STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155772	A. BUILDING **01** B. WING _____	R **07/18/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 06/06/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/18/23 Facility Number: 011906 Provider Number: 155772 AIM Number: 20114960 At this PSR survey, Cobblestone Crossings Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 39. Quality Review completed on 07/19/23	{E 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/06/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/18/23 Facility Number: 011906 Provider Number: 155772 AIM Number: 201114960 At this PSR survey, Cobblestone Crossings Health Campus was found in compliance with	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155772	A. BUILDING **01** B. WING _____	R **07/18/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1 Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. A fire wall with a 2-hour fire resistive rating separates the healthcare occupancy from the assisted living areas. The facility has a capacity of 60 and had a census of 39 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/19/23	{K 000}		