

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630
---	---

(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
F0000	<p>This visit was for the Investigation of Complaints IN00097878, IN00096613, and IN00097498.</p> <p>Complaint IN00097498 - Substantiated. Federal/state deficiencies related to the allegations are cited at F250, F322.</p> <p>Complaint IN00097878 - Substantiated. Federal/state deficiencies related to the allegations are cited at F310, F441.</p> <p>Complaint IN00096613 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: October 11, 12, 2011</p> <p>Facility number: 000173 Provider number: 155273 AIM number: 100290920</p> <p>Survey team: Carole McDaniel RN TC Martha Saull RN Terri Walters RN</p> <p>Census bed type: Medicare: 13 Medicaid: 61 Other: 22 Total: 96</p> <p>Census payor type:</p>	F0000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> <p>Cypress Grove Nursing and Rehabilitation Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective November 11, 2011.</p>	

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: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
F0167 SS=C	<p>SNF: 17 SNF/NF: 79 Total: 96</p> <p>Sample: 12</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/18/11 by Suzanne Williams, RN</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to post the most recent survey results on 2 of 2 days of survey with potential to affect 96 of 96 residents residing in the facility.</p> <p>Findings include:</p> <p>On 10/11/11 at 8:30 A.M. and on 10/12/11 at 8:00 A.M., the facility's most recent survey could not be located according to the posted sign which indicated "Survey results can be found in the binder on the front lobby table."</p>	F0167	It is the policy of Cypress Grove to make the results of the most recent survey conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility readily accessible for examination, along with a posting indicating its availability. All residents have the potential to be affected by the alleged deficient practice.	10/12/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>On 10/12/11 at 9:15 A.M., the Administrator was informed. She identified a leather bound photograph album style book with no identifiable markings. It was on a lower open shelf of the lobby table with papers and brochures on top of it. It contained prior survey material but did not provide the most recent survey. The Administrator was interviewed regarding the observation. She indicated she had taken the contents to reorganize it. She went to her office to find it and was unable to provide the contents after trying to locate it. She stated she had been aware of the problem when she observed fall decorating had displaced the book, and when she attempted to replace it, noticed there were a few surveys loosely "stuffed in the front without even holes punched" to secure them. She indicated it had not been posted on the two survey days. She indicated she had been intending to get it re-posted.</p> <p>3.1-3(b)(1)</p>		<p>Step 1: The most recent survey was placed in the survey book immediately (October 12, 2011) after being informed by the survey that it was not present. A one time review of the survey book was completed by the Administrator.</p> <p>Step 2: All Administrative staff were re-educated regarding the requirement to place any survey conducted in the center in the survey binder located in an area of the center clearly visible to residents and visitors.</p> <p>Step 3: The Administrator/Designee will be responsible to ensure the placement of any survey conducted three times/week X 2 weeks, then weekly X 10 weeks, and then monthly for 2 quarters. Any issues identified will be immediately corrected.</p> <p>Step 4: The audits will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
F0241 SS=D	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure dignity and respect were afforded 1 of 1 resident observed attempting to communicate with staff working in her room in the sample of 12. Resident C</p> <p>Findings include:</p> <p>On 10/11/11 at 10:20 A.M., Resident C was observed from her doorway to be seated in her wheelchair next to her bed. She was positioned between LPN #2 and CNA#2, who were working in her room. The nurse was directing sequence of care on another resident by CNA # 2. The two staff talked back and forth. The resident said "I am cold." Her voice was readily audible from the door. Neither staff responded. The resident said again in a louder tone, "I am cold." Again the</p>	F0241	<p>forwarded to the Quality Assurance Committee monthly for 3 months, and then quarterly for 1 quarter for review. Any further action necessary will be determined by the QA committee.</p> <p>It is the policy of Cypress Grove that the facility promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Step 1: Staff immediately made Resident C comfortable. Resident C was assessed for any negative psychosocial effects by Social Services with none noted.</p> <p>Step 2: All residents have the potential to be affected by the alleged deficient</p>	11/11/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>resident was ignored. The resident stated more loudly still "Can't you hear me I am cold?" The resident was ignored as the staff finished their conversation and the LPN commenced to make the bed while the CNA took soiled linens from the room. The resident said to the nurse "I am so cold." When the nurse failed to respond, she was informed that her resident was cold. LPN #2 responded she was just going to finish the bed first. After she was informed the resident's need, she stopped making the bed and got a wrap and blanket for the resident.</p> <p>At this time, the Director of Nursing was interviewed regarding the above observation and indicated it was not consistent with the facility efforts toward excellent service.</p> <p>3.1-3(t)</p>		<p>practice. A one time 100% facility walk through has been completed by the facility Administrator and the Social Services Director with no negative psychosocial effects relating to dignity and respect being noted.</p> <p>Step 3: The Education & Training Director (ETD)/Designee will provide re-education to staff on the facility's policy regarding Residents Rights including but not limited to treating residents with dignity and respect. This education will be added to the orientation of all newly hired staff. A Sensitivity Training Session has been scheduled on November 10, 2011 by the Social Services Director.</p> <p>Observational Dignity Rounds have been implemented and will be conducted by facility's management team on a daily basis. Observations will include but not be limited to treating residents with respect and dignity as</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
			<p>well as timeliness in responding to residents' needs. Dignity Rounds will be documented on the Compliance Rounds tool.</p> <p>Step 4: A Resident Dignity audit tool has been developed and will be conducted by the Social Services Director, Director of Nursing or Designee. The Dignity Audit tool will include but not be limited to interviews with residents identified per the Minimum Data Set (MDS) as interview able as well as observation of residents unable to verbalize needs to ensure response and acknowledgement of residents needs are met timely with dignity and respect. DON/Designee will conduct an audit on 20% of the facility residents daily X 4 weeks, 15% of the facility residents 2 X/week X 4 weeks and 10% of the facility residents one time/week weekly thereafter.</p> <p>Step 5: Identified</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
F0250 SS=D	<p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure social services were provided related to scheduling eye appointments and care conferences for 1 of 3 residents reviewed for requested eye appointments and care conferences in a sample of 12.</p> <p>Resident A</p> <p>Findings include:</p> <p>On 10/11/11 at 1:10 P.M. the clinical record of Resident A was reviewed. A social service note, dated 5/11/11, indicated the following: "Family conference, daughter in attendance...Discussed care of mother...Requested to be seen by the optometrist at the next visit. Daughter feels that things are passed off to the next</p>	F0250	<p>non-compliance will result in 1:1 re-education with repeat non-compliance resulting in progressive disciplinary action per facility policy. Findings will be forwarded to the Quality Assurance Committee monthly for review to ensure continued compliance.</p> <p>It is the policy of Cypress Grove to ensure that medically related social services are provided to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. All residents have the potential to be affected by the alleged deficient practice.</p> <p>Step 1: For Resident A, the facility immediately contacted the responsible party regarding the consent for vision care and an eye appointment was scheduled.</p>	11/11/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>shift instead of being taken care of." This was the most recent note observed in the social service section of the chart.</p> <p>On 10/12/11 at 11:20 A.M., the Social Service Director (SSD) was interviewed. She indicated the resident was scheduled to have a care conference on 9/7/11 but the resident was in the hospital and returned to the facility on 9/8/11. The SSD indicated that after a resident returns to the facility and has missed a care conference, she would be responsible to contact the family to see if they wanted to reschedule the care conference. The SSD indicated documentation was lacking of her attempting to contact the family to reschedule the care conference, until 10/10/11.</p> <p>The SSD indicated the resident has not been seen by the optometrist after the 5/11/11 entry as the daughter had not signed a permission slip until 10/10/11. The SSD indicated she didn't know why the resident's daughter had not signed the permission slip. The SSD indicated the resident was on the list to be seen by the optometrist at the next visit, which should be the end of October or the beginning of November.</p> <p>On 10/12/11 at 1:20 P.M., the SSD provided a current copy of the policy and</p>		<p>For Resident A, responsible party was contacted regarding scheduling of a care plan conference.</p> <p>Step 2: A one time 100% medical record review was conducted to ensure consents to receive vision care services were present.</p> <p>A one time 100% medical record review was conducted for residents that have returned from the hospital within the last 30 days requiring a Care Plan Conference.</p> <p>Step 3: Social Services Director/Designee will maintain an on-going log of residents identified as requesting or requiring vision care services. Social Services/Designee will contact responsible party to obtain consent as applicable.</p> <p>Social Services/Administrator/Designee will review Daily Census Report</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011	
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630			
(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			
	<p>procedure for "Community Resources -Referral to." This policy and procedure was dated 4/2000. This policy included, but was not limited to, the following: "Discuss issues with the resident, legal representative, and/or family/friends to advise them of possible solutions and available resources. Refer the appropriate party(s) to the agencies, as needed. Follow up on the referrals to community services as appropriate and document the outcome of referrals in the resident's chart."</p> <p>At this time, the SSD also provided a current copy of the facility policy and procedure for "Resident/Family Conference." This policy was most recently updated 2/2011 and included, but was not limited to, the following: "...Schedule a resident, family and/or legal representative conference with the applicable disciplines, as needed...Ensure notification of the resident and family/legal representative of the next scheduled Resident/Family Conference. Document notification and method (phone or mail) in the medical record."</p> <p>On 10/12/11 at 1:30 P.M., the SSD provided a copy of the list of residents to be seen by the optometrist. Resident A was on this list.</p>		<p>Monday-Friday to identify residents that have been re-admitted to the facility. For those residents readmitting, a medical record review will be conducted to determine the need for scheduling the care plan conference.</p> <p>Step 4: During the weekly facility Plan of Care review, Social Services Director/Designee will audit the medical record to determine presence of a signed consent for vision care services.</p> <p>During the facility Daily Clinical Review process, Social Services Director/Designee will audit the medical record to identify residents needing a care plan conference to be re-scheduled due to leave of absence from the facility.</p> <p>Step 5: Findings will be forwarded to the Quality Assurance Committee monthly for review to ensure continued compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
F0310 SS=D	<p>This federal tag relates to complaint IN00097498.</p> <p>3.1-34(a)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>Based on observation, record review and interview, the facility failed to ensure the daily placement of a hearing aide on 2 of 2 survey days for 1 of 3 dependent residents with hearing aides from a sample of 12. Resident B</p> <p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 10/11/11 at 11:50 A.M. Diagnoses included hearing impairment with dependence on hearing aide. The resident's right ear required the assistive device.</p> <p>On 10/11/11 at 8:45 A.M., CNA #3 was observed assisting Resident B to wash up and dress for the day. The resident was smiling and participating. The resident responded to directions from the CNA</p>	F0310	<p>It is the policy of Cypress Grove to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>Step 1: Immediately, Resident B's hearing aide was cleaned and placed in his ear. A plastic container</p>	11/11/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011	
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630			
(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			
	<p>when in close proximity to his left side but was poorly responsive when approached on his right. No hearing aide was given to the resident at that time, and the resident was not observed to be wearing one on that shift until the end of the observation at 2:15 P.M.</p> <p>On 10/12/11 at 10:45 A.M., the resident was observed up in his wheelchair in his room and was without his hearing aide. CNA #3 was informed and indicated the hearing aide was locked on the medication cart, and either the aides or nurses were to put it in for the resident. The CNA got LPN #4 who procured the hearing aide from the locked cart. It was on a short tether with a collar clip in case of dislodgement. She indicated the device was routinely locked in the cart to ensure it was not lost due to the loss of several prior hearing aides. The resident was approached by staff as he was seated in his room with his right side to the doorway. He did not respond to their vocal direction until he could see the CNA. The device was then inserted with the collar clip secured, and the nurse said "Is that better?" and the resident nodded that it was.</p> <p>On 10/12/11 at 12:30 P.M., the DON was interviewed regarding the use of the hearing aide. She indicated the resident</p>		<p>with lid was obtained and labeled with resident's name for appropriate storage and placed in the medication cart.</p> <p>Step 2: A one time 100% medical record review, to include physician order sheets, was conducted to identify residents requiring hearing aides. The hearing aides of those residents identified were then assessed to ensure proper functioning, cleanliness, utilization and storage. It was determined that all hearing aides were functioning, clean, being utilized and stored properly (if needed).</p> <p>The Education & Training Director (ETD)/Designee will provide re-education to staff on the facility's standard of practice regarding hearing aides . This education will be added to the orientation of all newly hired staff.</p> <p>Step 3: A "Sign-In/Sign-Out" form was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>had had several different hearing aides, purchased by both the family and the facility, lost. In an effort to prevent additional loss, the system of locking had been developed. She indicated she would adapt the system to ensure daily use of the hearing aide.</p> <p>This federal tag relates to complaint IN00097878</p> <p>3.1-38(a)(2)(E)</p>		<p>implemented for those residents identified as dependent and requiring additional assistance with placement and utilization of their hearing aide(s). The Licensed Nurses will maintain the "Sign-In/Sign-Out" form in the Medication Administration Record to mitigate loss, and to provide the hearing aide to the CNA so they may assist the dependent resident</p> <p>Step 4: The DON/Designee will audit the "Sign-In/Sign-Out" form(s), and observe for proper storage, cleanliness and functionality Monday - Friday X 4 weeks, then weekly X 12, then monthly thereafter. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in progressive disciplinary action per facility policy.</p> <p>Step 5: Findings will be forwarded to the Quality Assurance Committee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630
---	---

(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
F0322 SS=G	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on interview and record review, the facility failed to ensure an enteral tube feeding was maintained at an infusion rate as specified by the physician for 1 of 3 residents reviewed with tube feedings in a sample of 12. This deficient practice resulted in vomiting and symptoms of aspiration after the resident received five times the prescribed amount of feeding for a period of three hours.</p> <p>Resident A</p> <p>Findings include:</p> <p>On 10/11/11 at 1:10 P.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, the following: congestive heart failure; psychosis, history left lower lobe pneumonia, diabetes mellitus, stroke, dementia, dysphagia, weakness, urinary</p>	F0322	<p>monthly for review to ensure continued compliance.</p> <p>It is the policy of Cypress Grove to ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills based on the resident's comprehensive assessment. Step 1: Upon identification of tube feeding infusion rate the enteral feeding for Resident A was immediately turned off. The physician was contacted and orders received to hold the feeding X 10 hours and obtain stat chest X-ray. A respiratory and GI assessment was completed per registered nurse. Resident A was placed at 45-90 degree angle with side to side turning every 2 hours initiated. Resident A was placed on increased monitoring of</p>	11/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>tract infection, aphasia, esophagitis and gastritis. The most recent MDS (Minimum Data Set assessment) dated 8/30/11, indicated the following for the resident: cognitive skills for decision making are severely impaired, feeding tube, range of motion was impaired on both sides, and bed mobility - required extensive assistance.</p> <p>A physician order for gastrostomy tube feeding, dated 9/8/11, indicated the following: "Glucerna 1.2 at 60 ml/hr (milliliters per hour), off at 0800 (8 A.M.) - 1000 (10 A.M.) and 1800 (6 P.M.) - 2000 (8 P.M.)."</p> <p>Nurses' notes, dated 9/24/11 at 8 A.M., indicated the following: "CNA (certified nursing assistant) reported resident was vomiting up what looked like 'watered down feeding.' At that time, it was observed the peg tube feeding was running at 300 cc/hr (same as ml/hr). Feeding was immediately stopped. Res (resident) was set up as much as tolerated and placed on R (right) side...Crackles heard in L (left) lower post (posterior) lung field...."</p> <p>Nurses' notes, dated 9/24/11 at 9:45 A.M., indicated the following: "Order for STAT CXR (chest x ray) received...crackles heard in left lower post lung field."</p>		<p>respiratory status to include respiratory assessment by Licensed Nurse. Responsible party notified of occurrence, physician orders that were received and resident's current clinical status. Step 2: A 100% medical record review of current in house residents receiving naso-gastric or gastrostomy tube feeding was conducted to ensure appropriate infusion rate per physician orders. Observational rounds were conducted to ensure appropriate tube feeding rate per physician orders. A Respiratory and GI assessment was completed on identified residents receiving naso-gastric or gastrostomy feeding with no negative findings noted. Step 3: Observation rounds for those residents receiving continuous naso-gastric or gastrostomy tube feeding have been implemented. Rounds will be conducted by 2 Licensed Nurses upon shift change to ensure accuracy of tube feeding rate. Verification of observation rounds upon shift change will be documented on the 24 hour report. The Education & Training Director (ETD)/Designee will provide re-education to licensed staff on the facility's standard of practice regarding enteral feeding Policy & Procedure/Standard of Practice. An Enteral Feeding Clinical Competency with return demonstration has been added to newly hired nurse orientation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630
---	---

(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
	<p>Nurses' notes, dated 9/24/11 at 8:30 A.M. [sic], indicated "Late entry: Dr. (name) notified of situation. Gave order to leave feeding off for 10 hours, (ADON [Assistant Director of Nursing] name) to inform daughter."</p> <p>Nurses' notes, dated 9/24/11 at 3 P.M., indicated, "...Few scattered rhonchi with some exp (expiratory) wheezes heard...." At 4 P.M."...Few scattered rhonchi et (and) faint exp wheezes heard, B (bilaterally). Lungs dimin (diminished) B (bilateral) bases...."</p> <p>The chest xray, dated 9/24/11 (no time documented) indicated the following: "...no evidence of an active pulmonary parenchymal or pleural disease process...."</p> <p>Nurses' notes, dated 9/25/11 at 6:30 P.M., indicated, "...crackles in rt (right) upper lobe, diminished left and right bases...."</p> <p>A chest xray, dated 9/27/11, indicated the following: "...appears to be an area of early infiltrate in the right lung base...."</p> <p>A physician order was received, dated 9/28/11, for the antibiotic "Levaquin 750 mg every day via tube...."</p> <p>The chest xray, dated 10/1/11, indicated</p>		<p>Step 4: The DON/Designee will conduct an observational audit to ensure appropriate infusion rate per physician's orders for residents receiving naso-gastric or gastrostomy tube feeding and audit of 24 hour report for verification of rounds being conducted by 2 Licensed Nurses upon shift change. The audit is being conducted daily X 4 weeks and weekly thereafter. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in progressive disciplinary action per facility policy. Step 5: Findings will be forwarded to the Quality Assurance Committee monthly for review to ensure continued compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630
---	---

(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
	<p>the following: "...compared to previous examination there is some resolution of the previously described infiltrate in the right lung base. Small amount of residual infiltrate persists...."</p> <p>On 10/11/11 at 9:15 A.M., the Administrator provided a copy of the "Fax/Incident Report." This form was faxed to the ISDH (Indiana State Department of Health) on 9/25/11 initially, and a final report was faxed on 9/30/11 before 8 A.M. and included, but was not limited to, the following information:</p> <p>At 8 A.M. on 9/24/11, it was reported to the RN (registered Nurse) by a CNA the resident was noted to have vomited. HOB (head of bed) was at 30 degrees.</p> <p>On 9/29/11- Investigation results: "Validation of enteral feeding rate at 300 cc per hour per feeding pump as reported. It was determined through the interview process, the LPN administering the enteral feeding at 0500 (5 A.M.) had primed the tubing at 300 cc/hr. Upon connecting the tubing to the resident's gastrostomy tube, the LPN unintentionally left the pump set at 300 cc/hr. Resident received enteral feeding at a rate of 300 cc/hr for approximately 3 hours; Type of injury: vomiting; 9/29/11: CXR taken on 9/24/11 = no active disease; 9/27/11 CXR results = early infiltrate in right lung base.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630
---	---

(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
	<p>Upon review of resident's history of chest x ray results, the resident exhibits intermittent infiltrates. Immediate action taken: Enteral feeding immediately turned off, MD contacted, orders received to hold feeding x 10 hours, stat chest x ray. Respiratory and gastrointestinal (GI) assessment completed...resident placed at 45 - 90 degree angle, side to side turning every 2 hours and increased monitoring implemented of respiratory assessment q 2 hours. Family notified of occurrence, MD orders, resident assessment, and current clinical status.</p> <p>9/29/11: MD on site visit, on 9/28/11 new orders received for antibiotic therapy related to 9/27 chest x ray results. Family aware of resident's clinical history and current clinical status related to event. Family (daughter), voices understanding and is in agreement with current investigative procedure and results. LPN in question is no longer employed with (this facility). Preventative measures taken: Re-education of licensed personnel regarding enteral feeding, policy and procedure with competency testing to include return demonstration completed. The following preventative monitoring systems were implemented immediately: Respiratory assessment to be completed every 2 hours; verification via 2 nurses for accuracy of enteral feeding rate per continuous feeding pump; resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>observation rounds for those residents receiving continuous feed per 2 nurses upon shift change to ensure policy and procedure compliance, and accuracy of MD orders. 9/29/11: Every 2 hour respiratory assessments were continued during the 5 day investigation period. Respiratory assessments to resume every 8 hours routinely. Continue 2nd nurse verification for accuracy of enteral feeding rate per continuous feeding pump, and shift change observation rounds. Enteral Feeding clinical competency validation is now included with the new hire nurse orientation."</p> <p>On 10/11/11 at 3:20 P.M., a copy of the resident's total fluid intake for September 2011 was received. From 9/9/11 to 10/10/11, the resident's total fluid intake ranged from 580 cc to 3290 cc.</p> <p>On 10/11/11 at 3:20 P.M. a copy of the policy and procedure for "enteral tubes" was received from the DON. The procedure was dated July 2010. The policy and procedure included, but was not limited to, the following: "For continuous tube feeding, fill bag with 4 hours of tube feeding, flush tubing, attach to volume control infuser...." The DON was interviewed at this time. She indicated the way to prime the tubing would not be to set the infusion at 300</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>cc/hr. The DON indicated the policy and procedure didn't specifically say how to infuse the tubing, but at 300 cc/hr was not it, and the LPN #1 shouldn't have left the rate at 300 cc/hr.</p> <p>On 10/12/11 at 10 A.M., the DON (Director of Nursing) was interviewed. She indicated LPN #1 is the LPN who left the tube feeding running at a rate of 300 cc/hr for 3 hours. The DON indicated LPN #1 stated she hung the new bottle of tube feeding at 5 A.M. The DON indicated a total of 900 cc of tube feeding infused in a 3 hour period via the gastrostomy into the resident. The DON provided a copy of the resident's September 2011 MAR. This form included, but was not limited to, the following: "Glucerna 1.2 at 60 cc/hr." This Glucerna was initialed as given on the 11-7 shift for 9/9/11 to 9/30/11. LPN #1 had documented for the 11 - 7 shift on 9/24/11. A physician order, dated 9/8/11, indicated the following: "Glucerna 1.2 at 60 ml/hr off at 0800 (8 A.M.) - 1000 (10 A.M.) and 1800 (6 P.M.) - 2000 (8 P.M.)."</p> <p>At this time, the DON indicated LPN #1 was no longer employed by the facility. She indicated the reason LPN #1's name appeared on the current employee roster was because "paperwork had not been</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>completed" to remove her from the roster. The DON indicated the last day LPN #1 worked was 9/24/11.</p> <p>At this time, the DON indicated on the final report to ISDH, where it stated "Every 2 hour respiratory assessments were continued during the 5 day investigation period", that she only intended for the 2 hour assessments to be continued for 24 hours and not the 5 day investigative period.</p> <p>On 10/12/11 at 11:30 A.M., the DON was interviewed regarding the range of fluid intakes for the gastrostomy tube. The DON indicated for a 24 hour period, the resident's total intake should be 1200 cc of Glucerna plus 1500 cc of water given with medications and flushes for a 24 hour total of 2700 cc. She indicated she was unable to explain the discrepancy of the daily 24 hour fluid total intakes.</p> <p>This federal tag relates to complaint IN00097498.</p> <p>3.1-44(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630
---	---

(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
F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to ensure infection control practices were followed during 1 of 3 observed dressing changes (Resident A) and regarding sanitation of</p>	F0441	It is the policy of Cypress Grove to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent	11/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630
---	---

(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
	<p>bathroom facilities to prevent cross contamination between resident showers on 2 of 2 units, for two randomly observed residents (D, E), with potential to affect 79 residents residing on the Willow and Garden units of a total of 96 residents in the facility.</p> <p>Findings include:</p> <p>1. On 10/10/11 at 10:30 A.M. the clinical record of Resident A was reviewed. The resident had Stage II pressure sores of the coccyx, right buttocks and both heels, which were being treated and covered with dressings according to physician orders.</p> <p>On 10/11/11 at 10:55 A.M., LPN #2 was observed changing dressings for Resident A. The nurse began by applying gloves to unwashed hands. She first cleansed and applied dressing to the coccyx pressure sore. At that point the resident had a loosely formed incontinent BM which the nurse cleaned. She removed the soiled gloves and applied new gloves without hand sanitizing and contaminated the left glove by reaching under the cuff of the right glove with her gloved left hand fingers. There were a total of 5 glove changes as she advanced from one pressure area to another during the procedure without hand sanitizing. The</p>		<p>the development and transmission of disease and infection. All residents have the potential to be affected by the alleged deficient practice. Step 1: Resident A has been assessed for signs and symptoms of infection with none found. The nurse involved has been re-educated on glove usage to include changing at appropriate times, hand washing at appropriate times, as well as appropriate aseptic technique during dressing change and application. The shower rooms and shower chairs were disinfected. Step 2: A 100% medical record review was completed on current in-house residents to identify those residents requiring dressing change(s). Identified residents were assessed for signs and symptoms of infection with none found. Each shower room was observed for proper cleanliness and presence of disinfectant for shower chairs. Step 3: It is the responsibility of the Licensed Nurse to ensure the shower room and shower chairs are cleaned between resident use 3 X weekly. Nursing Supervisor will observe the Licensed Nurse performing a dressing change to ensure hand washing at appropriate times and aseptc technique randomly on 10% of those residents requiring dressing changes on a weekly basis. The Education & Training</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>nurse removed a roll of tape from her right pocket and her pen before application of the second pair of gloves. She placed those on the blue vinyl covered shower bed surface, next to the resident's buttocks as the resident lay on her side. The surface had been uncleaned since the resident's shower and incontinent episode. Her clean scissors were also placed there. These supplies were used in the application of each dressing. Afterward, the nurse cleaned her scissors with an alcohol swab and deposited them, along with the soiled tape and pen, into her right pocket with her keys.</p> <p>On 10/12/11 the Director of Nursing was interviewed regarding the observations and indicated the practice was not consistent with facility Policy and Procedure. She provided the April 1999 Policy and Procedure regarding hand hygiene which directed "handwash after removing gloves."</p> <p>2. On 10/12/11 at 8:15 A.M., the Garden unit shower room toilet seat and shower chair seats were both soiled with dry urine.</p> <p>On the same morning at 8:30 A.M., the shower room on the Willows unit was observed to have dried smears of BM and a dried piece of BM the size of a standard</p>		<p>Director/Designee has conducted re-education for nursing staff on policy and procedure for hand washing, changing of gloves and the sanitizing of the shower chairs and shower room. Re-education included return demonstration by the nurse for dressing change, glove changing and hand washing. Re-education also included return demonstration by the CNA's on proper sanitization of the shower chairs and shower rooms between residents. Step 4: The DON/Designee will conduct sanitation observation rounds regarding shower rooms and shower chairs to ensure sanitization is being properly conducted. Sanitation observation rounds of shower rooms/shower chairs will be conducted across all shifts 5 X weekly X 4 weeks, then 2 X/week X 4 weeks, then weekly thereafter. The DON/Designee will conduct a 15% random dressing change observation across all shifts 5 X weekly X 4 weeks, weekly X 8 weeks and monthly thereafter. Identified non-compliance will result in 1:1 re-education with progressive discipline up to and including termination. Step 5: Results of the audit will be forwarded to the monthly Quality Assurance Committee meeting for further review and recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630
---	---

(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
	<p>marble soiling the dry floors around two floor drains.</p> <p>On 10/12/11 at 9:45 A.M., CNA #1 was observed removing Resident D from the Garden unit shower room following her shower. There were two fresh pieces of BM, approximately 1/2 teaspoon and 1/4 teaspoon in size, on the shower floor. The shower chair was still wet from the shower of Resident D. The CNA went directly to get Resident E for his shower. She showered that Resident on the same shower chair and with the BM still on the floor. By observation, there was no sanitizing done between residents. The CNA indicated there was supposed to be sanitizing spray in the locked cabinet in the shower room; however, none was available. She indicated when there was no supply, the CNAs could go to the housekeeper and borrow their sanitizing solution.</p> <p>On 10/12 11 at 10:30 A.M., the housekeeper was interviewed regarding sanitizing spray availability in the shower rooms. She indicated the housekeeping staff still had some U-1 spray (used for sanitizing showers and equipment) left; however, "We are running low since we are changing chemicals to one we mix ourselves." She indicated they had been waiting to get new spray bottles, which</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN47630		
(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	
	<p>had not yet come, to fill spray bottles with the new solutions, label them, and leave it in the shower rooms. She was unsure how long the bottles had been on order or when they would be obtained.</p> <p>LPN # 3 was interviewed on 10/12/11 at 1:30 P.M., regarding practices of CNAs she was supervising. She indicated "The girls know they are expected to clean shower chairs and the area between residents."</p> <p>This federal tag relates to complaint IN00097878.</p> <p>3.1-18(b)(1)</p>				