STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00111981. Complaint IN00111981 Substantiated, Federal/State deficiencies related to the allegations are cited at F157, F281, F282, F309, F315, F332, F441, and F514. Unrelated deficiency was cited. Survey dates: August 7 and 8, 2012 Facility number: 000173 Provider number: 155273 AIM number: 100290920 Survey team: Anne Marie Crays RN Census bed type: SNF: 17 SNF/NF: 68 Total: 85 Census payor type: Medicare: 8 Medicaid: 54 Other: 23 Total: 85 Sample: 7	F0000	**F 000** **This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **Cypress Grove Rehab desires this Plan of Correction to be considered the facility's Allegation of Compliance effective August 31, 2012.**	

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/14/12 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to ensure a physician was notified of a resident's elevated accu check blood sugar reading, for 1 of 4 residents reviewed for physician	F0157	**F 157** **SS = D** Resident B was assessed for signs and symptoms of hyperglycemia, none noted.	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notification, in a sample of 7. Resident B Findings include: 1. The clinical record of Resident B was reviewed on 8/7/12 at 11:25 A.M. Diagnoses included, but were not limited to, diabetes mellitus. A Physician's order, initially dated 1/14/12 and signed on the July 2012 orders, indicated: "Accucheck before meals and at bedtime...Novolog Flexpen Syringe: Inject...before meals 101-150 = 1 unit, 151-200 = 4 units, 201-250 = 6 units, 251-300 = 10 units, 301-350 = 15 units, 351-400 = 20 units, > [greater than] 400 = 20 units and call MD...at bedtime...351-400 = 10 units...." Nursing progress notes included the following notations: 7/3/12 at 8:00 P.M.: "Acc [check] of 478. Has been eating ice cream, cookies, and snacks. Covered her with sliding scale. SBAR [Situation, Background, Assessment, Request] sent to MD." A SBAR Physician communication note, dated 7/3/12, indicated, "...Situation...acc [check] of 478 at 2000 [8:00 P.M.]. Has been eating ice cream, cookies and snacks. Covered her with sliding scale.		Review of MD orders for Hyperglycemic protocol to ensure accuracy. MD was notified, responded on 7/5/12, no new orders received. DON/ Designee to complete a 100% review of residents' medical records to identify those residents having physician orders for accu checks and to ensure physician notification for those residents with accu checks of blood sugar results outside of diabetic protocol parameters. Those residents identified will be assessed and physician and responsible party will be notified. The ETD / Designee will provide re-education to licensed personnel regarding Diabetic P & P to include facility protocol and Physician Notification of Changes P & P. Utilizing the SBAR physician communication tool, the licensed nurse will be responsible to notify the physician and responsible party of identified changes in condition. DON/Designee will conduct a diabetic audit across all 3 shifts, 5 days per week, times 14 days; then 3 days per week for 30 days; then weekly for 30 days; then monthly thereafter for 3 months. Results of audits will be reviewed by the Quality Assurance committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Asymptomatic...." The document indicated it was faxed on 7/3/12 at 10:46 P.M., and was "sent through eClinicalWorks" at 7/5/12 at 9:03 A.M. A Nursing progress note, dated 7/5/12 and untimed, indicated, "Doctor aware of Blood Sugar elevation and non compliance [with] diet...." During interview with the Director of Nursing [DON] on 8/8/12 at 11:50 A.M., she indicated nurses utilize the SBAR report when contacting the physician, but the nurse can also call the physician. The DON indicated she spoke to the nurse who was working on 7/3/12, and she usually did contact the physician when the resident's blood sugar was elevated, but she could not remember if she did on that date. 2. On 8/8/12 at 11:45 A.M., the nursing consultant provided the current facility policy on "Notification of Resident Change in Condition," revised July 2011. The policy included: "...Notify the Physician and family or legal representative at the earliest possible time, during waking hours, if there is a non-critical change in condition (unless requested to do otherwise)...." This federal tag relates to Complaint			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	IN00111981. 3.1-5(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0164 SS=B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.			
	Based on observation and interview, the facility failed to ensure resident information, including medication administration records, were kept covered while unattended, on 2 of 2 units observed, in a sample of 3 units. Findings include:	F0164	**F 164** **SS = B** LPN #1 and LPN #2 were re-educated regarding Privacy/ Confidentiality P & P. Medication Administration Records were assessed for proper closure.	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/7/12 at 9:40 A.M., during a medication pass, a medication cart was observed on the E hallway, unattended. The Medication Administration Record [MAR] was on the top of the cart, and open to a resident's name and medications. The cart was unattended for approximately 5 minutes. On 8/7/12 at 12:00 P.M., during a medication pass, LPN # 1 indicated she needed to retrieve a resident from the dining room to administer her medications. LPN # 1 left her medication book open to a resident's name and medications on top of the medication cart while retrieving the resident, which took approximately 5 minutes. On 8/8/12 at 8:25 A.M., a medication cart was observed unattended on the Garden Suites hallway. A medication book was left open to a resident's name and medications. A shift report sheet was also observed on top of the medication cart, which included resident names personal health information. LPN # 2 was observed in a resident's room for approximately 10 minutes. LPN # 2 was then observed to draw up a resident's medications, and then go into the room to check the resident's blood pressure. LPN # 2 left the MAR open at that time, and left the shift report		DON /Designee conducted walk through of facility to identify any Medication Administration Records open on top of the Medication Cart allowing resident's personal/private information to been seen. None were found. The ETD/ Designee will provide re-education of facility staff regarding the policy and procedure regarding Personal Privacy / Confidentiality of Records. DON/Designee to conduct observation rounds across all 3 shifts to ensure properly closed Medication Administration Records 5 times weekly for 8 weeks, then a random observation will be conducted 3 times weekly for 4 weeks, then weekly thereafter for 3 months. Results of audits will be reviewed by the Quality Assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. 3.1-3(o)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.			
	Based on observation, interview, and record review, the facility failed to ensure a resident was instructed on the proper administration technique for inhalers, for 1 of 2 residents reviewed receiving inhalers, in a sample of 7. Resident F Findings include: On 8/7/12 at 9:40 A.M., during a medication pass, LPN # 1 was observed to give Resident F her Spiriva inhaler. The resident inhaled 2 puffs, one immediately after the other. LPN # 1 then gave the resident her Advair inhaler, and the resident took 2 puffs of that. LPN # 1 did not instruct the resident on how to properly use the inhaler, or to rinse her mouth after the inhaler. On 8/7/12 at 2:40 P.M., the clinical record of Resident F was reviewed. Physician orders, dated 4/16/12 and on the current August 2012 orders, indicated, "Advair diskus...Inhale 1 puff by mouth every 12 hours - rinse mouth 3 times after each use." The "Lippincott Manual of Nursing	F0281	**F 281** **SS = D** Resident F was assessed for any side effects related to the improper administration of inhalers. None were noted LPN #1 was re-educated on proper technique and instruction regarding the proper administration of inhalers to residents. A 100% medical record review conducted to identify those residents receiving inhalers per physician orders. Physician orders of those resident's identified will be reviewed for appropriate instruction regarding proper use and corrected as indicated. The ETD / Designee will provide re-education to licensed staff to include return demonstration to Licensed personnel on "How to Use an Inhaler" as indicated in the Lippincott Manual of Nursing Practice Handbook. DON / Designee will conduct Medication Pass Observation rounds across all 3 shifts on a random 25% to ensure proper	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Practice Handbook," third edition, indicated, "How to Use an Inhaler...Breathe out through your mouth...While starting to inhale through your open mouth, press down firmly on the top of the canister...Continue to inhale for 3 to 5 seconds to obtain a full breath, then try to hold your breath for 5 to 10 seconds...Wait at least 30 seconds before you take your next inhalation if more than one is prescribed." The "Nursing Spectrum Drug Handbook," dated 2010, indicated, "Spiriva Handihaler...Patient Teaching...Teach patient to take prescribed dose in these steps:...Exhale completely before placing mouthpiece into mouth with head upright. Then breathe in slowly and deeply at a rate fast enough to hear capsule vibrate, until lungs are full. Holding breath as long as comfortable, take HandiHaler device out of mouth. Then place device back in mouth and inhale again to get full dose...." This federal tag relates to Complaint IN00111981. 3.1-35(g)(1)		administration of inhalers. The observation will be conducted 5 times a week for 2 weeks, then 3 times a week for 4 weeks, then weekly thereafter for 3 months. Results of audits will be reviewed by the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on interview and record review, the facility failed to ensure Lidocaine ointment [a pain medication] was applied three times daily to the neck and base of the skull as ordered by the physician, for 1 of 4 residents reviewed for following plans of care, in a sample of 7. Resident C Findings include: The closed clinical record of Resident C was reviewed on 8/7/12 at 3:30 P.M. Diagnoses included, but were not limited to, Chronic migraine headache and meningitis. A hospital transfer sheet, dated 7/19/12, indicated: "Continue these medications which have NOT CHANGED...Lidocaine ointment [a pain ointment used for migraine headaches], Apply topically 3 times daily...." Facility admission orders, dated 7/19/12, indicated: "Lidocaine 5% ointment apply topically 3x day." Nursing progress notes, dated 7/23/12 at	F0282	**F 282** **SS = D** Resident 7 no longer resides at Cypress Grove Rehabilitation Center. A 100% medical record review conducted to identify those residents receiving physician orders for ointment to be applied for pain control and Medication Administration Records for accuracy of transcription of physician orders. Any identified inaccuracies of transcription will be corrected immediately with physician and responsible party notification. ETD/Designee will provide re-education to licensed staff regarding Medication Administration to include following physician orders and proper transcription of physician orders. DON / Designee will conduct Medication Pass Observation rounds across all 3 shifts on a random 25% to ensure proper administration of ointments ordered for pain. The observation will be conducted 5 times a week for 2 weeks, then 3 times weekly	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8:00 A.M., indicated, "Pt. [patient] had a phone call from a male et [and] he requested that pt. 'has an order for a Lidocaine topical cream et she has not been getting it! That is a doctor's order et I have been dealing [with] the doctors asking why she isn't getting it...Upon 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)		for 4 weeks, then weekly thereafter for 3 months. DON/Designee will conduct an audit of the Medication Administration Record for accuracy of physician order transcription 5 times a week for 2 weeks, then 3 times weekly for 4 weeks, then weekly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	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.			
	Based on interview and record review, the facility failed to ensure a resident who complained of pain was treated for pain, for 1 of 3 residents reviewed for pain control, in a sample of 7. Resident C Findings include: The closed clinical record of Resident C was reviewed on 8/7/12 at 3:30 P.M. Diagnoses included, but were not limited to, chronic migraine headache and meningitis. A Nursing Comprehensive Admission assessment, dated 7/19/12 at 3:30 P.M., indicated, "...Alert [and] orient. x 3...Pain present now: Yes, Pain present in the past several months: Yes...." A Pain Data Collection and Assessment, dated 7/19/12 and untimed, indicated, "...1. On a scale of 0-10, with 0 being 'no pain' and 10 being the 'most intense pain imaginable,' what would you rate the severity or intensity of your pain right	F0309	**F 309** **SS = D** Resident C no longer resides at Cypress Grove Rehabilitation Center. A 100% medial record review conducted to identify those residents receiving pain management and complained of pain to ensure availability of pain medication and that pain medication is being administered as ordered per physician. A pain assessment will be completed for those residents identified to ensure appropriate pain relief. ETD/Designee will provide re-education to licensed staff regarding Pain Management P & P, and Medication Administration P & P. DON / Designee will conduct an 50% random audit on residents receiving pain management to ensure availability of pain medication per physician orders, and proper administration of pain	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	now? 1. Verbal Numeric Pain Scale Number: 8...Over the past five days, what precipitates/exacerbates pain: everything...Ask the resident 'How important is it to completely eliminate their pain?': Extremely important...What interventions relieve the pain (Pharmalogical and Non-pharmacological): [Left blank]...Identify type and frequency of pain over the past 5 days: Type: Site A [lower back]...Frequency: Frequently, Pain intensity: Current 10...Site B [head], Frequency: Almost constantly, Pain intensity: Current 8...." Nursing progress notes, dated 7/19/12 and untimed, indicated, "Readmit...Resid. [resident] [alert and oriented] x 3 [to person, to place, to time]...C/O [complains of] head ache. [Physician] office call [sic] will leave message [with] answering service, Dr. office closed...order received for Tyl [Tylenol] 650 mg q [every] 4 [hours] PRN [as needed] pain, MAR [medication administration record] [updated]...." There was no documentation in the clinical record regarding the resident receiving pain medication until after 7:00 P.M. on 7/19/12. The Medication Administration Record		medication to residents voicing complaints of pain. Audit will be conducted across all 3 shifts 5 times a week for 2 weeks, then 3 times weekly for 4 weeks, then weekly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[MAR] indicated the resident did not receive pain medication on 7/19/12. On 8/8/12 at 3:00 P.M., the nurse consultant indicated she thought the nurse probably gave the Tylenol when she obtained the order, but just did not document it. This federal tag relates to Complaint IN00111981. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
	Based on observation, interview, and record review, the facility failed to ensure a catheter was connected properly, for 1 of 4 residents reviewed with potential infections, in a sample of 7. Resident D Findings include: 1. On 8/7/12 at 11:35 A.M., Resident D was observed wheeling himself down the hallway. A foley catheter bag was observed hanging on the back of the wheelchair, and tubing was observed dragging unconnected on the floor. RN # 1 was alerted at that time. RN # 1 indicated the foley catheter had been changed earlier that day. On 8/7/12 at 1:30 P.M., during interview with LPN # 3, she indicated the physician had been notified, a new foley catheter had been placed, and the physician did not want a urinalysis done at that time.	F0315	**F 315** **SS = D** Resident D was immediately assessed, and assisted with changing of clothing via RN # 1. MD notified and orders received to change Foley catheter and drainage bag system. MD did not want a urinalysis done at that time. A 100% medical record review to 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 Bladder P&P to include proper Foley catheter closed drainage system. DON/Designee will conduct observation rounds on those	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record of Resident D was reviewed on 8/7/12 at 3:10 P.M. A Minimum Data Set [MDS] assessment, dated 7/26/12, indicated the resident's BIMS [Brief Interview for Mental Status] was 11, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two+ staff for transfer, and extensive assistance of one staff for dressing and toilet use. 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 7/21/12 for 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."		residents with Foley catheters to ensure proper closed drainage system. Observation rounds will be conducted across all 3 shifts 5 times a week for 2 weeks, then 3 times weekly for 4 weeks, then weekly for 3 months. Nursing staff will conduct observation rounds on those residents with Foley catheters to ensure proper closed drainage system 5 times a week 2 times per shift for 2 weeks, then 3 times a week 1 time per shift thereafter for 3 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/7/12 at 3:25 P.M., CNA # 1 indicated she had gotten the resident up in his wheelchair at approximately 9:45 A.M. that morning, and he had been in his room watching tv until seen at 11:35 A.M. RN # 1 indicated at that time that the resident was slightly confused, and "really didn't know" that his foley catheter was disconnected when she took him back to his room. RN # 1 indicated she did not know how long the catheter had been disconnected. On 8/8/12 at 11:50 A.M., during interview with the Director of Nursing, she indicated she did not know why the resident's pants were wet, when the foley catheter was actually disconnected from the drainage bag, unless the catheter had been kinked. This federal tag relates to Complaint IN00111981. 3.1-41(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.			
	Based on observation, interview and record review, the facility failed to ensure it was free of medication error rates of five percent or greater, for 2 of 10 residents observed during medication administration, in that 6 errors were made out of 42 opportunities for error, resulting in an error rate of 14 percent. (Residents F and E) Findings include: 1. On 8/7/12 at 9:40 A.M., LPN # 1 indicated she was going to administer Resident F her medications. LPN # 1 administered the resident oral medications including Prednisone and Calcium. LPN # 1 gave the resident her Spiriva inhaler, and the resident took 2 puffs, 1 immediately after the other. The resident then took her Advair inhaler, and gave herself 2 puffs of that medication. On 8/7/12 at 10:10 A.M., MDS [Minimum Data Set] Coordinator # 1 indicated Resident F's unit ate breakfast at 7:45 A.M. On 8/7/12 at 1:45 P.M., LPN # 4	F0332	**F 332** **SS = D** Resident F and Resident E were assessed for side effects related to the inaccurate administration of their medication. MD and family were notified of occurrence. A 100% audit of Medication Administration Record to ensure appropriate medication administration as indicated via licensed personnel initials. Residents identified were assessed for side effects related to the inaccurate / absence of medication administration. MD and family were notified of occurrence ETD/Designee will provide re-education regarding Medication Administration DON/Designee will conduct medication pass observation on licensed personnel to ensure proper procedure and administration of resident's medication as ordered per physician. A 25% random medication pass observation will be conducted on licensed personnel, across all three shifts	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated LPN # 1 had left for the day. The clinical record of Resident F was reviewed on 8/7/12 at 2:40 P.M. Physician's orders, initially dated 4/16/12 and on the current August 2012 orders, indicated: "Advair 250-50 Diskus...Inhale 1 puff by mouth every 12 hours - Rinse mouth 3 times after each use," "Spiriva 18 mcg -Handihaler...Inhale 2 times per capsule...," "Calcium 600 mg + Vitamin D Take with food/meal...Give 1 tablet orally bid," "Prednisone 5 mg tablet, Take with food/meal Give 1 tablet orally once a day," and "Prednisone 2.5 mg tablet, Take 1 tablet orally once a day." The physician orders indicated the medications were to be given at 8:00 A.M. On 8/8/12 at 2:00 P.M., during interview with the Director of Nursing [DON], she did not offer additional information regarding the medications being given without food, and the inhalers being given incorrectly. 2. On 8/7/12 at 12:00 P.M., LPN # 1 administered Resident E the following medications: Lopressor, Renvela, Requip, and Effexor. The resident was not observed to get Aspirin or Norco. On 8/7/12 at 1:30 P.M., the clinical record of Resident E was reviewed.		to ensure each nurse schedule will be observed, 5 times weekly for 2 weeks, then 3 times weekly for 4 weeks, then weekly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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...."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This federal tag relates to Complaint IN00111981. 3.1-25(b)(9)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and interview, the facility failed to ensure inhaler	F0441	**F 441** **SS = D**	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications were not placed on an unsanitary surface, the tank of a toilet, for 1 of 7 residents reviewed for infection control, in a sample of 7. Resident E Findings include: On 8/7/12 at 9:40 A.M., LPN # 1 was observed during her medication pass to Resident E. Following the medication pass, LPN # 1 was observed to enter the resident's bathroom, place the 2 hand held inhalers on the tank of the toilet, and wash her hands. On 8/8/12 at 2:00 P.M., during interview with the Director of Nursing, she indicated staff should not place any medications on the tank of a toilet. This federal tag relates to Complaint IN00111981. 3.1-18(b)(1)		Resident E assessed for adverse effects related to inappropriate infection control practice/procedure during administration of inhaler. None were noted A !00% medical record review to identify those residents having physician orders for inhalers. Those residents identified received a respiratory assessment to ensure resident was absent of respiratory infectious s/s. None were noted LPN#1 was re-educated regarding Infection Control Practices / Procedures and Medication Administration P & P, including a medication pass observation conducted by Pharmacy Representative. ETD /Designee will provide re-education to all staff regarding infection control policy and procedure to include sanitary 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			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, then 3 times weekly for 4 weeks, then weekly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on interview and record review, the facility failed to ensure clinical records were accurate and complete, in that a resident's order for Flomax was written for after supper, but was given after breakfast; and documentation regarding medication administration was incomplete, for 2 of 7 residents reviewed for complete and accurate documentation, in a sample of 7. Residents G and E Findings include: 1. The clinical record of Resident E was reviewed on 8/7/12 at 1:30 P.M. A Physician's order, dated 3/4/12 and on the current August 2012 orders, indicated, "Aspirin 81 mg...Give 1 tablet orally once a day."	F0514	**F 514** **SS = D** Resident E and resident G were assessed via RN for any adverse effect related to the inaccuracy of the documentation on the Medication Administration Record. Resident G = Flomax ordered to be administered after supper and the time was computer printed as 0900. Resident E = Aspirin 81mg once a day; no initials were present on the medication administration record for 8/1-8/4/12. LPN #5 was re-educated on Medication Administration P & P to the 6 rights. Physician and responsible party notification. A 100% review of resident's medical record to identify inappropriate documentation.	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident's Medication Administration Record, dated August 2012, indicated the resident's medication was not initialed as given on 8/1, 8/2, 8/3, and 8/4. On 8/8/12 at 2:00 P.M., during interview with the Director of Nursing, she indicated she did not know why the medication was not initialed. 2. On 8/8/12 at 8:25 A.M., LPN # 5 was observed to administer Resident G medications including Tamsulosin. The clinical record of Resident G was reviewed on 8/8/12 at 9:00 A.M. A Physician's order, dated 7/3/12, indicated, "Tamsulosin [Flomax] 0.4 mg one capsule daily after supper (within 1/2 hr of meal) 1800 [6:00 P.M.]." The current physician's order, signed 8/1/12, indicated, "Tamsulosin...Take 1/2 hr after same meal, Give 1 capsule orally 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.		Physician and responsible party notification for those resident's identified. New/clarification orders received as indicated, medical record updated ETD / Designee to provide re-education to licensed personnel regarding Medication Administration P & P to include the 6 right to medication pass, and accurate documentation on the Medication Administration Record. DON/Designee will conduct medication pass observation on licensed personnel to ensure proper procedure, accuracy of documentation, and administration of resident's medication as ordered per physician, including the 6 rights. 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, then 3 times weekly for 4 weeks, then weekly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/8/12 at 11:50 A.M., during interview with the Director of Nursing, she indicated she did not know why there was a discrepancy regarding the times the medication was to be given, but that the nurse was calling the physician to clarify. This federal tag relates to Complaint IN00111981. 3.1-50(a)(1) 3.1-50(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	08/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE