STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155772	A. BUILDING 00 B. WING	05/23/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 16, 17, 18, 19, 22, and 23, 2023 Facility number: 011906 Provider number: 155772 AIM number: 201114960 Census Bed Type: SNF/NF: 23 SNF: 20 Residential: 25 Total: 68 Census Payor Type: Medicare: 15 Medicaid: 21 Other: 7 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 1, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by Cobblestone Crossings 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 Crossings 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.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 0641	Resident 52 was affected.	06/12/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Griffith	Executive Director	06/09/2023

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	Based on interview and record review, the facility failed to accurately code a resident's discharge location on the "Discharge Return not Anticipated" Minimum Data Set (MDS) assessment for 1 of 14 residents reviewed for MDS assessments (Resident 52). Finding includes: The record for Resident 52 was reviewed on 5/22/23 at 10:15 a.m., The profile indicated the resident's diagnosis included but was not limited to, fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing (a fracture is described as a broken bone that occurs when the physical force on the bone is stronger than the bone itself). A discharge Minimum Data Set (MDS) assessment, dated 3/17/23, indicated Resident 52 was discharged to a psychiatric hospital. A Social Services observation comprehensive note, dated 3/17/23 at 9:05 a.m., indicated the resident was discharged to home with her husband. The medical record lacked documentation of the actual discharge from the facility. During a telephone interview with Resident 52, on 5/22/23 at 10:42 a.m., she indicated she had a planned discharge and went home with home health care services. During an interview with the MDS Coordinator, on 5/22/23 at 1:50 p.m., she indicated according to the social services progress note, the resident was discharged home. She obtained the information related to a discharge from documentation in the		Resident is without adverse effects. On 3/17/23 ARD (assessment reference date) A2100 has been modified to reflect discharge was to home and not a psychiatric hospital. All residents have the potential to be affected. MDS coordinator was educated on accurate discharge assessment. All discharged residents were audited to ensure accurate coding. As a measure of ongoing compliance, the Assessment Support Nurse or designee will audit 5 MDSs for accurate coding of discharges, as available, weekly x4 weeks, then every other week x2 months, then monthly x3 months.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 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 met	

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	resident's chart, including the nurse's notes and social service's notes. The MDS Coordinator indicated Resident 52's discharge MDS assessment was incorrectly coded. On 5/22/23 at 2:20 p.m., the MDS Coordinator provided and identified a document as a current facility policy, titled "CMS's (Center for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2019. The manual indicated,"...A2100: OBRA Discharge Status...1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location...Coding Instructions...Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home...."			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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			

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	participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure a resident had participated in care plan meetings for 1 of 1 resident reviewed for care plan meetings (Resident 29). Findings include: During an interview, on 5/16/23 at 10:42 a.m., Resident 29 indicated she could not remember if she had attended any of her care plan meetings. Resident 29's record was reviewed on 5/22/23 at 1:17 p.m. The profile indicated the resident's diagnoses included, but were not limited to, atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). An annual Minimum Data Set (MDS-a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) assessment, dated 3/28/23, indicated the resident had no cognitive deficit.	F 0657	Resident 29 suffered no ill effects from the alleged deficient practice. Residents will be invited to resident care conferences. Active resident's have the potential to be affected by the alleged deficient practice. Active resident's have been audited to ensure being invited to care conferences. The social services director was educated on inviting residents to care conferences and documenting the invite. As a measure of ongoing compliance, ED or designee will audit to ensure residents are invited to resident care conferences 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. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	06/12/2023

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	The resident's Face Sheet indicated the resident's daughter was her financial representative and her initial contact person. The Face Sheet lacked any documentation of any designated Power of Attorney (POA-gives authority to act for another person in specified or all legal or financial matters) or guardianship (legal process, utilized when a person can no longer make or communicate safe or sound decisions about his/her person and/or property or has become susceptible to fraud or undue influence). Review of care plan conference forms, indicated the following: a. A care plan conference, dated 9/30/22, indicated the resident's representative had attended the meeting. The note lacked documentation of the resident attending or declining to attend. b. A care plan conference, dated 12/30/22, indicated the resident's representative had attended the meeting. The note lacked documentation of the resident attending or declining to attend. c. A care plan conference, dated 2/10/23, indicated the resident's representative had participated via electronic device. The note lacked documentation of the resident attending or declining to attend. During an interview, on 5/22/23 at 2:30 p.m., the Executive Director (ED) indicated she was unable to find any documentation that the resident had attended, or declined to attend, the care plan meetings, or any documented explanation of why the resident had not attended. She indicated the expectation was that the resident and their representative should attend each meeting, if possible. A note would be placed in the resident's			

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	record of who attended the meeting. On 5/22/23 at 2:51 p.m., the ED provided a document, with a revision dated of 4/25/22, titled, "Resident First Meeting Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures...6. Director of Social Service or designee should send invitations to the resident and/or representative notifying them of the date and time of the conference as far in advance as possible...17. A record of the meeting should be documented within the electronic health record...It must list all attendees present...18. Resident/Resident Representative to e-sign...if present...." 3.1-35(d)(2)(B)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 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. Based on observation, record review, and interview, the facility failed to ensure proper labeling of respiratory equipment, and failed to obtain and follow physician orders for 2 of 4 residents reviewed for respiratory care (Resident 5 & 19). Findings include:	F 0695	Residents 5 and 19 were not affected by alleged deficient practice. Residents with O2 were audited to reflect orders. Resident's orders were updated to reflect resident's preference on wearing O2 and a plastic storage bag put in place at time of	06/12/2023

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	1. On 5/16/23 at 10:16 a.m., Resident 5 was observed to be sitting up in her bed eating breakfast. Her oxygen tubing was laying on top of the oxygen concentrator (a medical device that gives you oxygen) and the tubing was dated 4/14. The oxygen concentrator was turned off. On 5/17/23 at 9:30 a.m., Resident 5 was observed to be sitting up in her bed working a word search puzzle. Her oxygen tubing was laying on top of the oxygen concentrator and the tubing was dated 4/14. The oxygen concentrator was turned off. On 5/17/23 at 1:36 p.m., Resident 5 was observed to be sitting up in her bed watching TV. Her oxygen tubing was laying on top of the oxygen concentrator and the tubing was dated 4/14. The oxygen concentrator was turned off. On 5/18/23 at 10:32 a.m., Resident 5 was observed to be sitting up in her bed working on a word search puzzle. Her oxygen tubing was lying on the floor next to the oxygen concentrator. The oxygen tubing was dated 4/14 and the oxygen concentrator was turned off. Resident 5's record was reviewed on 5/17/23 at 11:47 a.m. The profile indicated the resident's diagnoses included, but were not limited to, encephalopathy (a term for any diseases of the brain that alters brain function or structure), urinary tract infection (an infection in any part of the urinary system, the kidneys, bladder, or urethra), pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), and Alzheimer's (a progressive disease that destroys memory and other important mental functions).		observation with date when not in use. 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 O2 per resident preference/MD orders and storage bags are placed in resident's rooms to place O2 tubing in when not in use. 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 MD orders/resident preference or O2 and providing a plastic storage respiratory bag to store O2 tubing when not in use. As a measure of ongoing compliance, assistant director of health services (ADHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	A quarterly Minimum Data Set (MDS) assessment, dated 5/8/23, indicated the resident had moderate cognitive deficit and received oxygen therapy. A care plan, dated 5/17/23, indicated the resident had potential for complications, functional, and cognitive status decline related to respiratory disease related to pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred). Interventions included, but were not limited to, Administer oxygen per orders. A physician order, dated 12/12/18, indicated change oxygen tubing monthly. The Medication Administration Record (MAR) lacked documentation of resident's refusal. A physician order, dated 3/16/23, indicated to administer oxygen at 2 liters (L) per nasal canula (device used to deliver supplemental oxygen through the nose) continuously to maintain oxygen (O2) saturation (sat) greater than 90% three times a day. The MAR lacked documentation of resident's refusal. Review of vital signs obtained, dated 5/15/23 at 9:10 a.m., indicated Resident 5 had a O2 saturation of 93% and was marked no for oxygen use. Review of vital signs obtained, dated 5/16/23 at 3:34 p.m., indicated Resident 5 had a O2 saturation of 99% and was marked no for oxygen use. Review of skilled nursing note, dated 5/17/23 at 12:50 p.m., Resident 5 was marked no for oxygen use. During an interview, on 5/16/23 at 10:16 a.m., Resident 5 indicated she had oxygen if she			

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	needed it, but she did not need it all the time. During an interview, on 5/17/23 at 1:43 p.m., Certified Residential Medication Aide (CRMA) 8 indicated Resident 5 had a physician's order for continuous oxygen. During an interview, on 5/18/23 at 1:44 p.m., the Administrator indicated Resident 5 had never used the oxygen on a continuous basis. The resident had returned from the hospital with the order for oxygen. She was unsure why she had an order for continuous oxygen. During an interview, on 5/18/23 at 1:51 p.m., the Clinical Support Nurse indicated the oxygen tubing should be changed monthly. 2. During an observation on 5/16/23 at 10:10 a.m., Resident 19 was sitting in recliner next to the bed. Oxygen (O2) was being administered at 3.5 Liters (L) via nasal cannula (NC), per concentrator. There was no date on the bag. The attached humidifier bottle was empty. During an observation on 5/16/23 at 3:08 p.m., the resident had O2 administered at 2 L via NC, through a concentrator. The humidifier bottle was filled with water. No date was on the bottle. A small piece of tape on the tubing indicated 5/5. During an observation on 5/18/23 at 11:54 a.m., the resident was in her room with O2 off. At the same time, Licensed Practical Nurse (LPN) 7 indicated the order was now for as needed (PRN). She indicated she would clarify the order in the chart to reflect this change. Resident 19's record was reviewed on 5/16/23 at 11:32 a.m. The profile indicated diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-a group of			

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	diseases that cause airflow blockage and breathing-related problems). The record lacked an order for O2 administration. A care plan, dated 1/24/23, indicated the resident had potential for shortness of breath (SOB) while lying flat. The record lacked a care plan for oxygen use or care plan for diagnosis of and effects of COPD. A physician's order, dated 5/16/23, indicated to change O2 tubing monthly, once a day on the 1st of the month. A physician's order, dated 5/16/23, indicated clean external concentrator filter every two weeks. Once a day on Sunday. Hospice documentation indicated, the resident had been admitted under hospice services, related to terminal diagnosis of atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery). A hospice physician's order, dated 7/22/22, indicated to administer O2 at 3 L per NC continuously. A review of a hospice document titled, "Hospice/Facility Coordinated Task Plan of Care," dated 5/11/23, indicated the resident was on oxygen with a diagnosis of COPD. A hospice nurse's note, dated 5/11/23, indicated durable medical equipment (DME) provided an O2 concentrator.			

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	During an interview, on 5/16/23 at 11:32 a.m., LPN 7 indicated she could not find an order for the O2. The resident only had it on in her room. She would call the physician to clarify the order for the O2. During an interview, on 5/16/23 at 11:35 a.m., the Director of Health Service (DHS) was informed that the medical record did not indicate an order for O2 via NC at 3.5 L. She indicated would check into the concern. During an interview, on 5/16/23 at 3:05 p.m., LPN 7 indicated an order had been received for O2 to be administered at 2 L per NC. During a telephone interview, on 5/18/23 at 1:30 p.m., Hospice Registered Nurse (RN) 15 indicated she visited the resident two times per week. The resident was placed on O2 at 3 L PRN when they began services. The facility was to call her and let her know when any orders were received or changed. She had not been made aware of any changes in the order. The only time hospice would administer oxygen was for comfort only. They provided the concentrator, and the facility changed the tubing and humidifiers. During an interview, on 5/18/23 at 1:45 p.m., DHS indicated orders and changes were told to the hospice nurse when they visited the resident. The Cleveland Clinic: Hypercapnia, dated 3/9/23, retrieved from internet on 5/22/23, indicated, The administration of oxygen at a higher liter flow could result in Hypercapnia (respiratory failure-when there is too much carbon dioxide in the blood, and near normal or not enough oxygen in the blood), which could be fatal. It commonly occurred in people with COPD who were given			

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	too much or uncontrolled amounts of oxygen. On 5/19/23 at 11:40 a.m., the Executive Director (ED) provided a document, dated 5/2018, titled, "Administration of Oxygen," and indicated it was the policy currently being used by the facility. The policy indicated, "...Standard Operating Procedures (SOP) Details. 1. Verify physician's order for the procedure...13. Date the tubing for the date it was initiated. A. Tubing should be changed monthly and PRN...19. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order...Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through...." 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose			

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	should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure pharmacy recommendations were reviewed, addressed, and dated in a timely manner, and failed to ensure documented physician rationale for a declination of pharmacy recommendations for 3 of 5 residents reviewed for unnecessary medications (Resident 9, 21, and 28). Finding include: 1. Resident 9's record was reviewed on 5/18/23 at 10:45 a.m. The profile indicated that the resident's diagnoses included, but were not limited to, encephalopathy (a term for any diseases of the brain that alters brain function or structure), pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and hypotension (low blood pressure). A pharmacy recommendation, dated 11/21/22, recommended to avoid dosing midodrine (a medication used to treat low blood pressure that causes severe dizziness or fainting) medication after the evening meal or within 4 hours of bedtime. Recommended to change the second daily dose administration time to 3 to 6 p.m. The pharmacy recommendation indicated the resident's second dose of the medication was currently being given at bedtime.	F 0757	Residents 9, 21 and 28 suffered no ill effects from the alleged deficient practice. Pharmacy recommendations are reviewed by MD timely. All residents have the potential to be affected by the deficient practice and through MD in-servicing and changes in pharmacy requisition processes, the campus will ensure MD includes documentation of review with rationale given for declinations, recommendations are dated upon review and addressed timely. IDT and medical director educated on Pharmacy recommendations and will be dated upon review. DHS/designee will monitor all residents Pharmacy recommendations x30 days to ensure MD has completed a documented response to the recommendation as required , then 5 random recommendations per month x3 months, then 3 random monthly x3 months. Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments. As a quality measure, the DHS or designee will review any findings and corrective action at least	06/12/2023

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	A pharmacy recommendation, dated 1/13/23, recommended to avoid dosing midodrine medication after the evening meal or within 4 hours of bedtime. Recommended to change the second daily dose administration time to 3 to 6 p.m. The pharmacy recommendation indicated the resident's second dose of the medication was currently being given at bedtime. A pharmacy recommendation, dated 2/23/23, recommended to avoid dosing midodrine medication after the evening meal or within 4 hours of bedtime. Recommended to change the second daily dose administration time to 3 to 6 p.m. The pharmacy recommendation indicated the resident's second dose of the medication was currently being given at bedtime. During an interview on 5/18/23 at 3:00 p.m., the Administrator indicated that they were unable to provide documentation where the pharmacy recommendation had been addressed until the current physician order of 4/18/23 for the midodrine medication. A physician order, dated 4/18/23 indicated an order for midodrine 10 milligrams(mg) three times daily to be given at 6 to 8:00 a.m., 11:00 a.m. to 1:00 p.m., and 4 to 6:00 p.m. 2. Resident 21's record was reviewed on 5/19/23 at 10:25 a.m. The profile indicated the resident's diagnoses included, but not limited to, pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), acute respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body), and vascular disease with behavioral disturbances (refers to changes to memory, thinking, and behavior resulting from conditions that affect the		quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	blood vessels in the brain). A pharmacy recommendation, dated 3/14/23, indicated Resident 21 was receiving Depakote (a mood stabilizer medication) 250 milligram (mg) twice daily. Recommended to attempt a reduction to 125 mg twice daily. The physician signed with a symbol that indicated no change. The form lacked documentation of a rationale by the physician to justify the decline, or a date the physician signed the pharmacy recommendation. A physician order dated 4/24/23, indicated Depakote 250 mg twice daily. During an interview, on 5/19/23 at 11:50 a.m., the Clinical Support nurse indicated that they were aware the provider was not dating and or including a rationale on the pharmacy recommendation forms. 3. Resident 28's record was reviewed on 5/17/23 at 11:43 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified intracranial injury with loss of consciousness of unspecified duration (a medical classification under the range - Injury, poisoning and certain other consequences of external causes), traumatic brain injury (TBI-a sudden injury that causes damage to the brain), and ataxic gait (an unsteady, staggering gait). A care plan, dated 1/28/22 and revised on 3/7/23, indicated the resident had a traumatic brain injury. A historical review of the resident's physician's orders, indicated an order for Amantadine (a medication used to treat dyskinesia [involuntary, erratic, writhing movements of the face, arms, legs or trunk]), 100 milligrams (mg) twice daily (BID), since his admission to the facility on 1/17/22.			

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	A Pharmacy recommendation, dated 6/15/22, indicated to consider weaning from Amantadine 100 mg BID to 100 mg once daily times 1 week and then discontinue (DC), due to concerns of central nervous system (CNS) side effects with TBI. The recommendation form had a check mark next to "No" which followed a statement which indicated the physician agreed with all the recommendations. The form lacked documentation of a rationale by the physician to justify the declination, the signature of the physician, or a date the physician checked "No" on the recommendation. A progress note, dated 6/16/22 at 9:23 a.m., indicated the interdisciplinary team (IDT) review had been completed with this nurse, Director of Health services (DHS), Director of Social Services (DSS), and Executive Director (ED) present. The Pharmacist reviewed with a recommendation and noted it would be communicated with the physician. On 5/18/23 at 10:15 a.m., the DHS provided a copy of the Pharmacy recommendation, dated 6/15/23. The form had the physician's initials at the bottom. At the same time the DHS indicated the physician had made symbols next to his initials which indicated no changes. The form lacked documentation of a rationale by the physician to justify the declination and a date the physician had made the symbols and initialed the form. A Pharmacy recommendation, dated 9/26/22, indicated a second recommendation to consider weaning from Amantadine 100 mg BID to 100 mg once daily times 1 week and then discontinue (DC), due to concerns of central nervous system (CNS) side effects with TBI. The form indicated			

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	the recommendation had been agreed to by the physician, by a check mark next to "Yes" at the bottom of the form. A documented statement indicated medication reduced for 7 (seven) days and then DC. A historical review of the resident's physician's orders indicated the Amantadine had been changed from BID to daily on 10/18/22, then discontinued on 10/24/22. During an interview, on 5/19/23 at 1:56 p.m., the Clinical Support indicated she was not able to locate a specific policy related to the physician addressing the pharmacy recommendations. They would follow the State and Federal regulations. It was expected that all pharmacy recommendations would be addressed timely by the physician and any decision by the physician would include a written rationale and be signed and dated by the physician at the time the decision was made. On 5/19/23 at 1:50 p.m., the Clinical Support provided a document, dated 12/31/22, titled, "Guidelines for Medication Orders," and indicated it was the policy currently used by the facility. The policy indicated, "...Procedures...3. Physician orders/progress notes must be signed and dated in accordance with state regulations...." 3.1-48(a)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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.			

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	§483.45(h) Storage of Drugs and Biologicals §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. §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. Based on observation, interview, and record review, the facility failed to ensure medication was stored properly for 1 of 2 medication carts reviewed for medication storage (200 hallway). Findings include: On 5/22/23 at 9:40 a.m., the back half of the 200 hallway medication cart contained an unopened vial of Humalog (medication used to lower blood sugar level). The insulin vial was in a pharmacy container and had a label that indicated it was ordered for Resident 203. The pharmacy container had a blue sticker on it, and indicated medication was to be refrigerated until opened. During an interview, on 5/22/23 at 9:40 a.m., Licensed Practical nurse (LPN) 11 indicated the insulin vial should have been refrigerated until opened.	F 0761	Resident 203 suffered no ill effects from the alleged deficient practice. Insulin was updated with documentation of open date upon being used at time of need. Insulin was kept out from new shipment that morning in anticipation of being needed during AM med pass. Like residents have the potential to be affected. Medication carts have been audited to ensure insulins contained open dates were noted on the insulin. Nursing staff were educated on placing open dates on insulins when pulled from the refrigerator. As a measure of ongoing compliance, director of health services (DHS) or designee will audit both medication rooms to ensure proper dating and	06/12/2023

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	Resident 203's record was reviewed on 5/22/23 at 10:00 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A physician order, dated 5/21/23, indicated Humalog (insulin medication) 100 unit/ml (milliliter), by subcutaneous (under the skin) injection per sliding scale before meals every day. On 5/22/23 at 11:02 a.m., the Clinical Support nurse provided and identified a document as a current facility policy, titled "Medication Storage in the Facility," revised date 11/18. The policy indicated, " ...Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations ...k. Refrigerated medications are kept in closed and labeled containers ...." 3.1-25(m)		storage of insulin weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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			

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	practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure a sanitary kitchen environment, clean food carts, labeled and dated food, beard restraints were worn when in the kitchen, and dishwasher temps were within acceptable ranges for 2 of 2 kitchen observations and 2 of 2 dining room observations. This had the potential to effect 36 residents who ate food from the kitchen. Findings include: 1. On 5/16/23 at 9:15 a.m., during an initial kitchen tour with the Area Director of Food Services, the following issues were observed: a. The stove was heavily soiled with dried food and grease buildup. The nobs on the stove were soiled with dark debris. A soiled spatula was on the floor in front of the stove. b. A cart was sitting next to the stove was a foil lined tray covered with a thick layer of grease and brown debris. A fry basket, ladle, and a serving spoon were laying on the tray in the grease. c. In the walk-in cooler, cooked poultry was on a shelf uncovered and undated. A plastic covered roll of raw ground beef was on a tray, underneath the poultry.	F 0812	No resident's suffered ill effects from the alleged deficient practice. Dishwasher was scheduled for maintenance and corrected prior to exit of survey. All residents have the potential to be affected. The cleaning calendar has been audited for completeness, dishwasher has been repaired, food carts were cleaned, food has been labeled and dated according to facility policy. As a measure of ongoing compliance, executive director (ED) or director of food services (DFS) or designee will complete 5 kitchen observations weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. As a measure of ongoing compliance, executive director (ED) or director of food services (DFS) or designee will complete audits to ensure food carts are clean 5 xs weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. As a measure of ongoing compliance, executive director (ED) or director of food services (DFS) or designee will complete audits to ensure food is labeled and dated appropriately, audits will	06/12/2023

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	d. The Regional Dietary Manager was observed with uncovered facial hair entering the kitchen food service area multiple times during initial walk through and during the noon dining service observation. e. The dish washer wash temperature was 138 degrees Fahrenheit (F), and the rinse temperature was 142 degrees F. The Area Director of Food Services indicated temperatures had just been checked and water temperature was 168 degrees F. She identified a document titled, dishwasher temp log, dated May 2023, and identified it as the current daily temperature log for May 2023. Daily recorded temperature logs indicated correct temperatures. Employee 4 indicated the dishwasher was a high temperature dishwasher, and the wash temperatures should be at least 150 degrees F and the rinse should be at least 180 degrees F. Employee 4 indicated the poultry should have been covered, dated, and labeled. 2. On 5/16/23 at 12:15 p.m., during an observation of the noon meal service in the dining room the following were observed: a. The glass cover of the hot food serving cart was covered in a cloudy film, soiled with dried food debris, and grime. b. The inside glass cover of the salad bar cart was covered in a cloudy film, dried food debris, and grime. 3. On 5/16/23 at 12:45 p.m., during an observation of the hall tray lunch meal service in the common area the following were observed: a. The food cart containing cold food bottom edge base was soiled with a brown debris and rust		be completed 5 xs weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 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 xs weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. As a measure of ongoing compliance, executive director (ED) or director of food services (DFS) or designee will complete audits to ensure dishwasher temperatures are at optimal range, audits will be completed 5 xs weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	colored debris. The glass cover on the front of the cart was soiled with food debris, grime, and a cloudy film. b. The hot food cart was soiled with dried food on the inside bottom of the cart, on the outside track and on the inside of the glass door with, grime, dried food debris, and a cloudy film. 3. On 5/17/23 at 10:00 a.m., during a second kitchen observation, the following was observed: a. The stove hood above the grill was soiled with grease and brown debris. b. The stove from top to bottom was observed with dried food spilled down the front. The stove knobs were heavily soiled with a dark debris. There was a heavy buildup of grease like substance on the floor around the base of the stove. c. A cart sitting next to the deep fryer, with a tray covered in foil, was heavily soiled with grease like substance and brown debris. A fry basket, ladle, and serving spoon was laying on the tray in the grease like substance. Area Director of Food Services indicated the tray was there from the day prior and needed to be cleaned. d. The hot food cart was soiled with dried food on the inside bottom of the cart, on the outside track and on the inside of the glass door with, grime, dried food debris, and a cloudy film. Area Director of Food Services indicated it should have been cleaned. 4. On 05/17/23 at 10:00 a.m., Area Director of Food Services provided and identified a document as a current kitchen cleaning schedule, dated April			

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	2023, titled, "Aides cleaning list," and she indicated the document as the dietary aides cleaning schedule for the kitchen. The log lacked documentation that the cleaning had been completed for April 2023 as scheduled and unable to provide a May schedule. At the same time, she provided a document, dated 5/14 to 5/20, titled, "Cooks Cleaning List," and identified the document as the cook's kitchen cleaning schedule. The log lacked documentation that the cleaning had been completed as scheduled for the months of April and May 2023. On 5/19/23 at 11:15 a.m., Area Director of Food Services indicated, she had contacted the dishwasher service company and they had to replace the temperature thermostat due to it not working right. On 5/19/23 at 11:40 a.m., the Executive Director (ED) provided and identified a document as a current facility policy, dated 01/2023, titled, "Storage procedures, policies, and procedures culinary." The policy indicated, " ...Food, and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value, and appearance. ...Procedures... Refrigerated storage.... 5. Food is covered, dated, and stored loosely to permit air circulation ...8. Meat, fish, and poultry are stored on lower shelves below fruits, vegetables, juices, and breads to prevent contamination...." On 5/19/23 at 11:40 a.m., the ED provided and identified a document as a current facility policy, titled, "Beard Restraint Policy," dated 01/2023. The policy indicated, "...Policy...Beard, and mustache hair will be neat and trimmed. Beard restraints are required in any production area...Keep beards and mustaches neat and			

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	trimmed. Beard restraints are required in any food production area. Facial hair is not exempt from the hair restraining standard. It is up to each campus to define which type of facial hair requires a beard net ...Procedures ...cover all facial hair below the corner of the mouth ...More than a day or two of growth ...More than 1/8 inch ... Like hair covers, beard nets must be worn...." On 5/19/23 at 11:40 a.m., the ED provided and identified a document as a current facility policy titled, "Dish Machine, Policies, and Procedures Dining Services," dated 01/2023. The policy indicated, "...High temperature dishwasher (heat sanitation) recommended guideline: Wash-150-165 degrees F...Final Rinse - 180 degrees F...." On 5/19/23 at 11:40 a.m., the ED provided and identified a document as a current facility policy titled, "Food Labeling and Dating Policy," dated 01/2023. The policy indicated, "...Policy ...Any food product removed from its original container, has a broken seal, has been processed in any way must have a label...Purpose...To have food product properly labeled and dated ...Procedures ...Any food product removed from its original contained, has a broken seal, has been processed in any way must have a label that contains the following information: ...1. Item Name...2. Date and time the food was labeled ...3. Use by date...4. Initials of the person labeling the item ...5. Securely cover the food item...." On 5/22/23 at 2:27 p.m., the ED indicated, the facility did not have a kitchen cleaning schedule policy and procedure. The facility followed the Indiana retail food sanitation requirements. 3.1-21(i)(1) 3.1-21(i)(3)			

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COBBLESTONE CROSSINGS HEALTH CAMPUS	1850 E HOWARD WAYNE DR 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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 16, 17, 18, 19, 22, and 23, 2023 Facility number: 011906 Residential Census: 25 Cobblestone Crossings Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on June 1, 2023.	R 0000	The submission of this plan of correction does not indicate an admission by Cobblestone Crossings 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 Crossings 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.	