NTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	155273	A. BUILDING	00	08/08/2012
		155275	B. WING		
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	Έ
CVDDES		BILITATION CENTER		/IEDWELL DR JURGH, IN 47630	
	-				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	
TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPE DEFICIENCY)	
=0000	REGELITORIO	RESC IDENTIFY THAT IN ORMATION)	1110		DATE
	This visit was f	or the Investigation of	F0000	F 000	
	Complaint IN00	-			
	1			This Plan of Correction	
	Complaint IN00	0111981 Substantiated,		center's credible allegat	
	-	eficiencies related to the		compliance. Preparation	
		cited at F157, F281, F282,		execution of this plan de constitute admission or	
	-	32, F441, and F514.		agreement by the provid	
	1509, 1515, 15	52, 1 ⁴ 41, and 1 ⁵ 14.		the truth of the facts alle	
	I Innalata di dafia			conclusions set forth in	•
		iency was cited.		statement of deficiencie	s. The
	Survey dates:			plan of correction is pre	-
	August 7 and 8,	2012		and/or executed solely lit is required by the prov	
	August / and o,	, 2012		of federal and state law.	
	Facility number				
	Provider number			Cypress Grove Reha	ab
				desires this Plan of	
	AIM number: 1	00290920		Correction to be	
	C			considered the facil	ity's
	Survey team:			Allegation of Compl	iance
	Anne Marie Cra	ays Kin		effective August 31,	2012.
	Comments			_	
	Census bed type	e.			
	SNF: 17				
	SNF/NF: 68				
	Total: 85				
	Conque novor t	100			
	Census payor ty Medicare: 8	/pe.			
	Medicaid: 54				
	Other: 23				
	Total: 85				
	Sample: 7				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 08/31/2012

FORM APPROVED

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	(X2) MULTIPLE C A. BUILDING B. WING	00 COM 08/0) DATE SURVEY COMPLETED 08/08/2012	
	PROVIDER OR SUPPLIEI	LITATION CENTER	4255 N	ADDRESS, CITY, STATE, ZIP MEDWELL DR SURGH, IN 47630	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	findings cited in 16.2.	es also reflects state accordance with 410 IAC completed 8/14/12 r RN					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	~ <i>`</i>	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155273	A. BUILDING B. WING	08/08/2012		
	PROVIDER OR SUPPLIE	R BILITATION CENTER	4255	T ADDRESS, CITY, STATE, ZIP CODI MEDWELL DR BURGH, IN 47630	Ε	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETI	
F0157 SS=D	A facility must in resident; consul- physician; and if legal representa member when th the resident whi- the potential for intervention; a s resident's physic status (i.e., a de or psychosocial threatening cond complications); a significantly (i.e. existing form of consequences, of treatment); or discharge the re specified in §483 The facility must resident and, if k representative of when there is a roommate assig §483.15(e)(2); of under Federal of specified in para The facility must update the addre the resident's lea- interested family Based on interve facility failed to notified of a resident of the resident and the the specified in para	NE/ROOM, ETC) mediately inform the with the resident's known, notify the resident's tive or an interested family here is an accident involving ch results in injury and has requiring physician gnificant change in the cal, mental, or psychosocial terioration in health, mental, status in either life ditions or clinical a need to alter treatment , a need to discontinue an treatment due to adverse or to commence a new form a decision to transfer or sident from the facility as 3.12(a). also promptly notify the snown, the resident's legal r interested family member change in room or nment as specified in r a change in resident rights r State law or regulations as igraph (b)(1) of this section. record and periodically ess and phone number of gal representative or member. iew and record review, the o ensure a physician was ident's elevated accu gar reading, for 1 of 4	F0157	F 157 SS = D Resident B was assessed signs and symptoms of hyperglycemia, none note		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOD MEDICADE & MEDICAD SEDVICES

	R MEDICARE & MEDIC			ONSTRUCTION	OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155273	B. WING		08/08/2012
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				IEDWELL DR	
CYPRE	SS GROVE REHAB	ILITATION CENTER	NEWB	URGH, IN 47630	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	_{DN} (X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DATE
	notification, in a	a sample of 7. Resident B		Review of MD orders for Hyperglycemic protocol to	ensure
	Findings include	e:		accuracy. MD was notified responded on 7/5/12, no no orders received.	l,
	1. The clinical r	ecord of Resident B was			
		/12 at 11:25 A.M.		DON/ Designee to complet	ie a
		ded, but were not limited		100% review of residents'	46
	to, diabetes mel			medical records to identify residents having physician	
				for accu checks and to ens	
	A Physician's or	der, initially dated		physician notification for th	
		ned on the July 2012		residents with accu checks	
		blood sugar results outside of diabetic protocol parameters.			
		dtimeNovolog Flexpen		Those residents identified	
		.before meals $101-150 = 1$		assessed and physician ar	nd
		4 units, 201-250 = 6		responsible party will be no	otified.
	,	= 10 units, 301-350 = 15		The ETD / Designee will pr	ovido
		= 20 units, > [greater than]		re-education to licensed	ovide
	400 = 20 units a			personnel regarding Diabe	tic P &
		00 = 10 units"		P to include facility protoco	
	bedtime	00 10 units		Physician Notification of Cl	nanges
	Nursing progras	s notes included the		P & P. Utilizing the SBAR physician communication t	ool the
	following notati			licensed nurse will be resp	
	10110willg 110tati	ons.		to notify the physician and	
	7/2/12 -+ 0.00 B	\mathbf{M} , $\ \mathbf{A} $ as $[abac^{1}-1] = f 479$		responsible party of identifi	ied
		.M.: "Acc [check] of 478.		changes in condition.	
	•	ice cream, cookies, and		DON/Designee will conduct	ta
		her with sliding scale.		diabetic audit across all 3 s	
	SBAR [Situatio	-		days per week, times 14 da	-
	Assessment, Re	quest] sent to MD."		then 3 days per week for 3	-
				then weekly for 30 days; th	
	A SBAR Physician communication note,			monthly thereafter for 3 mc Results of audits will be rev	
		ated 7/3/12, indicated, "Situationacc		by the Quality Assurance	
		at 2000 [8:00 P.M.]. Has		committee	
	been eating ice	cream, cookies and			
	snacks. Covered	l her with sliding scale.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RJMF11

If continuation sheet

Page 4 of 33

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 155273	A. BUILD B. WING			(X3) DATE SURVEY COMPLETED 08/08/2012	
	PROVIDER OR SUPPLIEF	RILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
	indicated it was P.M., and was "s eClinicalWorks" A Nursing progr	at 7/5/12 at 9:03 A.M. ress note, dated 7/5/12 and ed, "Doctor aware of					
	Nursing [DON] she indicated nu report when con the nurse can als DON indicated s who was workin usually did conta resident's blood	h] diet" w with the Director of on 8/8/12 at 11:50 A.M., rses utilize the SBAR tacting the physician, but so call the physician. The she spoke to the nurse og on 7/3/12, and she act the physician when the sugar was elevated, but member if she did on that					
	consultant provi policy on "Notif Change in Cond The policy inclu Physician and fa representative at time, during wal	the earliest possible king hours, if there is a nge in condition (unless					
	This federal tag	relates to Complaint					

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	(X2) MULTIPLE CC A. BUILDING B. WING	00	COI	(X3) DATE SURVEY COMPLETED 08/08/2012	
	PROVIDER OR SUPPLIE	R ILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
	IN00111981. 3.1-5(a)(1)						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(-)	(X3) DATE SURVEY COMPLETED 08/08/2012	
AND I LAN	OF CORRECTION	155273	A. BUILDIN B. WING	G <u>00</u>			
	PROVIDER OR SUPPLIE		42	REET ADDRESS, CITY, STATE 255 MEDWELL DR	E, ZIP CODE		
		ILITATION CENTER	IN	EWBURGH, IN 47630			
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	II PRE	FIX (EACH CORRECTIVE A CROSS-REFERENCED 1	TO THE APPROPRIATE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TA	AG DEFICIE	ENCY)	DATE	
F0164 SS=B	 483.10(e), 483.7 PERSONAL PRIOF RECORDS The resident has privacy and configure personal and cline Personal privacy medical treatment communications meetings of familithis does not record private room for Except as provide this section, the refuse the release records to any in The resident's rigon personal and cline when the resident required by law. The facility must information contarecords, regardle methods, except transfer to anoth law; third party personal and cline withing the facility failed to information, incommetion, incommetion administration records. 	5(I)(4) VACY/CONFIDENTIALITY the right to personal identiality of his or her nical records. r includes accommodations, nt, written and telephone , personal care, visits, and ly and resident groups, but juire the facility to provide a	F0164	F 164 SS = B LPN #1 and LPN re-educated rega Confidentiality P & P. Medicatio Records were as	arding Privacy/ on Administration	08/31/201	
	Findings includ	e:		proper closure.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAR CERVIC

TERS FOI	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLE	
		155273	A. BUILDING			
			B. WING	ADDRESS, CITY, STATE, ZIP CODI		
NAME OF I	PROVIDER OR SUPPLIE	R		MEDWELL DR	<u>تا</u>	
CYPRES	S GROVE REHAE	SILITATION CENTER		BURGH, IN 47630		
X4) ID			ID			(X5)
		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	(A3) COMPLETION
TAG			TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
	REGULATORY OF On 8/7/12 at 9:4 medication pass observed on the The Medication [MAR] was on open to a reside medications. The approximately 5 On 8/7/12 at 12 medication pass needed to retrie dining room to medications. LH book open to a medications on while retrieving approximately 5 On 8/8/12 at 8:2 was observed uf Suites hallway. left open to a re medications. A observed on top	A LSC IDENTIFYING INFORMATION) 40 A.M., during a 5, a medication cart was 6 E hallway, unattended. 6 Administration Record the top of the cart, and 6 the top of the cart, and 7 the top of the cart, and 7 the cart was unattended for 7 minutes. 200 P.M., during a 6, LPN # 1 indicated she ve a resident from the administer her PN # 1 left her medication resident's name and top of the medication cart 9 the resident, which took 5 minutes. 25 A.M., a medication cart nattended on the Garden A medication book was sident's name and shift report sheet was also o of the medication cart,		CROSS-REFERENCED TO THE APPR DEFICIENCY) DON /Designee conducte through of facility to identi Medication Administration Records open on top of th Medication Cart allowing resident's personal/private information to been seen. were found. The ETD/ Designee will pi re-education of facility sta regarding the policy and procedure regarding Pers Privacy / Confidentiality of Records. DON/Designee to conduct observation rounds across shifts to ensure properly of Medication Administration Records 5 times weekly for weeks, then a random observation will be conduct times weekly for 4 weeks, weekly thereafter for 3 mo Results of audits will be re by the Quality Assurance committee.	opriate d walk fy any ne e None rovide ff onal f t s all 3 closed or 8 cted 3 then onths.	
		resident names personal				
		ion. LPN # 2 was observed				
		bom for approximately 10				
		2 was then observed to				
		ent's medications, and then				
	-	n to check the resident's				
	-	LPN # 2 left the MAR				
-		e, and left the shift report		1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RJMF11

Facility ID: 000173

If continuation sheet Page 8 of 33

NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	A. BUI	LDING IG	00	- 08/	te survey Mpleted 08/2012
			4255 M	EDWELL DR	ODE	
(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETIO DATE
information liste of the cart. On 8/8/12 at 2:0 with the Directo DON indicated to they should keep	ed, unattended on the top 00 P.M., during interview or of Nursing [DON], the the nursing staff are aware p the MAR books closed					
	OF CORRECTION PROVIDER OR SUPPLIED SS GROVE REHAB SUMMARY S (EACH DEFICIEN REGULATORY OF sheet, with name information listed of the cart. On 8/8/12 at 2:0 with the Directo DON indicated they should keep while unattende	OF CORRECTION IDENTIFICATION NUMBER: 155273 PROVIDER OR SUPPLIER SS GROVE REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) sheet, with names of residents and health information listed, unattended on the top of the cart. On 8/8/12 at 2:00 P.M., during interview with the Director of Nursing [DON], the DON indicated the nursing staff are aware they should keep the MAR books closed while unattended.	OF CORRECTION IDENTIFICATION NUMBER: 155273 A. BUI B. WIN PROVIDER OR SUPPLIER SS GROVE REHABILITATION CENTER SS GROVE REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) sheet, with names of residents and health information listed, unattended on the top of the cart. On 8/8/12 at 2:00 P.M., during interview with the Director of Nursing [DON], the DON indicated the nursing staff are aware they should keep the MAR books closed while unattended.	OF CORRECTION IDENTIFICATION NUMBER: 155273 A. BUILDING B. WING PROVIDER OR SUPPLIER STREET / 4255 M NEWBU SS GROVE REHABILITATION CENTER STREET / 4255 M NEWBU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG sheet, with names of residents and health information listed, unattended on the top of the cart. TAG On 8/8/12 at 2:00 P.M., during interview with the Director of Nursing [DON], the DON indicated the nursing staff are aware they should keep the MAR books closed while unattended. Id	OF CORRECTION IDENTIFICATION NUMBER: 155273 A. BUILDING B. WING 00 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP C 4255 MEDWELL DR NEWBURGH, IN 47630 SS GROVE REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF COR (EACH ORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) sheet, with names of residents and health information listed, unattended on the top of the cart. TAG PROVIDER SPLAN OF COR (EACH ORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) Sheet, with names of residents and health information listed, unattended on the top of the cart. TAG PROVIDER SPLAN OF COR (EACH ORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) On 8/8/12 at 2:00 P.M., during interview with the Director of Nursing [DON], the DON indicated the nursing staff are aware they should keep the MAR books closed while unattended. ID	OF CORRECTION IDENTIFICATION NUMBER: 155273 A. BUILDING B. WING 00 COM 08// 08// 08// 200 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) sheet, with names of residents and health information listed, unattended on the top of the cart. ID PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Sheet, with names of residents and health information listed, unattended on the top of the cart. ID PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ON 8/8/12 at 2:00 P.M., during interview with the Director of Nursing [DON], the DON indicated the nursing staff are aware they should keep the MAR books closed while unattended. I

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/08/2012
	PROVIDER OR SUPPLI	BR BILITATION CENTER		4255 M	ADDRESS, CITY, STATE, ZIP CODE EDWELL DR JRGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL IR LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIC DATE
F0281 SS=D	483.20(k)(3)(i) SERVICES PRO PROFESSIONA The services pro facility must me quality. Based on observices of the resident was in administration 1 of 2 residents inhalers, in a satisfication of the resident service of the resident On 8/7/12 at 9: medication pass to give Resident The resident in immediately aff gave the resident the did not instruct properly use the mouth after the On 8/7/12 at 2: of Resident F worders, dated 4/ August 2012 of the resident for the	DVIDED MEET AL STANDARDS by ded or arranged by the et professional standards of vation, interview, and the facility failed to ensure nstructed on the proper technique for inhalers, for reviewed receiving umple of 7. Resident F le: 40 A.M., during a s, LPN # 1 was observed tt F her Spiriva inhaler. haled 2 puffs, one ter the other. LPN # 1 then nt her Advair inhaler, and k 2 puffs of that. LPN # 1 the resident on how to e inhaler, or to rinse her	F028		F 281 SS = D Resident F was assessed for side effects related to the improper administration of inhalers. None were noted LF #1 was re-educated on prope technique and instruction regarding the proper administration of inhalers to residents. A 100% medical record review conducted to identify those residents receiving inhalers po physician orders. Physician orders of those resident's identified will be reviewed for appropriate instruction regard proper use and corrected as indicated. The ETD / Designee will provi re-education to licensed staff include return demonstration f Licensed personnel on "How f Use an Inhaler" as indicated in the Lippincott Manual of Nurs Practice Handbook.	any PN r v er ing de to to n
	use."	outh 3 times after each t Manual of Nursing			DON / Designee will conduct Medication Pass Observation rounds across all 3 shifts on a random 25% to ensure proper	l l

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	00	· · ·	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155273	A. BUILDING B. WING		COMPLETED 08/08/2012	
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP	CODE	
CYPRES	SS GROVE REHAI	BILITATION CENTER		MEDWELL DR BURGH, IN 47630		
(X4) ID	-	STATEMENT OF DEFICIENCIES	ID	1		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S	HOULD BE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
	Practice Handb	ook," third edition,		administration of inhal	ers. The	
	indicated, "How			observation will be con		
	· · · · ·	e out through your		times a week for 2 we		
		starting to inhale through		times a week for 4 we weekly thereafter for 3		
		th, press down firmly on		Results of audits will b		
		anisterContinue to inhale		by the Quality Assurar	nce	
	1	ids to obtain a full breath,		Committee.		
		your breath for 5 to 10				
		at least 30 seconds before				
		next inhalation if more than				
	one is prescribe					
	dated 2010, ind HandihalerPa patient to take steps:Exhale mouthpiece int Then breathe in rate fast enough until lungs are long as comfor device out of m back in mouth dose"	Spectrum Drug Handbook," licated, "Spiriva ttient TeachingTeach prescribed dose in these completely before placing to mouth with head upright. In slowly and deeply at a in to hear capsule vibrate, full. Holding breath as table, take HandiHaler nouth. Then place device and inhale again to get full g relates to Complaint				
	3.1-35(g)(1)					

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	te survey Apleted 08/2012
	ROVIDER OR SUPPLIE	R ILITATION CENTER	STREE 4255 NEW	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FUL		ID PREFIX TAG	PROVIDER'S PLAN OF COB PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		(X5) COMPLETIO DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN C	Γ OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		X3) DATE SURVEY
NAME OF PI	JI CORRECTION	IDERTIFICATION NOMBER.			COMPLETED
		155273	A. BUILDING	00	08/08/2012
		155275	B. WING		00/00/2012
CYPRES	ROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE	
CYPRES					
	S GROVE REHAB	ILITATION CENTER	NEWB	URGH, IN 47630	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
:0282 SS=D	CARE PLAN	QUALIFIED PERSONS/PER			
		vided or arranged by the			
		rovided by qualified dance with each resident's			
	written plan of ca				
	•	iew and record review, the	F0282	F 282	08/31/2012
		ensure Lidocaine		SS = D	
	•	medication] was applied			
		y to the neck and base of		Resident 7 no longer resides at	:
		ered by the physician, for 1		Cypress Grove Rehabilitation Center.	
		viewed for following			
		a sample of 7. Resident C		A 100% medical record review	
	plans of care, in	a sample of 7. Resident C		conducted to identify those	
	Findings include	2 .		residents receiving physician orders for ointment to be applie for pain control and Medication	
	The closed clini	cal record of Resident C		Administration Records for	
	was reviewed or	n 8/7/12 at 3:30 P.M.		accuracy of transcription of	
		ded, but were not limited		physician orders. Any identified inaccuracies of transcription with	
	-	raine headache and		be corrected immediately with	111
	meningitis.			physician and responsible party	<i>y</i>
	meningitis.			notification.	
	A hospital trans	fer sheet, dated 7/19/12,			
	•	tinue these medications		ETD/Designee will provide re-education to licensed staff	
		T CHANGEDLidocaine		regarding Medication	
				Administration to include follow	ing
		ointment used for		physician orders and proper	
	-	ches], Apply topically 3		transcription of physician orders	s.
	times daily"			DON / Designee will conduct	
				Medication Pass Observation	
	•	on orders, dated 7/19/12,		rounds across all 3 shifts on a	
		caine 5% ointment apply		random 25% to ensure proper	
	topically 3x day	."		administration of ointments	
				ordered for pain. The observation will be conducted 5 times a week	
	Nursing progres	s notes, dated 7/23/12 at		for 2 weeks, then 3 times week	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155273 08/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4255 MEDWELL DR CYPRESS GROVE REHABILITATION CENTER NEWBURGH. IN 47630 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG for 4 weeks, then weekly 8:00 A.M., indicated, "Pt. [patient] had a thereafter for 3 months. phone call from a male et [and] he DON/Designee will conduct an requested that pt. 'has an order for a audit of the Medication Lidocaine topical cream et she has not Administration Record for been getting it! That is a doctor's order et accuracy of physician order transcription 5 times a week for 2 I have been dealing [with] the doctors weeks, then 3 times weekly for 4 asking why she isn't getting it...Upon weeks, then weekly for 3 months. researching the medications, it was discovered that the medication that pt's husband claimed she wasn't getting was a PRN [as needed] " The resident's Medication Administration Record [MAR], dated July 2012, indicated the Lidocaine was to be administered every shift PRN. The MAR indicated the resident did not receive the ointment from 7/19 until 7/22. The MAR indicated the resident refused the ointment 6 times from 7/22 through 7/26. On 8/8/12 at 11:15 A.M., during interview with the Director of Nursing [DON], she indicated the resident should have been receiving the Lidocaine ointment three times a day routinely. The DON indicated she was unaware of how or why the "PRN' was added to the MAR. This federal tag relates to Complaint IN00111981. 3.1-35(g)(2)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RJMF11

Facility ID: 000173

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	Γ OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	CON	te survey Mpleted 08/2012
	ROVIDER OR SUPPLIE	R ILITATION CENTER	4255 M	ADDRESS, CITY, STATE, ZIP C IEDWELL DR URGH, IN 47630	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
	-99) Previous Versions O	bsolete Event ID: R	JMF11 Facility	ID: 000173 If con	itinuation sheet	Page 15 of 33

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 155273 08/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4255 MEDWELL DR CYPRESS GROVE REHABILITATION CENTER NEWBURGH. IN 47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG F0309 483.25 PROVIDE CARE/SERVICES FOR SS=D 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. F0309 08/31/2012 Based on interview and record review, the F 309 SS = D facility failed to ensure a resident who complained of pain was treated for pain, for 1 of 3 residents reviewed for pain Resident C no longer resides at control, in a sample of 7. Resident C Cypress Grove Rehabilitation Center. Findings include: A 100% medial record review conducted to identify those The closed clinical record of Resident C residents receiving pain was reviewed on 8/7/12 at 3:30 P.M. management and complained of pain to ensure availability of pain Diagnoses included, but were not limited medication and that pain to, chronic migraine headache and medication is being administered meningitis. as ordered per physician. A pain assessment will be completed for those residents identified to A Nursing Comprehensive Admission ensure appropriate pain relief. assessment, dated 7/19/12 at 3:30 P.M., indicated, "...Alert [and] orient. x 3...Pain ETD/Designee will provide present now: Yes, Pain present in the past re-education to licensed staff regarding Pain Management P & several months: Yes " P, and Medication Administration P & P. A Pain Data Collection and Assessment, dated 7/19/12 and untimed, indicated, DON / Designee will conduct an 50% random audit on residents "...1. On a scale of 0-10, with 0 being 'no receiving pain management to pain' and 10 being the 'most intense pain ensure availability of pain imaginable,' what would you rate the medication per physician orders, severity or intensity of your pain right and proper administration of pain

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RJMF11

MF11 Facility

Facility ID: 000173

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	COM	e survey pleted 8/2012
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP (CODE	
CYPRE	SS GROVE REHAE	BILITATION CENTER		MEDWELL DR BURGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
IAG	now? 1. Verbal Number: 8Ov precipitates/exa everythingAs important is it t their pain?': Ex- interventions re (Pharmalogical Non-pharmacol blank]Identify pain over the pa [lower back]F Pain intensity: O Frequency: Alm intensity: Curre	Numeric Pain Scale ver the past five days, what accerbates pain: k the resident 'How o completely eliminate tremely importantWhat elieve the pain and logical): [Left y type and frequency of ast 5 days: Type: Site A Frequency: Frequently, Current 10Site B [head], nost constantly, Pain ent 8"		medication to resident complaints of pain. Au conducted across all 3 times a week for 2 wee times weekly for 4 wee weekly for 3 months.	udit will be 3 shifts 5 eks, then 3	DATE
	[resident] [alert person, to place [complains of] office call [sic] answering serve closedorder re 650 mg q [ever needed] pain, M administration re	head ache. [Physician] will leave message [with] ice, Dr. office eceived for Tyl [Tylenol] y] 4 [hours] PRN [as IAR [medication record] [updated]"				
	clinical record r receiving pain r P.M. on 7/19/12	ocumentation in the regarding the resident nedication until after 7:00 2. n Administration Record				

	R MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273		LDING	NSTRUCTION 00	CON	te survey Mpleted 08/2012
NAME OF	PROVIDER OR SUPPLIE		-		DDRESS, CITY, STATE, ZIP C	CODE	
CYPRE	SS GROVE REHAB	ILITATION CENTER			EDWELL DR IRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
	[MAR] indicated receive pain med On 8/8/12 at 3:0 consultant indica probably gave th obtained the ord document it.	d the resident did not dication on 7/19/12. 0 P.M., the nurse ated she thought the nurse ne Tylenol when she er, but just did not relates to Complaint					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì.	ULTIPLE C	ONSTRUCTION 00	(X3) DATE COMPI	SURVEY LETED
		155273	A. BUI B. WIN			08/08	/2012
			D . 111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		4255 N	IEDWELL DR		
CYPRES	SS GROVE REHAE	ILITATION CENTER		NEWB	URGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
TAG	-	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315 SS=D	483.25(d) NO CATHETER BLADDER Based on the re- assessment, the resident who enti- indwelling cathet the resident's cli that catheterizat resident who is i receives approp- to prevent urinar restore as much possible. Based on obser- record review, t a catheter was co of 4 residents re- infections, in a Findings includ 1. On 8/7/12 at was observed w hallway. A fole- observed hangin wheelchair, and dragging uncon 1 was alerted at indicated the fo changed earlier On 8/7/12 at 1:3 with LPN # 3, s had been notified had been placed	, PREVENT UTI, RESTORE sident's comprehensive facility must ensure that a ter is not catheterized unless incal condition demonstrates on was necessary; and a noontinent of bladder riate treatment and services y tract infections and to normal bladder function as vation, interview, and he facility failed to ensure onnected properly, for 1 eviewed with potential sample of 7. Resident D heeling himself down the y catheter bag was ng on the back of the tubing was observed nected on the floor. RN # that time. RN # 1 ley catheter had been that day. 30 P.M., during interview he indicated the physician ed, a new foley catheter l, and the physician did not	F03		F 315 SS = D Resident D was immediated assessed, and assisted with changing of clothing via RN MD notified and orders rece to change Foley catheter and drainage bag system. MD want a urinalysis done at the time. A 100% medical record rev identify those residents with indwelling Foley catheter. Residents identified were assessed for proper closed drainage system. ETD/ Designee will provide re-education to nursing staff regarding Bowel and Bladd P&P to include proper Fole catheter closed drainage sy DON/Designee will conduct	f f er y t t f f f f f f f f f f f f f f f f f	08/31/201
	want a urinalysi	s done at that time.			observation rounds on thos	е	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 00 COMPLETED . BUILDING 155273 08/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4255 MEDWELL DR CYPRESS GROVE REHABILITATION CENTER NEWBURGH. IN 47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG residents with Foley catheters to ensure proper closed drainage The clinical record of Resident D was system. Observation rounds will reviewed on 8/7/12 at 3:10 P.M. A be conducted across all 3 shifts 5 Minimum Data Set [MDS] assessment, times a week for 2 weeks, then 3 dated 7/26/12, indicated the resident's times weekly for 4 weeks. then weekly for 3 months. Nursing BIMS [Brief Interview for Mental Status] staff will conduct observation was 11, with 15 indicating no memory rounds on those residents with impairment. The MDS assessment Foley catheters to ensure proper closed drainage system 5 times a indicated the resident required extensive week 2 times per shift for 2 assistance of two+ staff for transfer, and weeks, then 3 times a week 1 extensive assistance of one staff for time per shift thereafter for 3 dressing and toilet use. months A "Catheter Plan of Care," dated 5/1/12, indicated a problem of "...Urinary Retention...Urethral catheter." The Interventions included: "Maintain closed drainage system ... " The record indicated the resident had been started on an antibiotic on 7/21/12for 7 days for a urinary tract infection. Nursing progress notes included the following notations: 8/7/12 at 12:00 P.M.: "Resident's catheter was noticed to be disconnected from his cath bag. Resident brought back to his room to await Dr.'s response to replace. In the mean time, resident assessed et [and] stated he had no pain anywhere. Resident had urine on himself, soaked into his sweat pants." RJMF11 Facility ID: 000173 If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	(X2) MULTIPLE C A. BUILDING B. WING	00		te survey Mpleted 08/2012
	PROVIDER OR SUPPLIEF	RILITATION CENTER	4255 N	ADDRESS, CITY, STATE, ZIP IEDWELL DR URGH, IN 47630	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	indicated she ha his wheelchair a A.M. that morni room watching t A.M. RN # 1 ind the resident was "really didn't kn was disconnecte back to his room did not know ho been disconnect On 8/8/12 at 11: interview with th she indicated sho resident's pants catheter was act the drainage bag been kinked.					

	T OF DEFICIENCIES DF CORRECTION	x1) provider/supplier/clia identification number: 155273	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	te survey Mpleted 08/2012
	ROVIDER OR SUPPLIE S GROVE REHAB	R ILITATION CENTER	4255	et address, city, state, zip MEDWELL DR 'BURGH, IN 47630	, CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	(A2) MULTIPLE C		COMPLETED
AND FLAN	OF CORRECTION	155273	A. BUILDING	00	08/08/2012
		135275	B. WING		00/00/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
0.00000					
CYPRES	S GROVE REHAB	ILITATION CENTER	NEWE	BURGH, IN 47630	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0332	483.25(m)(1)				
SS=D	OF 5% OR MOF	CATION ERROR RATES			
		ensure that it is free of			
		rates of five percent or			
	greater.				
	•	vation, interview and	F0332	F 332	08/31/2012
		he facility failed to ensure		SS = D	
		edication error rates of			
		greater, for 2 of 10			
				Resident F and Resident E w	
		red during medication		assessed for side effects rela	
		in that 6 errors were made		to the inaccurate administration their medication. MD and far	
		unities for error, resulting		were notified of occurrence.	illiy
		of 14 percent. (Residents F			
	and E)			A 100% audit of Medication	
				Administration Record to ens	ure
	Findings includ	e:		appropriate medication	
				administration as indicated v	a
	1. On 8/7/12 at	9:40 A.M., LPN # 1		licensed personnel initials. Residents identified were	
		as going to administer		assessed for side effects rela	ated
		nedications. LPN # 1		to the inaccurate / absence of	
		e resident oral medications		medication administration. M	1D
				and family were notified of	
	-	isone and Calcium. LPN #		occurrence	
	-	ent her Spiriva inhaler,		ETD/Designee will provide	
	and the resident	-		re-education regarding	
		er the other. The resident		Medication Administration	
	then took her A	dvair inhaler, and gave			
	herself 2 puffs of	of that medication.		DON/Designee will conduct	
				medication pass observation	
	On 8/7/12 at 10	:10 A.M., MDS		licensed personnel to ensure	
		Set] Coordinator # 1		proper procedure and administration of resident's	
	-	ent F's unit ate breakfast at		medication as ordered per	
	7:45 A.M.			physician. A 25% random	
	/.TJ / 1.1VI.			medication pass observation	will
	$Om \frac{9}{7} \frac{1}{12} = 1$	5 D.M. I.DNI # 4		be conducted on licensed	
	$0^{11} 0^{1} 0^{1} 1^{12}$ at 1:2	5 P.M., LPN # 4		personnel, across all three sl	nifts

Event ID: RJMF11 Facility ID: 000173

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) I	MULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155273	A. BU B. WI	VILDING NG	00		ipleted 08/2012
NAME OF	PROVIDER OR SUPPLIE	ER	_		ADDRESS, CITY, STATE, ZIP COL	DE	
CYPRE	SS GROVE REHA	BILITATION CENTER			1EDWELL DR URGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	indicated LPN	# 1 had left for the day.			to ensure each nurse sch		
					will be observed, 5 times for 2 weeks, then 3 times	•	
	The clinical rec	cord of Resident F was			for 4 weeks, then weekly	•	
	reviewed on 8/	7/12 at 2:40 P.M.			months.		
	Physician's ord	ers, initially dated 4/16/12					
	and on the curr	ent August 2012 orders,					
	indicated: "Adv	air 250-50 DiskusInhale					
	1 puff by mout	h every 12 hours - Rinse					
	mouth 3 times	after each use," "Spiriva 18					
	mcg -Handihal	erInhale 2 times per					
	capsule," "Ca	lcium 600 mg + Vitamin					
	D Take with fo	od/mealGive 1 tablet					
	orally bid," "Pr	ednisone 5 mg tablet, Take					
		Give 1 tablet orally once a					
		Inisone 2.5 mg tablet, Take					
		once a day." The physician					
		d the medications were to					
	be given at 8:00						
	On 8/8/12 at 2:	00 P.M., during interview					
	with the Direct	or of Nursing [DON], she					
	did not offer ad	ditional information					
	regarding the m	nedications being given					
	without food, a	nd the inhalers being given					
	incorrectly.						
	2. On 8/7/12 at	12:00 P.M., LPN # 1					
		esident E the following					
		opressor, Renvela, Requip,					
		ne resident was not					
		Aspirin or Norco.					
	On 8/7/12 at 1: of Resident E v	30 P.M., the clinical record					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 155273 08/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4255 MEDWELL DR CYPRESS GROVE REHABILITATION CENTER NEWBURGH. IN 47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG Physician orders, dated 3/4/12 and on the current August 2012 orders, indicated, "Aspirin 81 mg chew...Give 1 tablet orally once a day 1200 [12:00 P.M.]." Physician orders, dated 3/5/12 and on the current August 2012 orders, indicated, "Norco 7.5-325...Give 1 tablet orally 2 times a day for pain 1200, 2100 [9:00 P.M.]." The resident's Medication Administration Record [MAR], dated August 2012, was then reviewed. The MARs entries for both the Aspirin and Norco was not initialed as given on 8/7/12 at 12:00 P.M. On 8/7/12 at 1:45 P.M., during interview with LPN # 4, she indicated LPN # 1 had gone home, and prior to leaving had informed her she had given all of her medications 3. On 8/8/12 at 11:40 A.M., the nursing consultant provided the current facility policy on "Medication Administration, revised July 2010. The policy included: "...The licensed nurse and/or medication assistant will check the following to administer medication: Right medication, Right dose, Right dosage form, Right route, Right resident, Right time "

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RJMF11

Facility ID: 000173

If continuation sheet

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TERS FO	R MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-03
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	ISTRUCTION	(X3) DA	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	CO	MPLETED
		155273	B. WIN				08/2012
					DDRESS, CITY, STATE, ZII	P CODE	
NAME OF	PROVIDER OR SUPPLIE	R		4255 ME	DWELL DR		
CYPRES	SS GROVE REHAB	ILITATION CENTER			RGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	DATE
		relates to Complaint					
	IN00111981.	relates to complaint					
	1100111981.						
	2.1.25(1)(0)						
	3.1-25(b)(9)						

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 00		TE SURVEY MPLETED
		155273	A. BUILDING B. WING		08/	08/2012
NAME OF F	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZI	P CODE	
CYPRES	S GROVE REHAB	ILITATION CENTER		MEDWELL DR BURGH, IN 47630		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY)		DATE
F0441 SS=D	SPREAD, LINEN The facility must Infection Control provide a safe, s environment and development an and infection. (a) Infection Cor The facility must Control Program (1) Investigates, infections in the (2) Decides wha isolation, should resident; and (3) Maintains a r corrective action (b) Preventing S (1) When the Inf determines that prevent the spre must isolate the (2) The facility m a communicable lesions from dire their food, if dire disease. (3) The facility m their hands after for which hand v accepted profes (c) Linens Personnel must	establish and maintain an Program designed to anitary and comfortable it to help prevent the d transmission of disease attrol Program establish an Infection a under which it - controls, and prevents facility; t procedures, such as be applied to an individual ecord of incidents and s related to infections. pread of Infection ection Control Program a resident needs isolation to ad of infection, the facility resident. hust prohibit employees with o disease or infected skin ect contact with residents or ct contact will transmit the hust require staff to wash each direct resident contact washing is indicated by				
		vation and interview, the	F0441	F 441 SS = D		08/31/201

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155273 08/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4255 MEDWELL DR CYPRESS GROVE REHABILITATION CENTER NEWBURGH. IN 47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG medications were not placed on an unsanitary surface, the tank of a toilet, for Resident E assessed for adverse 1 of 7 residents reviewed for infection effects related to inappropriate control, in a sample of 7. Resident E infection control practice/procedure during administration of inhaler. None Findings include: were noted On 8/7/12 at 9:40 A.M., LPN # 1 was A !00% medical record review to observed during her medication pass to identify those residents having physician orders for inhalers. Resident E. Following the medication Those residents identified pass, LPN # 1 was observed to enter the received a respiratory resident's bathroom, place the 2 hand held assessment to ensure resident inhalers on the tank of the toilet, and was absent of respiratory infectious s/s. None were noted wash her hands. LPN#1 was re-educated On 8/8/12 at 2:00 P.M., during interview regarding Infection Control with the Director of Nursing, she Practices / Procedures and Medication Administration P & P, indicated staff should not place any including a medication pass medications on the tank of a toilet. observation conducted by Pharmacy Representative. ETD This federal tag relates to Complaint /Designee will provide re-education to all staff regarding IN00111981. infection control policy and procedure to include sanitary 3.1-18(b)(1)surface, appropriate practice and procedure. ETD /Designee will provide re-education to licensed personnel regarding Medication Administration P & P to include infection control practice / procedure during medication pass to residents. DON/Designee will conduct medication pass observation on licensed Facility ID: 000173

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(X4) ID PREFIX	ROVE REHABILITA SUMMARY STATE (EACH DEFICIENCY M	ATION CENTER EMENT OF DEFICIENCIES AUST BE PERCEDED BY FU IDENTIFYING INFORMAT	ULL	4255 N	F ADDRESS, CITY, STATE, ZIP CODE MEDWELL DR BURGH, IN 47630 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) personnel to ensure proper procedure and administration of resident's medication as ordered per physician, as well as appropriate infection control practice/procedure during administration of a resident's medication. A 25% random medication pass observation will be conducted on licensed personnel, across all three shifts to ensure each nurse schedule will be observed, 5 times weekly for 2 weeks,	
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TAG R	REGULATORY OR LSC	IDENTIFYING INFORMAT	FION)	TAG	personnel to ensure proper procedure and administration of resident's medication as ordered per physician, as well as appropriate infection control practice/procedure during administration of a resident's medication. A 25% random medication pass observation will be conducted on licensed personnel, across all three shifts to ensure each nurse schedule will be observed, 5 times weekly for 2 weeks,	
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					 conducted on licensed personnel, across all three shifts to ensure each nurse schedule will be observed, 5 times weekly for 2 weeks, 	
					shifts to ensure each nurseschedule will be observed,5 times weekly for 2 weeks,	
					schedule will be observed, 5 times weekly for 2 weeks,	
					5 times weekly for 2 weeks,	
					-	
					then 3 times weekly for 4	
					weeks, then weekly for 3	
					months.	

		X1) PROVIDER/SUPPLIER/CLIA	()	LE CONSTRUCTION	. ,	TE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155273	A. BUILDING	00		COMPLETED 08/08/2012	
		155275	B. WING		_	00/00/2012	
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, Z	IP CODE		
		ILITATION CENTER		55 MEDWELL DR WBURGH, IN 47630			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	J DEFICIENCE	. ,	DATE	
0514 SS=D	SSIBLE The facility must each resident in professional star are complete; ac readily accessibl organized. The clinical reco information to ide of the resident's care and service any preadmissio the State; and pr Based on interv facility failed to were accurate at resident's order for after supper, breakfast; and d medication adm incomplete, for for complete an in a sample of 7 Findings includ 1. The clinical r reviewed on 8/7 A Physician's or	iew and record review, the ensure clinical records and complete, in that a for Flomax was written but was given after ocumentation regarding inistration was 2 of 7 residents reviewed d accurate documentation, . Residents G and E	F0514	F 514 SS = D Resident E and resi assessed via RN fo effect related to the the documentation of Medication Adminis Record. Resident G ordered to be admir supper and the time computer printed as Resident E = Aspirit a day; no initials we the medication adm record for 8/1-8/4/12 was re-educated on Administration P & I rights. Physician ar party notification.	r any adverse inaccuracy of on the tration 5 = Flomax histered after was 5 0900. n 81mg once re present on hinistration 2. LPN #5 h Medication P to the 6	08/31/2012	
	•	Give 1 tablet orally once		A 100% review of re medical record to id			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155273 08/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4255 MEDWELL DR CYPRESS GROVE REHABILITATION CENTER NEWBURGH. IN 47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG Physician and responsible party notification for those resident's The resident's Medication Administration identified. New/clarification Record, dated August 2012, indicated the orders received as indicated, resident's medication was not initialed as medical record updated given on 8/1, 8/2, 8/3, and 8/4. ETD / Designee to provide re-education to licensed On 8/8/12 at 2:00 P.M., during interview personnel regarding Medication with the Director of Nursing, she Administration P & P to include the 6 right to medication pass, indicated she did not know why the and accurate documentation on medication was not initialed. the Medication Administration Record. 2. On 8/8/12 at 8:25 A.M., LPN # 5 was DON/Designee will conduct observed to administer Resident G medication pass observation on medications including Tamsulosin. licensed personnel to ensure proper procedure, accuracy of The clinical record of Resident G was documentation, and reviewed on 8/8/12 at 9:00 A.M. A administration of resident's medication as ordered per Physician's order, dated 7/3/12, indicated, physician, including the 6 rights. "Tamsulosin [Flomax] 0.4 mg one A 25% random medication pass capsule daily after supper (within 1/2 hr observation will be conducted on of meal) 1800 [6:00 P.M.]." licensed personnel across all three shifts to ensure each nurse schedule will be observed. 5 The current physician's order, signed times weekly for 2 weeks, then 3 8/1/12, indicated, "Tamsulosin...Take 1/2 times weekly for 4 weeks, then hr after same meal, Give 1 capsule orally weekly for 3 months. once a day after supper..." The time to be given indicated 9:00 A.M. The resident's Medication Administration Record was then reviewed, and indicated the medication was to be given after supper, although the time was listed as 9:00 A.M.

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	TERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155273			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 08/08/2012	
	PROVIDER OR SUPPLIEF	LITATION CENTER		4255 M	ADDRESS, CITY, STATE, ZIP EDWELL DR JRGH, IN 47630	CODE		
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	she indicated she was a discrepand medication was nurse was calling	50 A.M., during ne Director of Nursing, e did not know why there by regarding the times the to be given, but that the g the physician to clarify. relates to Complaint						

						PRIN	TED: 08/31/20	12	
DEPARTMENT	FORM APPROVED								
CENTERS FOR	OM	OMB NO. 0938-0391							
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 B. WING		00	COMPLETED			
		155273				08/08/2012			
NAME OF P	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR				
CYPRES	CYPRESS GROVE REHABILITATION CENTER				NEWBURGH, IN 47630				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)		
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