

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 03/05/2013
--	---	--	---

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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00124920.</p> <p>Complaint IN00124920 Substantiated - Federal/State deficiencies related to the allegations are cited at F279, F309, and F323.</p> <p>Survey dates: March 4 and 5, 2013</p> <p>Facility number: 000173 Provider number: 155273 AIM number: 100290920</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 16 SNF/NF: 66 Total: 82</p> <p>Census payor type: Medicare: 13 Medicaid: 52 Other: 17 Total: 82</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings</p>	F000000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</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 03/05/2013
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	
	cited in accordance with 410 IAC 16.2. Quality review completed on March 8, 2013, by Jodi Meyer, RN				

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 03/05/2013
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	
F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to develop a plan of care regarding a wound vac, for 1 of 4 residents reviewed who received wound care, in a sample of 5. Resident B</p> <p>Findings include:</p> <p>On 3/4/13 at 9:10 A.M., during the initial tour, the Assistant Director of Nursing [ADON] indicated Resident B had a wound vac for stasis ulcers on his leg.</p> <p>On 3/4/13 at 10:00 A.M., Resident B was</p>	F000279	<p>F 279</p> <p>1) Skin Assessment Plan of Care for Resident B was immediately reviewed. The care plan was updated to reflect residents current status by the Daily Clinical Review Team. (Resident B is receiving care based on current assessment and Skin Plan of Care.)</p> <p>2) A 100% review of Physicians orders for the past 30 days of current in-house residents has been completed to identify residents with orders for a wound vac in place. Skin Assessment</p>	03/29/2013	

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 03/05/2013
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>observed lying in bed. A wound vac was attached to the resident's right lower calf, and appeared to be pulling light reddish drainage. The wound vac was set on "125." RN # 1 indicated at that time that she was the resident's nurse that day. RN # 1 indicated she thought the wound vac dressing was changed every 3 days.</p> <p>The clinical record of Resident B was reviewed on 3/4/13 at 11:15 A.M.</p> <p>Documentation indicated the resident was transferred to the hospital on 2/22/13, and returned to the facility on 2/26/13.</p> <p>Nursing progress notes, dated 2/26/13 at 4:45 P.M., indicated, "Resident arrived via wheelchair van from hospital. He has a wound vac...."</p> <p>A care plan, initially dated 8/5/12 and updated 1/2/13, included the following: "Skin Integrity Assessment: Prevention and Treatment Plan of Care. At risk related to: Paraplegia...Areas of Impairment: O/A's [open areas] to BLE [bilateral lower extremities]." Interventions did not include the wound vac.</p> <p>Physician orders regarding care of the wound vac was not seen in the clinical record. A care plan addressing the wound</p>		<p>Care Plans were reviewed and appropriately updated by the DCR Team where needed.</p> <p>3) Re-education has been scheduled for professional staff regarding the review of transfer orders from the hospital. The Nurse on duty at the time of the admission/re-admission will ensure orders for wound vacs are properly transcribed to the Physician Order Sheet, MAR's and TAR's. A review of re-admission orders will be conducted by the Interdisciplinary Team (IDT) on the following day after re-admission, Mon thru Friday to ensure orders have been care planned accordingly.</p> <p>4) Audits will be completed monthly on all wounds requiring a wound vac with the use of the "Clinical Systems Review Tool" for "Skin and Wounds." This audit includes a question that states: "Skin Integrity Assessment and Care Plan completed on admission and updated quarterly." (This is to include all wound vacs) Identified non-compliance will result in 1on1 education. Any further non-compliance will result in progressive disciplinary action. The results of these wound vac audits will be forwarded monthly to the QA committee x 6 months for further review and recommendations as deemed appropriate.</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 03/05/2013
--	---	--	---

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>vac was not documented in the clinical record.</p> <p>On 3/4/13 at 2:15 P.M., RN # 1 and RN # 2 were interviewed regarding physician orders for the wound vac. RN # 1 and RN # 2 searched the resident's clinical record, and indicated they could not find orders or a transfer sheet from the hospital.</p> <p>On 3/4/13 at 2:45 P.M., the MDS [Minimum Data Set] Coordinator indicated she "pulled the hospital records off of the computer." A hospital discharge summary, dated 2/26/13, indicated, "...The following is the patient's hospital course: Infected ulcer of the right leg with possible osteomyelitis. Status post debridement and wound VAC placement...PICC line has been placed today. Can be d/ced [discharged] to [name of facility]. Wound vac orders have been faxed...." The MDS Coordinator, RN # 1, and RN # 2 indicated at that time that they could not find the faxed wound vac orders.</p> <p>On 3/5/13 at 11:15 A.M., during interview with RN # 1, she indicated she was unsure if orders for the wound vac were "found or not."</p> <p>On 3/5/13 at 11:30 A.M., during interview with the Director of Nursing</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 03/05/2013
--	---	--	---

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>[DON], he indicated staff had called Resident B's physician regarding physician orders for the wound vac, but the physician was in surgery. The DON indicated the physician's nurse had informed the staff that the "125" setting was sufficient at that time, and the physician would call the facility regarding care of the wound vac site later that day.</p> <p>This federal tag relates to Complaint IN00124920.</p> <p>3.1-35(a)</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 03/05/2013
--	---	--	---

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

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 03/05/2013	
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			
F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to accurately assess a leg ulcer, resulting in wound infections which required 2 hospitalizations, for 1 of 4 residents assessed with wound care, in a sample of 5. Resident B</p> <p>Findings include:</p> <p>1. On 3/4/13 at 9:10 A.M., during the initial tour, the Assistant Director of Nursing [ADON] indicated Resident B had a wound vac for a stasis ulcer on his leg.</p> <p>On 3/4/13 at 10:00 A.M., Resident B was observed lying in bed. A wound vac was attached to a wound in his right lower calf area.</p> <p>The clinical record of Resident B was</p>	F000309	<p>F 309</p> <p>1) The leg ulcer on Res B's leg was immediately re-assessed. The care plan was updated to reflect residents current status. Physician was notified and orders were received. Resident B is receiving care and services per current physician orders and plan of care.</p> <p>2) A 1 time 100% medical record review for the past 30 days of current in-house residents was completed to identify residents with wounds. Review included but was not limited to Physicians orders, Nurses Notes, TAR and skin grids. Wounds on identified residents were re-assessed to identify S/S of infection to include but not limited to drainage, odor, color. Skin grids and care plans were updated to reflect current status. Licensed Nurses will be responsible for weekly and PRN assessments as well as documenting these assessments on the skin grids.</p> <p>3) Re-education has been</p>	03/29/2013			

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 03/05/2013	
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>reviewed on 3/4/13 at 11:15 A.M. Diagnoses included, but were not limited to, paraplegia.</p> <p>A Physical Therapy Plan of Care, dated 11/19/12, included: "...The patient exhibits R [right] foot ulcer: lateral malleolus measuring: 2.8 cm [centimeters] x 2.1 cm x 0.1 cm with 50% necrotic tissues and R lateral heel: 0.8 cm x 0.4 cm x 0.1 cm..."</p> <p>A Skin Grid indicated: "Right Ankle...12/3/12, Length 1.8, Width 2.0, Depth 1.0, Color of Drainage S [Serosanguinous], Color R [red]...Wound bed macerated [and] sanguinous [sic] [with] 50% necrotic tissue present." The wound was measured on 12/10/12, 12/16/12,12/26/12, and 1/1/12. The measurements, dated 1/1/13, indicated: "1.8 x 1.4 x 0.4...Area is healing...."</p> <p>A Skin Grid indicated: "12/17/12, Was the wound present on admission? No, Site: Rt [right] lat [lateral] lower leg, Trauma...Dimensions (in cm) Length 0.6, Width 1, Depth 0.1..." The Skin Grid indicated the wound was measured on 12/26/12, and again on 1/2/13. The measurements, dated 1/2/13, indicated: "0.8 x 0.9 x 0.1, Color of Drainage [Serosanguinous], Color [red]...."</p>		<p>scheduled for licensed Nurses on Policy and Procedure on Wound Prevention and Management to include but not limited to timeliness of assessment, and assessing for S/S of Wound infection including but not limited to drainage, odor, color. A weekly review/audit of Skin Grid – Pressure/Venous Insufficiency Ulcer/Other Form will be completed by Nursing Administration on an ongoing basis to ensure wound assessment compliance. Review will also include a visual observation of wound.</p> <p>4) DON/Designee will review Skin Grid – Pressure/Venous Insufficiency Ulcer/Other Form for appropriateness and timeliness of documentation weekly x 8/weeks and then monthly x 4/months. Identified non-compliance will result in 1on1 education. Any further non-compliance will result in progressive disciplinary action. The results of these wound audits will be forwarded monthly to the QA committee x 6 months for further review and recommendations as deemed appropriate.</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 03/05/2013
--	---	--	---

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>A Skin Grid for the right lateral lower leg prior to 12/17/12 was not documented.</p> <p>A Physician's order, dated 1/2/13, indicated: "Clarification of PT [Physical Therapy] orders for ulcer on [right] LE [lower extremity]: PT to tx [treat] 3 x 1 wk x 8 weeks for wound care...."</p> <p>A Physician's order, dated 1/7/13, indicated: "PT to [increase] frequency of wound care from 3 x/wk to 5 x/wk x 8 weeks...."</p> <p>Nurses notes included the following notations:</p> <p>1/7/13 at 10:49 P.M.: "Res. [resident] stated he wanted to go to the hospital to have his wound checked out. This nurse writer paged to have [physician] call facility to get order to send to ER."</p> <p>1/8/13 at 12:20 A.M.: "[Ambulance] here to take res to [hospital]...."</p> <p>A PT Progress Note, dated 1/8/13, included: "...The patient exhibits ankle ulcer, 2 lateral leg ulcers (superior and inferior with necrotic tissues present at periwound...[Right] lateral malleolus (R ankle): 1.0 cm x 1.4 cm x 0.4 cm, R lateral superior ulcer: 3.0 cm x 2.0 cm x 0.2 cm, R lateral inferior ulcer: 1.0 cm x</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 03/05/2013
--	---	--	---

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>1.4 cm x 0.2 cm...effective yesterday, patient's ulcer on the R lateral malleolus was very foul and oozing very dark red blood which therapist had recommended for a bone scan to rule out osteomyelitis...."</p> <p>A hospital discharge note, dated 1/12/13, included: "...Active Hospital Problems, Diagnoses, Ulcer of right leg, Tenosynovitis of right ankle...Hospital Course:...Came with worsening of pressure ulcers on right leg/foot...Was put on VANC and zosyn [antibiotics], provided with wound care. Cultures showed...E. Coli/Proteus Mirabilis/MRSA in wound...."</p> <p>Nurses notes included the following notations:</p> <p>1/12/13 at 4:20 P.M.: "Resident returned from [hospital]...."</p> <p>A Skin Grid indicated the resident's right lateral lower leg was assessed and measured on 1/12, 1/15, 1/22, and 1/29/13. The resident's measurements on 1/29/13 indicated: "1.8 x 1.6 x 0.2, Color of Drainage S, Color R...."</p> <p>There was no skin assessment again until 2/14/13. The Skin Grid, dated 2/14/13, indicated: "...10 cm x 6 cm x 0.3, Color of</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 03/05/2013
--	---	--	---

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>Drainage P [purulent], Color R, Odor M [mild]...."</p> <p>Nurses notes continued:</p> <p>2/14/13 at 11:00 A.M.: "Resident's right distal lower leg - lateral aspect - drsg [dressing] changed - area @ wound base red, beefy [with] no drainage also single area lateral [illegible]area of right ankle - small [with] no drainage - [name] DON [Director of Nursing] in to observe wound."</p> <p>2/18/13 at 2:50 P.M.: "Wound [right] distal lower lateral leg appears larger today - measured @ approx 9.2 cm x 4.6 cm; 0.04 deep [with] some yellowish foul-smelling drainage. [Physician] called, message left to ask for wound clinic evaluation. [Name] DON is aware."</p> <p>2/19/13 at 10:30 A.M.: "Appt [appointment] made [with] [Name] Wound Clinic for Feb. 27...."</p> <p>2/22/13 at 4:14 P.M.: "Resident wanted dressing to leg changed. I explained it was supper time and I needed to do [illegible] [and] assist residents to eat. He said that was not ok and he was getting up."</p> <p>2/22/13 at 5:00 P.M.: "Resident asking people on phone to take him to the</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 03/05/2013
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>hospital."</p> <p>2/22/13 at 5:10 P.M.: "Called [physician]. Message left RE: Resident wanting to go to hospital."</p> <p>2/22/13 at 5:15 P.M.: "Resident called 911."</p> <p>2/22/13 at 5:20 P.M.: "Resident said he was afraid 'I might lose my leg' and that he could die."</p> <p>2/22/13 at 5:39 P.M.: "[Physician] called. I told him resident had left by ambulance (911) to [hospital] ER. [Physician] said that was fine."</p> <p>A hospital discharge summary, dated 2/26/13, included: "...Hospital Course:...The patient comes in today because he felt that he was not being well taken care of at the nursing home. He feels that his wound is getting worse and has foul, smelling odor...He had a CT scan of his right lower extremity which showed possible underlying abscess with associated osteomyelitis as well...The following is the patient's hospital course: Infected ulcer of the right leg with possible osteomyelitis. Status post debridement and wound VAC placement...PICC line has been placed today...."</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 03/05/2013
--	---	--	---

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>Nurses notes, dated 2/26/13 at 4:45 P.M.: Resident arrived via wheelchair van from hospital. He has a wound VAC and power PICC...."</p> <p>On 3/4/13 at 2:15 P.M., during interview with Resident B, he indicated, "[On 2/22/13] I asked the nurse to change my [leg] dressing, but she wouldn't. It was dripping blood. I called the ambulance myself." Resident B indicated the drainage was very foul smelling. Resident B indicated, " I was afraid I was going to have my leg amputated."</p> <p>On 3/5/13 at 2:20 P.M., during interview with the Director of Nursing [DON], he indicated he had only been at the facility for 2 weeks. He indicated he looked at Resident B's leg on 2/14/13, and wanted the physician notified at that time to obtain a wound consultation. The DON indicated he was unable to find a complete, accurate assessment on Resident B's leg wounds.</p> <p>2. On 3/5/13 at 1:25 P.M., the Education Director provided the current facility policy on "Wound Prevention and Treatment," revised April 2009. The policy included: "...Progression of wound healing will be documented by length, width, and depth measurements.</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 03/05/2013
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>Documentation shall also include: Drainage/Exudate, Color, Odor, Tunneling/undermining, Periwound condition, Wound edges, Location, Pain, S/S [signs and symptoms] of infection, Wound base...Regardless of who is doing the wound treatment, Nursing Services will do the weekly assessment...."</p> <p>This federal tag relates to Complaint IN00124920.</p> <p>3.1-37(a)</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 03/05/2013	
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			
F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident at risk for falls was provided the proper supervision and proper placement of bolsters to prevent falls; and failed to ensure he was transferred correctly by staff, in that the resident was being pushed in a wheelchair by staff when he fell out of the wheelchair and sustained an abrasion to his forehead requiring 3 sutures, for 1 of 3 residents reviewed for falls, in a sample of 5. Resident D</p> <p>Findings include:</p> <p>On 3/4/13 at 9:10 A.M., during the initial tour, the Assistant Director of Nursing [ADON] indicated Resident D had recently fallen.</p> <p>On 3/5/13 at 9:10 A.M., Resident D was observed sitting in a wheelchair near the nursing station with his eyes closed.</p> <p>The clinical record of Resident D was</p>	F000323	F 323	03/29/2013			
			<p>1) Res D has been re-assessed for appropriate wheelchair adaptations for proper seating. Immediate room surroundings have been observed to ensure appropriate fall interventions are in place. Care plan has been updated to reflect current status as appropriate.</p> <p>2) A one time 100% medical record review of current in-house residents has been completed to identify residents with falls in the past 30 days. Review will include but is not limited to, 24 hour status report sheet, physician orders, Nurses notes and Accident and Incident log. Identified residents will be reviewed by the Interdisciplinary Team (IDT) to ensure appropriate falls interventions are in place. Review will include observational rounds of resident rooms and equipment. Care plans will be updated as appropriate.</p> <p>3) Staff will be re-educated on the Policy and Procedure for Risk</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 03/05/2013	
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>reviewed on 3/5/13 at 9:20 A.M. Diagnoses included, but were not limited to, dementia with behavior problems and macular degeneration.</p> <p>Physician orders, initially dated 9/16/12 and on the current March 2013 orders, indicated, "Pressure alarm to bed, check placement [and] function every shift. Pressure alarm to chair, check placement [and] function every shift."</p> <p>A care plan, dated 5/29/12 and updated 1/6/13, indicated: "Fall/Injury Risk related to: pain, unsteady...cardiovascular diagnosis, bladder incontinence...Dementia...Hx [history] of Fall/Injury: 1/30/12 - [no] injury, 5/2/12 - [no] injury, 9/16/12, 9/18/12, 10/18/12, 10/23/12, 11/6/12, 12/3/12, 12/9/12..."</p> <p>Interventions included: "...Resident Supervision General...Chair alarm 9/16, Bed alarm sensor 9/16, Floor sensor 9/18...."</p> <p>Nurses notes included the following notations:</p> <p>11/6/12 at 7:45 P.M.: "Resident fell out of bed. Found by CNA. DON [Director of Nursing], [Physician] notified. Pt. [patient] assessed no injury. Bed to have bolsters...."</p>		<p>Reduction: "Falls and Injury Program". Re-education will include but will not be limited to, proper placement of bolsters and wheel chair transportation per plan of care. The IDT will be responsible for reviewing any resident with a fall during Daily Clinical Review (DCR) Monday thru Friday. Review will include visual observation of interventions and the updating of the care plan as appropriate.</p> <p>4) DON/Designee will review each fall weekly x 4/wks then monthly on-going utilizing the Clinical Systems Review Tool. Identified non-compliance will result in 1on1 education. Any further non-compliance will result in progressive disciplinary action. The results of these audits will be forwarded monthly to the QA committee for further review and recommendations as deemed appropriate x 6 months.</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 03/05/2013
--	---	--	---

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>12/3/12 at 9:50 A.M.: "Resident in wheelchair, leaning forward and fell onto right side. Head did not hit floor...."</p> <p>A Progress Note, dated 12/4/12 and untimed, indicated, "...Incident report r/t [related to] fall (witnessed). Resident sleeping in chair...Staff inserviced to place resident in bed [after] breakfast for AM nap...."</p> <p>12/9/12 at 4:05 P.M.: "Laying on floor next to bed...."</p> <p>A Progress Note, dated 12/10/12 and untimed, indicated, "...fall on 12/9/12. Res [resident] was noted laying on floor next to bed. Bed bolsters in place, alarm was sounding; nurse reported that bed was in low position [with] mat in place...Nurse reported that slow response time to alarm resulted in fall. Staff educated on proper response time...."</p> <p>A Minimum Data Set [MDS] assessment, dated 1/7/13, indicated Resident scored a 2 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated Resident D required extensive assistance of two+ staff for bed mobility and transfer, and extensive assistance of one person physical assist for locomotion on and off of the unit. A test for balance during</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 03/05/2013
--	---	--	---

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>transitions and walking indicated, "Not steady, only able to stabilize with staff assistance." The MDS assessment indicated the resident had fallen 2 times since the prior assessment.</p> <p>A Progress Note, dated 1/14/13 and untimed, indicated, "...resident had a fall on 1-13-13 alarm was sounding, resident found face down on floor mat next to bed. Intervention is to educate staff on proper placement of bolsters."</p> <p>1/21/13 at 5:45 P.M.: "Resident lying on floor mat next to his bed on his right side. CNA kneeling next to him...."</p> <p>A Physician Communication Note, dated 1/29/13 at 6:00 P.M., indicated: "...Res. [resident] fell forward out of his w/c [wheelchair], hitting his face on the floor. Has a laceration on the [left] brow. Sent to ER for [evaluation and treatment]."</p> <p>Nurses notes continued:</p> <p>1/29/13 at 10:55 P.M.: "Res. [resident] returned from hospital @ this time has 3 sutures on [left] brow. Will cont. [continue] to monitor."</p> <p>A Progress Note, dated 1/30/13 and untimed, indicated: "DCR review R/T [related to] resident had a witnessed fall</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 03/05/2013	
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>on 1-29-13 [with] a bruise and abrasion to his left eye was sent to ER for treatment...intervention is to ensure resident is in upright position before pushing resident in wheelchair."</p> <p>Nurses notes continued:</p> <p>2/2/13 at 6:00 P.M.: "We heard resident scream 'Hey, Hey' loudly. I looked in the direction of the voice and noticed resident lying on his right side at an angle to the wall. He was not able to explain how he fell. His wheelchair was by his side."</p> <p>On 3/5/13 at 9:55 A.M. and 11:00 A.M., Resident D was observed sitting in the activity room, in a wheelchair, asleep.</p> <p>On 3/5/13 at 2:20 P.M., during interview with the Director of Nursing [DON], he indicated he had only been at the facility for 2 weeks. The DON indicated he had no further documentation regarding Resident D's falls; whether alarms were sounding or not, and how the resident fell out of his wheelchair on 1/29/13. The DON indicated he was told that Resident D usually kept his legs elevated when being transferred in his wheelchair, but put them down on 1/29/13, which caused him to fall out of the wheelchair and hit his head.</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 03/05/2013
--	---	--	---

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
	This federal tag relates to Complaint IN00124920. 3.1-45(a)(1)			