| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155772 | A. BUILDING 00<br>B. WING | 07/12/2024 |

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| COBBLESTONE CROSSINGS HEALTH CAMPUS | 1850 E HOWARD WAYNE DR<br>TERRE HAUTE, IN 47802 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00433801 and IN00438476. This visit included a State Residential Licensure Survey.<br><br>Complaint IN00433801 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00438476 - Federal deficiencies related to the allegations are cited at F778.<br><br>Survey dates: July 7, 8, 9, 10, 11, and 12, 2024<br><br>Facility number: 011906<br>Provider number: 155772<br>AIM number: 201114960<br><br>Census Bed Type:<br>SNF/NF: 23<br>SNF: 21<br>Residential: 29<br>Total: 73<br><br>Census Payor Type:<br>Medicare: 13<br>Medicaid: 22<br>Other: 38<br>Total: 73<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review was completed July 19, 2024. | F 0000 | The submission of this plan of correction does not indicate an admission by Cobblestone Crossing Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Cobblestone Crossing Health Campus. The facility recognizes 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 skilled health care facilities. To this end, the 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. The facility respectfully requests from the department a desk review for substantial compliance.<br>Completion Date: 8/9/24 | |
| F 0554<br>SS=D<br>Bldg. 00 | 483.10(c)(7)<br>Resident Self-Admin Meds-Clinically Approp<br>§483.10(c)(7) The right to self-administer | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Theresa Adams | Executive Director | 08/02/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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| | medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>Based on observations, interviews, and record review, the facility failed to ensure a medication self-administration assessment was completed for 1 of 3 residents reviewed for respiratory (Resident 11).<br><br>Findings include:<br><br>During an initial interview with Resident 11 on 7/7/24 11:12 a.m., observed an inhaler located on her bedside table. The label indicated it was Trelegy Elipta 100 micrograms (mcg)/62.5 micrograms (mcg)/ 25 mcg, and the dose indicator read to have 29 of 30 doses left. The resident indicated that the inhaler was hers, she always had it, and she also normally had her emergency inhaler in her room but could not find it, so staff were ordering her another one.<br><br>During a random observation on 7/9/24 at 2:32 p.m., observed two vials of nebulizer solution medication on Resident 11's bedside table. The resident indicated that it was her medication, normally she would set it up herself, but the wrist brace made it difficult to open the vials. When asked about the inhaler that was on her bedside table, she indicated that staff left the Trelegy Ellipta inhaler in her room every day for her to take, and she gave it back to them later, then mentioned again that she was supposed to have a rescue inhaler in her room, but she lost it, and seemed to lose everything.<br><br>A record review for Resident 11 was completed on 7/8/24 2:01 p.m. The profile indicated the resident's diagnoses included, but were not limited to, bipolar II (a form of mental illness), schizoaffective | F 0554 | **F554-Resident Self-Admin Meds-Clinically Approp**<br>1. What corrective action was taken for the resident affected by the alleged deficient practice.<br>Resident 11 suffered no ill effects from the alleged deficient practice. Residents will have a self-administration of medications assessment completed as needed per policy.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?<br>All residents have the potential to be affected by the alleged deficient practice. Residents who are appropriate to self-administer medications will be assessed. The nurse leaders and staff nurses were educated on completing self-administer medications assessments.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br><br>Residents who are appropriate to self-administer medications will be reviewed during clinical meetings to ensure assessment is completed. As a measure of ongoing compliance, DHS or designee will audit to ensure | 08/09/2024 |

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| | disorder (a mental illness that can affect your thoughts, mood and behavior), chronic obstructive pulmonary disorder (COPD- a chronic inflammatory lung disease that causes obstructed airflow from the lungs).<br><br>A physician's order, dated 3/9/24, indicated to administer Trelegy Ellipta (fluticasone-umeclidin-vilanter )100-62.5-25 mcg blister with device (an inhaled combination medication that helps control symptoms of lung disease such as difficulty in breathing and shortness of breath), one puff, inhalation, once a day, rinse mouth with water after use.<br><br>A physician's order, dated 3/9/24, indicated to administer ipratropium-albuterol 0.5 milligram (mg) -3 mg (2.5 mg base) solution (an inhaled medication that helps control symptoms of lung disease such as difficulty in breathing and shortness of breath) for nebulization, one unit dose, inhalation, four times a day for cough or shortness of breath.<br><br>A physician's order, dated 3/9/24, indicated to administer albuterol sulfate 90 micrograms (mcg)/actuation, hydrofluoroalkane (HFA) aerosol inhaler (a quick-relief inhaled medication used to treat symptoms of lung disease), 2 inhalations every 6 hours and as needed (PRN).<br><br>A care plan, dated 6/18/24, indicated Resident 11 had potential for complications, functional, and cognitive status decline related to respiratory disease, COPD. Interventions included, but were not limited to, respiratory therapy per orders.<br><br>A quarterly minimum data set (MDS) assessment, dated 6/21/24, indicated Resident 11 had a brief interview for mental status (BIMS) score of 15, | | residents have self-administration medications assessed, audits will consist of 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months<br><br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur. /p> | |

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| | indicating the resident was cognitively intact.<br><br>During an interview on 7/9/24 at 10:40 a.m., Licensed Practical Nurse (LPN) 9 indicated they did not have any residents who self-administer their own medications.<br><br>On 7/9/24 at 2:58 p.m., during an observation with LPN 9, she observed two vials of solution on Resident 11's bedside table and indicated them to be medication vials for breathing treatment used in the nebulizer machine. She indicated that she knew Resident 11 would ask staff to bring extra to her but did not think they were leaving them in the room. The LPN confirmed again that no resident had an order to self-administer medications and for Resident 11, they never knew how she was going to be, so she should not do them on her own.<br><br>During an interview on 7/9/24 at 3:28 p.m., the Director of Health Services (DHS) indicated she could not explain the medications at bedside for Resident 11. She could not locate a current or historical assessment to self-administer medications. The DHS indicated that Resident 11's daughter was moving to Florida, so the resident had been asking for certain things to be brought in to her. She was not sure what they had brought in but thought it was possible they could have brought her medications from home, so she wanted to check the expiration dates.<br><br>During an interview on 7/9/24 at 3:30 p.m. with the Regional Director of Clinical Services (RDCS), she reviewed Resident 11's record and indicated that the resident receives nebulizer treatments four times daily, and could not find any current, or historical, documentation from the physician indicating the Resident could self-administer | | | |

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| | medications. The order was to administer one dose, which was one vial. She was not sure if it was possible that the nurse had accidentally laid the medications down and left them there. She also suggested checking the expiration dates on the vials.<br><br>On 7/9/24 at 3:47 p.m., with the DHS, observed the two medication vials that LPN 4 indicated to be the ones removed from Resident 11's room. The expiration dates on both vials read 12/2025 with a lot number of 41a0022x2. This information was compared to Resident 11's package of medication in the facilities medication cart. The package in the facilities medication cart also read that the expiration date was 12/2025 with a lot number of 41a0022x2. The DHS indicated the information matched, and that the vials that were on the resident's bedside table had come from the facilities medication cart.<br><br>On 7/10/24 at 3:11 p.m., the RDCS provided a document dated 12/31/23, titled, "Guidelines for Self-Administration of Medications," and indicated it was the policy currently being used by the facility. The policy indicated, " ...To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is part of their plan of care ...Procedures ...1. Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed using the observation Trilogy-Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication ...3. The medication will be kept in a locked drawer in the residents' room. The resident will maintain the key, as well as, a key will be maintained by the licensed nurse and or QMA | | | |

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| | ...8. The assessment will be documented in the EHR ...."<br><br>On 7/10/24 at 3:11 p.m., the RDCS provided a document dated 11/18, titled, "Specific Medication Administration Procedures," and indicated it was the policy currently being used by the facility. The policy indicated, " ...F. Administer medication and remain with resident ...Do not leave medications at bedside, unless specifically ordered by prescriber ...."<br><br>3.1-11(a) | | | |
| F 0578 SS=D Bldg. 00 | 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance | | | |

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| | directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>Based on record reviews and interviews, the facility failed to ensure a choice of code status was accurately documented in the medical record for 2 of 2 residents reviewed for code status (Residents 34 and 196).<br><br>Findings include:<br><br>1. On 7/8/24 at 11:04 a.m., a basic review of Resident 34's record was conducted. The face sheet indicated the code status (the type of emergency treatment a person would or would not receive if their heart or breathing were to stop) was do not resuscitate (DNR). A physician's order, dated 3/27/24, indicated the resident was a DNR. In the documents section, the most recent physicians order for scope and treatment (POST) form, signed and completed on 6/8/24, indicated the resident was a full code and resuscitation/cardiopulmonary resuscitation (CPR) was to be attempted. | F 0578 | =”” b=””><br>1. What corrective action was taken for the resident affected by the alleged deficient practice.<br>Resident 34 and 196 suffered no ill effects from the alleged deficient practice. Residents code status orders will be updated in a timely manner.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?<br>All residents have the potential to be affected by the alleged deficient practice. All residents were audited to ensure code status was updated and matched orders. The nurse leaders and staff nurses were educated on ensuring code status orders are updated and | 08/09/2024 |

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| | On 7/9/24 at 10:00 a.m. Resident 34's record was reviewed. The profile indicated the resident's diagnoses included, but were not limited to, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), malignant neoplasm of the colon (cancerous growth in the colon), stage 3 chronic kidney disease (kidneys do not work as well as they should to filter waste and extra fluid out of the blood), chronic ischemic heart disease (heart weakening caused by reduced blood flow to the heart), and psychotic disorder with hallucinations (seeing or hearing things that others do not, such as hearing voices telling them to do something or criticizing them).<br><br>A care plan, dated 6/18/24, indicated that the resident or resident representative had chosen the following advanced directives: code status, with a problem start date of 4/5/24. Interventions had an approach start date of 4/5/24 and included, but were not limited to, review the resident's code status quarterly and as needed, honor the residents right to change advanced directives at any time, provide information, education, and assistance to resident and family regarding advance directives, and provide treating entities with updated notification of advance directives.<br><br>A quarterly minimum data set (MDS), dated 6/17/24, indicated Resident 34 had severe cognitive impairment with a brief interview for mental status (BIMS) score of 5.<br><br>During an interview on 7/9/24 at 10:34 a.m., when asked what Resident 34's code status was, Licensed Practical Nurse (LPN) 9 checked Resident 34's record and indicated that, on the face sheet, he was a DNR. She checked the | | match signed forms.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br><br>Residents will be reviewed during clinical meetings to ensure code status orders are updated and match. As a measure of ongoing compliance, DHS or designee will audit code status orders signed forms match, audits will consist of 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months<br><br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br>="" p=""> | |

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| | documents, and on the POST form, he was a full code. She indicated that was weird because she remembered it being a discussion when he signed up for hospice care. When she went to check the hospice binder, it could not be located.<br><br>On 7/9/24 at 11:18 a.m., the hospice services binder was reviewed. The first page was a form titled, "Facility Document Delivery" dated 6/19/24, indicated "copy of advanced directives, as applicable to patient ...DNR ...Post". The next two pages included a copy of the signed POST form, dated 6/8/24, that indicated the resident was a full code.<br><br>During an interview on 7/9/24 at 12:02 p.m., the Regional Director of Clinical Services (RDCS) indicated she believed the discrepancy was a clerical error, they had a call out to hospice and were going to call the resident's wife to verify Resident 34's code status.2. On 7/7/24 at 2:11 p.m., a brief review of the clinical record for resident 196 was completed. The record indicated the resident was to be DNR (Do Not Resuscitate). The physician order indicated "Code Status" no other information was provided with the order. On 7/2/24 the resident signed a DNR form. On the same date, 7/2/24 a CPR (Cardiopulmonary Resuscitation) consent form was signed by the resident and indicated initiate CPR.<br><br>On 7/9/24 at 9:30 a.m., during an interview with the Director of Health Services (DHS) she indicated she had noted the discrepancy with the code status for the resident and acknowledged the two different directives created a confusing situation regarding the residents advanced directives.<br><br>On 7/9/24 at 1:00 p.m., review of medical record of resident 196. The resident was admitted on 7/2/24. | | | |

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| | Diagnosis included but were not limited to, unilateral primary osteoarthritis, right knee, (a degenerative joint disease, in which the tissues in the joint break down over time), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), aftercare following joint replacement surgery, type 2 diabetes mellitus without complications (a disease that occurs when your blood glucose, also called blood sugar, is too high).<br><br>Physician orders included but were not limited to. 7/2/2024, Code Status.<br><br>An admission Minimum Data Set (MDS) assessment dated 7/8/24 indicated the resident was cognitively intact and required assistance from the staff for activities of daily living.<br><br>The medical record lacked a care plan for advanced directives.<br><br>On 7/9/2024 at 11:14 a.m., the Regional Nurse Consultant provided a document, titled, "Guidelines for Advanced Directives," dated 12/24/23, and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: to ensure facility staff obtains and follows resident's advanced directives regarding end-of-life care ...Procedures ...1. Advanced Directives will be reviewed with resident and or resident representative by the Customer Service representative or designee at the time of admission ...2. The resident or representative will advise the CSR/designee regarding wishes for end-of-life directives and code status. The "DNR" form will be completed documenting these desires and scanned into the medical record ...6. The nursing staff will obtain an order from the | | | |

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| | attending physician for the desired code status<br>...8. Designation of code status and obtainment of physician order will be part of the medical record<br>...."<br><br>3.1-4(f)(4)(ii)<br>3.1-4(f)(5) | | | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on interview and record review, the facility | F 0657 | F657-Care Plan Timing and | 08/09/2024 |

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| COBBLESTONE CROSSINGS HEALTH CAMPUS | 1850 E HOWARD WAYNE DR<br>TERRE HAUTE, IN 47802 |

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| | failed to ensure care plan meetings were held at least quarterly for 1 of 2 residents reviewed for care plan meetings (Resident 8).<br><br>Findings include:<br><br>During an interview, on 7/8/24 at 8:54 a.m., Resident 8 indicated she could not recall having a care plan meeting for quite some time.<br><br>Resident 8's record was reviewed on 7/9/24 at 9:05 a.m. The census indicated the resident had been admitted to the facility on 6/8/23, for diagnoses which included, but were not limited to, displaced bimalleolar fracture of right lower leg (a type of ankle fracture that involve the distal [the area away from the point of attachment] ends of the fibula and tibia, respectively) and type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel).<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the resident had no cognitive deficit.<br><br>Review of the Resident First Meeting Minutes (care plan meeting minutes) lacked documentation that a care plan meeting had been held since 11/1/23.<br><br>During an interview, on 7/9/24 at 9:46 a.m., the Resident Services Manager indicated the facility was behind in completing their care plan meetings. Meetings should be held every quarter for all residents.<br><br>During an interview, on 7/9/24 at 11:15 a.m., the Regional Director of Clinical Services indicated they were unable to locate any documentation | | Revision<br>1. What corrective action was taken for the resident affected by the alleged deficient practice.<br>Resident 8 suffered no ill effects from the alleged deficient practice. Residents will have resident care conferences completed in a timely manner per policy.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?<br>Active residents have the potential to be affected by the alleged deficient practice. Active residents have been audited to ensure care conferences are completed in a timely manner.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br>The IDT-SSD, DHS, ADHS, ED, MDS were educated on completing care conferences timely and documenting the care conference. As a measure of ongoing compliance, ED or designee will audit to ensure residents resident care conferences are held timely and appropriate documentation is included in medical record, audits will consist of 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months<br>4. How will corrective actions be monitored to ensure the alleged | |

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| | that indicated the resident had a care plan meeting since November 2023.<br><br>On 7/9/24 at 11:15 a.m., the Regional Director of Clinical Services provided a document, dated 12/31/23, titled. "Resident's First Meeting Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...2...meetings for non-Medicare residents should be conducted at a minimum of quarterly and with significant change. 3...meetings for Medicare residents should be conducted minimally quarterly and prior to discontinuing Medicare services or being discharged from the facility...."<br><br>3.1-35(d)(2)(B) | | deficient practice does not recur. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue for the past 6 months if warranted until 100% compliance is met. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observations, record reviews, and interviews, the facility failed to assess and ensure that a physician was notified of a resident's change in condition related to edema for 1 of 1 resident's reviewed (Resident 7).<br><br>Finding includes:<br><br>On 7/7/24 at 11:08 a.m., Resident 7 was observed sitting up in her chair, the resident had edema | F 0684 | F684-Quality of Care<br>1.What corrective action was taken for the resident affected by the alleged deficient practice?<br>Resident 7 was not affected by alleged deficient practice. Resident was assessed and repeat x-rays were ordered immediately.<br>2. What corrective action was | 08/09/2024 |

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| | (swelling) to her left foot and ankle. The resident indicated nothing really helps with the edema and she tried to elevate her feet as much as possible. She indicated she has had edema to her left foot off and on since she fractured it a couple years ago.<br><br>On 7/8/24 at 2:37 p.m., Resident 7 was sitting up in her chair reading a book with her legs elevated on the seat of her wheelchair. Edema was noted to her left foot and ankle.<br><br>On 7/8/24 at 10:23 a.m., Resident 7 was observed sitting in her chair in her room with her left foot on the floor and her right leg elevated on the wheelchair seat. The left foot was notably larger than the right foot.<br><br>On 7/10/24 at 8:36 a.m., Resident 7 was sitting in her chair in her room and both feet were touching the floor. Her left foot and ankle were noted to be swollen.<br><br>Resident 7's record was reviewed on 7/8/24 at 1:17 p.m. The profile indicated the resident's diagnosis included, but were not limited to, age-related osteoporosis without current pathological fracture (a bond disease that occurs when bone mass decreases, or when the structure or strength of the bone changes), history of DVT to left leg (occurs when a blood clot forms in one or more of the deep veins in the body), and chronic kidney disease, stage 3b (mild to moderate kidney damage and they are less able to filter waste and fluid out of your blood).<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 5/22/24, indicated the resident was cognitively intact and required supervision with toilet use and moderate assistance with | | taken for those residents having the potential to be affected by the alleged deficient practice?<br>Like residents have the potential to be affected by the alleged deficiency and have been audited for any follow up documentation completed. Nursing staff have been educated on follow-up assessments and documentation with change of conditions.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br>During CCM nurse leaders will review follow up documentation with change in conditions. As a measure of ongoing compliance, the DHS or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months.<br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue for the | |

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| | showers.<br><br>The record lacked a care plan related to edema to left foot/ankle.<br><br>A care plan, dated 10/19/22, indicated the resident has chronic kidney disease, stage 3b. Interventions included, but were not limited to, assess for fluid excess (edema, worsening of edema, and weight gain) and administer medication as ordered.<br><br>A progress note dated 4/29/24 indicated Resident 7 had edema to the left lower extremity. MD (medical doctor) was notified, and he ordered a venous doppler (a non-invasive diagnostic test that evaluates blood flow through the body's major veins and arteries).<br><br>A progress note, dated 5/3/24, indicated Resident 7 had a red, swollen left leg and the doppler showed a DVT. MD ordered Xarelto (blood thinner).<br><br>The record lacked any recent progress notes related to edema of the left foot/ankle.<br><br>A physician order, dated 5/24/24, indicated to administer Xarelto 15mg (milligrams) by mouth daily.<br><br>The record lacked continued monitoring of the edema and DVT by staff.<br><br>During an interview, on 7/8/24 at 1:52 p.m., Certified Resident Care Assistant (CRCA) 5 indicated Resident 7 would elevate her legs and feet as much as possible because she had issues with swelling off and on. | | past 6 months if warranted until 100% compliance is met. | |

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| | During an interview, on 7/8/24 at 1:53 p.m., Registered Nurse (RN) 6 indicated she had spoken to Resident 7 a couple months ago about the edema to her left foot, but she had not recently assessed the edema. The nurse indicated she had noticed in the past the swelling in her left foot is always worse than the right.<br><br>During an interview, on 7/10/24 at 9:45 a.m., Regional Director of Clinical Services (RDCS) indicated the edema should be addressed with the physician, and she would make sure the resident was added to his list to be seen.<br><br>During an interview, on 7/10/24 at 11:53 a.m., RDCS indicated a CAR (clinical assessment record) should have been completed on Resident 7 because it would have been a good way to ensure monitoring of the DVT had been completed and a good way to monitor for worsening or improving edema.<br><br>On 7/10/24 at 11:50 a.m., the RDCS provided a document dated 5/10/16, titled, "Clinically at Risk Program Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Every effort will be made to identify those residents who are clinically at risk and provide proactive interventions to manage their medical needs and minimize/eliminate further decline when possible ... Resident is to be discussed in CAR meeting until it is determined the resident's condition has stabilized ...5. The CAR team will review current interventions for effectiveness and potential changes and make recommendations based on individual resident's needs ...."<br><br>3.1-37(a) | | | |

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| F 0690<br>SS=D<br>Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>Based on observations, record review and interview, the facility failed to ensure a resident's indwelling urinary catheter (a semi-flexible plastic | F 0690 | F690-Bowel/Bladder Incontinence, Catheter, UTI<br>1.What corrective action was | 08/09/2024 |

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| | tube with one end inserted into the bladder) which was attached to a urinary drainage bag (a bag that collects urine) and a biliary drain (a thin plastic tube inserted into the gallbladder to drain fluid) bag, did not touch the floor for 1 of 1 resident reviewed for catheter care (Resident 201).<br><br>Findings include:<br><br>On 7/07/24 at 12:01 p.m., during routine observation, the resident lying in bed, the urinary drainage bag lying on the floor. No covering over the bag. The biliary drainage bag was lying on the floor. No covering over bag.<br><br>On 7/08/24 at 9:29 a.m., observed the biliary drainage bag drain touching the floor. No covering over the bag. The urinary drainage bag was attached to the side of the bed frame. No covering over the drainage bag.<br><br>On 7/09/24 at 8:40 a.m., during routine observation resident observed sitting up in a wheelchair. The foley drain bag was attached to the lower left side of the wheelchair. No covering over the drainage bag. The biliary drainage bag was attached to the upper right side of the wheelchair without a covering, the bag was half full of a dark colored liquid.<br><br>On 7/9/24 at 8:46 a.m., during an interview, Certified Resident Care Associate (CRCA) 3 indicated any resident with an indwelling catheter and or a drainage bag, both bags should always be covered. She indicated the drain bag for the biliary drain is covered with a pillowcase when the resident is up in a chair. She indicated the drainage bags should not touch the floor.<br><br>On 7/9/24 at 9:30 a.m., during an interview with the | | taken for the resident affected by the alleged deficient practice?<br>Resident 201 was not affected by alleged deficient practice.<br>Resident's catheter bag and biliary bag was placed in a dignity bag.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?<br>Like residents have the potential to be affected by the alleged deficiency and have been audited to ensure dignity bags are in place. Nursing staff have been educated on utilizing dignity bags for devices in need.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br>As a measure of ongoing compliance, the DHS or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months for dignity bag placement.<br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased | |

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| | Director of Health Services (DHS) she indicated a urinary drain bag should be covered if the resident was in a wheelchair or using a walker.<br><br>Clinical record review completed on 7/9/24 at 11:00 a.m., for Resident 201. The resident was admitted to the facility on 4/12/24. Diagnosis included, but were not limited to, 5/31/24 acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin), 4/12/24 cellulitis (a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin), unspecified, chronic atrial fibrillation (an irregular heart rhythm (arrhythmia) that begins in the upper (atria) of your heart), 11/4/20 chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), unspecified, obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep), dyspnea (difficult, painful breathing or shortness of breath). Type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high) with diabetic chronic kidney disease (the kidneys are damaged and can't filter blood the way they should).<br><br>Physician orders included but were not limited to. Albuterol sulfate solution for nebulization (used to prevent and treat wheezing, difficulty breathing); 2.5 mg (milligrams)/3 mL (milliliters) (0.083 %); amount: 3 ml; inhalation admin as needed for SOB (shortness of breath or wheezing every 6 Hours as needed. Eliquis (apixaban) tablet (used to treat blood clots) 5 mg; amt: 5 mg; oral | | concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue for the past 6 months if warranted until 100% compliance is met. | |

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| | twice a day. Empty biliary drain every shift three times a day. Change catheter bag PRN (as needed) based on clinical indications such as infection, obstruction, or when the closed system is compromised once a day PRN. Foley catheter care every shift three times a day, indwelling urinary catheter, medical reason BPH (benign prostatic hyperplasia, a noncancerous enlargement of the prostate gland) with urinary retention (a condition in which you are unable to empty all the urine from your bladder).<br><br>An admission Minimum Data Set (MDS) assessment dated, 4/17/24 indicated the resident was cognitively intact and required maximum assist of two persons for activities of daily living and had an indwelling foley catheter during the look back period.<br><br>A care plan dated 6/24/2024 indicated the resident used a foley catheter. Interventions included, but were not limited to, maintaining a closed system with urinary bag below the resident's bladder and cover.<br><br>A care plan dated 4/14/24 indicated a risk for skin breakdown related to biliary drain. The record lacked interventions specific to the biliary drain.<br><br>The facility did not have a policy specific to biliary drain.<br><br>On 7/9/2024 at 11:15 a.m., the Regional Nurse Consultant provided a document, titled, "Preserving Dignity with Indwelling Catheter," dated 12/31/23, and indicated it was the policy currently being used by the facility. The policy indicated,"...SOP Details ...1. General guidelines ...a) Keep drain bag covered with an appropriate device ...Urinary drainage bags and catheter | | | |

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| | tubing should be kept from touching the floor surface...."<br><br>3.1-41(a)(1) | | | |
| F 0695<br>SS=D<br>Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>Based on observation, interview, and record review, the facility failed to ensure proper cleaning and storage of nasal cannula and CPAP (continuous positive airway pressure) mask and tubing for 1 of 2 residents reviewed for respiratory care (Residents 201).<br><br>Findings include:<br><br>On 7/7/24 at 12:05 p.m., observed Resident 201, lying down in his room, resting. Oxygen was being administered at 3 L (liters) per nasal cannula (a thin flexible tube device to provide supplemental oxygen therapy to people who have lower oxygen levels) there was no date indicated on oxygen tubing and did not observe a dated storage bag in the room.<br><br>On 7/8/24 at 2:52 p.m., during routine observation, Resident 201 was lying in bed. Oxygen was being administered per nasal cannula at 3 L. There was no date on the oxygen tubing and did not observe | F 0695 | F695-Respiratory/Tracheostomy Care and Suctioning<br>1.What corrective action was taken for the resident affected by the alleged deficient practice?<br>Residents 201was not affected by alleged deficient practice.<br>Residents with O2 were audited to reflect dates when tubing was changed. Resident's tubing was audited and dated per policy.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?<br>All like residents have the potential to be affected by the alleged deficiency and through alterations in processes and in-servicing the campus nursing staff will ensure that the residents have dated tubing storage bags | 08/09/2024 |

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| | 155772 | A. BUILDING 00<br>B. WING | 07/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| COBBLESTONE CROSSINGS HEALTH CAMPUS | 1850 E HOWARD WAYNE DR<br>TERRE HAUTE, IN 47802 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 |
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| | an oxygen or CPAP (continuous positive airway pressure) (a machine that uses mild air pressure to keep breathing airways open while you sleep) dated storage bag in the room.<br><br>On 7/9/24 9:13 a.m., observed the resident sitting in wheelchair. The oxygen nasal cannula tubing was lying on the couch next to the resident. Did not observe an oxygen or CPAP dated storage bag the room.<br><br>On 7/9/24 8:46 a.m., during an interview Licensed Practical Nurse (LPN) 4 indicated the night shift changed oxygen tubing and the nurse did not normally date the tubing.<br><br>On 7/9/24 at 9:30 a.m., during an interview the Director of Health Services (DHS) indicated the oxygen tubing was not dated; the bag was dated and changed monthly. She indicated the physician's order to clean the mask and place it in bag was for the CPAP mask not the oxygen mask.<br><br>On 7/9/24 at 10:18 a.m., the clinical record for Resident 201 was reviewed. The resident was admitted to the facility on 4/12/24. Diagnosis included, but were not limited to, 5/31/24 acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin), 4/12/24 cellulitis (a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin), unspecified, chronic atrial fibrillation (an irregular heart rhythm (arrhythmia) that begins in the upper (atria) of your heart), 11/4/20 chronic obstructive pulmonary disease (a group of diseases that | | are placed in resident's rooms to place O2 tubing in when not in use.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br>Resident's rooms with oxygen in use will be observed for a plastic storage bag to label/store O2 when not in use. Nursing staff were educated on dating O2 tubing and providing a plastic storage respiratory bag to store O2 tubing when not in use. As a measure of ongoing compliance, IP Nurse or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months.<br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. | |

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| | cause airflow blockage and breathing-related problems), unspecified, obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep), dyspnea (difficult, painful breathing or shortness of breath). Type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high) with diabetic chronic kidney disease (the kidneys are damaged and can't filter blood the way they should).<br><br>Physician orders included, but were not limited to, Albuterol sulfate solution for nebulization (used to treat shortness of breath and wheezing) 2.5 mg (milligrams)/3 mL (milliliters) (0.083 %); amount: 3 ml; inhalation admin as needed for SOB (shortness of breath or wheezing every 6 Hours - as needed. Eliquis (apixaban) (used to treat blood clots) tablet; 5 mg; amt: 5 mg; oral twice a day. Empty biliary drain every shift three times a day. O2(oxygen) - Change oxygen tubing monthly once a day on the 1st of the month. O2- CPAP at 14 cm H2O (water) pressure with oxygen at 3 liters at NOC (night) as needed during the day at bedtime (continuous positive airway pressure) a machine that uses mild air pressure to keep breathing airways open while you sleep. (Oxygen) O2- mask and tubing should be cleaned weekly with soapy water and rinsed. Air dry and place mask in clean setup bag once a day on Sun. O2- Oxygen at 3L (liters) per nasal canula continuous three times a day.<br><br>An admission Minimum Data Set (MDS) assessment dated 4/17/24 indicated the resident was cognitively intact and required maximum assistance of two persons for (ADL) activities of daily living and required oxygen during the look back period. | | | |

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| | A care plan dated 4/14/2024 indicated the resident had potential for complications, functional and cognitive status decline related to respiratory disease related to: COPD, sleep apnea. Interventions included, but were not limited to, Administer oxygen per orders. CPAP at night, Resident to wear CPAP machine at night.<br><br>On 7/9/2024 at 11:14 a.m., the Regional Nurse Consultant provided a document, titled, "Respiratory Equipment," dated 12/31/23, and indicated it was the policy currently being used by the facility. The policy indicated, "... SOP Details ...2. j. Keep oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use ...3 ...f. Store circuit in plastic bag, marked with date and resident's name between uses ...."<br><br>3.1-47(a)(6) | | | |
| F 0732 SS=A Bldg. 00 | 483.35(g)(1)-(4)<br>Posted Nurse Staffing Information<br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements. | | | |

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| | (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>Based on observation and interview, the facility failed to ensure the daily nursing staff posting was maintained as current, for 4 of 4 observations.<br><br>Findings include:<br><br>During the initial tour observation, on 7/7/24 at 10:23 a.m., the facility nursing staff posting was observed dated for 7/3/24.<br><br>During a random observation, on 7/7/24 at 1:00 p.m., the daily nursing staff posting was observed to remain dated for 7/3/24.<br><br>During a random observation, on 7/9/24 at 8:46 a.m., the daily nursing staff posting was observed dated for 7/8/24.<br><br>During a random observation, on 7/9/24 at 10:06 a.m., the daily nursing staff posting was observed | F 0732 | In substantial compliance. | 08/09/2024 |

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| | to remain dated for 7/8/24.<br><br>During an interview, on 7/9/24 at 11:33 a.m., the Regional Director of Clinical Services indicated the daily nursing staff posting was required to be posted with the current nurse staffing every day.<br><br>On 7/9/24 at 12:18 p.m., the Regional Minimum Data Set (MDS) Support provided a document, dated 12/31/23, titled, "Guidelines for Staff Posting," and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: To ensure compliance with federal regulations requiring posting on a daily basis for each shift, the number of nursing personnel responsible for providing direct resident care. Procedures: 1. At the beginning of each day the number and amount of hours licensed nurses...and the number and hours of unlicensed personnel, per shift, who provide direct care to residents will be posted...." | | | |
| F 0761<br>SS=E<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) 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. | | | |

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| | §483.45(h)(2) The facility must provide separately locked, 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.<br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were labeled and stored properly for 2 of 2 medication carts reviewed for medication storage (Residents 8, 6, 19, and 146).<br><br>Findings include:<br><br>1. On 7/9/24 at 9:10 a.m., the 200 hall (front) medication cart contained an undated and opened Lantus (medication used to lower blood sugar) insulin pen. The insulin pen contained a label that indicated it was for Resident 8.<br><br>During an interview, on 7/9/24 at 9:12 a.m., Registered Nurse (RN) 6 indicated insulin pens should have an open date placed on them when they are used.<br><br>Resident 8's record was reviewed on 7/9/24 at 9:40 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar).<br><br>A physician order, dated 5/1/24, indicated to administer Lantus Solostar (insulin medication) insulin pen 100 unit/ml (milliliter). Inject 25 units subcutaneously (under the skin) once a day in the | F 0761 | F761-Label/Store Drugs and Biologicals<br>1. What corrective action was taken for the resident affected by the alleged deficient practice.<br>Resident 8, 6, 19, and 146 suffered no ill effects from the alleged deficient practice. Insulin was removed from cart at the time of observation and had not been used.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?<br>Like residents have the potential to be affected. Medication carts have been audited to ensure insulins contained open dates were noted on the insulin.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br>Nursing staff were educated on placing new insulin pens to remain in refrigerator until needed to use and place open dates on insulins when pulled from the refrigerator. | 08/09/2024 |

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| | morning.<br><br>A physician order, dated 5/1/24, indicated to administer Lantus Solostar insulin pen 100 units/ml. Inject 70 units subcutaneously once a day at bedtime.<br><br>2. On 7/9/24 at 9:15 a.m., the 200 hall (back) medication cart contained the following items:<br><br>a. An unopened and non-refrigerated box of 5 Basaglar (insulin medication) pens. The box of insulin pens contained a label that indicated it was for Resident 6.<br><br>b. An unopened and non-refrigerated vial of Humalog (insulin medication). The vial of insulin contained a label that indicated it was for facility stock and was delivered from the pharmacy on 7/8/24.<br><br>c. An unopened and non-refrigerated box of 5 Lantus (insulin mediation) pens. The box of insulin pens contained a label that indicated it was for Resident 19.<br><br>d. An unopened and non-refrigerated bottle of Latanoprost (eye drop medication) 0.005%. The bottle contained a label that indicated it was for Resident 146.<br><br>e. An unopened and non-refrigerated vial of Humalog. The vial contained a label that indicated it was for Resident 146.<br><br>During an interview, on 7/9/24 at 9:20 a.m., RN 6 indicated insulin and eye drops that were not opened, should be refrigerated until used. She indicated the night shift had a new nurse and she must not have known to refrigerate the | | As a measure of ongoing compliance, the director of health services (DHS) or designee will audit both medication rooms to ensure proper dating and storage of insulin weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months.<br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue for the past 6 months if warranted until 100% compliance is met. | |

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| | medications until used.<br><br>Resident 6's record was reviewed on 7/9/24 at 9:50 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes (a chronic condition that affects the way the body processes blood sugar).<br><br>A physician order, dated 6/14/24, indicated to administer Basaglar Kwik-Pen 100 unit/milliliter. Inject 32 units subcutaneously (under the skin) at bedtime.<br><br>Resident 19's record was reviewed on 7/9/24 at 9:55 a.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease (a serious complication that occurs when the kidneys are not functioning properly to remove waste products and excess fluid from the body).<br><br>A physician order, dated 6/7/24, indicated to administer Lantus Solostar pen 100 unit/ml. Inject 55 units subcutaneously at bedtime.<br><br>Resident 146's record was reviewed on 7/9/24 at 10:00 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes and glaucoma (a group of eye conditions that can cause blindness).<br><br>A physician order, dated 7/5/24, indicated to administer Latanoprost 0.005%. Give 1 drop to each eye once a day.<br><br>A physician order, dated 7/6/24, indicated to administer Humalog 100 units/ml. Inject subcutaneously per sliding scale before meals and at bedtime. | | | |

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| | During an interview on 7/9/24 at 11:00 a.m., the Regional Director of Clinical Services (RDCS) indicated the facility had a new nurse on night shift and needed to be educated on proper storage of medications.<br><br>On 7/9/24 at 11:10 a.m., the RDCS provided and identified a document as a current facility policy, titled, "Vials and Ampules of Injectable Medications," revised date 11/18. The policy indicated, " ...at a minimum the date opened should be recorded ...."<br><br>On 7/9/24 at 11:10 a.m., the RDCS provided and identified a document as a current facility policy, untitled, with a revised date of July 2021. The policy indicated, " ...Unused Pens: Store unused pens in the refrigerator ...."<br><br>On 7/9/24 at 11:10 a.m., the RDCS provided and identified an undated document as a current facility policy, untitled. The policy indicated, " ...Store unused Lantus in a refrigerator ...."<br><br>3.1-25(j)<br>3.1-25(m) | | | |
| F 0778 SS=D Bldg. 00 | 483.50(b)(2)(iii)<br>Assist w/ Transport Arrangements to Radiology<br>§483.50(b)(2)(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.<br>Based on record review and interview, the facility failed to ensure transportation to a medical appointment was set-up and completed for 1 of 1 resident reviewed for transportation (Resident B). | F 0778 | F778-Assist w/Transport Arrangements to Radiology<br>1. What corrective action was taken for the resident affected by the alleged deficient practice. | 08/09/2024 |

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| | Findings include:<br><br>Review of a complaint intake form, dated 7/10/24, indicated Resident B had missed her appointment with her urologist (a physician who has special training in diagnosing and treating diseases of the urinary organs) because the facility had not scheduled transport services for her.<br><br>Resident B's record was reviewed on 7/11/24 at 8:45 a.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic kidney disease (damage to the kidneys which makes them unable to filter blood the way they should), hypertensive chronic kidney disease (high blood pressure caused by damage to the kidneys) and obstructive uropathy (a blockage or obstruction where the ureter [the tube that carries urine] connects to the kidney or bladder).<br><br>A care plan, dated 1/3/23, indicated the resident had an indwelling urinary catheter (a tube which is inserted into the bladder to drain urine) related to obstructive uropathy.<br><br>A physician's order, dated 7/10/24, dated one time 6:00 a.m., to 2:00 p.m., indicated to set up transport for a visit with the urology nurse practitioner (NP) for a treatment appointment at 12:30 p.m. The order indicated Lifeloop (a software system used to set up transport for residents) request had been put in.<br><br>During an interview, on 7/11/24 at 9:33 a.m., the Life Enrichment Director indicated she was responsible for the transport of the facility residents to their appointments. She did not have Resident B on her schedule to transport to an appointment on 7/10/24. Scheduling transport for | | Resident B suffered no ill effects from the alleged deficient practice. Resident's Urology appointment was rescheduled that day and nursing education was initiated on scheduling appointments in electronic scheduling system.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?<br>Like residents have the potential to be affected. Nursing staff have been educated on how to enter/schedule appointments in electronic scheduling system.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br>Transportation appointments will be reviewed during CCM to ensure completed appropriately. As a measure of ongoing compliance, the Director of health services (DHS) or designee will audit both medication rooms to ensure proper dating and storage of insulin weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months.<br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The | |

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| | appointments was set up by the nursing staff.<br><br>During an interview, on 7/11/24 at 9:36 a.m., Registered Nurse (RN) 17 indicated the nurses were responsible for transport requests when an appointment order was received. Setting up transport requests for the facility bus was very easy, but to set up for an outside transport, they now were required to use a process that takes them to a government website. This made it very time-consuming to set up. Resident B cannot be transported by the facility bus, because she required stretcher transport.<br><br>During an interview, on 7/11/24 at 10:10 a.m., the Regional Director of Clinical Services indicated she was not able to locate a specific policy on setting up transportation for resident appointments. The expectation would be that transportation would be set up by facility staff for any resident who had an appointment outside of the facility.<br><br>During an interview, on 7/11/24 at 10:47 a.m., the Executive Director (ED) indicated the facility policy was that transportation would be set up and provided for all residents who required transportation to any appointment.<br><br>This citation relates to Complaint IN00438476.<br><br>3.1-49(i)(3) | | plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue for the past 6 months if warranted until 100% compliance is met. | |
| F 0812<br>SS=D<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources | | | |

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| COBBLESTONE CROSSINGS HEALTH CAMPUS | 1850 E HOWARD WAYNE DR<br>TERRE HAUTE, IN 47802 |

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| | approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation and interview, the facility failed to maintain a safe and sanitary environment for food safety and failed to ensure beard covers were worn by an employee for 1 of 2 kitchen observations.<br><br>Findings Include:<br><br>1. On 7/10/24 at 12:00 p.m., observed raw hamburger meat on a tray on the bottom of the rolling cart outside of the cooler with prepared salads on the cart.<br><br>On 7/10/24 at 12:05 p.m., during an interview with Area Director of Food Services the director acknowledged the meat should not be on the cart and should have been in the cooler.<br><br>On 7/10/24 at 12:08 p.m., during an interview with the Director of Food Services he indicated he had removed the hamburger meat from the cooler and placed it on the cart with the salads. He indicated | F 0812 | **F812-Food Procurement, Store/Prepare/Serve-Sanitary**<br>1. What corrective action was taken for the resident affected by the alleged deficient practice.<br>No residents suffered ill effects from the alleged deficient practice. DFS was educated at time of observation to ensure beard guard is in place in food areas. Cold food that was out was disposed of at time of observation.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?<br><br>All residents have the potential to be affected. Kitchen staff have been educated on wearing a beard guard in food service areas and | 08/09/2024 |

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| | he did not recall how long the meat had been out of the cooler.<br><br>2. On 7/10/24 at 12:08 p.m., during an interview with the Director of Food Services it was noted the employee did not have a beard covering on. He indicated he had one on and had removed it.<br><br>On 7/10/2024 at 2:47 p.m., the Regional Nurse Consultant provided a document, titled, "Food Production Guidelines," dated May 31, 2016, and indicated it was the policy currently being used by the facility. The policy indicated, "... Policy ...Safe and Sanitary handling of food will be employed during food production ...7. Food prepared in advance must be covered, labeled, dated, and refrigerated ...28. Potentially hazardous foods that have stood for more than (4) hours at room temperature are not considered safe from contamination and must be discarded ...."<br><br>On 7/10/2024 at 2:47 p.m., the Regional Nurse Consultant provided a document, titled, "Beard and Mustache policy," dated November 30, 2021, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...Beard and mustache hair must be covered while in kitchen food product areas, Facial hair restraints are required in any production area ...Purpose ...Beards and mustache hair must be covered while in the kitchen food product areas ...Procedures ...Some common approaches include ...cover all beard or mustache hair that is more than 1/8 of an inch growth ...."<br><br>3.1-21(i)(1)<br>3.1-21(i)(3) | | cold food storage.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br>As a measure of ongoing compliance, executive director (ED) or director of food services (DFS) or designee will complete 5 kitchen observations to ensure cold foods are stored properly per policy weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months.<br>As a measure of ongoing compliance, executive director (ED) or director of food services (DFS) or designee will complete audits to ensure beard nets are worn properly, audits will be completed 5 times a week for 4 weeks, then every other week for 2 months, and then monthly for 3 months.<br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br><br="" span=""> Ongoing monitoring will continue for the past 6 months if warranted until 100% compliance is met. | |
| F 0880 SS=D | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control | | | |

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| Bldg. 00 | §483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to: | | | |

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| | (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, record review and interview, the facility failed to ensure proper handling of the glucometer (small portable machine that's used to measure how much glucose [type of sugar] is in the blood) meter during medication administration pass for 2 of 5 residents reviewed during medication administration (Residents 8 and 19).<br><br>Finding includes: | F 0880 | F880-Infection Control<br>1. What corrective action was taken for the resident affected by the alleged deficient practice?<br>Residents were not harmed. The nurse's and CRMAs were immediately re-educated on proper cleaning procedures of blood glucose machines before and after use. | 08/09/2024 |

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| | During a medication administration observation, on 7/9/24 at 11:43 a.m., Registered Nurse (RN) 6 had a glucometer meter in a drawer on the right side of the medication cart, she took the meter out of the drawer and placed it on top of the medication cart, no barrier was placed under the machine. The nurse obtained Resident 8's blood sugar at the nurse's station. The nurse placed the meter back on top of the medication cart, no barrier was placed under the machine. No satiation of the machine was observed. 5 minutes later the nurse picked up the meter from the medication cart and entered Resident 19's room. The nurse placed the meter on the resident's side table in her room, no barrier was placed under the machine. The nurse obtained Resident 19's blood sugar and placed the meter back onto the medication cart, no barrier placed under the machine.<br><br>Resident 8's record was reviewed on 7/9/24 at 12:10 p.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar).<br><br>A physician order, dated 4/28/24, indicated to obtain Accu check (name of blood glucose monitoring system) before each meal and before bed.<br><br>Resident 19's record was reviewed on 7/9/24 at 12:15 p.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes mellitus.<br><br>A physician order, dated 6/7/24, indicated to administer Humalog (insulin medication) 100 units/ml (milliliter). Inject 8 units subcutaneously (under the skin) before meals. | | 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?<br>All residents have the potential to be affected by the alleged practice and through altercations in processes and in servicing will ensure the campus provides a safe and sanitary environment for both staff and residents. All nurses and CRMAs will be educated on cleaning procedures of blood glucose machines per policy and residents having their own machine.<br>3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur.<br>For systemic change all nursing staff will do repeat demonstrations of cleaning procedures of blood glucose machines per policy. Residents will have separate glucometer machines. As a measure of ongoing compliance, the director of health services (DHS) or designee will audit both medication rooms to ensure proper dating and storage of insulin weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months.<br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br>For quality assurance, The ED and/or Designee will review any findings, and subsequent | |

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| | During an interview, on 7/9/24 at 12:32 p.m., Licensed Practical Nurse (LPN) 12 indicated nursing staff should place a barrier down underneath the glucose meter when being placed on surfaces. She also indicated the machine should be cleaned in between use. LPN 12 indicated the residents do not have their own meters; the glucose meter would be used for multiple residents.<br><br>On 7/9/24 at 2:38 p.m., the Regional Director of Clinical Services (RDCS) provided a document with a revised date of 12/2/21, titled, "Glucometer Cleaning and Control Test Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. If glucometers are used from one resident to another, they should be cleaned and disinfected after each use ...."<br><br>3.1-18(b) | | corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue for the past 6 months if warranted until 100% compliance is met. | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This survey included a Recertification and State Licensure Survey and Investigation of Complaint IN00433801 and IN00438476.<br><br>Complaint IN00433801 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00438476 - Federal deficiencies related to the allegations are cited at F778.<br><br>Survey dates: July 11, and 12, 2024<br><br>Facility number: 011906 | R 0000 | The submission of this plan of correction does not indicate an admission by Cobblestone Crossing Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Cobblestone Crossing Health Campus. The facility recognizes its obligation to provide legally and medically necessary | |

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| | Residential Census: 29<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on July 19, 2024 | | 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 skilled health care facilities. To this end, the 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. The facility respectfully requests from the department a desk review for substantial compliance.<br>Completion Date: 8/9/24 | |
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.<br>Based on observations, interviews, and record review, the facility failed to ensure proper handwashing for 1 of 1 dining observations. This had the potential to affect 10 of 10 residents who ate in the Memory Care Unit.<br><br>Finding includes:<br><br>1. During a dining observation on the Memory Care Unit, on 7/12/24 at 11:43 a.m., Activity Assistant 24 washed her hands at the sink in the dining area and turned off the water faucet with her bare hands, she grabbed a paper towel and dried off her hands. She then went over to the | R 0273 | R273-Food and Nutritional Services-Deficiency<br>1. What corrective action was taken for the resident affected by the alleged deficient practice.<br>No residents suffered ill effects from the alleged deficient practice. Hand washing guidelines and techniques education was immediately initiated with staff.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. | 08/09/2024 |

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| | dining room table where a resident had spilled her drink and the activity assistant cleaned up the spill with the paper towel, she had just dried her hands with. The activity assistant then proceeded back to the sink to wash her hands. She washed her hands for less than 20 seconds and turned off the water faucet with her bare hands. She grabbed a paper towel to dry her hands with and then exited the unit to go to the kitchen.<br><br>2. During a dining observation, on 7/12/24 at 11:53 a.m., Licensed Practical Nurse (LPN) 25 washed her hands for less than 20 seconds and turned off the water faucet with her bare hands and began to take out trays of salad and desserts from the food cart. The LPN served salad to the residents at the dining room table.<br><br>3. During a dining observation, on 7/12/24 at 11:54 a.m., Activity Assistant 24 washed her hands for less than 20 seconds and turned off the water faucet with her bare hands and adjusted the glasses on her face and opened the food cart door. The activity assistant then left the unit to obtain food from the kitchen.<br><br>4. During a dining observation, on 7/12/24 at 11:56 a.m., Certified Residential Medication Aide (CRMA) 26 washed her hands at the stink and turned off the water faucet with her bare hands. The CRMA served a female resident her salad and main course meal.<br><br>During an interview, on 7/12/24 at 12:05 p.m., LPN 23 indicated staff should wash their hands for at least 20 seconds and should not turn off the water faucet with their bare hands.<br><br>During an interview, on 7/12/24 at 12:11 p.m., Regional Director of Clinical Services (RDCS) | | All residents have the potential to be affected by the alleged deficient practice. Staff have been educated on hand washing guidelines and techniques and will perform return demonstrations on hand washing.<br>3. What systemic measures or changes are put in place to assure the alleged deficient practice does not recur.<br>Return demonstrations on hand washing guidelines and techniques will be performed with staff. As a measure of ongoing compliance, IP (Infection preventionist) Nurse or designee will complete of 5 staff members weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months.<br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br>As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted | |

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| | indicated staff should not turn off the water faucet with their bare hands.<br><br>On 7/12/24 at 12:26 p.m., the RDCS provided a document with a revised date of 8/11/16, titled, "AL-Hand Washing Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Hands should be washed for 20-30 seconds ...6. Using the paper towel, turn off the faucet ...." | | | |
| R 0410<br><br>Bldg. 00 | 410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance<br>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.<br>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>Based on record review and interview the facility failed to administer tuberculin test to 2 of 7 residents reviewed for tuberculin testing (Residents 05 and 028). | R 0410 | R410-Infection Control-Noncompliance<br>1. What corrective action was taken for the resident affected by the alleged deficient practice. | 08/09/2024 |

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| | Findings include:<br><br>1. On 7/12/24 at 8:30 a.m., the medical record of Resident 05 was reviewed. The resident was admitted to the facility on 5/10/24. Diagnoses included, but were not limited to, Hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. This makes your metabolism slow down. Also called underactive thyroid), COPD (a group of diseases that cause airflow blockage and breathing-related problems), Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks).<br><br>Physician orders included, but were not limited to, 5/10/24 Aplisol (tuberculin ppd) solution; 5 tub. unit /0.1 mL (milliliter); amount: 0.1 mL; intradermal once a day on the 1st of every 12th month.<br><br>An initial tuberculin test was administered on 5/12/24 the record lacked documentation of administration of a second step tuberculin test.<br><br>2. On 7/12/24 at 9:15 a.m., the medical record of Resident 028 was reviewed. The resident was admitted to the facility on 2/1/24. Diagnoses included, but were not limited to, Myasthenia Gravis (a chronic autoimmune disorder in which antibodies destroy the communication between nerves and muscle, resulting in weakness of the skeletal muscles), Depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks), Hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into | | Resident 05 and 028 suffered no ill effects from the alleged deficient practice.<br>2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice.<br>All residents have the potential to be affected by the alleged deficient practice. Active residents were audited for TB tests on admission and have been updated. The staff nurses were educated on completing admission TB tests as appropriate.<br>3. What systemic measures or changes are put in place to assure the alleged deficient practice does not recur.<br>Residents will be reviewed after admission to ensure TB tests are performed on admission. As a measure of ongoing compliance, DHS or designee will audit admission TB tests, audits will consist of 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months<br>4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur.<br>As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155772 | A. BUILDING 00<br>B. WING | 07/12/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 |
|---|---|---|---|---|
| | your bloodstream. This makes your metabolism slow down. Also called underactive thyroid).<br><br>Physician orders included but not limited to, 2/1/24 Aplisol (tuberculin ppd) solution; 5 tub. unit /0.1 mL; amt: 0.1 mL; intradermal Once a day on the 1st of Every 12th Month.<br><br>The record lacked documentation of administration of tuberculin test initial and second step.<br><br>On 7/12/24 at 10:00 a.m., during an interview with the regional nurse consultant acknowledged the residents are to have an initial 2-step tuberculin test before or upon admission to the facility.<br><br>On 7/12/24 at 10:17 a.m., the Regional Nurse Consultant provided an undated document, titled, "AL-Tuberculin Testing Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "... Policy ...Assisted living tuberculin testing ...Procedures ...b. Indiana - within 3 months of admission if proof of previous testing or upon admission ...2. Mantoux testing should be a two-step process unless there has been continuous annual testing following the two-step process...." | | and updated as warranted | |