13 pills and 2 nasal sprays				same deficient practice will	
	to Resident 1:				identified and what corrective	/e
		po (by mouth) bid (twice a			action(s)will be taken?	
	day).	1 11			All residents have the potentia	al to
	Amlodipine 5 mg 1	-			be affected by the alleged	
	Baby Asa (aspirin)				deficiency. QMA 10 educated	I
	CertaVite 1 tablet 1	-			medication administration poli	· ·
		milligrams) 2 po bid.			with focus on medication refus	sais
		release 125 mg 1 po bid.			and crushing medications.	4
	-	qtt (drop) both eyes BID.			What measures will be put in	nto
	_	g (microgram) (0.1%) 1 spray			place and what systemic	
	each nostril bid.	muova hid oo sh mootuil			changes will be made to ens	
	Lisinopril 10 mg 1	prays bid each nostril.			that the deficient practice do	Jes
		po bid. nits 2 tabs po daily.			not recur?	
	Protonix 40 mg 1 p				All nursing staff educated on	iov
	Propranolol 40 mg	•			medication administration poli	
		0 mg (sennosides/docusate) 1			by DNS/designee with focus of	
	po bid.	o mg (semiosides/docusate) i			medication refusals and crush medications.	III 19
	_	calciferol) capsule 1,250 mcg			How the corrective action(s)	will
		ly every Wednesday.			be monitored to ensure the	WIII
	Tizadine 2 mg 1 po				deficient practice will not	
	MS Contin 100 MC				recure, IE: what quality	
	MIS COMMITTOU MIC	3.1 po 01u.			1	nut
	During an interview	v on 8/9/23 at 8:51 A.M., QMA			assurance program will be p	,ut
	_	ls were not available because			into place. The DNS/designee will be	
	10 maicaica me pii	is were not available because			The Divoruesignee will be	l

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 08/14/2023	
	PROVIDER OR SUPPLIER		621 V	T ADDRESS, CITY, STATE, ZIP COD V COLUMBIA ST NSVILLE, 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 CROSS-REFERENCED TO THE APPRO	DBE COMPLETION COMPLETION
F 0761	the resident used a capacitity and were not QMA 10 did not ad and Tradjenta, also ordered that day. Resident 1's record 11:56 A.M. Diagnolimited to, Type 2 dobstructive Pulmon Resident 1's quarter Assessment, dated 7 was cognitively inta Resident 1's physici (linagliptin), 5 mg (Type 2 diabetes me Alfuzosin 10 mg, or Movantik(naloxego constipation. On 8/14/23 at 11:32 Changing and Discorrevised 1/1/22, was (Director of Nursing sets forth procedure medication reorders to the pharmacyre to reorder medication whenever possible	minister Alfuzosin, Naloxegol, indicated the drugs will be was reviewed on 8/11/23 at sees included, but were not iabetes mellitus and Chronic lary Disease. Ily MDS (Minimum Data Set) 1/31/23, indicated the resident lect. an orders include Tradjenta milligrams), once a day for littus without complications, nee a day for retention of urine, 10/25 mg, once a day for A.M. a current "Reordering, portinuing Orders" policy, provided by the DON g) and indicated this "policy is for communications of any, change or discontinuations orders/refills are encouraged ons electronically or by fax"	TAG	responsible for the comple medication administration of weekly times 4 weeks, bintimes 2 months, monthly till and then quarterly until corcompliance is maintained from consecutive quarters. The of these audits will be reviet the QAPI committee overset the ED. If threshold of 100° achieved, an action plan will developed. Deficiency in the practice will result in discip action up to and including termination of responsible employee. By what date the systemic changes for each deficiency be completed? September 14, 2023.	QA Tool nonthly mes 4 ntinued for 2 results ewed by een by % is not ill be nis linary
F 0761 SS=D Bldg. 00	Drugs and biologic must be labeled in				

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155224	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/14/2023
	PROVIDER OR SUPPLIER		621 W	ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION CCESSORY and cautionary	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In a Federal laws, the and biologicals in under proper tempermit only author access to the keys §483.45(h)(2) The separately locked compartments for listed in Schedule Drug Abuse Preved 1976 and other drexcept when the fipackage drug dist the quantity stored dose can be reading Based on observation of medications in 4 carts. Loose pills and biologicals/medicat treatment cart and medication cart, Fir Hall medication cart. Findings include: 1. On 8/9/23 at 9:05	the expiration date when the of Drugs and Biologicals ccordance with State and facility must store all drugs locked compartments berature controls, and tized personnel to have s. facility must provide permanently affixed storage of controlled drugs II of the Comprehensive ention and Control Act of tugs subject to abuse, facility uses single unit ribution systems in which the is minimal and a missing the detected. The interview, and record failed to provide proper storage of 6 medication/treatment the dunlabeled tions were found in drawers of facedication carts. (1400 Hall the interview of th	F 0761	F761 Label/Store Drugs and biologicals What corrective action(s) wind accomplished for those residents found to have been affected by the deficient practice? No residents were affected by alleged deficient practice. How other residents having potential to be affected by the same deficient practice will identified and what corrective.	n this the he be
	1 large white oblon	g pill with numbers 1104 30		action(s)will be taken? All residents have the potentia	al to

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1 large white pill

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be affected by the alleged 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. BU	UILDING	00	COMPL	LETED
		155224	B. W	ING		08/14/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OE 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	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2 bottles of multivit	tamin with the initial [resident			practice.		
	initial]				All areas of medication storag	е	
	1 bottle of opened A	Activa (protein supplement) no			have been audited and all out	dated	
	label or name				medications were destroyed.		
	1 bottle of Melaton	in no label with the [resident			What measures will be put in	nto	
	initial]				place and what systemic		
	-	ms with Resident 1 name but			changes will be made to ens	ure	
	no label				that the deficient practice do	es	
					not recur?		
		50 A.M., the medication cart on			Observational rounds will be		
		erved to have the following			completed daily by DNS/desig	jnee	
	medications unlabe	eled in the cart:			and when needed pharmacy		
					consultant to audit medication		
	1 Tresiba insulin pen not labeled.				dates and storage areas to en	sure	
	1 Victoza insulin with no name or prescription				compliance.	_	
	label				License staff will be re-educat	ed	
					by DNS/Designee related to		
		54 A.M., the treatment cart on			medication storage.		
		noted to have the following			How the corrective action(s)	WIII	
	biological unlabeled	d in the cart:			be monitored to ensure the		
	1 4-1				deficient practice will not		
	label or date.	e with the [resident name] no			recure, IE: what quality	4	
	label or date.				assurance program will be p	ut	
	1 On 9/10/22 at 9:0	09 A.M., the medication cart on			into place.		
		observed to have the following			The DNS/designee will be	of a	
		beled medications in the cart:		responsible for the completion of		ıoıa	
	1005c pins and unia	accica medications in the eart.			Medication Storage QA Tool weekly times 4 weeks, bi-mon	thly	
	1 small yellow pill				times 2 months, monthly times	-	
		gine, and Humalog, for			and then quarterly until contin		
		the same bag for prescription			compliance is maintained for 2		
	label for one on the				consecutive quarters. The res		
		aglar, NovoLog, other, for			of these audits will be reviewe		
	_	the same bag with the			the QAPI committee overseen	-	
	prescription label for	C			the ED. If threshold of 100% is	•	
	presemption moet it	or omagini.			achieved, an action plan will b		
	During an interview	w on 8/9/23 at 9:05 A.M., QMA			developed. Deficiency in this		
		ion Aide) 10 indicated that			practice will result in disciplina	irv	
		loose medications and when			action up to and including	9	
		aced in a Drug Ruster solution			termination of responsible		

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

PRINTED: 09/22/2023 FORM APPROVED OMB NO. 0938-039

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 08/14/2023	
	PROVIDER OR SUPPLIER		621 W	T ADDRESS, CITY, STATE, ZIP COD V COLUMBIA ST ISVILLE, 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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
	DON (Director of N liquid protein was o bottle with the name opened. She indicat from the dietician o would have to check that needed to be ad	or on 8/10/23 at 7:43 A.M., the dursing) indicated that once the pened, she would label the e of the resident and dated ed that it was a prescription redered. She also indicated she k about the prescription label ided to the bottle.		employee. By what date the system changes for each deficie be completed? September 14, 2023.	
	Registered Nurse 12 placed in the bags for the resident based or pens. On 8/14/23 at 11:32 "Storage and Expira Biological", revised DON. The policy in procedures relating dates of medication destroybiological. labelsshould ensur	2 indicated the insulin was or convenience and safety of in the color of the insulin 2 A.M., a current policy ation Dating of Medications, 8/7/23, was presented by the idicated "The policy sets the to the storage and expiration is, biologicalsfacility should with incomplete or missing that medications for each			
F 0802 SS=E Bldg. 00	were originally received 3.1-25(m) 483.60(a)(3)(b) Sufficient Dietary 3 §483.60(a) Staffin The facility must ethe appropriate conton to carry out the function service, taresident assessment care and the number of the facility's resident service.	Support Personnel			

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

Event ID:

ND2211

Facility ID: 000129

If continuation sheet

Page 28 of 41

required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation and interview, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the function of preparing pureed diets for 8 resident meals during 1 of 1 food processing reviewed. Findings include: On 8/9/23 at 11:35 A.M., the puree process for the noon meal was observed. The Dietary Manager oversaw the process while Kitchen Staff 17 prepared the pureed food. Kitchen Staff 17 indicated she was preparing 10 servings for 8 residents who required pureed food. TAG CRCSS-REPBRACED TO REPARCHED TO REPARCHORD TO PROPERTION TO PRO	NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE COMPLETED BY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PRECEDED BY FULL TAG (BASS. REPEMBLY ACTION SHOULD BE PARKED. TO BE APPROPRIATE CONTINUED BY ACTION SHOULD BE PARKED. TO BE APPROPRIATE CONTINUED BY ACTION SHOULD BE PARKED. TO BE APPROPRIATE CONTINUED BY ACTION SHOULD BE PARKED. TO BE APPROPRIATE CONTINUED BY ACTION SHOULD BE PARKED. TO BE APPROPRIATE CONTINUED BY ACTION SHOULD BE PARKED. TO BE APPROPRIATE CONTINUED BY ACTION SHOULD BE PARKED. TO BE APPROPRIATE CONTINUED BY ACTION SHOULD BE PARKED. TO BE APPROPRIATE CONTINUED BY ACTION SHOULD BE PARKED. TO BE APPROPRIATE CONTINUED BY ACTION SHOULD BY ACTION SHOULD BY ACTIO	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG required at \$483.70(e). \$483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and Nutrition Services staff must participate on the interdisciplinary team as required in \$483.2(b)(2)(ii). Based on observation and interview, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the function of preparing pured diets for 8 resident meals during 1 of 1 food processing reviewed. Findings include: On 8/9/23 at 11:35 A.M., the puree process for the noon meal was observed. The Dictary Manager oversaw the process while Kitchen Staff 17 prepared the pureed food. Kitchen Staff 17 indicated she was preparing 10 servings for 8 residents who required purced food.	NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (PEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the function of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation and interview, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the function of preparing pureed diets for 8 resident meals during 1 of 1 food processing reviewed. Findings include: On 8/9/23 at 11:35 A.M., the purce process for the noon meal was observed. The Dietary Manager oversaw the process while Kitchen Staff 17 prepared the purced food. Kitchen Staff 17 prepared the purced food. Kitchen Staff 17 indicated she was preparing 10 servings for 8 residents who required purced food. When measuring the dry potato pearls, Kitchen Staff 17 indicated she was preparing 10 servings for 8 residents who required purced food. When measuring cup sideways so both the amount to measure, and held the measuring cup sideways so both the amount	AND PLAN	OF CORRECTION		A. BU	JILDING	00		
COLUMBIA HEALTHCARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION THE facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation and interview, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the function of preparing purced diets for 8 resident meals during 1 of 1 food processing reviewed. Findings include: On 8/9/23 at 11:35 A.M., the purce process for the noon meal was observed. The Dictary Manager oversaw the process while Kitchen Staff 17 prepared the purced food. Kitchen Staff 17 indicated she was preparing 10 servings for 8 residents who required purced food.	COLUMBIA HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRICEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION (Required at \$483.70(e). \$483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. \$483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation and interview, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the function of preparing purced diets for 8 resident meals during 1 of 1 food processing reviewed. Findings include: On 8/9/23 at 11:35 A.M., the purce process for the noon meal was observed. The Dietary Manager oversaw the process while Kitchen Staff 17 prepared the purced food. Kitchen Staff 17 indicated she was preparing 10 servings for 8 residents who required purced food. When measuring the dry potato pearls, Kitchen Staff 17 misread the amount to measure, and held the measuring cup side-ways so both the amount			155224	B. W	ING		08/14/	/2023
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When measuring the dry potato pearls, Kitchen Staff 17 misread the amount to measure, and held All residents on a pureed diet have	out of the butter blend listed in the recipe, so staff have been in-serviced on		required at §483. §483.60(a)(3) Sure facility must personnel to safe the functions of the functions of the functions of the function Services the interdisciplinary 483.21(b)(2)(ii). Based on observating failed to employ struction of preparimeals during 1 of 10. Findings include: On 8/9/23 at 11:35 noon meal was observed the pureous prepared the pureous indicated she was presidents who required. When measuring the staff 17 misread the measuring cup and the measurement out of the butter block.	pport staff. provide sufficient support ly and effectively carry out ne food and nutrition service. mber of the Food and s staff must participate on any team as required in § con and interview, the facility aff with the appropriate skills sets to carry out the ng pureed diets for 8 resident I food processing reviewed. A.M., the puree process for the served. The Dietary Manager ss while Kitchen Staff 17 d food. Kitchen Staff 17 oreparing 10 servings for 8 ired pureed food. me dry potato pearls, Kitchen the amount to measure, and held sideways so both the amount cent were incorrect. They were end listed in the recipe, so	F 08		Sufficient Dietary Support Personnel What corrective action(s) we accomplished for those residents found to have been affected by the deficient practice? Residents on pureed had no negative effects from the allest deficient practice. How other residents having potential to be affected by the same deficient practice will identified and what correcting action(s) will be taken? All residents on a pureed diet the potential to be affected by alleged deficient practice. Custaff have been in-serviced or	ged the be ve t have y the linary	09/14/2023
individual 5-gram packets. Neither Kitchen Staff RD,				-				. ,	
17 nor the Dietary Manager knew the conversion What measures will be put into			· ·	_			<u> </u>	into	
from grams to ounces and did not check to make place and what systemic changes will be made to ensure			-				_ ·		
sure they were meeting the nutritional changes will be made to ensure			-	_			_		
requirements outlined by the Dietician. that the deficient practice does not recur?			requirements outlin	ied by the Dietician.			-	oes	
i indirecur?			The recipe for the s	nuree menu that was prepared				ureed	
The recipe for the puree menu that was prepared Daily observations utilizing Pureed	for lunch on 8/9/23 was requested twice and not prep tool will be completed by						_		

ND2211

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/22/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155224	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 08/14/	ETED
	PROVIDER OR SUPPLIEF		621 W	ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST SVILLE, IN 47710		
COLUM (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Culinary Supervisor, RD or designee How the corrective action(s) be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be pinto place. The Culinary Manager/design will be responsible for the completion of a Puree Food Preparation QA Tool weekly to 4 weeks, bi-monthly times 2 months, monthly times 4 and quarterly until continued compliance is maintained for 2 consecutive quarters. The resof these audits will be reviewed the QAPI committee overseer the ED. If threshold of 100% is achieved, an action plan will be developed. Deficiency in this	will out ee then 2 sults ed by n by s not	(X5) COMPLETION DATE
				practice will result in disciplina action up to and including termination of responsible employee. By what date the systemic changes for each deficiency be completed? September 14, 2023.		

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

Temp

483.60(d)(1)(2)

Nutritive Value/Appear, Palatable/Prefer

F 0804

SS=E Bldg. 00

Event ID:

ND2211

Facility ID: 000129

If continuation sheet

Page 30 of 41

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î '				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	00	COMPLETED	
		155224	B. WIN	IG		08/14/2	2023
	PROVIDER OR SUPPLIER			621 W (ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST 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	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	§483.60(d) Food a Each resident recording provides- §483.60(d)(1) Food conserve nutritive appearance; §483.60(d)(2) Food palatable, attractive appetizing temper Based on observation interview, the facility drink that are palatate and appetizing temper trays and resident in served at a palatable. Findings include: 1. The following resolutions include: 1. The following resolution on 8/8/23 at 9:07 Atthe food being cold. On 8/8/23 at 10:04 on cold food. On 8/8/23 at 10:56 of lukewarm food. 2. During Resident 9:30 A.M., resident portions, some were portions they order and the food being calculated about getting spoile juice. One resident meal they had recent	and drink eives and the facility od prepared by methods that value, flavor, and od and drink that is ve, and at a safe and rature. on, record review and ty failed to provide food and able, attractive, and at a safe perature for 1 of 1 meal test interviewed for palatable food the temperature. sident interviews were a.M. Resident 5 complained of A.M., Resident 26 complained A.M., Resident 72 complained	F 080		F 804 Nutritive Value/Appear, Palatable/Prefer Temp What corrective action(s) will accomplished for those residents found to have been affected by the deficient practice? Residents 5, 26, and 72 sufferno adverse effects from this alleged deficient practice. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken? All residents have the potential be affected by alleged practice. Residents have been interview about food concerns. Food Service Director/Registered Dietician will audit food temperatures during mealtime ensure food is served at an appetizing temperature and for palatable What measures will be put in	Il be In the he be re al to e. wed	DATE 09/14/2023
		e plate, the rice covered over			place and what systemic		
1	1 3/4 of the plate, the	chicken stir fry was about 1/2	1		changes will be made to ens	ure	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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 08/14/2023 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 cup on the side of the rice, and the single egg roll that the deficient practice does was about 2" long and 3/4" wide. The resident not recur? produced pictures of several egg rolls that were Dietary staff and nursing staff will burnt. Residents also complained about not be reeducated on food getting bed time snacks. temperatures and delivering the food carts, and food trays timely 3. On 8/9/23 at 2:10 P.M. a meal tray was received to residents. Daily observational form the room cart. The food temperatures as wounds will be completed for food follows: temps & taste of food. French fries-106 degrees F (Fahrenheit) How the corrective action(s) will Hamburger 116 degrees F be monitored to ensure the Bacon 106 degrees F deficient practice will not Fruit salad 55.5 degrees F recure, IE: what quality Iced tea no ice 58.3 degrees F assurance program will be put The french fries were cold and mushy, no taste. into place. The burger on bun with cheese lukewarm and The Culinary Manager/designee tasteless. will be responsible for the Bacon sour tasting. completion of an Food Fruit salad room temperature not chilled. Temperature Monitoring QA Tool weekly times 4 weeks, bi-monthly During an interview on 8/14/23 at 9:50 A.M. with a times 2 months, monthly times 4 resident on the 1100 hallway, he indicated the and then quarterly until continued food was hot on Friday and Monday, and was compliance is maintained for 2 cold all weekend. Another resident indicated that consecutive quarters. The results he was glad state was here because the food has of these audits will be reviewed by been better this week. the QAPI committee overseen by the ED. If threshold of 100% is not On 8/9/23 at 3:30 P.M. the facility food achieved, an action plan will be temperature policy was received and reviewed. developed. Deficiency in this The policy was last reviewed by facility on practice will result in disciplinary 6/21/23, indicated that all hot and cold food items action up to and including will be served to the resident at a temperature that termination of responsible is considered palatable at the time the resident employee. receives the food. By what date the systemic 3.1-21(a) changes for each deficiency will 3.1-21(e) be completed? September 14, 2023.

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155224	r í	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 08/14/	LETED
	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 BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0809 SS=E Bldg. 00	§483.60(f) Freques §483.60(f)(1) Each the facility must properties and plant in requests, and plant §483.60(f)(2) Therefore between a search breakfast the anourishing snact to 16 hours may esubstantial evening following day if a rethis meal span.	h resident must receive and rovide at least three meals mes comparable to normal community or in esident needs, preferences, n of care. e must be no more than 14 substantial evening meal following day, except when k is served at bedtime, up					
	review, the facility snack at bed time for for bedtime snacks,	no observation, and record failed to provide a nourishing or 5 of 5 residents interviewed and to provide meals at times and mealtimes in the community served.	F 08	809	F 809 Frequency of Meals/Snacks Bedtime What corrective action(s) wi accomplished for those residents found to have bee	ill be	09/14/2023
	_	Council meeting on 8/9/23 at s complained about not getting			affected by the deficient practice? Residents 24, 57, 112, 113 has negative effects by the allege		

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bed time snacks. Resident 10 indicated they all

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deficient practice.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155224	B. W	ING		08/14/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			COLUMBIA ST		
COLLIME	BIA HEALTHCARE	CENTER			SVILLE, IN 47710		
OOLOWIL		<u> </u>		LVANC			
(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 APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		sh of snacks that they buy			How other residents having		
	, , ,	al-Mart. They also complained			potential to be affected by t		
	about meals being	late.			same deficient practice will		
					identified and what correcti	ve	
	The following inter	rviews were obtained:			action(s)will be taken?		
					All residents have the potenti		
		0 A.M., Resident 24 complained			be affected by the alleged de	ficient	
	about not getting b				practice.		
		5 A.M., Resident 57 complained			Residents were interviewed in	າ for	
	about not getting b				desire for snacks		
		0 A.M., Resident 113			Staff was educated on snack		
		not getting bed time snacks.			delivery and meal times		
		5 A.M., Resident 112			What measures will be put i	nto	
	_	not getting bed time snacks. He			place and what systemic		
	1	extra snacks at Wal-Mart for			changes will be made to en		
	himself and other r	esidents.			that the deficient practice d	pes	
					not recur?		
	_	w on 8/11/23 at 11:07 A.M. with			Staff was educated on mealti	mes	
		r, he indicated the residents do			and providing snacks.		
	_	h meal choices on it to select			Observational rounds will be		
	_	f they want something other			completed daily for snack pas	ss &	
		menu, they have to call the			compliance on meal times		
		ed resident preferences such as			How the corrective action(s) will	
		ored on a computer program in			be monitored to ensure the		
		these are printed on the tickets			deficient practice will not		
	_	te the food. The dietary			recure, IE: what quality		
	_	the alternative meal choices are			assurance program will be p	out	
	•	nd include grilled cheese,			into place.		
	hamburger, cheese	burger, and leftovers.			The Food Service		
	D	and Div. M.			Director/designee will		
	_	w with the Dietary Manager on			monitor/audit nourishing bedt	ime	
		M., he indicated that snacks			snacks.		
		r they can get in". He indicated			The ED/designee will be		
	1 -	person on diabetic (controlled			responsible for the completion		
		At the same time, the white			Meal Time/Snack Provision C	ĮA.	
		wall listed the special diets on			Tool weekly times 4 weeks,		
		g controlled carbohydrate diets,			bi-monthly times 2 months,		
	of which there wer	e approximately 10.			monthly times 4 and then		
	The C /C	2022 1 C			quarterly until continued	0	
	The Spring/Summe	er 2023 monthly meal menu for			compliance is maintained for	2	

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		155224	B. W	/ING		08/14/	/2023
	PROVIDER OR SUPPLIER			621 W (ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST VILLE, 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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
	meals beginning 4/1	16/23 lacked alternative meal			consecutive quarters. The res	sults	
	choices or snack ch	oices of any type.			of these audits will be reviewe	d by	
					the QAPI committee overseen	-	
		er indicated they had no snack			the ED. If threshold of 100% is		
	policy or snack mer	nu.			achieved, an action plan will b	е	
	2 0 0 0/11/22 -4 0 6	00 A M the Dining1 de-1-			developed. Deficiency in this		
	2. On 8/11/23 at 9:0 was reviewed. Mea	00 A.M., the Dining schedule			practice will result in disciplina	ıry	
	was reviewed. Mea.	i times fisieu weie:			action up to and including termination of responsible		
	Breakfast: cottage (locked unit) 7:15 A.M., first			employee.		
		cond floor 8:05 A.M.			By what date the systemic		
		5 P.M., dining room 12:20			changes for each deficiency	will	
	P.M., first floor 12:	35 P.M., second floor 1:05 P.M.			be completed?		
	1	5 P.M., first floor 5:35 P.M.,			September 14, 2023.		
	second floor 6:05 P	.M.					
		0.000					
	_	of meal service on 8/9/23 at					
	at 1:50 P.M.	as delivered to the dining room					
	at 1.50 1 .WI.						
	After serving the re	sidents in the dining room, the					
	_	ng trays to the residents on					
	1	00, and 2500 hallways. The trays					
	on the 2 carts were	mixed up, so the staff had to					
		rts to find the trays for the					
		on. Then they went to the next					
		ough the rest of the trays to					
		ne residents on that hall. At					
	•	ray that was to be delivered on					
	me 2500 naliway w	as received from the cart.					
	No policy for timely	y delivery of meals was					
	provided.	, actively of means was					
	^						
	3.1-21(c)						
	3.1-21(e)						
E 0040	400.00(1)(1)(2)						
F 0812	483.60(i)(1)(2)						
SS=E	Food						1

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155224		JILDING	instruction 00	(X3) DATE (COMPL 08/14 /	ETED
	ROVIDER OR SUPPLIER			621 W (ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
Bldg. 00	§483.60(i) Food signal The facility must - §483.60(i)(1) - Proceed approved or consistederal, state or logical applicable State a regulations. (ii) This provision of facilities from using gardens, subject to applicable safe graphicable safe gr	does not prohibit or prevent g produce grown in facility o compliance with owing and food-handling does not procured by the ore, prepare, distribute and ordance with professional diservice safety. On and interview, the facility are, distribute, and serve food professional standards for for 1 of 1 kitchens reviewed.	F 08	312	F 812 Food Procurement, Store/Prepare/Serve-Sanitary What corrective action(s) will accomplished for those residents found to have beer affected by the deficient practice? No residents were affected by alleged deficient practice. Kitchen floor has been cleaned Storage bins have been cleaned Drywall has been repaired abot the 3 well sink, ceiling lights in kitchen have been replaced, lig in the dishroom have been	this d, ed, ove the	09/14/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2):		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		155224	B. WI	NG	_	08/14/2023		
				CENTER	A DDDDGG GITTY GT ATE TID GOD			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
COLLINA		CENTED			COLUMBIA ST			
COLUMB	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	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ght burned out in dishwashing			replaced, 3 missing light cove			
		iling lights were without covers			have been replaced, all food t	hat		
	in the kitchen.				was not dated or expired was			
					immediately discarded			
	_	ion of the walk-in refrigerator			How other residents having			
	on 8/7/23 at 10:00 A				potential to be affected by th			
	6. 1 gallon of milk	•			same deficient practice will			
	_	rs of yellow-colored drink, 1 of			identified and what corrective	⁄e		
	3 was labeled, all ex	•			action(s)will be taken?			
		of sliced cheese was open not			All residents have the potentia			
	labeled	. 10/5/22			be affected by the same alleg			
	_	er of ham was expired 8/5/23			deficient practice. An audit of			
	_	ner sliced tomatoes not labeled,			storage areas has been condu			
	with a white slimy				and all undated & expired food			
	_	er BBQ chicken expired 8/5/23			discarded. Kitchen & dish roo			
	_	er vegetables expired 8/5/23			have been audited for cleanling	ness		
	_	r ketchup, unreadable			& have been cleaned	L		
	expiration date				All food and beverages have t			
	In the wealtrin freeze	er, there was 1 package of			discarded that were not prope	-		
		ts that was wrapped in brown			labeled/dated. Culinary staff v			
		p, not labeled or dated.			be educated on the procedure	es		
	paper and clear wra	p, not labeled of dated.			and expectations regarding storage and sanitation.			
	During an interview	v on 8/7/23 at 10:13 A.M. with			Storage and Samtation.			
		ry Manager (ADM), he			 What measures will be put in	nto		
		containers were to be marked			place and what systemic	110		
	^	and the use-by date, and			changes will be made to ens	sure		
	•	container that was labeled			that the deficient practice do			
		te how it was to be done. The			not recur?			
	-	s on the rack had only one			The Food Service Director/Cu	llinary		
	_	licated he did not know			Manager/RD and/or designee	-		
	· ·	open date or the use-by date.			complete observations daily for			
		not know how long spices			sanitation, labeled and outdate			
		e kept after opening. After			food			
		ontainers, he threw 3 of them in			How the corrective action(s)	will		
	the trash.				be monitored to ensure the			
					deficient practice will not			
	During an interview	v on 8/7/23 at 10:22 A.M. with			recure, IE: what quality			
	the ADM, he indica	ated that once they open an			assurance program will be p	out		
	item, the date they j	put on it is the use-by date.			into place.			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155224	· ′	UILDING	onstruction 00		SURVEY LETED 1/2023
	PROVIDER OR SUPPLIER			621 W (ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
	During an observation 8/7/23 at 10:24 A.M. cornbread stuffing it were food wrappers and crumbs on floor During an observation refrigerators on 8/10 thermometer in the 1100 hall pantry incidence in the 1100 hall	on of the dry storage room on f., there was 1 open box of mix that expired 4/12/23. There is, a pack of animal crackers, is under the shelves. on of the 3 unit nourishment 0/23 at 9:52 A.M., the nourishment refrigerator in the dicated 50 degrees F. At that mometer placed in the ed 47.4 degrees F. The ed perishable food such as is, and lunch meat sandwiches. M. the food storage policy was red. The policy last reviewed 23, indicated that refrigerated, itally hazardous foodshall be in the date the original container rate by which the food shall be ded. The opened food can be for less for no more than 7 at are not considered as such as salad ce, pickles and relish will be ded and used or disposed of opening or the use-by-date, rist; temperatures for be <41 degrees F; food items self stable are to be used within all foods shall be covered or			The Food Service Director/designee will monitor/audit food storage a kitchen sanitation. Audits are to be done 5 time week for four weeks and co weekly for no less than two additional months. The resi be presented to the monthly Quality Assurance Performa Improvement IDT Committe facility will achieve a 100% compliance threshold prior to adjusting the frequency of a Plan to be updated as indicate by Committee. By what date the systemic changes for each deficient be completed? September 14, 2023.	es a ntinue ults will ance e. The udits. ated	
F 0921 SS=F	483.90(i) Safe/Functional/S	anitary/Comfortable Environ					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 08/14/2023 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 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 09/14/2023 Based on observation and interview, the facility F 0921 failed to maintain a safe, clean, comfortable, and F 921 homelike environment for 1 of 1 locked dementia Safe/Functional/Sanitary/comfo unit. (The Cottage) rtable Environment What corrective action(s) will be Findings include: accomplished for those residents found to have been During observation of the unit on 8/8/23 at 1:00 affected by the deficient P.M.: practice? No residents were affected by this 1. The bathroom between rooms 1303 and 1305, alleged deficient practice. which was shared by 4 residents, was observed to The bathroom between 1303 and have 2 nail holes and a 13" diameter area on the 1305 nail holes have been wall where the toilet paper holder had been repaired, 1305 the paint chipped replaced. The surface of the drywall was torn off. on the door frame has been painted, the bathroom between 2. In room 1305, there was a fist-sized patch of 1308 and 1310 has had the paint paint chipped off on the left side of the bathroom missing repainted, 1312 has had door frame about halfway up. the bathtub cleaned, toilet plunger has been stored properly and the 3. In the bathroom between rooms 1308 and 1310, plastic bag was removed & which was shared by 4 residents, there was a 12" discarded. The broken hand rail x 4" area behind the left side of the toilet that had has been repaired. 1302 the bath not been painted and had 2 different colors (red tub has been cleaned, Bathroom and blue) showing through. between 1310 and 1312 has had the black crape above the hand 4. On 8/9/23 at 3:39, during an observation and rail removed and the hallway in interview with LPN (Licensed Practical Nurse) 14, 1300 hall has repainted to cover Room 1312 was found to have a bathtub that was missing paint dirty on the bottom, with a crumpled plastic bag How other residents having the over the drain, an uncovered toilet plunger, and a potential to be affected by the

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broken toilet assist bar also in the tub. LPN 14

5. In room 1302, there was a bathtub that was

dementia residents use the toilet and sink.

indicated no one ever uses the bathtub, though 2

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same deficient practice will be

identified and what corrective

All residents have the potential to

be affected by the same alleged

action(s)will be taken?

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DENTIFICATION NUMBER 1.8 NOT 1	STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER (N4) ID SUMMARY STATEMENT OF DEFICIENCIE (IACH IDERICINCY MIST IN EPRICIDED BY PLI.) TAG REGULATORY OR SEE IDENTIFYING NIFORMATION observed to be dirty on the bottom and a missing the bathtub, though 2 dementia residents use the toilet and sink. 6. On 8/11/23 at 11:38 A.M., the hallway between rooms 1310 and 1312 was observed to have a 3 ft. long black scrape above the handrail. 7. There were 2 fist-sized areas of paint flaking off the wall next to room 1309. 8. There were numerous dime-sized places of peeled-off paint with blue paint showing through on both sides of the hall from room 1305 to the end of the hall. Policy for maintenance was not available for review. 3.1-19(f) STREET ADDRESS, CITY, STATE, ZIP COD 621 W COLUMBIA ST EVANSVILLE, IN 47710 D PRIFIX TAG PROVIDES IN ANOTORIZEMENT TAG PROVIDES IN ANOTORIZEMENT TAG PROVIDES IN ANOTORIZEMENT TAG deficient practice. House wide audit was completed for any maintenance or environmental observational rounds will be completed by ED/ MaintenanceHSK or designee What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Housekeeping and maintenance have been in-service on environment cleantineass, repair and painting. Preventative Program TELS is in place, with work orders available to all staff. The Administrator/designee will monitor/audit resident rooms daily to ensure cleannineass, safety, functionality, sanitary, and comfortable environment. How the corrective action(sy will be responsible for the completion of an Food Temperature Monitoring QA Tool weekly times 4 weeks, bi-monthy times 2 months, monthly times 4 and then quarefy until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ND2211 Facility ID: 000129

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

PRINTED: 09/22/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155224	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/14/2023
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 NCY 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) the ED. If threshold of 100% is achieved, an action plan will b developed. Deficiency in this practice will result in disciplina action up to and including termination of responsible employee. By what date the systemic changes for each deficiency be completed? September 14, 2023.	s not one
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION	TAG	the ED. If threshold of 100% is achieved, an action plan will be developed. Deficiency in this practice will result in disciplinal action up to and including termination of responsible employee. By what date the systemic changes for each deficiency be completed?	s not pe ary

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