

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 03/06/2015
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NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00167615 and IN00168214.</p> <p>Complaint IN00167615 - Substantiated. Federal/State deficiencies related to the allegation(s) are cited at F323 and F282.</p> <p>Complaint IN00168214 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: March 6, 2015.</p> <p>Facility number: 011906 Provider number: 155772 AIM number: 201114960</p> <p>Survey team: Lora Brettnacher, RN-TC</p> <p>Census bed type: SNF: 26 SNF/NF: 22 Residential: 32 Total: 80</p> <p>Census payor type: Medicare: 29 Medicaid : 8 Other: 11</p>	F 000		

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.

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F 282 SS=D Bldg. 00	<p>Total: 48</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 3/12/15 by Brenda Marshall, RN.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure residents were provided with assistance according to their plan of care in regards to transfers and ambulation. This deficient practice affected 1 of 3 residents reviewed for care plans (Resident C).</p> <p>Findings include: Resident C's record was reviewed on 3/6/15 at 11:00 a.m. A social service note, dated 11/25/15, indicated she was</p>	F 282	Resident C no longer resides at this facility. All residents that require assistance with transfers have the potential to be affected, and through the alteration in transportation practices, the facility will ensure that assistance is provided. The systemic change is the updated "Transportation Request Form" which will include the amount of assistance that the resident requires. If being transported by a non-certified employee, the resident will be transported via wheelchair. All department	04/05/2015

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	<p>admitted from an acute care hospital for physical and occupational therapy following surgery to her right knee.</p> <p>A physical therapy plan of care, dated 11/25/15, indicated Resident C's functional deficit level was "contact guard assist (contact with patient due to unsteadiness) for walking on level services...."</p> <p>A Minimum Data Set assessment tool (MDS), dated 12/8/15, indicated Resident C required extensive assistance of one person physical assist for locomotion off the unit, her balance was not steady and could stabilize with staff assistance only while walking, and she was cognitively intact with a Brief Interview Mental Status score (BIMS) of 15 out of 15.</p> <p>A activity of daily living care plan, dated 12/8/15, indicated Resident C was weight bearing as tolerated, utilized a wheel chair or walker for ambulation, and needed staff assistance for her locomotive needs.</p> <p>A fall circumstance assessment and intervention record, dated 12/9/15, indicated Resident C fell "transferring off facility van platform."</p> <p>A nurse's note, dated 12/10/14 at 7:00</p>		<p>leaders, nursing staff, activitives, and social service will be inserviced on the transportation forms and processes. The ED or designee will monitor the transportation request forms as they are reviewed in the morning meeting, daily for 30 days, and then 1/weekly x 2 months, and monthly thereafter. QA committee will review transportations during monthly meeting x12 months.</p>	

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	<p>a.m., indicated, "Noted bruise 20.0 x 9.0 cm [centimeter]... (L) [left] back. Res [Resident] stating from fall she had yest [yesterday]..."</p> <p>During an interview on 3/6/15 at 1:15 p.m., Bus Driver #1 indicated upon arrival to the facility after a physician's appointment on 12/9/14, without assistance, Resident C ambulated with a walker onto the wheel chair lift. Bus Driver #1 lowered the wheel chair lift to the ground and proceeded to verbally instruct Resident C to move her hands from the yellow safety bars to her walker. Bus Driver #1 indicated when Resident C removed her hands from the safety bars she fell backwards "into the gap between the lift and the van." Bus Driver #1 indicated she was outside of the vehicle near the rear of the van and was not providing Resident C with assistance at the time of the fall. She indicated she was not aware she needed assistance. Bus Driver #1 indicated "as far as she knew" Resident C "just needed verbal cueing." She indicated she could not remember if she was provided a transportation request form for Resident C. She indicated she did not save the forms because they were for her information only. She further indicated if she had been aware she needed physical assistance she would have transported her</p>			

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F 323 SS=D Bldg. 00	<p>in a wheel chair.</p> <p>During an interview on 3/6/15 at 1:30 p.m., The Administrator indicated the facility utilized a transfer form to ensure bus drivers were aware of Residents' needs during transfers. The Administrator indicated the facility did not have a policy regarding communication of the plan of care between nursing and transportation but the facility did have a form titled "Transportation Request Form" that should have been provided to the bus driver.</p> <p>A facility form titled "Transportation Request Form" was reviewed on 3/6/15 at 1:30 p.m. The form indicated, "...note: resident must be ambulatory or able to ride in a wheelchair...."</p> <p>This Federal tag relates to complaint IN00167615.</p> <p>3.1-35(g)(2)</p> <p>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,</p>	F 323	Resident C no longer resides at	04/05/2015

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	<p>the facility failed to ensure residents were provided ambulation assistance to prevent falls for 1 of 3 residents reviewed for accidents (Resident C).</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 3/6/15 at 11:00 a.m. A social service note, dated 11/25/15, indicated she was admitted from an acute care hospital for physical and occupational therapy following surgery to her right knee.</p> <p>A physical therapy plan of care, dated 11/25/15, indicated Resident C's functional deficit level was "contact guard assist (contact with patient due to unsteadiness) for walking on level services...."</p> <p>A Minimum Data Set assessment tool (MDS), dated 12/8/15, indicated Resident C required extensive assistance of one person physical assist for locomotion off the unit, her balance was not steady and could stabilize with staff assistance only while walking, and she was cognitively intact with a Brief Interview Mental Status score (BIMS) of 15 out of 15.</p> <p>A activity of daily living care plan, dated 12/8/15, indicated Resident C was weight bearing as tolerated, utilized a wheel chair or walker for ambulation, and</p>		<p>this facility. All residents that require assistance with transfers have the potential to be affected, and through the alteration in transportation practices, the facility will ensure that assistance is provided. The systemic change is the updated "Transportation Request Form" which will include the amount of assistance that the resident requires. If being transported by a non-certified employee, the resident will be transported via wheelchair. All department leaders, nursing staff, activitives, and social service will be inserviced on the transportation forms and processes. The ED or designee will monitor the transportation request forms as they are reviewed in the morning meeting, daily for 30 days, and then 1/weekly x 2 months, and monthly thereafter. QA committee will review transportations during monthly meeting x12 months.</p>		

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	<p>needed staff assistance for her locomotive needs.</p> <p>A fall circumstance assessment and intervention record, dated 12/9/15, indicated Resident C fell "transferring off facility van platform."</p> <p>A nurse's note, dated 12/10/14 at 7:00 a.m., indicated, "Noted bruise 20.0 x 9.0 cm [centimeter]... (L) [left] back. Res [Resident] stating from fall she had yest [yesterday]..."</p> <p>During an interview on 3/6/15 at 1:15 p.m., Bus Driver #1 indicated upon arrival to the facility after a physician's appointment on 12/9/14, without assistance, Resident C ambulated with a walker onto the wheel chair lift. Bus Driver #1 lowered the wheel chair lift to the ground and proceeded to verbally instruct Resident C to move her hands from the yellow safety bars to her walker. Bus Driver #1 indicated when Resident C removed her hands from the safety bars she fell backwards "into the gap between the lift and the van." Bus Driver #1 indicated she was outside of the vehicle near the rear of the van and was not providing Resident C with assistance at the time of the fall. She indicated she was not aware she needed assistance. Bus Driver #1 indicated "as far as she</p>			

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	<p>knew" Resident C "just needed verbal cueing." She indicated she could not remember if she was provided a transportation request form for Resident C. She indicated she did not save the forms because they were for her information only. She further indicated if she had been aware she needed physical assistance she would have transported her in a wheel chair.</p> <p>During an interview on 3/6/15 at 1:30 p.m., the Administrator indicated the facility utilized a transfer form to ensure bus drivers were aware of Residents' needs during transfers. The Administrator indicated the facility did not have a policy regarding accident prevention or communication between nursing and transportation but the facility did have a form titled "Transportation Request Form" that should have been provided to the bus driver.</p> <p>A facility form titled "Transportation Request Form" was reviewed on 3/6/15 at 1:30 p.m. The form indicated, "...note: resident must be ambulatory or able to ride in a wheelchair...."</p> <p>This Federal tag relates to complaint IN00167615.</p> <p>3.1-45(a)(2)</p>			

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R 000 Bldg. 00	Cobblestone Crossings Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00168214.	R 000			