

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/29/2012
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NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
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F0000	<p>This visit was for Investigation of Complaint IN00110577.</p> <p>This visit was in conjunction with the Recertification and Licensure Survey and included the Investigation of Complaint IN00109327.</p> <p>Complaint IN00110577-Substantiated. Federal/state deficiencies related to the allegations are cited at F203, F505 and F456.</p> <p>Survey dates: June 18, 19, 20, 21, 22, 25, 26, 27, 28, 2012</p> <p>Facility number: 000173 Provider number: 155273 AIM number: 100290920</p> <p>Survey team: Carole McDaniel, RN-TC Terri Walters, RN Martha Saull, RN Dorothy Watts, RN 6/26, 27, 28, 2012</p> <p>Census bed type: SNF 9 SNF NF 80 Total 89</p>	F0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Cypress Grove Nursing and Rehabilitation Center desires this Plan of Correction to be considered the facility's Allegation of Compliance effective July 26, 2012.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Census Payor type:</p> <p>Medicare 9 Medicaid 56 Other 24 Total 89</p> <p>Sample size: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 11, 2012 by Bev Faulkner, RN</p>			

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F0203 SS=E	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State</p>				

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	<p>long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on record review and interview, the facility failed to ensure Transfer and Discharge information was provided to residents or their health care representatives for 3 of 4 residents at the time of transfer and discharge. Resident J Resident V Resident A</p> <p>Findings include:</p> <p>1. The clinical record of Resident J was reviewed on 6/27/12 at 10:30 A.M. The resident diagnosis, included but was not limited to Downs Syndrome. The resident had been transferred to the hospital on 5/7/12. Documentation was lacking to indicate appropriate Transfer and Discharge information was provided. Documentation was present on the nurses' notes in the form of a post-it</p>	F0203	<p>It is the policy of Cypress Grove Rehabilitation Center to ensure Transfer and Discharge information is provided to resident or their health care representatives at the time of transfer and discharge. Residents A, J and V no longer reside at Cypress Grove Rehabilitation Center. A 100% medical record review including physician orders and nurses notes of current in-house residents for the past 30 days was completed to determine transfer and discharge information was provided to residents/responsible parties at the time of transfer or discharge. The Education Training Director (ETD)/Designee will provide re-education to licensed personnel on policy and procedure regarding correct information to be provided to residents/responsible parties upon transfer or discharge. During Monday-Friday department head</p>	07/26/2012

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	<p>note, written at an unknown time after the transfer, which noted " need Bed Hold put in chart and copy mailed to family."</p> <p>On 6/27/12 at 2:45 P.M., the Director of Nursing indicated during interview the note was her reminder, but the Transfer Discharge forms (signified as Bed Hold on the note) had not been filled out or provided to the family on behalf of the resident.</p> <p>2. The clinical record of Resident V was reviewed on 6/27/12 at 11:30 A.M. The resident was transferred to the hospital on 6/11/12. An undated transfer form appeared to have been from the 6/11/12 transfer. Documentation was lacking, as per facility policy to indicate appropriate Transfer and Discharge forms were provided.</p> <p>3. The clinical record of Resident A was reviewed on 6/27/12 at 1:00 P.M. The Resident had been transferred to the hospital on 3/24/12. Documentation was lacking to indicate appropriate Transfer Discharge forms were provided as directed by facility policy.</p> <p>4. Resident Care Manager R.N. #32 was interviewed on 6/25/12 at 9:30</p>		<p>meetings, a census review is conducted. Residents identified as transferred or discharged are reviewed. A review is conducted of the 24-hour status report and physician orders. Those residents identified as being transferred or discharged will be reviewed by the IDT to ensure transfer/discharge information has been provided to resident/responsible parties. It is standard of practice for the DON to be notified upon any resident's transfer or discharge to discuss appropriate information is provided to the resident/responsible party. If it is determined that the appropriate information has not been correctly disseminated, the appropriate forms will be completed and hand-delivered or mailed via certified mail to the resident/responsible party. A review of the census worksheet and Daily Clinical Review (DCR) clinical tool will take place 5X weekly. Identified non-compliance will result in 1:1 re-education with progressive discipline up to and including termination. Results of audits will be reviewed by Quality Assurance committee for review and recommendations as deemed appropriate X 6 months.</p>				

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	<p>A.M. She indicated she had assisted at times to fill out transfer sheets to assist the nurses, but she had not filled out Transfer and Discharge forms as the unit nurses usually did that and were to photocopy each item sent to the family and hospital.</p> <p>5. The facility Policy and Procedure, effective April 2011, for Transfer and Discharges was reviewed on 3/27/12 at 1:30 P.M. It directed "1. Complete the RESIDENT TRANSFER CHECKLIST for all resident transfers."</p> <p>The Policy and Procedure did not address inclusion of the required information about Appeal Rights, contact information for the State Long term Care ombudsman or contact information for protection and advocacy agencies for the developmentally disabled and/or mentally ill residents.</p> <p>6. The Social Service Director was interviewed on 6/28/12 at 2:00 P.M., regarding the information requirement not addressed in the policy. She indicated the facility was aware of the requirement for that information and indicated she it was usually provided since charts were reviewed to ensure its provision.</p>				

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	<p>This Federal tag relates to Complaint IN00110577</p> <p>3.1-12(a)(9)</p>			
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F0456 SS=D	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Based on observation, interview and record review, the facility failed to ensure call lights were functional and answered promptly for 2 of 2 residents interviewed who voiced concerns with call lights not working properly and 1 of 4 family members interviewed.</p> <p>Resident M, Resident S, Confidential Family Interview</p> <p>Findings include:</p> <p>1. On 6/19/12 at 9:12 A.M., during interview Resident #S indicated early this a.m., on night shift, staff did not answer her call light and she had to go to the bathroom. She indicated she got up herself in her wheelchair, which she was not supposed to do. She indicated she went to the bathroom herself. She indicated she was being treated at present for a bladder infection. She indicated this was the only time staff had not answered her call light.</p> <p>On 6/19/12 at 9:22 A.M., Resident S's</p>	F0456	<p>It is the policy of Cypress Grove Rehabilitation Center to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Resident S and M's call lights were immediately replaced upon notification. There was no communication from the staff or "Confidential Family" that their family member's call light was not functioning; however an immediate 100% inspection of all call-lights was conducted to determine functionality and that call light was replaced immediately as well. The 100% inspection completed of each call light in the facility identified no other mal-functioning call-lights. All residents have the potential to be affected. The immediate 100% inspection that was completed determined that the facility's call-lights were all functioning properly. Through the preventative maintenance program, the Maintenance Director/Designee will inspect weekly each call light thoroughly and document appropriately. Any call-light found to be non-functioning will be immediately replaced. In addition, managers make Monday-Friday rounds to</p>	07/26/2012

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	<p>call light was checked for functioning. It didn't sound or light above her resident room door when checked. At this time, CNA #10 was made aware of the call light not working. CNA #10 checked the call light connection at the wall site and initiated the call light. The call light did not sound or light up. CNA #10 indicated she would notify the maintenance staff.</p> <p>CNA #10 indicated occasionally call lights don't work and maintenance would be notified and they would get the resident another call light.</p> <p>On 6/19/12 at 10:15 A.M., CNA #10 was interviewed regarding the call light of Resident S. She indicated she had told maintenance and it was fixed immediately. Resident S's call light was checked at this time and it was functioning. CNA #8 in the hall at this time was interviewed regarding the toileting of Resident S. She indicated Resident S can toilet herself but if she needs help she will ask staff.</p> <p>2. On 6/18/12 at 10:00 A.M., a family member of a resident at the facility initiated a confidential interview with Indiana State Department of Health. The first problem the family member indicated was the problem of staff not responding to call lights. She</p>		<p>assigned resident's rooms and an inspection of the call light will be conducted at that time and documented on the daily rounds audit tool. Weekend managers will make rounds and will conduct a 25% random inspection of call-light functionality. Notification of the Maintenance Director/Designee will be required if issues are identified so that a replacement call-light can be installed immediately, or an alternative means to summon assistance is provided to the resident. Administrator/Designee will review daily and weekly documentation of call-light functionality and will conduct rounds daily to inspect 20 different call lights/day Monday-Friday X 5 weeks, then monthly thereafter. Results of audits will be forwarded to the Quality Assurance committee for review and recommendations as deemed appropriate X 6 months.</p>				

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	<p>indicated her family member went for a two week period without a call light. She indicated the facility did not give the resident a hand held bell or any other device for the resident to use to notify staff that assistance was needed.</p> <p>She indicated her family member was able to use a call light independently. She indicated she had timed staff response to call lights. She indicated she had timed call lights and had observed a 20 to 30 minute interval before call lights were answered. She indicated when staff answered call lights they frequently indicated the resident would have to wait because staff were passing meal trays.</p> <p>The family member indicated her family member had waited 15 minutes for the call light to be answered yesterday. The family member indicated she had thought about pulling the wheel chair alarm yesterday when waiting for the call light to be answered. She indicated the staff had been passing meal trays to the residents and won't toilet residents at that time.</p> <p>3. On 6/18/12 at 2:15 P.M., the call light in Resident M's room was tested</p>			

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	<p>at the bedside. The resident was in the bed at this time. When the bedside call light was pushed, the light did not illuminate over the door.</p> <p>On 6/18/12 at 3:45 P.M., the Administrator was made aware of the call lights that were known to not be functioning.</p> <p>On 6/27/12 at 1:32 P.M., the Maintenance Man was interviewed. He indicated the following: when he comes in the building in the morning, he goes to the nurses' station to make sure the call lights activated are illuminating at the main call light panel, which is located at the nurses station on each of the 3 units. Then as he is walking down the halls, he randomly observes if call lights are illuminating and if they sound. He indicated there was no system in place to verify the call lights were all sounding and/or lighting up at the room and/or control panel at the nurses station.</p> <p>This Federal Tag relates to Complaint IN00110577.</p> <p>3.1-19(bb)</p>			

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F0505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings.</p> <p>Based on record review and interview, the facility failed to promptly notify the physician of lab results ordered for 1 of 1 sampled residents for whom Stat lab test were ordered from a sample of 3 closed records. Resident A</p> <p>Findings include:</p> <p>The clinical record of Resident A was reviewed on 6/26/12 at 12:30 P.M. Resident diagnosis included but were not limited to Bipolar disorder, dementia and anxiety disorder. The resident was returned to the facility on 4/18/2012 from a hospitalization during which her medication for mood disorder management was changed. She was to be given Depakote Extended Release 500 mg by mouth twice daily. The medication dosages of Depakote were to be monitored by lab blood tests results which determined blood levels of the drug within normal desirable ranges. On 6/08/12, the physician ordered a STAT lab test (STAT being a test done as immediately as possible) to determine the resident's blood level of Depakote. The blood test was drawn</p>	F0505	<p>It is the policy of Cypress Grove Rehabilitation Center to promptly notify the attending physician of lab results. Physician has been notified of Resident A's STAT lab results. No new orders received. Resident A no longer resides at Cypress Grove. DON/Designee conducted a 100% medical record review for the past 30 days was conducted for current in-house residents, including but not limited to notifying the attending physician and responsible party of STAT lab results. The Education Training Director (ETD)/Designee will provide re-education to licensed personnel on policy and procedure regarding notification of STAT lab results. Utilizing the Situation/Background/Assessment/Request (SBAR) physician communication tool/progress note, the licensed nurse will be responsible to notify the physician and responsible party of STAT lab results and document such in the nursing notes. Through review of 24-hour status report sheet and physician orders, and computer generated reports which includes STAT labs, the DON/Designee will identify residents requiring physician and responsible party notification of such STAT labs. The medical</p>	07/26/2012	

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	<p>STAT and results were received at the facility the same day. The range or normal for the acceptable levels were to be between 50 ug/ml and 100 ug/ml and the result was marked "Low" at 40 ug/ml. Documentation was lacking to reflect follow up on the results with the physician for 7 days until 6/14/12, when it was refaxed to the physician. On 6/14/12, the resident was transferred to the E.R. by family request. The resident did not return to the facility.</p> <p>Between 6/08/12 and 6/14/12, nurses notes reflected the resident's behavior indicated problems as follows:</p> <p>6/09/12 at 2:45 A.M. "...threw a glass of water out the door (of her room) causing glass to shatter everywhere it was the logical thing to do when you are upset...resident is having paranoid episode thinks there are small babies crying-someone breaking in..."</p> <p>6/09/12 at 11:00 P.M. " Continues antibiotic therapy for UTI (urinary tract infection), fluids encouraged ...requires frequent staff redirection with behaviors of yelling at others, wandering into others rooms etc..."</p> <p>6/14/12 at 4:00 A.M. "knocked off</p>		<p>record of identified residents will be reviewed by the Interdisciplinary Team (IDT) to ensure the physician is notified of STAT lab results. Review will take place 5X weekly. Identified non-compliance will result in re-education with progressive discipline up to and including termination. Results of audits will be reviewed by Quality Assurance committee for review and recommendations as deemed appropriate X 6 months.</p>	

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NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630		
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	<p>Dutch Figurine (glass ceramic) to get attention...assisted to wheel chair and brought to nurses station stated there was a ...man in her room and he slit my throat...speaking in a low tone of voice...has a distressed frightened look on her face..."</p> <p>6/14/12 at 6:00 A.M. "Looked up at this nurse with the saddest eyes and stated 'Please just let me die!'"</p> <p>On 6/27/12 at 3:00 P.M., the Director of Nursing was interviewed regarding the failure to follow up on the STAT lab test. She indicated she would have it researched for additional documentation. She was unable to provide additional information.</p> <p>This F Tag relates to Complaint IN00110577</p> <p>3.1-49(f)(2)</p>				