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 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COBBLESTONE CROSSINGS HEALTH CAMPUS	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
F000000	This visit was for Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: April 1, 2, 3, 4, 7, 8, and 9, 2014. Facility number: 011906 Provider number: 155772 AIM number: 200912380 Survey team: Lora Brettnacher RN-TC (April 1, 2, 3, 7, 8, and 9, 2014) Mary Weyls RN Laura Brashear RN Kewanna Gordon RN Census bed type: SNF: 45 SNF/NF: 9 Residential: 35 Total: 89 Census payor type: Medicare: 30 Medicaid: 9 Other: 50 Total: 89	F000000	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.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	Residential sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2			
F000167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview the facility failed to post a notice of the availability of the results of the most recent survey results. This deficient practice had the potential to affect 54 of 54 residents who resided at the facility. Findings include: On 4/8/14 at 11 a.m., a notice indicating the location of the most recent survey results were not observed. During interview of the Administrator on 4/9/14, at 11 a.m., the Administrator indicated a notice was not posted,	F000167	No residents were affected by alleged deficient practice.Facility has placed sign in front lobby indicating where survey results are located. ED or designee will monitor placement of sign weekly for one month then monthly. All audit results will be reported to QA monthly for 12 months.	05/09/2014

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	indicating where the most recent surveys conducted by the State was located. 3.1-(b)(1)			
F000242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview the facility failed to ensure the residents had the right to make choices concerning their care for 3 of 4 residents who met the criteria for choices, in that the facility failed to ensure resident preferences were honored in regard to showers and time to go to bed (Residents #115, #135, and #18). Findings include: 1. On 4/2/14 at 11:48 a.m., Resident #115 was interviewed. The resident indicated she had not been asked how many times a week she would prefer to have a bath or shower. A Quarterly Minimum Data Set (MDS)	F000242	Resident #115, #135, and #18 were interviewed to determine resident's bathing and bedtime preferences and staff that care for them have been in-serviced on these preferences. Since all residents have the potential to be affected by alleged deficient practice, all current residents have been interviewd to determine bedtime and bathing preferences. Systemic change is that the facility will expand the customary routine questions to include bathing and bedtime preferences. Through in-servicing and alteration in preference questions will ensure preferences are met. All nursing, social service, and activity staff have been inserviced on changes. The DHS/designee will monitor through random resident interviews. DHS/designee will	05/09/2014

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	assessment dated 2/11/14, coded the resident with no cognitive impairment, required limited assistance of one for personal hygiene. The quarterly assessment tool did not include the resident's preferences for customary routines. An initial MDS dated 1/21/14, coded the resident as not interviewable on admission and lacked information regarding the resident's preferences.		interview five residents weekly for one month, then five monthly for one quarter. Monthly resident council will include questions about resident preferences to ensure compliance. All audits will be forwarded to QA monthly for twelve months.	
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review services were not provided in accordance with a resident's plan of care, for 1 of 3 residents reviewed for falls, in that interventions developed to prevent falls were not followed. (Resident #81) Findings include: During interview of LPN #2 on 4/2/14 at 11:52 a.m., the LPN indicated Resident #81 had experience falls. Resident #81's clinical record was reviewed on 4/4/14 at 10 a.m. A nurses note, dated 2/27/14 at 2:00 a.m., indicated the resident was transferring self to the bathroom and did not have the	F000282	Resident #81 has had no further fals and all staff that care for resident have been in-serviced on fall interventions.There were no other residents affected by the alleged deficient practice and through in-servicing and rounding will ensure alarms are in place and residents with alarms are not left unattended in bathroom.All nursing staff will be in-serviced on rounding to ensure proper placement of alarms and to not leave residents with alarms unattended for any reason.DHS/designee will monitor 2 alarms daily for proper placement for 8 weeks and 2 alarms weekly thereafter.All results of audits will be forwarded to QA monthly x12 months.	05/09/2014

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	bed alarm plugged in from the previous shift. A CNA (Certified Nursing Assistant) tried to get to the resident before the resident lost her balance but the resident fell to her "bottom." A nurse's note on 3/20/13 at 11:25 p.m. indicated a CNA assisted the resident to the bathroom and left the resident on the toilet "to get pull ups" and when the CNA returned, the resident was standing with a walker and began to walk backwards and fell. The note indicated the resident "hit her head." A form titled "RESIDENT FIRST CONFERENCE NOTES" dated 11/26/13, indicated the resident had decreased safety awareness and decreased cognition. Documentation indicated to continue with a bed and chair alarm. During interview of the DNS (Director of Nursing Services) on 4/9/14 at 12:34 p.m., the DNS indicated the staff were re-educated concerning the falls, including to not leave a resident requiring alarms alone in the bathroom. The DNS indicated alarms were not present when the resident was left alone in the bathroom. 3.1-35(g)(2)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review the facility failed to maintain good grooming for 1 of 3 residents reviewed that met the criteria for ADL (activities of daily living) assistance. Resident #16 Findings include: On 4/2/14 at 1:08 p.m., Resident #16 was sitting in a chair in her room. The resident was observed with several long facial hairs. Resident #16's clinical record was reviewed on 4/4/14 at 3 p.m. The most recent assessment (30 day scheduled assessment) was dated 2/14/14. The assessment identified the resident without cognitive impairment, requiring limited assistance of one person for personal hygiene needs and did not exhibit behaviors of rejection of care.	F000312	Resident #16 no longer resides at facility. All female residents have the potential to be affected by alleged deficient practice and have been assessed and all excessive facial hair has been removed. All nursing staff have been in-serviced on proper facial hair grooming. DHS/designee will randomly monitor one female resident's facial hair daily for thirty days then two random females per week thereafter. All results will be forwarded to QA for twelve months.	05/09/2014

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	An assignment worksheet provided by LPN #2 on 4/9/14 at 11:10 a.m., indicated the resident required assistance of one to assist with personal hygiene. During interview of LPN #2 on 4/9/14 at 11:10 a.m., the LPN indicated Resident #16 did not resist care. 3.1-38(a)(3)(D) ...			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the facility failed to ensure residents received adequate supervision and/or assistant devices to prevent accidents for 1 of 3 residents reviewed that met the criteria for accidents, in that interventions developed for resident #81, to reduce	F000323	Resident #81 has had no further fals and all staff that care for resident have been in-serviced on fall interventions.There were no other residents affected by the alleged deficient practice and through in-servicing and rounding will ensure alarms are in place and residents with alarms are not	05/09/2014

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	falls were not followed. Findings include: During interview of LPN #2 on 4/2/14 at 11:52 a.m., the LPN indicated Resident #81 had experienced falls. Resident #81's clinical record was reviewed on 4/4/14 at 10 a.m. A nurses note, dated 2/27/14 at 2:00 a.m., indicated the resident was transferring self to the bathroom and did not have the bed alarm plugged in from the previous shift. A CNA tried to get to the resident before the resident lost her balance but the resident fell to her "bottom." A nurse's note on 3/20/13 at 11:25 p.m. indicated a CNA assisted the resident to the bathroom and left the resident on the toilet "to get pull ups" and when the CNA returned, the resident was standing with a walker and began to walk backwards and fell. The note indicated the resident "hit her head". A form titled "RESIDENT FIRST CONFERENCE NOTES" dated 11/26/13, indicated the resident with decreased safety awareness and decreased cognition. Documentation indicated to continue with a bed and chair alarm.		left unattended in bathroom.All nursing staff will be in-serviced on rounding to ensure proper placement of alarms and to not leave residents with alarms unattended for any reason.DHS/designee will monitor 2 alarms daily for proper placement for 8 weeks and 2 alarms weekly thereafter.All results of audits will be forwarded to QA monthly x12 months.	

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	A form titled "Fall Circumstances, Assessment and Intervention" dated 2/27/14, indicated the resident was unable to maintain balance while sitting, standing or walking without assistance....and refuses to comply with safety measures such as call light use, alarms, appliances etc." A quarterly assessment dated 2/17/14, indicated the resident with severe cognitive impairment, a fall since admission, and requiring extensive assist of one when walking in her room. During interview of the DNS (Director of Nursing Services) on 4/9/14 at 12:34 p.m., the DNS indicated the staff were re-educated concerning the falls, including to not leave a resident requiring alarms alone in the bathroom. The DNS indicated alarms were not present when the resident was left alone in the bathroom. 3.1-45(a)(2)			

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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review the facility failed to assess and change approaches timely to stabilize weight loss for 1 of 2 residents who met the criteria for significant weight loss. (Resident #55). Finding includes: On 4/7/14 at 12:37 p.m., Resident #55 was observed in the Restorative Dining Room, being fed by staff. The resident was served baked potato with butter and sour cream, watermelon, and Coke. The dietary card had documentation that the family chose the resident's menus. The entree of chicken for the day had been crossed off. The CNA who assisted the	F000325	Resident #55 has careplan interventions updated and registered dietician consult. All residents receiving supplements have the potential to be affected by the alleged deficient practice and through in-servicing and alteration in documentation will ensure that supplement consumption is adequately recorded.Systemic change is that supplement consumption is marked on MAR not just an initial. All nursing staff in-serviced on supplement documentation change and that any ordered supplement refusal should have MD notification for further instructions.DHS/designee will monitor supplement documentation weekly during CAR for compliance.Results of audits will be forwarded to QA	05/09/2014

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	resident, indicated the family frequently marked food items off. Resident #55's clinical record was reviewed on 4/3/14 at 1:35 p.m. The weight record indicated documentation of a weight of 113 pounds on 3/6/14. On 2/3/14, a weight was recorded of 124 pounds, a 9.7 percent loss. Physician orders noted on the January 2014, Medication Administration Record (MAR) included, but was not limited to, "MED PASS (nutritional supplement) 120 CC (cubic centimeters) BY MOUTH 2 X (two times) DAILY TO AID IN STABILIZING WEIGHT," dated 11/4/13. Daily documentation of nurses' provision of the supplement was noted by signed initials. Three morning administrations were blank. None of the documentation included the amount of the supplement taken by the resident. The February 2014 MAR documented the resident received the supplement two times daily with two refusals from 2/1-14/14. The amounts taken were not documented. On 2/14/14 a new physician's order was obtained for Med Pass 2.0 120 ml (milliliters) po (by mouth) four times a day for weight loss. Documentation of the supplement being given four times a		monthly.	

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	day was denoted by the nurses' initials. Of the 56 opportunities for the resident to receive the supplement 45, were initialed and circled indicating the resident refused the supplement. Three opportunities were blank. The March, 2014 MAR for the Med Pass 120 cc four times daily from 3/1-3/8/14 had documentation of the resident taking the supplement one of 32 times. It did not include the amount taken. A clinically at risk monitoring sheet dated 2/13/14, provided by the Director of Health Services (DHS) on 4/7/14 at 1:50 p.m., indicated the resident's weight was addressed as well as overall decline. The monitoring sheet included, but was not limited to, the resident's continued weight loss. The form included information of a discussion with the resident's family not wanting any artificial nutrition and discussion of Hospice Services due to continued decline with the resident overall. The resident was picked up by hospice due to congestive heart failure diagnosis. The Resident received fortified foods and Med Pass 120 cc two times daily. The monitoring sheet indicated a plan to discuss other interventions with the Dietitian for weight stabilization and indicated a request was made to increase the nutritional supplement from two			

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	times daily to four times daily. A form titled "Quarterly Nutrition Progress and Data Collection" form with most recent date of 1/2/14 for 12/29/13, indicated the resident had significant weight loss for 60 and 180 days. "Diet monitored eats in Restorative dining room...supplements and fortified foods in place." The assessment indicated the resident received Med Pass 120 cc two times daily and took in 100 percent. On 4/8/14 at 2:30 p.m., the Dietary Manager was interviewed. The Manager indicated the Registered Dietician looked at the MARS in regard to dietary supplements and if they were marked as given assumed 100 percent was taken. A form titled "Weight Change Notification" dated 3/7/14, was noted of the resident having weight loss from 122 pounds on 2/6/14 to 113 pounds on 3/6/14, which was a 7.4 percent loss in 30 days. The resident information on the form indicated the resident was on a regular diet with fortified foods at meals and average consumption of 57 percent. Supplements included Med pass but the resident refused to take. A Dietician recommendation was made to discontinue the Med Pass and attempt to give Magic cup. The physician was			

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	notified on 3/7/14. A physician's order was received on 3/7/14, for Magic Cup two times a day at lunch and supper. Chart acceptance of magic cup on MAR by percentage. Documentation reflected the resident refused 13 of 42 times. Documentation of the amount of the supplement taken was lacking. Documentation on a Clinically at risk monitoring sheet for weekly follow up on 3/14/14, included the "Resident's weight remains stable or exhibits progress towards goal. Continue current interventions....Spoke with family and said resident 'really likes the magic cup she is getting now." 3.1-46(a)(1)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure residents who had not used anti-psychotic medications were not given anti-psychotic medications without an appropriate indication for use for 1 of 5 residents reviewed for unnecessary medications (Residents #30),	F000329	Resident #30 no longer resides at the facilityThere were no other residents affected by the deficient practice and through in-servicing will ensure proper supporting conditions for medication exists.Social Service and licensed nurses in-serviced on conditions required for antipsychotic medication use.DHS/designee will ensure required condition is	05/09/2014

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	Findings include: Resident #30's record reviewed on 4/7/2014 at 11:53 A.M. Resident #30 had diagnoses which included, but were not limited to, depression, hypertension, dementia, and insomnia. A skilled nursing assessment dated 3/30/2014 at "10-6," indicated Resident #30 had memory problems, had severely impaired vision, and had highly impaired hearing. A physician's order dated 3/25/2014 at 1:40 P.M., indicated, "Seroquel (anti-psychotic) 25 mg (milligrams) 1 po (by mouth) bid (twice daily) for anxiety." A physician's order dated 3/26/2014 at 5:10 P.M., indicated the Seroquel was to be reduced to once a day and given at bedtime. The record lacked documentation of a diagnoses or appropriate indication for the use of an anti-psychotic medication. During an interview on 4/7/2014 at 12:40 P.M., Licensed Practical Nurse [LPN] #4 Resident #30 became combative with her husband and because he had never seen her act that way he requested she be put on something. She further indicated she		listed in documentation or on order at time of initiation for any antipsychotic medication.All residents receiving antipsychotic medications and their condition will be forwarded to QA committee monthly for compliance with requirement.	

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	called the doctor and that he ordered Seroquel. She indicated she called him back the next day and he reduced it to once a day because she was too sleepy. During an interview 4/7/2014 at 12:40 P.M. the Director of Nursing Services [DNS] was queried regarding Resident #30's anti-psychotic medication use. The DNS was asked to provide documentation of indication for the use of Seroquel. During the exit conference on 4//9/2014 at 2:20 P.M., with the DNS and ED present, the DNS indicated the facility did not have documentation which indicated Resident #30 had an indication for the use of Seroquel. A policy dated August 2013, and identified as current by the DNS on 4/8/2014 at 12:21 P.M., indicated, "GUIDELINES FOR: Psychotropic Medication Usage.... Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process.... Non-pharmacological interventions (such as behavioral interventions) are to be			

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	considered and used when indicated, instead of or in addition to, medications..." 3.1-48(a)(4) 3.1-48(b)(1)			
F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,			

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	permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review the facility failed to ensure stored drugs were accessible only to authorized personnel for 3 of 3 medication preparation areas. Findings include: On 4/2/14 at 12:24 p.m., a person was observed to walk behind the 200 unit nurses' station and use a key to open the door of a room, identified by a door plate, as a medication preparation area. The person entered the room and the door shut behind him. During observation of the 200 unit medication preparation area, on 4/2/14 at 12:45 p.m. with LPN #2, two small red plastic boxes, locked with a plastic strip, were noted in the unlocked refrigerator as well as four bottles of insulin. Two large plastic boxes, locked with a plastic strip were noted on a counter. A large empty plastic tub was observed at the end of the counter.	F000431	There were no residents affected by the alleged deficient practice and by changing the locks will ensure that only authorized personnel have access to med prep areas.All licensed nurses in-serviced on the requirement.DHS/designee will monitor compliance with regulation and those accessing the med prep areas daily during rounds.Audits will be forwarded to QA monthly x12 months.	05/09/2014

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	During medication storage observation on 4/9/14 at 1 p.m., insulins were observed stored in unlocked refrigerators on units 100 and 200. During interview of LPN (Licensed Practical Nurse) #2 on 4/2/14 at 12:30 p.m., the LPN identified the person as the facility's maintenance person. The LPN indicated he stocked supplies in the prep area. The LPN indicated emergency drug kits were stored in the medication preparation area as well as medications to be sent to pharmacy or to be destroyed. During interview with LPN #2 on 4/2/14 at 12:45 p.m., the LPN indicated the two small red boxes in the refrigerated were EDKs (emergency drug kits), and that one of the boxes housed narcotics. The two large plastic boxes on the counter top housed medications for emergencies that did not need to be refrigerated and the empty plastic box at the end of the counter was used to place medications that either needed to be returned to the pharmacy or destroyed. The LPN indicated when a nurse needed to remove medication from those EDKs the strips locking the box could be twisted to break and/or cut with a pair of scissors. During interview of the maintenance person on 4/9/14 at 1 p.m., the			

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	maintenance person indicated he had a master key that allowed him into the medication preparation areas. He indicated he had worked for this facility about two and a half years, and had always had the master key. During interview of the DNS on 4/9/14 at 1:30 p.m., the DNS indicated the maintenance person should not have access to medication preparation areas. During review of a facility policy titled "MEDICATION STORAGE IN THE FACILITY" received from the DNS (director of nursing services) on 4/9/14 at 1 p.m., documentation was noted indicating "Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access." 3.1-25(m)			
R000000				

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	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	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.	
R000026	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and			

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	general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.			
	Based on observation and interview, the facility failed to post resident rights information in the secured locked unit. This deficient practice had the potential to affect 13 of 13 of the residents who resided on the unit. Findings include: On 4/7/14 at 10:45 am, observations were made fn the facility's secured memory care unit. Residents rights information was not posted. During an interview on 4/7/14 at 10:50 am, Licensed Practical Nurse [LPN] #5 indicated resident rights information was not posted on the secured unit. During an interview on 4/8/14 at 12:35 pm, the Executive Director [ED] indicated residents rights information was not posted on the secured unit. She indicated the information was posted on	R000026	Required posting of resident rights has been posted in secured unit. ED or designee will monitor placement of posting weekly for one month then monthly. All results will be reported to QA monthly for 12 months.	05/09/2014

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	the health care side of the facilility but was not aware it needed to be posted for the residents in the secured unit. 16.2-5-1.2(a)			
R000033	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview the facility failed to post in an area accessible to residents, the address and phone numbers of the Department; Office of the Secretary Social Services, Ombudsman; Area Agency on Aging and Adult Protective Services. This deficient practice had the potential to affect 13 of	R000033	Required posting of agency phone numbers has been posted in secured unit. ED or designee will monitor placement of posting weekly for one month then monthly.All audit results will be reported to QA monthly for 12 months.	05/09/2014

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	13 of the residents residing on the secured unit. Findings include; On 4/7/14 at 10:45 am, observations were made on the facilities secured memory care unit. The address and phone numbers of the Department; Office of the Secretary Social Services, Ombudsman; Area Agency on Aging and Adult Protective Services were not posted. During an interview on 4/7/14 at 10:50 am, Licensed Practical Nurse [LPN] #5 indicated the required information was not posted on the secured unit. During an interview on 4/8/14 at 12:35 pm, the Executive Director [ED] indicated the required contact information was not posted on the secured unit. She indicated the information was posted on the health care side of the facility but was not aware it needed to be posted for the residents in the secured unit. 16.2-5-1.2(h)(F)			
R000042	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent			

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	annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.			
	Based on observation and interview the facility failed to post in an area accessible to residents, the results of the most recent annual survey, conducted by state surveyors. This deficient practice had the potential to affect 13 of 13 of the residents residing on the unit. Findings include; On 4/7/14 @ 10:45 am, observations were made on the facilities secured memory care unit. The results of the most recent survey were not available for the residents who resided on the secured unit. During an interview on 4/7/14 at 10:50 am, Licensed Practical Nurse [LPN] #5 indicated the required information was not posted, and she was not aware the the survey results needed to be available to the residents. During an interview on 4/8/14 at 12:35 pm, the Executive Director [ED], indicated the survey results were not available for the residents on the secured unit. 16.2-5-1.2(h)(f)	R000042	The results of the most recent annual survey have been made available in a binder located in secured unit. ED or designee will monitor placement of survey binder weekly for one month then monthly.All audit results will be reported to QA monthly for 12 months.	05/09/2014

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