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	09/08/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents dependent on staff for ADLs (activities of daily living) were showered for 7 of 8 residents reviewed for ADL care. (Resident B, Resident C, Resident D, Resident E, Resident F, Resident H, and Resident J)Findings include: 1. On 9/3/25 at 8:53 A.M., Resident E indicated that she didn't always get showers twice a week. She indicated that sometimes she would go two to three weeks without a shower, and if she refused a shower, staff did not allow her to have it at a different time. On 9/3/25 at 1:17 P.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, rheumatoid arthritis and major depressive disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 7/29/25, indicated Resident E was cognitively intact, required partial to moderate assistance of staff (staff does less than half of the effort) for bathing, and did not reject care during the look-back period. A care plan conference was completed on 7/29/25 with the resident in attendance. Care plans were reviewed and updated. A current ADL care plan, dated 1/12/23, included the intervention Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. A Preferences for Customary Routine and Activities note, dated 7/24/25, indicated the resident preferred to be bathed more than twice per week in the morning and preferred showers. A current shower schedule indicated Resident E received showers on Tuesdays and Fridays during the day shift. The Point of Care (POC) (a charting system for Certified Nurse Aides) Task Response for Showering and shower sheets were reviewed. Resident E did not receive showers or a complete bed bath on the following days in August 2025: 8/8/25 8/12/25 8/22/25 (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current shower schedule indicated Resident J received showers on Tuesdays and Fridays during the day shift. The Point of Care (POC) (a charting system for Certified Nurse Aides) Task Response for Showering and shower sheets were reviewed. Resident J did not receive showers or a complete bed bath on the following days in August 2025: 8/5/25 8/8/25 8/12/25 8/15/25 8/22/25 8/29/25 4. On 9/2/25 at 12:20 P.M., Resident C's hair appeared unbrushed and oily. On 9/4/25 at 9:25 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease. The most current admission Minimum Data Set (MDS) Assessment, dated 6/21/25, indicated Resident C had severe cognitive impairment, required partial to moderate assistance of staff (staff does less than half of the effort) for bathing, and had no rejection of care during the look back period. A care plan conference was completed on 8/26/25 with a family member in attendance. Care plans were reviewed and updated. A current ADL care plan, dated 6/16/25, included an intervention to Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. A Preferences for Customary Routine and Activities note, dated 9/3/25, indicated the resident preferred showers. A current shower schedule indicated Resident C received showers on Wednesdays and Saturdays during the day shift. The Point of Care (POC) (a charting system for Certified Nurse Aides) Task Response for Showering and shower sheets were reviewed. Resident C did not receive showers or a complete bed bath on the following days in August 2025: 8/2/25 8/6/25 8/9/25 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/27/25 8/30/25 5. On 9/2/25 at 12:16 P.M., Resident H was observed screaming in the middle of the dining room that she had not had a shower for 2 weeks and wanted one at that time. Resident H was also observed with greasy hair. On 9/4/25 at 10:48 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and diabetes mellitus. The Current Quarterly MDS dated [DATE] indicated the resident was cognitively intact and needed supervision with hygiene, dressing, transferring, and mobility. A care plan conference was conducted on 5/20/25, and the care plan was reviewed and updated. A current ADL care plan dated 5/20/25 included an intervention, assist with bathing as needed per resident preference. Offer showers two times per week, a partial bath in between. A current Shower Sheet indicated the resident received showers on Tuesday and Thursday during the day shift. Shower sheets indicated Resident H did not receive showers on the following dates: 8/14, 8/18, 8/25. The Point of Care Task indicated the resident did not receive a shower or partial bath on 08/22/2025. 6. On 9/3/25 at 12:31 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 8/15/25, indicated Resident B was maximal assist (staff do more than half of the work) for bathing. A current shower schedule indicated Resident B received showers on Monday and Thursday during the day shift. The Point of Care Task Response for Showering and shower sheets were reviewed. Resident B did not receive or refuse showers or a complete bed bath on the following scheduled days in August 2025: 8/4/25 8/7/25 8/14/25 8/28/25 7. On 9/4/25 at 12:02 P.M., Resident F's clinical record was reviewed. Resident F's diagnoses (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included, but were not limited to, quadriplegia. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 8/6/25, indicated Resident F was dependent on staff (staff do all of the work) for bathing. The current care plan included, but was not limited to: Resident requires assistance with ADLs (activities of daily living); Assist with bathing as needed per resident preference. Offer full bed bath two times per week, partial bath in between. Start date: 9/23/24 A current shower schedule indicated Resident F received showers on Tuesday and Friday during the evening shift. The Point of Care Task Response for Showering and shower sheets were reviewed. Resident F did not receive or refuse showers or a complete bed bath on the following scheduled days in August 2025: 8/1/25 8/5/25 8/12/25 8/22/25 On 9/4/25 at 9:36 A.M., the Director of Nursing (DON) indicated that shower sheets were a part of the clinical record. Staff were supposed to transfer all information on the shower sheets over to the POC Response, but sometimes they forgot. On 9/4/25 at 2:42 P.M., the Assistant Director of Nursing (ADON) indicated that residents got at least two showers per week or more if that was what they preferred. If a resident refused a shower, staff should reattempt or offer to give the shower on a day and time that the resident preferred. On 9/8/25 at 11:00 A.M., the Administrator provided a current undated Resident Rights policy that indicated You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose. This citation is connected to Intake 2592689. 3.1-38(a)(2)(A)3.1-38(b)(2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's comprehensive care plan interventions were implemented for 1 of 1 residents reviewed for falls. Resident G was not observed to have Dycem in use in the wheelchair.(Resident G) Findings include: On 9/3/25 at 10:30 A.M., Resident G was observed lying in bed with the wheelchair (W/C) next to the bed. There was no Dycem (non-slip device) observed in the w/c. On 9/4/25 at 3:42 P.M., Resident G was observed lying in bed with W/C next to the bed. There was no Dycem observed in the W/C. On 9/3/25 at 1:11 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of the upper lobe, right bronchus, secondary malignant neoplasm of the liver, and chronic obstructive pulmonary disease (COPD). The most Current admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident G was cognitively intact. Resident G is dependent on toileting and dressing and needs partial assistance of 1 for hygiene. Current physician orders included but were not limited to Dycem to W/C every shift, dated 8/29/25. The current fall care plan was reviewed on 8/28/25. Interventions included were not limited to Dycem to W/C and W/C at bedside. During an interview on 9/4/25 at 3:42 P.M., Resident G indicated that the Dycem was supposed to be in the W/C but has not been there for a while. During an interview on 9/5/25 at 9:30 A.M., Licensed Practical Nurse (LPN) 4 indicated the resident is care planned for a Dycem pad. She indicated that for this resident, there should be one on top and one on the bottom. She did not know why it was not in the wheelchair. On 9/8/25 at 11:00 A.M., the Administrator provided a current policy IDT Comprehensive Care Plan Policy revised 8/23. The policy indicated .the care plan must include . specific interventions based on the resident's needs and preferences to promote the resident's highest level of functioning . Physician orders are considered part of the comprehensive care plan . 3.1-35(a)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review and interview, the facility failed to ensure a Resident's medication side effects were addressed after a medication change for 1 of 1 residents reviewed for mood and behaviors. (Resident F) Finding includes: On 9/4/25 at 12:02 P.M., Resident F's clinical record was reviewed. Resident F's diagnoses included, but were not limited to, quadriplegia. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 8/6/25, indicated Resident F was dependent on staff (staff do all of the work) for bathing and toileting. Current physician orders included, but were not limited to: Citalopram (antidepressant medication) tablet, take 10 milligrams (mg) at bedtime; Start date: 8/20/25 Discontinued physician orders included, but were not limited to: Citalopram tablet, take 20 milligrams (mg) at bedtime; Started on 3/21/25 and discontinued on 8/20/25 Anti-Anxiety Medication Use - Observe the resident closely for significant side effects. Special Instructions: Document observed side effects in progress notes and notify MD, as needed. Start date 1/21/25 Anti-Depressant Medication Use - Observe the resident closely for significant side effects. Special Instructions: Document observed side effects in progress notes and notify MD, as needed. Start date: 1/21/25 The current care plan included, but was not limited to: Resident is at risk for signs and symptoms of depression; Start date 09/25/2024 The resident is at risk for signs and symptoms of anxiety. Psych services as appropriate; Start date 9/30/24 A nursing progress note, recorded as a late entry on 8/22/25 at 12:04 A.M., indicated Resident F was tearful that shift. An Interdisciplinary team note, dated 8/22/25 at 9:47 A.M. and 12:17 P.M., indicated acknowledgement of Resident F's increased side effects of tearfulness following the medication reduction. A nursing progress note, dated 8/28/25 at 09:00 P.M., indicated Resident F was tearful that shift; multiple staff members witnessed the resident crying. A nursing progress note, dated 8/29/25 at 11:55 P.M., indicated Resident F was tearful and emotional that shift. The resident's family reported that the resident has been more tearful and angry this past week. A nursing progress note, dated 8/30/25 at 6:46 P.M., indicated Resident F was tearful again at this time. A nursing progress note, dated 9/1/25 at 3:09 A.M., indicated Resident F was tearful off and on that shift. A nursing progress note, dated 9/1/25 at 6:00 P.M., indicated that the family reported that the resident had been tearful many times that day. A nursing progress note, dated 9/3/25 at 12:37 A.M., indicated Resident F was tearful at the beginning of the shift. Staff reported that the resident had been more tearful over the last week and a half. Notification to the psychiatric nurse practitioner, or follow-up from the nurse practitioner, for experiencing side effects post medication reduction was not documented from 8/20/25 through 9/3/25. During an interview on 9/4/25 at 2:38 P.M., the Assistant Director of Nursing indicated if a resident has side effects following a medication reduction, it would be addressed immediately, the psychiatric nurse practitioner visits the building twice a week, and that staff were aware of Resident F's increased tearfulness follow the medication reduction but had not notified the psychiatric nurse practitioner to evaluate the resident yet. On 9/8/25 at 11:16 A.M., the Administrator provided a policy titled Psychotropic Management, revised 7/25, that indicated It is the policy to ensure a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical, and psychosocial well being For all psychotropic medication order changes, the resident will be observed for 72 hours for any changes in symptoms or adverse effects.3.1-37(a)