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	10/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to prevent physical and mental abuse of a resident by a staff member during resident transfer for 1 of 3 residents reviewed for abuse. (Resident B)Findings include:An Indiana report form, dated 10/10/25 at 6:01 p.m., indicated CNA (Certified Nursing Aide) 2 had reported CNA 4 had rushed Resident B during care. CNA 4 was suspended, and an investigation was initiated. Residents with a BIMS (Brief Interview for Mental Status) of 8 or above were interviewed and skin checks completed on residents with a BIMS below 8 were completed. In-service trainings were started with staff. Resident B was to be monitored for psychosocial well-being.A clinical record review for Resident B was completed on 10/22/25 at 11:30 a.m. Diagnoses included Alzheimer's disease, depression, and total urinary and bowel incontinence.An admission Minimum Data Set (MDS) assessment, dated 10/1/25, indicated the resident had severe cognitive impairment. She had difficulty communicating some words or finishing thoughts but was able, if prompted or given time, and could usually understand although missed some part/intent of a message but comprehends most conversation. She had no behaviors, no delusions or hallucinations, and no rejection of care. The resident used a wheelchair for mobility and was dependent on staff for all activities of daily living. She was totally incontinent of bowel and bladder and had a fall in the last month before admission.A health care plan, dated 9/19/25, indicated resident was at risk for skin breakdown related to mobility, weakness, Alzheimer's disease, and received hospice services. The goal was for resident's skin to remain intact. Interventions included to avoid shearing skin during positioning, turning, and transferring.A health care plan, dated 9/19/25, indicated Resident B required staff assistance to complete self-care and mobility functional tasks completely and safely. The goal was the resident would have functional needs met safely by staff. Interventions included to allow resident sufficient time to complete all or parts of tasks and to not rush the resident.A health care plan, dated 9/30/25, indicated resident's profile care guide included maximum assistance of two staff members for transfers.An Investigation Summary, dated 10/12/25 at 6:00 p.m., provided by the Administrator on 10/22/25 at 12:01 p.m., indicated a staff member had reported a concern about an interaction with CNA 4 during care with Resident B. The staff member felt CNA 4 had rushed the resident during care.A nursing progress note, dated 10/10/25 at 4:40 p.m., (recorded as a late entry on 10/12/25 at 6:47 a.m.) indicated physical and psychological assessments were completed. The resident was smiling, responsive and without distress. No physical injuries were noted and no bruising was noted at this time. Will continue to observe and update as needed.A care conference note, dated 10/12/25 at 9:30 a.m., with resident's husband, indicated the following: Discussed occurrence regarding incident with team member and provided information to resident husband. Resident husband stated that resident does become combative at times, and DHS [Director of Health Services] stated that should not affect care that is given, and it is the resident's right to be treated fairly. Resident's husband stated that he was grateful for the follow-up with this situation. DSS [Director of Social Services] to continue to check on resident daily x3 days and assess for psycho-social well-being. Will continue to hold care conferences as needed and quarterly. During a telephone interview, on 10/22/25 at 12:12 p.m., CNA 4 indicated she only knew of one incident when the resident was in bed and when she reached for her brief to change her, she kicked her in the face and knocked her glasses off. She responded by picking up her glasses and leaving the room after making sure the resident was covered and safe. She returned a bit later and she was cooperative with care, and she was able to provide it. The staff told her that she had not explained what she was going to do with the resident prior to performing care and that was why she reacts in that manner. She had no problem with her prior to this. She reported that the resident kicked her in the face. She did not have any injury to her face except a small scratch where her glasses had scratched her. She was suspended about a week after this occurrence. She had no other incidents that she recalls following that. The DON (Director of Nursing) indicated that she had to jump through hoops not to report her license. The DON indicated that it was because of CNA 4's tone and attitude and that was why she was being suspended. She would not have had an attitude with Resident B due to her dementia, and she was very aware of how to care for a resident with dementia. If they start to become upset, she will leave and come back (if safe to do so). She was not told what incident they were referring too. She was fired without explanation except her tone, attitude. She has felt like the DON had it out for her since the DON started with the facility. During an interview on 12/22/25 at 1:58 p.m., the Corporate Nurse Consultant indicated she had received a phone call from the DON regarding an incident that had been reported to her where CNA 4 had rushed a resident during care. They did not think

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report an incident of potential resident abuse by a staff member in a timely manner to the Administrator for 1 of 3 residents reviewed for abuse. (Resident B)Findings include:An Indiana report form, dated 10/10/25 at 6:01 p.m., indicated CNA (Certified Nursing Aide) 2 had reported CNA 4 had rushed Resident B during care. CNA 4 was suspended, and an investigation was initiated. Residents with a BIMS (Brief Interview for Mental Status) of 8 or above were interviewed and skin checks completed on residents with a BIMS below 8 were completed. In-service trainings were started with staff. Resident B was to be monitored for psychosocial well-being.A clinical record review for Resident B was completed on 10/22/25 at 11:30 a.m. Diagnoses included Alzheimer's disease, depression, and total urinary and bowel incontinence.An admission Minimum Data Set (MDS) assessment, dated 10/1/25, indicated the resident had severe cognitive impairment. She had difficulty communicating some words or finishing thoughts but was able, if prompted or given time, and could usually understand although missed some part/intent of a message but comprehends most conversation. She had no behaviors, no delusions or hallucinations, and no rejection of care. The resident used a wheelchair for mobility and was dependent on staff for all activities of daily living. She was totally incontinent of bowel and bladder and had a fall in the last month before admission.A health care plan, dated 9/19/25, indicated resident was at risk for skin breakdown related to mobility, weakness, Alzheimer's disease, and received hospice services. The goal was for resident's skin to remain intact. Interventions included to avoid shearing skin during positioning, turning, and transferring.A health care plan, dated 9/19/25, indicated Resident B required staff assistance to complete self-care and mobility functional tasks completely and safely. The goal was the resident would have functional needs met safely by staff. Interventions included to allow resident sufficient time to complete all or parts of tasks and to not rush the resident.A health care plan, dated 9/30/25, indicated resident's profile care guide included maximum assistance of two staff members for transfers.An Investigation Summary, dated 10/12/25 at 6:00 p.m., provided by the Administrator on 10/22/25 at 12:01 p.m., indicated a staff member had reported a concern about an interaction with CNA 4 during care with Resident B. The staff member felt CNA 4 had rushed the resident during care.A nursing progress note, dated 10/10/25 at 4:40 p.m., (recorded as a late entry on 10/12/25 at 6:47 a.m.) indicated physical and psychological assessments were completed. The resident was smiling, responsive and without distress. No physical injuries were noted and no bruising was noted at this time. Will continue to observe and update as needed.During an interview on 12/22/25 at 1:58 p.m., the Corporate Nurse Consultant indicated she had received a phone call from the DON on 10/10/25 at 4:40 p.m., indicating on 10/9/25 at around 8:30 p.m., LPN 8 had observed an incident with Resident B and CNA 4, where CNA 4 had was pulling on Resident B's arm in an effort to transfer her from her chair to her bed. An investigation was started at that time. LPN 8 had indicated to her that she had performed a head-to-toe assessment of Resident B, but had failed to document the incident or the assessment in the clinical record. She had not taken vital signs or completed a pain assessment following the incident. The facility follows their policy regarding any needed assessments. A current facility policy, undated, titled, Abuse and Neglect Procedural Guidelines, provided by the Administrator on 10/22/25 at 12:01 p.m., included the following: .Identification.ii. Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal.iv. Immediately notify the Executive Director.This citation relates to Intake 2641594.3.1-28(c)