

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 04/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 Complaint IN00105342.</p> <p>Complaint IN00105342 Substantiated, Federal/State deficiencies related to the allegations are cited at F 514.</p> <p>Survey dates: April 3 and 5, 2012</p> <p>Facility number: 000173 Provider number: 155273 AIM number: 100290920</p> <p>Survey team: Anne Marie Crays RN TC (April 5, 2012) Diane Hancock RN (April 3, 2012)</p> <p>Census bed type: SNF: 16 SNF/NF: 76 Total: 92</p> <p>Census payor type: Medicare: 10 Medicaid: 58 Other: 24 Total: 92</p> <p>Sample: 11</p>	F0000		

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 04/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 4/9/12 Cathy Emswiller RN</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 04/05/2012	
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630			
(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			
F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a physician's order for the antibiotic Amoxicillin was transcribed to the resident's Medication Administration Record, for 1 of 5 residents reviewed during medication passes, in a sample of 11. Resident A</p> <p>Findings include:</p> <p>On 4/3/12 at 7:50 p.m., RN #1 was observed administering medications to Resident A. She administered 8 pills and one injection. The medications did not include Amoxicillin.</p> <p>At 8:15 p.m. on 4/3/12, Resident A's clinical record was reviewed. Physician's orders included, but were not limited to, a telephone order for "Amoxicillin (sic) [an</p>	F0514	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. Cypress Grove Nursing and Rehabilitation Center desires this Plan of Correction to be considered the facility's Allegation of Compliance effective May 2, 2012. It is the policy of Cypress Grove to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. It is also Cypress Grove's policy to contain sufficient information to identify	05/02/2012			

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 04/05/2012	
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630			
(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>antibiotic] 500 mg [milligrams] i [one] P.O. [by mouth] TID [three times a day] X 10 days, dated 3/28/12."</p> <p>The Medication Administration Records [MAR] for March and April, 2012 were reviewed at 8:30 p.m. on 4/3/12. The order for the Amoxicillin had been included on the March, 2012 MAR, beginning on 3/29/12. The April, 2012 MAR did not include the Amoxicillin. The medications administered by RN #1 failed to include Amoxicillin.</p> <p>On 4/3/12 at 8:45 p.m., the physician's orders and MARs were reviewed with the Director of Nursing [DON], the Administrator and the Resident Care Manager. All indicated, during interview, they could not find the Amoxicillin on the April, 2012 MAR.</p> <p>On 4/5/12 at 12:50 P.M., during interview with the Director of Nursing, she indicated the resident did not miss any doses of the antibiotic except the one dose on 4/3/12 at 8:30 P.M. according to the medication count. The DON indicated it was a transcription error in that the medication was not on the April 2012 MAR.</p> <p>On 4/5/12 at 1:00 P.M., the DON provided the current facility policy on</p>		<p>the resident; a record of the resident's assessments; the plan of care and services provided; the results on an preadmission screening conducted by the State; and progress notes. Medication order for resident A was immediately verified via MD orders for accuracy and medication was transcribed to the April Medication Administration Record (MAR). A 100% medical record review of current in house residents has been completed. Medical record review included physician orders and MAR's for the past 60 days to ensure transcription and accuracy of MD orders. Resident physicians were contacted on identified transcription accuracies, clarification orders were received and transcribed to current MAR's</p> <p>The Education & Training Director (ETD)/Designee will provide re-education to licensed personnel regarding monthly medication record review. Designated personnel will update and make corrections on the MAR through the last day of that respective month. DON/Designee will conduct an additional medication and record review to ensure accuracy and transcription from the respective month. The DON/Designee will conduct an audit of physician orders daily (Monday-Friday) to ensure accuracy and transcription of new orders. DON/Designee will conduct a monthly medication</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 04/05/2012
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630		
(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>"Medication Record Review," dated 10/15/05. The policy included: "...The nursing facility is responsible for verifying the accuracy of all data on the physician's order sheets, medication/treatment administration records by the time of inclusion in the resident's medical record on the first of each month...."</p> <p>This federal tag relates to Complaint IN00105342.</p> <p>3.1-50(a)(1)</p>		<p>record review to verify the accuracy and transcription of data on the physician order sheets to ensure orders have been carried over to the new month's records. Identified non-compliance will result in 1:1 re-education with progressive discipline up to and including termination. Results of audits will be forwarded to the Quality Assurance Committee monthly times 6 months for review and recommendations.</p>		