

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/05/2013
NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0000	<p>This visit was for Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: January 28, 29, 30, 31, 2013 and February 1, 2013; February 4 and 5, 2013.</p> <p>Facility number: 011906 Provider number: 155772 AIM number: 200912380</p> <p>Survey team: Teresa Buske RN-TC Mary Weyls RN Laura Brashear RN January 28-31, February 1 and 4, 2013</p> <p>Census bed type: SNF: 49 SNF/NF: 10 Residential : 39 Total: 98</p> <p>Census payor type: Medicare: 40 Medicaid: 5 Other: 53 Total: 98</p> <p>Residential sample: 5</p>	F0000	<p>The submission of this plan of correction does not indicate an admission by the Cobblestone Crossings Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Cobblestone Crossings Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18 & 19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>		

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/05/2013
NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 02/11/2013 by Brenda Nunan, RN.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/05/2013
NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to routinely assess a dialysis access site for 1 of 1 random observation of a resident currently receiving hemodialysis services. [Resident #14]</p> <p>Finding includes:</p> <p>On 1/31/13 at 3:00 p.m., Resident #14 was interviewed. The resident indicated she went to the dialysis center on Monday, Wednesday, and Friday for hemodialysis. The resident indicated she had a right arm fistula. During the interview, the resident indicated nursing staff in the facility did not feel the site to assess for a thrill (palpable sensation of blood flow through the fistula), or listen with a stethoscope for a bruit (audible auscultation over fistula) .</p> <p>During the interview on 1/31/13 at 3 p.m., an AV (arteriovenous) fistula was observed in the resident's right arm.</p>	F0309	Resident 14 had shunt assessed. No other residents were affected by alleged deficiency and through in-servicing will have adequate assessment of residents with shunts on a daily basis. All licensed nurses were in-serviced on proper shunt assessment and return demonstration of competency. DHS or designee will monitor all shunt assessments daily for 30 daily then randomly interview resident and observe nurse assessment skills 1 time per week for 3 months and monthly thereafter. Results of audits will be forwarded to QA committee monthly for 12 months. We respectfully ask for desk review due to scope and severity of deficiency.	03/07/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/05/2013
NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Resident #14's clinical record was reviewed on 2/1/13 at 10:00 a.m. A physician's order was noted dated 11/23/12 to check right arm fistula every shift for bruit/thrill.</p> <p>A Minimum Data Set Assessment, [MDS], dated 11/28/12, coded the resident with no cognitive impairments.</p> <p>The January Medication Administration Record was reviewed on 2/4/13 at 3:00 p.m. Documentation was noted for each shift by the nurses for the order to check right fistula ever shift for bruit/thrill.</p> <p>On 2/4/13 at 9:30 a.m., LPN #1 was interviewed. The LPN indicated she usually works the unit where the resident resides. The LPN indicated she was not aware of doing anything with the resident's dialysis access site. The nurse indicated she thought once a day the resident was suppose to elevate it.</p> <p>A facility policy titled "Guideline for Dialysis Provider Communication," [no date] included, but was not limited to, "5. Upon return from the Dialysis Provider the campus shall: a.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/05/2013
NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Provide ongoing monitoring of the shunt site for signs of complication." 3.1-37(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure each resident's drug regimen was reviewed by a licensed pharmacist at least monthly for 2 of 8 residents reviewed for unnecessary medications who required monthly visits. [Residents #27 and #6]</p> <p>Findings include:</p> <p>1. Resident #27's clinical record was reviewed on 1/30/13 at 11:12 a.m. An admission date was noted of 10/25/12. The record did not indicate pharmacy reviews were completed for January 2013.</p> <p>The Director of Health Services [DHS] was interviewed on 2/1/13 at 1:00 p.m. The DHS provided a list of residents reviewed for the months of December 2012 and January 2013. The lists included reviewed residents without recommendations. The DHS indicated that a pharmacy review was</p>	F0428	Resident #27 and #6 have a current pharmacy review. All residents have the potential to be affected and through revised reconciliation process will ensure all residents have monthly pharmacy review. Pharmacy consultant and DHS have been in-serviced on reconciliation process. DHS will review monthly pharmacy reconciliation and cross reference with census to ensure all residents were reviewed by pharmacist. Audit results will be forwarded to QA monthly for 12 months. We respectfully ask for desk review due to scope and severity of deficiency.	03/07/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/05/2013
NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>not completed for Resident #27 during January 2013.</p> <p>2. Resident #6's clinical record was reviewed on 2/4/13 at 1 p.m. An admission date, was noted, of 12/18/12. The record lacked documentation of a pharmacy review since admission to the facility.</p> <p>On 2/4/13, 12:45 p.m., during interview of the Pharmacist, the Pharmacist indicated she was responsible for reviewing the resident's medication regimen. The pharmacist indicated she could not find where she had reviewed resident # 6's medication regimen. The pharmacist indicated " I see the residents they put on a paper for me to see."</p> <p>During interview of the DHS (Director of Health Services) and Administrator on 2/4/14 at 4:30 p.m., the DHS indicated the pharmacist receives a current census when she enters the facility. The Administrator and DHS were unable to identify how residents were missed during monthly medication regimen review.</p> <p>During review of a policy titled "Consultant Pharmacist Services Provider Requirement" dated 2/1/10, received from the Administrator on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2/5/13 at 10:54 a.m., documentation indicated specific activities that the consultant pharmacist performs includes, but is not limited to: "1) Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions, Incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen , and documenting the review and findings in the resident's medical record..."</p> <p>3.1-25(h)</p>			