

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Columbia Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 621 W Columbia St Evansville, IN 47710	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39130</p> <p>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 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)</p> <p>Finding includes:</p> <p>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.</p> <p>Resident B's hospital notes from a hospital admission on 3/22/24, prior to admitting to the facility on [DATE], 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 .</p> <p>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.</p> <p>Resident B's progress notes included the following:</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155224
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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>Resident B's physician order's included, but was not limited to, may discharge home with hospice services, dated 4/15/24.</p> <p>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.</p> <p>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 .</p> <p>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 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.</p> <p>During an interview on 5/9/24 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.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 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 .</p> <p>This citation relates to Complaint IN00432722.</p> <p>3.1-12(a)(3)</p>		