STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155772	A. Building B. Wing	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobblestone Crossings Health Campus	1850 E Howard Wayne Dr Terre Haute, IN 47802

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34525 Based on record review and interview, the facility failed to ensure a resident treated in a dignified manner during personal care for 1 of 4 residents reviewed for nursing services (Resident B). Finding includes: During an interview, on 2/1/24 at 11:08 a.m., Certified Resident Care Associate (CRCA) 4 indicated there had been an episode where she had been assisting a resident with personal care, the resident was very combative and was hitting her, she became frustrated and left the resident's room without telling any other staff on the unit she was leaving the resident unattended. She then gathered her personal items and was planning to leave the facility and going home. She ended up talking with the facility's Employee Experience Manager (EEM), who calmed her down. She returned to the unit shortly after to finish her shift. During an interview, on 2/1/24 at 11:45 a.m., the Director of Health Services (DHS) indicated CRCA 4 had become frustrated while providing personal care to a resident and left the unit. She was speaking with the EEM who contacted her to come and speak with the CRCA also. She and the EEM took the CRCA outside and calmed her down. The CRCA returned to her unit after she calmed down. The CRCA had been disciplined for her actions. During a telephone interview, on 2/1/24 at 1:30 p.m., Registered Nurse (RN) 5 indicated she was the nurse on the unit on the day that CRCA 4 left the unit and did not tell anyone she was leaving the resident unattended. CRCA 6 told the RN that CRCA 4 had left the resident unattended. The RN and CRCA 6 went to the resident's room and completed the personal care with the resident. The door to the resident's room was open when they entered to complete the personal care with the resident. When they completed the care, the RN went directly to the DHS to report what had happened. During a telephone interview, on 2/1/24 at 1:38 p.m., CRCA 6 indicated she was working on the unit when she saw CRCA 4 walk out of Resident B's room and walk off the unit. She went to the resident's room, looked in and saw the resident's personal care had not been completed. She went and located RN 5, and the two of them completed the resident's personal care. CRNA 4 did not ask anyone to go in and help her with the resident, or to take over for her when she left the unit. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident B's record was reviewed on 2/1/24 at 1:52 p.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities with agitation including verbal and physical aggression, and wandering). A quarterly Minimum Data Set (MDS) assessment, dated 12/28/23, indicated the resident had severe cognitive deficit. During review of the resident's care plans, multiple interventions were observed which addressed the resident's aggressive behavior with all hands-on care. A Social Services progress note, dated 9/8/23 at 1:57 p.m., indicated the resident's behaviors were reviewed by the interdisciplinary team (IDT). The resident was being followed by the facility contracted psychiatric services for behaviors and psychotropic medication (any drug that affects behavior, mood, thoughts, or perception) use. On 2/1/24 at 1:25 p.m., the Executive Director (ED) provided a document, dated 9/15/23, titled, Teachable Moment, and indicated it was the document reviewed with CRCA 4 following her leaving the unit on that date. The document indicated the CRCA had been counseled on when getting upset with a resident, she should separate herself from the resident, but should always ensure someone else goes into care for the resident. Residents cannot be left without care. The document had been signed by the DHS and CRCA 4. On 2/2/24 at 2:20 p.m., the Regional Director of Clinical Operations (RDCO) provided a document, with a review date of 12/31/23, titled, Resident Rights Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: .2. Our residents have the right to .a. Be treated with dignity and respect This citation relates to complaint IN00417618. 3.1-3(a)