STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Healthcare Center	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to follow the nebulizer policy for 1 of 1 resident reviewed for hospital discharge. (Resident D) The resident was not assessed prior to the nebulizer treatment, facility staff did not stay at bedside during the nebulizer treatment; Resident D was later found by a staff member with no respirations or pulse. Finding includes: On [DATE] at 10:54 A.M., Resident D's clinical record was reviewed. Resident D was admitted on [DATE]. A Minimum Data Set (MDS) Assessment had not been completed. Current physician orders included, but were not limited to: Continuous oxygen at 2 liters per nasal cannula, Start date [DATE] Albuterol sulfate solution (bronchodilator medication) for nebulization; 0.63 mg (milligrams) /3 mL (milliliters) inhalation every 4 Hours, Start date [DATE] Observe pulse, respirations and breath sounds before each nebulizer treatment, four times a day, Start date [DATE] Observe pulse, respirations and breath sounds after each nebulizer treatment, four times a day, Start date [DATE] Code status full code, Start date [DATE] A nursing progress note, dated [DATE] at 10:25 A.M., indicated a Qualified Medication Aide (QMA) yelled for help when Resident D was found not breathing and without a pulse during a breathing treatment. Cardiopulmonary resuscitation (CPR) was started and emergency medical technicians (EMT's) were notified. Resident D was transported to the hospital. The electronic medication administration record (eMAR) on [DATE] lacked documentation for the following: 10:00 A.M. albuterol nebulizer treatment (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pulse, respirations, breath sounds, oxygen saturation before nebulizer treatment administration An SBAR physician communication event, dated [DATE] at 10:52 A.M., indicated Resident D was not using oxygen. During an interview on [DATE] at 8:31 A.M., Registered Nurse (RN) 5 indicated that on [DATE] Resident D started a breathing treatment and did not look well. RN 5 left the room while the breathing treatment was running to call the nurse practitioner. RN 5 indicated a QMA yelled for assistance when Resident D was found unresponsive. The Director of Nursing (DON) initiated CPR. During an interview on [DATE] at 9:39 A.M., the DON indicated assessments should be completed and charted by a nurse before, during, and after each breathing treatment, and indicated RN 5 was the only nurse scheduled to cover the nursing duties on all five halls of the first floor from 6:00 A.M. to 2:00 P.M. on [DATE]. On [DATE] at 3:09 P.M., the Administrator indicated the facility did not have a nebulizer treatment policy and indicated all nurses had a nebulizer treatment skills check off during orientation. At that time, she provided a document titled Nebulizer Treatment that indicated 6. Perform pre-assessment including pulse, respiration, and breath sounds . 11. Stay with resident during entire procedure . 13. During procedure perform assessment including pulse, respiration, and breath sounds . 16. Perform post-assessment including pulse, respiration, and breath sounds. 19 . Document pertinent information on medication administration record (MAR) and nebulizer treatment flow sheet. This citation relates to complaint IN00449174. 3XXX,d+[DATE](a)(6)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48147 Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 4 of 8 resident records reviewed. Insulin administration and nebulizer treatments were not marked as complete on the Medication Administration Record. (Resident C, Resident O, Resident M, Resident U) Findings include: 1. On 12/30/24 at 10:32 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/6/24, indicated Resident C had moderate cognitive impairment, required substantial to maximal assistance from staff (staff did more than half) for bathing, and received insulin seven out of seven days during the lookback period. A current risk for hyperglycemia care plan, initiated 5/19/22 and last revised on 12/10/24, included an intervention to give medications as ordered. Physician orders included, but were not limited to: Fiasp FlexTouch U-100 Insulin (insulin aspart) (a short-acting insulin) - 100 unit/mL (units per milliliter) - Administer subcutaneously per sliding scale: If Blood Sugar is less than 60, call Medical Doctor (MD). If Blood Sugar is 0 to 199, give 0 Units. If Blood Sugar is 200 to 249, give 2 Units. If Blood Sugar is 250 to 299, give 3 Units. If Blood Sugar is 300 to 349, give 4 Units. If Blood Sugar is 350 to 399, give 5 Units. If Blood Sugar is 400 to 499, give 6 Units. If Blood Sugar is greater than 500, call MD, dated 11/19/24. insulin glargine solution (a long-acting insulin) 100 unit/mL - Administer 10 units subcutaneously twice a day, dated 11/29/24 with a stop date of 12/23/24. The December 2024 Medication Administration Record (MAR) lacked documentation to indicate Resident C received the 11:00 P.M. dose of insulin aspart on 12/8/24 and 12/10/24 and the 8:00 P.M. dose of insulin glargine on 12/16/24. On 12/31/24 at 9:38 A.M., the Director of Nursing (DON) indicated that she was unsure if Resident C got their insulin as ordered on 12/8/24, 12/10/24, and 12/16/24 since it was not documented as given. 48057 2. On 12/30/24 at 11:24 A.M., Resident U's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 10/16/24, indicated Resident U was cognitively intact, required partial assistance from staff for transfers, and received insulin seven of seven days during the lookback period. Current physician orders included, but were not limited to: Basaglar KwikPen (a hypoglycemic injection); Amount to administer: 60 units subcutaneous, Give half dose of insulin if blood sugar is below 120, at bedtime every day. Start date 10/18/24. The electronic medication administration record (eMAR) lacked documentation for the following: 12/16/24 8:00 P.M. blood sugar results 12/16/24 8:00 P.M. Basaglar insulin administration 3. On 12/30/24 at 12:20 P.M., Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/24, indicated Resident M's cognition was too low to be assessed, resident was substantial assistance (staff did more than half of the work) for toileting, bathing, and transfers, and received insulin seven of seven days during the lookback period. Current physician orders included, but were not limited to: insulin lispro pen; Amount to Administer: 9 units subcutaneous, three times a day, Start date 7/15/24. insulin lispro pen; Amount to Administer: If Blood Sugar is less than 60, call MD. If Blood Sugar is 0 to 149, give 0 Units. If Blood Sugar is 150 to 169, give 1 Units. If Blood Sugar is 170 to 189, give 2 Units. If Blood Sugar is 190 to 209, give 3 Units. If Blood Sugar is 210 to 229, give 4 Units. If Blood Sugar is 230 to 249, give 6 Units. If Blood Sugar is 250 to 269, give 8 Units. If Blood Sugar is 270 to 299, give 10 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Units. If Blood Sugar is greater than 299, give 12 Units. If Blood Sugar is greater than 300, call MD. Subcutaneous three times a day, Start date 12/4/24. The electronic medication administration record (eMAR) lacked documentation for the following: 12/28/24 12:00 P.M. insulin lispro 9 units administration 12/28/24 12:00 P.M. blood sugar results 12/28/24 12:00 P.M. insulin lispro sliding scale administration 12/29/24 12:00 P.M. insulin lispro 9 units administration 12/29/24 12:00 P.M. blood sugar results 12/29/24 12:00 P.M. insulin lispro sliding scale administration 4. On 12/30/24 at 2:10 P.M., Resident O's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/20/24, indicated Resident M's cognition was too low to be assessed, resident was dependent assistance (staff did all the work) for toileting, bathing, and mobility, and received oxygen therapy. Current physician orders included, but were not limited to: ipratropium bromide solution 0.02% inhalation (bronchodilator nebulizer medication) four times a day, Start date 11/25/24 Observe pulse, respirations and breath sounds before each nebulizer treatment, Start date 10/31/24 Observe pulse, respirations and breath sounds after each nebulizer treatment, Start date 10/31/24 The electronic medication administration record (eMAR) lacked documentation for the following: 12/1/24 8:00 A.M. ipratrompium bromide administration 12/1/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds 12/2/24 8:00 A.M. ipratrompium bromide administration 12/2/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/3/24 8:00 A.M. ipratrompium bromide administration 12/3/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds 12/6/24 12:00 P.M. ipratrompium bromide administration 12/23/24 8:00 A.M. ipratrompium bromide administration 12/23/24 8:00 A.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds 12/25/24 4:00 P.M. ipratrompium bromide administration 12/25/24 4:00 P.M. pre and post nebulizer assessment including pulse, respiration, and breath sounds On 12/30/24 at 3:09 P.M., the Administrator indicated the facility did not have a nebulizer treatment documentation policy, and indicated all nurses had a nebulizer treatment skills check off during orientation. At that time, she provided a document titled Nebulizer Treatment that indicated 6. Perform pre-assessment including pulse, respiration, and breath sounds . 11. Stay with resident during entire procedure . 13. During procedure perform assessment including pulse, respiration, and breath sounds . 16. Perform post-assessment including pulse, respiration, and breath sounds . 19. Document pertinent information on medication administration record (MAR) and nebulizer treatment flow sheet. During an anonymous interview, it was indicated that the facility was often not fully staffed during the evening shift making it difficult to complete all tasks. They indicated documentation was a task that was left unfinished. On 12/31/24 at 9:53 A.M., the DON provided a current Medication Administration policy, revised 7/2023, that indicated Mediation administration will be recorded on the MAR/EMAR or TAR (Treatment Administration Record) after given. This citation relates to complaint IN00449174. 3.1-50(a)(1) 3.1-50(a)(2)