STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLUMBIA HEALTHCARE CENTER	621 W COLUMBIA ST EVANSVILLE, IN 47710

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00434200, IN00433145, and IN00432722. Complaint IN00432722 - Federal/State deficiencies related to the allegations are cited at F660. Complaint IN00433145 - No deficiencies related to the allegations are cited. Complaint IN00434200 - No deficiencies related to the allegations are cited. Survey dates: May 8 & 9, 2024 Facility number: 000129 Provider number: 155224 AIM number: 100266780 Census bed type: SNF/NF: 116 Total: 116 Census payor type: Medicare: 3 Medicaid: 91 Other: 22 Total: 116 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 13, 2024.	F 0000	**F0000** **The creation and submission of the Plan of Correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey re-visit.**	
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an			

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

Andrea Beran | Administrator | 05/24/2024

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

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	effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made			

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	for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.			
	Based on interview and record review, the facility failed to ensure a the facility implemented the resident's discharge process for 1 of 3 residents reviewed for transfer/discharge rights. A resident	F 0660	**F660** **DISCHARGE PLANNING PROCESS** **What corrective action(s) will**	06/05/2024

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	who lacked the ability to care for herself discharged home from the facility prior to the arrangement of a home health service and without documentation being completed according to the facility's discharge policy. (Resident B) Finding includes: During record review on 5/8/24 at 11:00 A.M., Resident B's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), major depressive disorder, anxiety, chronic pain, history of falls, weakness, and unsteadiness on feet. Resident B's hospital notes from a hospital admission on 3/22/24, prior to admitting to the facility on 4/11/24, included, but was not limited to the following physician note; "...I have a great deal of concern with the overall safety and stability of this patient, both socially and mentally. As her own outpatient PCP (Primary Care Physician) team is unwilling to admit her, she was verbally abusive to hospital staff, she is questionably being neglected by her home care team, I really question her ability to maintain appropriate outpatient resources and follow up. She is extremely high-risk for multiple readmissions, decompensation, complications and death. I have made a case management referral at this time, I fully encourage and recommend an in-depth Adult Protective Services [APS] investigation into this patient's well-being..." Resident B's care plan included but was not limited to; Resident requires assistance with ADLs (Activities of Daily Living) including bed mobility, transfers, eating, and toileting, started 4/12/24. Resident is at risk for falls, started 4/12/24.		**be accomplished for those residents found to have been affected by the deficient practice?** · Resident no longer resides in facility **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with a planned discharge have the potential to be affected by the alleged deficient practice. A review of all residents' discharge plans was completed by SSD to ensure residents potential discharge needs were incorporated into the discharge plan and arrangements for services were completed. If resident is denied by the referring agency, SSD/designee will document the reason for the denial and will work with IDT to determine another resource as indicated by the physician, resident and/or residents' representative to meet their needs in the community. If the resident elects not to use the referring agency, SSD/designee will document the reason for the refusal and will work with IDT to determine another resource as indicated by the physician, resident and/or residents' representative to meet their needs in the community.	

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	Resident B's progress notes included the following: A Nurse's Note dated, 4/14/24 at 7:30 A.M., Resident has been yelling out since arrival of nurse. Resident attempting to scoot self out of chair. Nurse explained to resident that she can't get up out of the chair on her own, and that it took a minimum of three staff members to transfer the resident. A Social Service Note dated, 4/14/24 at 2:55 P.M., Resident wanting to go home but SS 4 (Social Service) had explained to her that she needs to see the doctor in the morning. A Social Service Note dated, 4/15/24 at 11:00 A.M., Social Service sent referral to hospice company for resident upon discharge home per resident request. Awaiting response. A Nurse's Note dated, 4/15/24 at 1:52 P.M., Orders to discharge patient home on hospice with hospice company and husband. Resident being sent home with medications and belongings. Resident is going home via car. Resident is not showing any signs or symptoms of distress and is aware of the plans to discharge home with hospice. A Social Service Note dated, 4/15/24 at 2:27 P.M., Social Service informed resident is wishing to discharge from facility today, order for discharge obtained. Social Service reached out to hospice company requesting status on resident referral. Representative stated she would have hospice staff contact Social Service back with status and confirmation of acceptance from hospice company before proceeding with discharge.		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·SSD/designee and IDT will review each discharge weekly during an IDT Discharge Meeting using the Home Discharge Summary Checklist. The checklist will be followed and completed for each resident with a planned discharge weekly and/or any resident identified as potentially unsafe for discharge. The facility will attempt to coordinate a home evaluation prior to discharge. Education and In-service to be conducted with all IDT members and Nurses on Discharge Summary Checklist. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·To ensure compliance, the SSD/designee will be responsible for the daily review of each discharge using a Discharge Planning QAPI tool. These will be reviewed by the ED weekly for 4 weeks, monthly for 6 months and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by	

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	Resident B's physician order's included, but was not limited to, may discharge home with hospice services, dated 4/15/24. An invalidated Discharge Summary for Resident B, dated 4/15/24, was completed and lacked a signature from Resident B or a resident representative. The discharge summary was invalidated on 5/3/24. During an interview on 5/8/24 at 12:45 P.M., SS 4 indicated that when a resident is discharged from the facility, a discharge summary is completed and signed by the resident or resident representative. Once the resident signs the discharge summary, a discharge packet that includes discharge orders and a discharge plan is given to the resident. SS 4 indicated that a discharge summary was completed for Resident B and that the facility was waiting on Resident B to sign. SS 4 was unsure if Resident B ever signed the discharge summary before discharging from the facility. Resident B was discharged from the facility with an order for hospice services to evaluate her. The hospice company met Resident B at her home after the discharge from the facility and did not accept Resident B. The original hospice company then referred Resident B to another hospice company and SS 4 indicated being unsure if she was accepted by the second hospice company. SS 4 indicated that Resident B was unable to care for herself and that typically the facility would assure a resident had been accepted to a home healthcare provider before being discharged. During an interview on 5/9/24 at 9:05 A.M., the Administrator indicated that Resident B was supposed to be evaluated by the hospice company on 4/16/24 and had an order to discharge home with hospice. Resident B refused		the ED. If a threshold of 100% is not achieved, an action plan will be developed.	

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	to wait to be evaluated and left the facility with her husband on 4/15/24. Resident B had been at the facility for four days, she was alert and oriented and had a referral for hospice care at home. The facility had not received any information regarding APS involvement with Resident B and the facility did not contact APS regarding Resident B's return home with her husband. During an interview on 5/9/24 at at 11:10 A.M., SS 4 indicated that Resident B was alert and oriented and had chosen to leave the facility without a transition of care being completed. SS 4 indicated when a resident wishes to leave the facility AMA (Against Medical Advice), staff should provide education and document that the education was provided to the resident. If a resident did leave the facility AMA, social service staff or nursing staff should complete an AMA observation to be included in the resident's record. Resident B's record lacked information regarding the exact time or date the resident left the facility and lacked documentation that education was given about leaving the facility AMA. No AMA observation was completed in Resident B's record. On 5/9/24 at 9:30 A.M., the Administrator supplied a facility policy titled, Discharge Against Medical Advice, dated 10/2022. The policy included, "...If a resident has decision making capacity (as determined by the resident's physician) and or their legal representative wishes the resident to leave the facility prior to his or her planned discharge and despite facility efforts to explain the risks of leaving, the discharge would be considered leaving against medical advice (AMA). Documentation in the medical record should indicate the facility staff attempted to			

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	provide other options to the resident and informed the resident of potential risks of leaving AMA. Residents will never be pressured, intimidated, or coerced into leaving AMA. Procedure: ...4. Facility staff will document in the medical record the options offered, risks explained, and information given to the resident/representative. Documentation will be completed on the Discharge Against Medical Advice observation in [the resident's electronic record]... 6. The Discharge Against Medical Advice observation and accompanying information should be reviewed with the resident/representative. If the resident/representative refuse the review, that must be noted on the observation... 7. Notify outside agencies (Adult Protective Services, etc.) if there is concern for the resident's safety and well-being..." This citation relates to Complaint IN00432722. 3.1-12(a)(3)			