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	07/12/2024

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 49068 Based on observations, interviews, and record review, the facility failed to ensure a medication self-administration assessment was completed for 1 of 3 residents reviewed for respiratory (Resident 11). Findings include: During an initial interview with Resident 11 on 7/7/24 11:12 a.m., observed an inhaler located on her bedside table. The label indicated it was Trelegy Elipta 100 micrograms (mcg)/62.5 micrograms (mcg)/ 25 mcg, and the dose indicator read to have 29 of 30 doses left. The resident indicated that the inhaler was hers, she always had it, and she also normally had her emergency inhaler in her room but could not find it, so staff were ordering her another one. During a random observation on 7/9/24 at 2:32 p.m., observed two vials of nebulizer solution medication on Resident 11's bedside table. The resident indicated that it was her medication, normally she would set it up herself, but the wrist brace made it difficult to open the vials. When asked about the inhaler that was on her bedside table, she indicated that staff left the Trelegy Ellipta inhaler in her room every day for her to take, and she gave it back to them later, then mentioned again that she was supposed to have a rescue inhaler in her room, but she lost it, and seemed to lose everything. A record review for Resident 11 was completed on 7/8/24 2:01 p.m. The profile indicated the resident's diagnoses included, but were not limited to, bipolar II (a form of mental illness), schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior), chronic obstructive pulmonary disorder (COPD- a chronic inflammatory lung disease that causes obstructed airflow from the lungs). A physician's order, dated 3/9/24, indicated to administer Trelegy Ellipta (fluticasone-umeclidin-vilanter)100-62.5-25 mcg blister with device (an inhaled combination medication that helps control symptoms of lung disease such as difficulty in breathing and shortness of breath), one puff, inhalation, once a day, rinse mouth with water after use. A physician's order, dated 3/9/24, indicated to administer ipratropium-albuterol 0.5 milligram (mg) -3 mg (2.5 mg base) solution (an inhaled medication that helps control symptoms of lung disease such as difficulty in breathing and shortness of breath) for nebulization, one unit dose, inhalation, four times a day for cough or shortness of breath. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 3/9/24, indicated to administer albuterol sulfate 90 micrograms (mcg)/actuation, hydrofluoroalkane (HFA) aerosol inhaler (a quick-relief inhaled medication used to treat symptoms of lung disease), 2 inhalations every 6 hours and as needed (PRN). A care plan, dated 6/18/24, indicated Resident 11 had potential for complications, functional, and cognitive status decline related to respiratory disease, COPD. Interventions included, but were not limited to, respiratory therapy per orders. A quarterly minimum data set (MDS) assessment, dated 6/21/24, indicated Resident 11 had a brief interview for mental status (BIMS) score of 15, indicating the resident was cognitively intact. During an interview on 7/9/24 at 10:40 a.m., Licensed Practical Nurse (LPN) 9 indicated they did not have any residents who self-administer their own medications. On 7/9/24 at 2:58 p.m., during an observation with LPN 9, she observed two vials of solution on Resident 11's bedside table and indicated them to be medication vials for breathing treatment used in the nebulizer machine. She indicated that she knew Resident 11 would ask staff to bring extra to her but did not think they were leaving them in the room. The LPN confirmed again that no resident had an order to self-administer medications and for Resident 11, they never knew how she was going to be, so she should not do them on her own. During an interview on 7/9/24 at 3:28 p.m., the Director of Health Services (DHS) indicated she could not explain the medications at bedside for Resident 11. She could not locate a current or historical assessment to self-administer medications. The DHS indicated that Resident 11's daughter was moving to Florida, so the resident had been asking for certain things to be brought in to her. She was not sure what they had brought in but thought it was possible they could have brought her medications from home, so she wanted to check the expiration dates. During an interview on 7/9/24 at 3:30 p.m. with the Regional Director of Clinical Services (RDCS), she reviewed Resident 11's record and indicated that the resident receives nebulizer treatments four times daily, and could not find any current, or historical, documentation from the physician indicating the Resident could self-administer medications. The order was to administer one dose, which was one vial. She was not sure if it was possible that the nurse had accidentally laid the medications down and left them there. She also suggested checking the expiration dates on the vials. On 7/9/24 at 3:47 p.m., with the DHS, observed the two medication vials that LPN 4 indicated to be the ones removed from Resident 11's room. The expiration dates on both vials read 12/2025 with a lot number of 41a0022x2. This information was compared to Resident 11's package of medication in the facilities medication cart. The package in the facilities medication cart also read that the expiration date was 12/2025 with a lot number of 41a0022x2. The DHS indicated the information matched, and that the vials that were on the resident's bedside table had come from the facilities medication cart. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 3:11 p.m., the RDCS provided a document dated 12/31/23, titled, Guidelines for Self-Administration of Medications, and indicated it was the policy currently being used by the facility. The policy indicated, .To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is part of their plan of care .Procedures .1. Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed using the observation Trilogy-Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication .3. The medication will be kept in a locked drawer in the residents' room. The resident will maintain the key, as well as, a key will be maintained by the licensed nurse and or QMA .8. The assessment will be documented in the EHR On 7/10/24 at 3:11 p.m., the RDCS provided a document dated 11/18, titled, Specific Medication Administration Procedures, and indicated it was the policy currently being used by the facility. The policy indicated, .F. Administer medication and remain with resident .Do not leave medications at bedside, unless specifically ordered by prescriber 3.1-11(a)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49068 Based on record reviews and interviews, the facility failed to ensure a choice of code status was accurately documented in the medical record for 2 of 2 residents reviewed for code status (Residents 34 and 196). Findings include: 1. On [DATE] at 11:04 a.m., a basic review of Resident 34's record was conducted. The face sheet indicated the code status (the type of emergency treatment a person would or would not receive if their heart or breathing were to stop) was do not resuscitate (DNR). A physician's order, dated [DATE], indicated the resident was a DNR. In the documents section, the most recent physicians order for scope and treatment (POST) form, signed and completed on [DATE], indicated the resident was a full code and resuscitation/cardiopulmonary resuscitation (CPR) was to be attempted. On [DATE] at 10:00 a.m. Resident 34's record was reviewed. The profile indicated the resident's diagnoses included, but were not limited to, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), malignant neoplasm of the colon (cancerous growth in the colon), stage 3 chronic kidney disease (kidneys do not work as well as they should to filter waste and extra fluid out of the blood), chronic ischemic heart disease (heart weakening caused by reduced blood flow to the heart), and psychotic disorder with hallucinations (seeing or hearing things that others do not, such as hearing voices telling them to do something or criticizing them). A care plan, dated [DATE], indicated that the resident or resident representative had chosen the following advanced directives: code status, with a problem start date of [DATE]. Interventions had an approach start date of [DATE] and included, but were not limited to, review the resident's code status quarterly and as needed, honor the residents right to change advanced directives at any time, provide information, education, and assistance to resident and family regarding advance directives, and provide treating entities with updated notification of advance directives. A quarterly minimum data set (MDS), dated [DATE], indicated Resident 34 had severe cognitive impairment with a brief interview for mental status (BIMS) score of 5. During an interview on [DATE] at 10:34 a.m., when asked what Resident 34's code status was, Licensed Practical Nurse (LPN) 9 checked Resident 34's record and indicated that, on the face sheet, he was a DNR. She checked the documents, and on the POST form, he was a full code. She indicated that was weird because she remembered it being a discussion when he signed up for hospice care. When she went to check the hospice binder, it could not be located. On [DATE] at 11:18 a.m., the hospice services binder was reviewed. The first page was a form titled, Facility Document Delivery dated [DATE], indicated copy of advanced directives, as applicable to patient .DNR . Post. The next two pages included a copy of the signed POST form, dated [DATE], that indicated the resident was a full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:02 p.m., the Regional Director of Clinical Services (RDCS) indicated she believed the discrepancy was a clerical error, they had a call out to hospice and were going to call the resident's wife to verify Resident 34's code status. 48226 2. On [DATE] at 2:11 p.m., a brief review of the clinical record for resident 196 was completed. The record indicated the resident was to be DNR (Do Not Resuscitate). The physician order indicated Code Status no other information was provided with the order. On [DATE] the resident signed a DNR form. On the same date, [DATE] a CPR (Cardiopulmonary Resuscitation) consent form was signed by the resident and indicated initiate CPR. On [DATE] at 9:30 a.m., during an interview with the Director of Health Services (DHS) she indicated she had noted the discrepancy with the code status for the resident and acknowledged the two different directives created a confusing situation regarding the residents advanced directives. On [DATE] at 1:00 p.m., review of medical record of resident 196. The resident was admitted on [DATE]. Diagnosis included but were not limited to, unilateral primary osteoarthritis, right knee, (a degenerative joint disease, in which the tissues in the joint break down over time), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), aftercare following joint replacement surgery, type 2 diabetes mellitus without complications (a disease that occurs when your blood glucose, also called blood sugar, is too high). Physician orders included but were not limited to. [DATE], Code Status. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact and required assistance from the staff for activities of daily living. The medical record lacked a care plan for advanced directives. On [DATE] at 11:14 a.m., the Regional Nurse Consultant provided a document, titled, Guidelines for Advanced Directives, dated [DATE], and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: to ensure facility staff obtains and follows resident's advanced directives regarding end-of-life care .Procedures .1. Advanced Directives will be reviewed with resident and or resident representative by the Customer Service representative or designee at the time of admission .2. The resident or representative will advise the CSR/designee regarding wishes for end-of-life directives and code status. The DNR form will be completed documenting these desires and scanned into the medical record .6. The nursing staff will obtain an order from the attending physician for the desired code status .8. Designation of code status and obtainment of physician order will be part of the medical record 3XXX,d+[DATE](f)(4)(ii) 3XXX,d+[DATE](f)(5)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34525 Based on interview and record review, the facility failed to ensure care plan meetings were held at least quarterly for 1 of 2 residents reviewed for care plan meetings (Resident 8). Findings include: During an interview, on 7/8/24 at 8:54 a.m., Resident 8 indicated she could not recall having a care plan meeting for quite some time. Resident 8's record was reviewed on 7/9/24 at 9:05 a.m. The census indicated the resident had been admitted to the facility on [DATE], for diagnoses which included, but were not limited to, displaced bimalleolar fracture of right lower leg (a type of ankle fracture that involve the distal [the area away from the point of attachment] ends of the fibula and tibia, respectively) and type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). A quarterly Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the resident had no cognitive deficit. Review of the Resident First Meeting Minutes (care plan meeting minutes) lacked documentation that a care plan meeting had been held since 11/1/23. During an interview, on 7/9/24 at 9:46 a.m., the Resident Services Manager indicated the facility was behind in completing their care plan meetings. Meetings should be held every quarter for all residents. During an interview, on 7/9/24 at 11:15 a.m., the Regional Director of Clinical Services indicated they were unable to locate any documentation that indicated the resident had a care plan meeting since November 2023. On 7/9/24 at 11:15 a.m., the Regional Director of Clinical Services provided a document, dated 12/31/23, titled. Resident's First Meeting Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: .2 .meetings for non-Medicare residents should be conducted at a minimum of quarterly and with significant change. 3 .meetings for Medicare residents should be conducted minimally quarterly and prior to discontinuing Medicare services or being discharged from the facility 3.1-35(d)(2)(B)

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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. 35317 Based on observations, record reviews, and interviews, the facility failed to assess and ensure that a physician was notified of a resident's change in condition related to edema for 1 of 1 resident's reviewed (Resident 7). Finding includes: On 7/7/24 at 11:08 a.m., Resident 7 was observed sitting up in her chair, the resident had edema (swelling) to her left foot and ankle. The resident indicated nothing really helps with the edema and she tried to elevate her feet as much as possible. She indicated she has had edema to her left foot off and on since she fractured it a couple years ago. On 7/8/24 at 2:37 p.m., Resident 7 was sitting up in her chair reading a book with her legs elevated on the seat of her wheelchair. Edema was noted to her left foot and ankle. On 7/8/24 at 10:23 a.m., Resident 7 was observed sitting in her chair in her room with her left foot on the floor and her right leg elevated on the wheelchair seat. The left foot was notably larger than the right foot. On 7/10/24 at 8:36 a.m., Resident 7 was sitting in her chair in her room and both feet were touching the floor. Her left foot and ankle were noted to be swollen. Resident 7's record was reviewed on 7/8/24 at 1:17 p.m. The profile indicated the resident's diagnosis included, but were not limited to, age-related osteoporosis without current pathological fracture (a bond disease that occurs when bone mass decreases, or when the structure or strength of the bone changes), history of DVT to left leg (occurs when a blood clot forms in one or more of the deep veins in the body), and chronic kidney disease, stage 3b (mild to moderate kidney damage and they are less able to filter waste and fluid out of your blood). A quarterly Minimum Data Set (MDS) assessment, dated 5/22/24, indicated the resident was cognitively intact and required supervision with toilet use and moderate assistance with showers. The record lacked a care plan related to edema to left foot/ankle. A care plan, dated 10/19/22, indicated the resident has chronic kidney disease, stage 3b. Interventions included, but were not limited to, assess for fluid excess (edema, worsening of edema, and weight gain) and administer medication as ordered. A progress note dated 4/29/24 indicated Resident 7 had edema to the left lower extremity. MD (medical doctor) was notified, and he ordered a venous doppler (a non-invasive diagnostic test that evaluates blood flow through the body's major veins and arteries). A progress note, dated 5/3/24, indicated Resident 7 had a red, swollen left leg and the doppler showed a DVT. MD ordered Xarelto (blood thinner). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record lacked any recent progress notes related to edema of the left foot/ankle. A physician order, dated 5/24/24, indicated to administer Xarelto 15mg (milligrams) by mouth daily. The record lacked continued monitoring of the edema and DVT by staff. During an interview, on 7/8/24 at 1:52 p.m., Certified Resident Care Assistant (CRCA) 5 indicated Resident 7 would elevate her legs and feet as much as possible because she had issues with swelling off and on. During an interview, on 7/8/24 at 1:53 p.m., Registered Nurse (RN) 6 indicated she had spoken to Resident 7 a couple months ago about the edema to her left foot, but she had not recently assessed the edema. The nurse indicated she had noticed in the past the swelling in her left foot is always worse than the right. During an interview, on 7/10/24 at 9:45 a.m., Regional Director of Clinical Services (RDCS) indicated the edema should be addressed with the physician, and she would make sure the resident was added to his list to be seen. During an interview, on 7/10/24 at 11:53 a.m., RDCS indicated a CAR (clinical assessment record) should have been completed on Resident 7 because it would have been a good way to ensure monitoring of the DVT had been completed and a good way to monitor for worsening or improving edema. On 7/10/24 at 11:50 a.m., the RDCS provided a document dated 5/10/16, titled, Clinically at Risk Program Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, .Every effort will be made to identify those residents who are clinically at risk and provide proactive interventions to manage their medical needs and minimize/eliminate further decline when possible . Resident is to be discussed in CAR meeting until it is determined the resident's condition has stabilized .5. The CAR team will review current interventions for effectiveness and potential changes and make recommendations based on individual resident's needs 3.1-37(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on observations, record review and interview, the facility failed to ensure a resident's indwelling urinary catheter (a semi-flexible plastic tube with one end inserted into the bladder) which was attached to a urinary drainage bag (a bag that collects urine) and a biliary drain (a thin plastic tube inserted into the gallbladder to drain fluid) bag, did not touch the floor for 1 of 1 resident reviewed for catheter care (Resident 201). Findings include: On 7/07/24 at 12:01 p.m., during routine observation, the resident lying in bed, the urinary drainage bag lying on the floor. No covering over the bag. The biliary drainage bag was lying on the floor. No covering over bag. On 7/08/24 at 9:29 a.m., observed the biliary drainage bag drain touching the floor. No covering over the bag. The urinary drainage bag was attached to the side of the bed frame. No covering over the drainage bag. On 7/09/24 at 8:40 a.m., during routine observation resident observed sitting up in a wheelchair. The foley drain bag was attached to the lower left side of the wheelchair. No covering over the drainage bag. The biliary drainage bag was attached to the upper right side of the wheelchair without a covering, the bag was half full of a dark colored liquid. On 7/9/24 at 8:46 a.m., during an interview, Certified Resident Care Associate (CRCA) 3 indicated any resident with an indwelling catheter and or a drainage bag, both bags should always be covered. She indicated the drain bag for the biliary drain is covered with a pillowcase when the resident is up in a chair. She indicated the drainage bags should not touch the floor. On 7/9/24 at 9:30 a.m., during an interview with the Director of Health Services (DHS) she indicated a urinary drain bag should be covered if the resident was in a wheelchair or using a walker. Clinical record review completed on 7/9/24 at 11:00 a.m., for Resident 201. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, 5/31/24 acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin), 4/12/24 cellulitis (a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin), unspecified, chronic atrial fibrillation (an irregular heart rhythm (arrhythmia) that begins in the upper (atria) of your heart), 11/4/20 chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), unspecified, obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep), dyspnea (difficult, painful breathing or shortness of breath). Type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high) with diabetic chronic kidney disease (the kidneys are damaged and can't filter blood the way they should). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders included but were not limited to. Albuterol sulfate solution for nebulization (used to prevent and treat wheezing, difficulty breathing); 2.5 mg (milligrams)/3 mL (milliliters) (0.083 %); amount: 3 ml; inhalation admin as needed for SOB (shortness of breath or wheezing every 6 Hours as needed. Eliquis (apixaban) tablet (used to treat blood clots) 5 mg; amt: 5 mg; oral twice a day. Empty biliary drain every shift three times a day. Change catheter bag PRN (as needed) based on clinical indications such as infection, obstruction, or when the closed system is compromised once a day PRN. Foley catheter care every shift three times a day, indwelling urinary catheter, medical reason BPH (benign prostatic hyperplasia, a noncancerous enlargement of the prostate gland) with urinary retention (a condition in which you are unable to empty all the urine from your bladder). An admission Minimum Data Set (MDS) assessment dated , 4/17/24 indicated the resident was cognitively intact and required maximum assist of two persons for activities of daily living and had an indwelling foley catheter during the look back period. A care plan dated 6/24/2024 indicated the resident used a foley catheter. Interventions included, but were not limited to, maintaining a closed system with urinary bag below the resident's bladder and cover. A care plan dated 4/14/24 indicated a risk for skin breakdown related to biliary drain. The record lacked interventions specific to the biliary drain. The facility did not have a policy specific to biliary drain. On 7/9/2024 at 11:15 a.m., the Regional Nurse Consultant provided a document, titled, Preserving Dignity with Indwelling Catheter, dated 12/31/23, and indicated it was the policy currently being used by the facility. The policy indicated, .SOP Details .1. General guidelines .a) Keep drain bag covered with an appropriate device .Urinary drainage bags and catheter tubing should be kept from touching the floor surface 3.1-41(a)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on observation, interview, and record review, the facility failed to ensure proper cleaning and storage of nasal cannula and CPAP (continuous positive airway pressure) mask and tubing for 1 of 2 residents reviewed for respiratory care (Residents 201). Findings include: On 7/7/24 at 12:05 p.m., observed Resident 201, lying down in his room, resting. Oxygen was being administered at 3 L (liters) per nasal cannula (a thin flexible tube device to provide supplemental oxygen therapy to people who have lower oxygen levels) there was no date indicated on oxygen tubing and did not observe a dated storage bag in the room. On 7/8/24 at 2:52 p.m., during routine observation, Resident 201 was lying in bed. Oxygen was being administered per nasal cannula at 3 L. There was no date on the oxygen tubing and did not observe an oxygen or CPAP (continuous positive airway pressure) (a machine that uses mild air pressure to keep breathing airways open while you sleep) dated storage bag in the room. On 7/9/24 9:13 a.m., observed the resident sitting in wheelchair. The oxygen nasal cannula tubing was lying on the couch next to the resident. Did not observe an oxygen or CPAP dated storage bag the room. On 7/9/24 8:46 a.m., during an interview Licensed Practical Nurse (LPN) 4 indicated the night shift changed oxygen tubing and the nurse did not normally date the tubing. On 7/9/24 at 9:30 a.m., during an interview the Director of Health Services (DHS) indicated the oxygen tubing was not dated; the bag was dated and changed monthly. She indicated the physician's order to clean the mask and place it in bag was for the CPAP mask not the oxygen mask. On 7/9/24 at 10:18 a.m., the clinical record for Resident 201 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, 5/31/24 acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin), 4/12/24 cellulitis (a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin), unspecified, chronic atrial fibrillation (an irregular heart rhythm (arrhythmia) that begins in the upper (atria) of your heart), 11/4/20 chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), unspecified, obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep), dyspnea (difficult, painful breathing or shortness of breath). Type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high) with diabetic chronic kidney disease (the kidneys are damaged and can't filter blood the way they should). (continued on next page)

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	155772	A. Building B. Wing	07/12/2024

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders included, but were not limited to, Albuterol sulfate solution for nebulization (used to treat shortness of breath and wheezing) 2.5 mg (milligrams)/3 mL (milliliters) (0.083 %); amount: 3 ml; inhalation admin as needed for SOB (shortness of breath or wheezing every 6 Hours - as needed. Eliquis (apixaban) (used to treat blood clots) tablet; 5 mg; amt: 5 mg; oral twice a day. Empty biliary drain every shift three times a day. O2(oxygen) - Change oxygen tubing monthly once a day on the 1st of the month. O2- CPAP at 14 cm H2O (water) pressure with oxygen at 3 liters at NOC (night) as needed during the day at bedtime (continuous positive airway pressure) a machine that uses mild air pressure to keep breathing airways open while you sleep. (Oxygen) O2- mask and tubing should be cleaned weekly with soapy water and rinsed. Air dry and place mask in clean setup bag once a day on Sun. O2- Oxygen at 3L (liters) per nasal canula continuous three times a day. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact and required maximum assistance of two persons for (ADL) activities of daily living and required oxygen during the look back period. A care plan dated 4/14/2024 indicated the resident had potential for complications, functional and cognitive status decline related to respiratory disease related to: COPD, sleep apnea. Interventions included, but were not limited to, Administer oxygen per orders. CPAP at night, Resident to wear CPAP machine at night. On 7/9/2024 at 11:14 a.m., the Regional Nurse Consultant provided a document, titled, Respiratory Equipment, dated 12/31/23, and indicated it was the policy currently being used by the facility. The policy indicated, . SOP Details .2. j. Keep oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use .3 .f. Store circuit in plastic bag, marked with date and resident's name between uses 3.1-47(a)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35317 Based on observations, interviews, and record reviews, the facility failed to ensure medications were labeled and stored properly for 2 of 2 medication carts reviewed for medication storage (Residents 8, 6, 19, and 146). Findings include: 1. On 7/9/24 at 9:10 a.m., the 200 hall (front) medication cart contained an undated and opened Lantus (medication used to lower blood sugar) insulin pen. The insulin pen contained a label that indicated it was for Resident 8. During an interview, on 7/9/24 at 9:12 a.m., Registered Nurse (RN) 6 indicated insulin pens should have an open date placed on them when they are used. Resident 8's record was reviewed on 7/9/24 at 9:40 a.m. The profile indicated the resident's diagnoses 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 5/1/24, indicated to administer Lantus Solostar (insulin medication) insulin pen 100 unit/ml (milliliter). Inject 25 units subcutaneously (under the skin) once a day in the morning. A physician order, dated 5/1/24, indicated to administer Lantus Solostar insulin pen 100 units/ml. Inject 70 units subcutaneously once a day at bedtime. 2. On 7/9/24 at 9:15 a.m., the 200 hall (back) medication cart contained the following items: a. An unopened and non-refrigerated box of 5 Basaglar (insulin medication) pens. The box of insulin pens contained a label that indicated it was for Resident 6. b. An unopened and non-refrigerated vial of Humalog (insulin medication). The vial of insulin contained a label that indicated it was for facility stock and was delivered from the pharmacy on 7/8/24. c. An unopened and non-refrigerated box of 5 Lantus (insulin mediation) pens. The box of insulin pens contained a label that indicated it was for Resident 19. d. An unopened and non-refrigerated bottle of Latanoprost (eye drop medication) 0.005%. The bottle contained a label that indicated it was for Resident 146. e. An unopened and non-refrigerated vial of Humalog. The vial contained a label that indicated it was for Resident 146. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 7/9/24 at 9:20 a.m., RN 6 indicated insulin and eye drops that were not opened, should be refrigerated until used. She indicated the night shift had a new nurse and she must not have known to refrigerate the medications until used. Resident 6's record was reviewed on 7/9/24 at 9:50 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes (a chronic condition that affects the way the body processes blood sugar). A physician order, dated 6/14/24, indicated to administer Basaglar Kwik-Pen 100 unit/milliliter. Inject 32 units subcutaneously (under the skin) at bedtime. Resident 19's record was reviewed on 7/9/24 at 9:55 a.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease (a serious complication that occurs when the kidneys are not functioning properly to remove waste products and excess fluid from the body). A physician order, dated 6/7/24, indicated to administer Lantus Solostar pen 100 unit/ml. Inject 55 units subcutaneously at bedtime. Resident 146's record was reviewed on 7/9/24 at 10:00 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes and glaucoma (a group of eye conditions that can cause blindness). A physician order, dated 7/5/24, indicated to administer Latanoprost 0.005%. Give 1 drop to each eye once a day. A physician order, dated 7/6/24, indicated to administer Humalog 100 units/ml. Inject subcutaneously per sliding scale before meals and at bedtime. During an interview on 7/9/24 at 11:00 a.m., the Regional Director of Clinical Services (RDCS) indicated the facility had a new nurse on night shift and needed to be educated on proper storage of medications. On 7/9/24 at 11:10 a.m., the RDCS provided and identified a document as a current facility policy, titled, Vials and Ampules of Injectable Medications, revised date 11/18. The policy indicated, .at a minimum the date opened should be recorded On 7/9/24 at 11:10 a.m., the RDCS provided and identified a document as a current facility policy, untitled, with a revised date of July 2021. The policy indicated, .Unused Pens: Store unused pens in the refrigerator On 7/9/24 at 11:10 a.m., the RDCS provided and identified an undated document as a current facility policy, untitled. The policy indicated, .Store unused Lantus in a refrigerator 3.1-25(j) 3.1-25(m)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48226 Based on observation and interview, the facility failed to maintain a safe and sanitary environment for food safety and failed to ensure beard covers were worn by an employee for 1 of 2 kitchen observations. Findings Include: 1. On 7/10/24 at 12:00 p.m., observed raw hamburger meat on a tray on the bottom of the rolling cart outside of the cooler with prepared salads on the cart. On 7/10/24 at 12:05 p.m., during an interview with Area Director of Food Services the director acknowledged the meat should not be on the cart and should have been in the cooler. On 7/10/24 at 12:08 p.m., during an interview with the Director of Food Services he indicated he had removed the hamburger meat from the cooler and placed it on the cart with the salads. He indicated he did not recall how long the meat had been out of the cooler. 2. On 7/10/24 at 12:08 p.m., during an interview with the Director of Food Services it was noted the employee did not have a beard covering on. He indicated he had one on and had removed it. On 7/10/2024 at 2:47 p.m., the Regional Nurse Consultant provided a document, titled, Food Production Guidelines, dated May 31, 2016, and indicated it was the policy currently being used by the facility. The policy indicated, . Policy .Safe and Sanitary handling of food will be employed during food production .7. Food prepared in advance must be covered, labeled, dated, and refrigerated .28. Potentially hazardous foods that have stood for more than (4) hours at room temperature are not considered safe from contamination and must be discarded On 7/10/2024 at 2:47 p.m., the Regional Nurse Consultant provided a document, titled, [NAME] and Mustache policy, dated November 30, 2021, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy .Beard and mustache hair must be covered while in kitchen food product areas, Facial hair restraints are required in any production area .Purpose .Beards and mustache hair must be covered while in the kitchen food product areas .Procedures .Some common approaches include .cover all beard or mustache hair that is more than 1/8 of an inch growth 3.1-21(i)(1) 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35317 Based on observation, record review and interview, the facility failed to ensure proper handling of the glucometer (small portable machine that's used to measure how much glucose [type of sugar] is in the blood) meter during medication administration pass for 2 of 5 residents reviewed during medication administration (Residents 8 and 19). Finding includes: During a medication administration observation, on 7/9/24 at 11:43 a.m., Registered Nurse (RN) 6 had a glucometer meter in a drawer on the right side of the medication cart, she took the meter out of the drawer and placed it on top of the medication cart, no barrier was placed under the machine. The nurse obtained Resident 8's blood sugar at the nurse's station. The nurse placed the meter back on top of the medication cart, no barrier was placed under the machine. No satiation of the machine was observed. 5 minutes later the nurse picked up the meter from the medication cart and entered Resident 19's room. The nurse placed the meter on the resident's side table in her room, no barrier was placed under the machine. The nurse obtained Resident 19's blood sugar and placed the meter back onto the medication cart, no barrier placed under the machine. Resident 8's record was reviewed on 7/9/24 at 12:10 p.m. The profile indicated the resident diagnoses 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 4/28/24, indicated to obtain Accu check (name of blood glucose monitoring system) before each meal and before bed. Resident 19's record was reviewed on 7/9/24 at 12:15 p.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes mellitus. A physician order, dated 6/7/24, indicated to administer Humalog (insulin medication) 100 units/ml (milliliter). Inject 8 units subcutaneously (under the skin) before meals. During an interview, on 7/9/24 at 12:32 p.m., Licensed Practical Nurse (LPN) 12 indicated nursing staff should place a barrier down underneath the glucose meter when being placed on surfaces. She also indicated the machine should be cleaned in between use. LPN 12 indicated the residents do not have their own meters; the glucose meter would be used for multiple residents. On 7/9/24 at 2:38 p.m., the Regional Director of Clinical Services (RDCS) provided a document with a revised date of 12/2/21, titled, Glucometer Cleaning and Control Test Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, .1. If glucometers are used from one resident to another, they should be cleaned and disinfected after each use 3.1-18(b)