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	06/20/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete thorough assessments for a resident with edema, lower extremity conditions, and weight gain for 1 of 3 residents reviewed for quality of care (Resident B). Findings include: A review of Resident B's clinical record was completed on 6/19/25 at 10:46 a.m. Diagnoses included liver disease, dementia, acute kidney failure, ascites, localized edema, and severe protein-calorie malnutrition. The resident was admitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment, dated 4/2/25, indicated the resident was severely cognitively impaired, was dependent on staff for showering, lower body dressing, bed mobility, and moving from sit to stand. The resident's weights were as follows: a. admission weight was recorded on 4/4/25 at 85.4 lbs (pounds); b. On 5/9/25, approximately 1 month post admission, the resident's weight had increased 15.22% to 98.4 lbs. c. At the time of discharge, on 5/29/25, the resident's weight had increased 24.12% to 106 lbs. Acute Care Hospital Progress note, dated 3/24/25, indicated Resident B had been admitted to the hospital on [DATE] following a right femur fracture as a result of a fall at home. The note included mild to moderate free fluid to right upper quadrant of the abdomen and moderate volume ascites (abnormal buildup of fluid in the abdomen, specifically within the peritoneal cavity), small-moderate left pleural effusion (fluid around the lung), difuse body wall edema complatible with anasarca (a severe, generalized swelling due to an excessive buildup of fluid in the body's tissues). The note included plans for further evaluation of ascites when medically ready following plan to discharge to the extended care facility. A Clinically at Risk assessment, dated 5/9/25, indicated the resident had a significant weight gain. The potential cause was indicated as due to a change in meal intake and eating much better. The resident had been receiving fortified foods and nutritional supplements. The physician was notified and agreed to changes of condition, new orders, and plan of care. The resident's family was notified and agreed to changes of condition, new orders, and plan of care. (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
	155772	A. Building B. Wing	06/20/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A New Onset of Edema Event, dated 5/25/25, indicated the resident had edema to her left and right legs and feet. The severity was indicated as 1 plus pitting edema and was present bilaterally. Interventions indicated to administer diuretic, apply elastic stockings, elevate extremities, and administer antibiotics. During a telephone interview on 6/19/25 at 1:20 p.m., Resident B's family member indicated she had complained to staff multiple times about the resident's increasing abdominal size and swelling in her lower legs. This just fell on deaf ears. The physician indicated not to worry about it and just blew off the swelling in the resident's legs. The staff ended up putting compression stockings on the resident that caused hematomas and dark discoloration and were very painful. She refused to allow staff to apply the stockings after seeing what the stockings did to the resident's legs after just one day. She took the resident to her regular primary care physician and he had her transferred to a local emergency room for evaluation because of her condition. The local emergency department performed multiple tests before transferring her to a larger hospital for treatment. She indicated the hospital performed a procedure to drain a large amount of fluid from the resident's abdomen. Her biggest complaint about the facility was they would not listen to her concerns about the resident's increased fluid retention. The facility told her over and over, the resident was just gaining weight from better nutrition. The facility basically just ignored her concerns and the resident's discomfort. When the resident was transferred to the acute care hospital from the emergency department visit, she was admitted and eventually had three liters of fluid drained from her abdomen. During an interview on 6/19/25 at 2:59 p.m., the Nurse Consultant indicated the resident had been see by the facility physician two times during her stay. When she first came into the facility she had swelling on her right lower extremity. She had some weight loss and was started on supplements. She began to develop edema in her bilateral lower extremeties and the physician was aware. She felt the physician was contacted and had provided orders. A nursing progress note, dated 5/29/25 at 12:26 p.m., indicated the resident had no edema to her bilateral lower extremities. The Emergency Department records were obtained on 6/20/25, and indicated on 5/29/25 at 5:11 p.m, the physician examined the resident's legs to be swollen and cold to touch. The resident had presented to the emergency room complaining of intermittent bilateral lower extremity swelling. The resident's family member indicated she was concerned about the resident's weight gain and development of a hematoma on the left lower extremity during her stay at the rehabilitation facility. The assessment indicated the resident had 2 to 3 plus pitting edema to her bilateral lower extremities. Her arms were equally cold to touch. There was a blood blister on the resident's left shin. The resident was sent to the emergency department by her primary care physician for concerns with leg swelling. The resident's family member had indicated she was treated for a femur fracture from a fall and had been at a nursing home for rehabilitation. She reported the resident had declined since being there, had bilateral lower extremity edema and a blister to her shin now. Her abdomen was more distended than usual per the resident. The resident was discharged to an another acute care hospital from the emergency department on 5/29/25 at 10:01 p.m. for further treatment. The acute care hospital was contacted and additional hospital records requested with no response. (continued on next page)

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	06/20/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/20/25 at 10:24 a.m., the Wound Nurse indicated the resident was examined 5/27/25. It had been reported that the resident had been having problems with edema in the evenings. She had 1 plus pitting edema to her bilateral lower extremities and her legs were discolored and a purpilish color for her entire stay. A blister developed after her compression stockings had been removed that had been applied on 5/25/25. She saw her on 5/26/25 and the blister had reabsorbed. She was not aware of any abdominal swelling or weight gain. During an interview on 6/20/25 at 3:03 p.m., the Nurse Consultant indicated the resident's edema had been documented as present in some assessments and absent in some assessments. On 5/29/25, the documentation of no edema was entered for the nursing assessment. The resident's emergency department documentation of 2 to 3 plus edema on assessment on the day of her visit which was 5/29/25 and the documentation of no edema, as entered by the facility nurse assessment, could have been in error, and she could not say if it was present, but she had to go with what the nurse had documented as no edema. A facility policy for Change of Condition was provided, but lacked a policy regarding this concern. This citation relates to Complaint IN00461032. 3.1-37(a)

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	06/20/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a resident during a dressing removal resulting in a laceration to her left lower extremity caused by bandage scissors for 1 of 3 reviewed for nursing services (Resident B). Findings include: During a telephone interview on 6/19/25 at 1:20 p.m., Resident B's family member indicated the laceration sustained during a wound dressing change had become infected and was treated with an oral antibiotic. It was almost healed now and had a small scab at the end of the cut remaining. She was upset when the event occured and she felt the nurse was not competent regarding the dressing removal. The laceration should have never occurred and was another thing the resident had to heal from. During an interview on 6/20/25 at 9:40 a.m., LPN 2 indicated she was in the middle of medpass on 4/1/25 when Resident B's family member asked her to come take off a dressing on the resident's left knee because she felt it was too tight. She paused her medpass and went to the resident's room. The dressing was gauze wrapped around her knee and was about 4-5 inches in width. She inserted the dull end of her bandage scissors under the dressing and to cut the dressing. The resident moaned a little as she was cutting the dressing. When she had finished and removed the gauze, she noted there was a superficial cut into the resident's skin that was about three inches long. The cut was scantly bleeding. She cleaned it with wound wash and covered it with a white bordered dressing. The gauze dressing that was removed was covering a small, V-shaped skin tear. She notified the ADON and the physician. The family member was very upset and LPN 2 apologized to the family member. She had not seen the wound since it happened and was unaware of the condition of the wound following the event. The resident had edema and the dressing was tight. She felt the skin was puffy under the dressing from the edema and caused the cut. She felt that since the dressing was so tight, she should have unwrapped the dressing as opposed to cutting through it. A review of Resident B's clinical record was completed on 6/19/25 at 10:46 a.m. Diagnoses included liver disease, dementia, ascites, and edema. An admission Minimum Data Set (MDS) assessment, dated 4/2/25, indicated the resident was severely cognitively impaired was dependent on staff for showering, lower body dressing, bed mobility, and moving from sit to stand. A nursing progress note, dated 4/1/25 at 8:54 p.m., indicated LPN 2 was in Resident B's room when her family member pointed out a dressing on resident's left knee and indicated it was too tight and needed removed. The dressing was dated 3/30/25. LPN 2 cut off the old dressing to the left knee and the dressing scissors accidentally cut into resident's skin causing a cut 8 cm (centimeters) by 0.1 cm with scant bleeding. She cleansed the area and applied a dressing. The family member had been in the room and was very upset. The physician was notified by text message. The ADON was notified by phone call. Wound Management Detail Reports regarding a left calf skin tear below a wound on her left knee, included the following: (continued on next page)

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	06/20/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Initial observation, dated 4/2/25, entered by LPN 2 indicated the resident had a cut to her left upper calf, measuring 8 cm by 0.1 cm. b. Observation, dated 4/9/25, entered by the ADON indicated the wound was improving with some bruising around the site. The physician had ordered a prophylactic oral antibiotic and bacitracin to the site. The measurements remained the same. c. Observation, dated 5/26/25, entered by the wound nurse, indicated the wound had healed. Measurements indicated 0 cm x 0 cm. An interdisciplinary team (IDT) note, dated 4/2/25 at 10:05 p.m., indicated the nurse from the evening shift was asked by Resident B's family member to remove a bandage that was in place to her left knee. The family member had concerns regarding the bandage being tight related to swelling that was present to her left lower extremity. When the nurse removed the dressing, the bandage scissors came in contact with the resident's skin making a very superficial linear cut. The nurse was able to stop the bleeding and cleansed the area and applied a dressing. The physician was notified. The family member was present when this occurred. Education was provided to the nurse on removal method of a bandage. Area was assessed today by the wound nurse and a dressing order was updated accordingly for the area of impairment. A nursing progress note, dated 4/6/25 at 8:17 a.m., indicated the physician observed the resident's wound to her left calf. The physician ordered laceration to be cleaned and bacitracin applied and covered with a dressing. The physician ordered Keflex (an antibiotic to treat infection) 500 mg (milligram), take three times daily for 10 days as a prevention measure to prevent infection. He ordered a tetanus booster to be administered. The resident's family member was notified. An infection control event, dated 4/6/25, indicated the resident had a laceration to her left lower leg. Infection developed after admission on [DATE]. The signs and symptoms were identified as redness, warmth, and sanguineous drainage. Medications administered on 4/6/25, included Booster Tdap (diphtheria, pertussis, and tetanus) intramuscular injection and cephalexin (generic for Keflex) 500 mg. A current facility policy, revised 2/23/23, titled, Guidelines for General Wound and Skin Care, provided by the DON on 6/20/25 at 5:53 p.m., included the following: Purpose Statement. The purpose of this policy is to: To provide measures that will promote and maintain good skin integrity .Procedure. The following general wound and skin care guidelines should be followed for all residents with potential and/or actual impairment in skin integrity .19. Use care when removing all dressings and tapes. This citation relates to Complaint IN00461032. 3.1-45(a)