

| | | | |
|--|---|--|---|
| 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 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| F000000 | <p>This survey was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey, completed 9/23/13.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of the Complaint Number IN000136298, completed on 9/23/13.</p> <p>Survey Dates: 11/4/13, 11/5/13</p> <p>Facility Number: 000173 Provider Number: 155273 AIM Number: 100290920</p> <p>Survey Team: Barbara Fowler, RN, TC Diane Hancock, RN Denise Schwandner, RN</p> <p>Census Bed Type: SNF: 12 SNF/NF: 65 Total: 77</p> <p>Census Payor Type: Medicare: 8 Medicaid: 46 Other: 23 Total: 77</p> | F000000 | | |

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

TITLE

(X6) DATE

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

| | | | | | |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/05/2013 |
| NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 11/8/13, by Jodi Meyer, RN</p> | | | | |

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/05/2013 | |
| NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| F000309 SS=D | <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure diabetic care was completed to control blood sugars, for 1 of 7 residents reviewed for insulin dependent diabetes, in a total sample of 12, and failed to ensure 1 of 2 residents sampled for dialysis had their access grafts checked for patency, in a total sample of 12. Resident #70 had on-going high blood sugars and did not receive insulin as ordered. Resident #114 had a dialysis access graft that was not routinely checked for patency.</p> <p>Findings include:</p> <p>1. Resident #70's clinical record was reviewed initially on 11/4/13 at 2:56 p.m. The resident was admitted to the facility on 3/17/12 with diagnoses including, but not limited to, type 1 diabetes mellitus, end stage renal disease, hypertension, seizure disorder, and peripheral neuropathy.</p> | F000309 | <p>1. Res #70 was sent to the ER for evaluation and treatment. Thrill and Bruit was immediately palpated and auscultated for resident #114 and found to be present. 2. The Director of Nursing has compiled a list of insulin dependent residents. The interdisciplinary team reviewed records of these residents to ensure insulin orders are being followed, blood sugars are recorded as ordered, doctors are notified as appropriate, and insulin administration is initialed on the Medication Administration Record. Care plans were updated as appropriate. The Director of Nursing will monitor the list and add new insulin diabetic residents as or when admitted. The Director of Nursing has compiled a list of residents with AV fistula grafts. The Director of Nursing will monitor the list and add new residents with AV fistula grafts as needed or when admitted. Thrill and Bruit on the current residents has been palpated and auscultated and the results documented on the Treatment Administration Record. Residents</p> | 12/02/2013 | | | |

| | | | | | | | |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/05/2013 | |
| NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>RN #1 on 11/5/13 at 9:40 a.m. indicated Resident #70 had been found on the floor in his room that morning, unresponsive. She indicated his blood pressure was elevated, pulse was elevated and he responded very little. The physician had been notified and the resident had been sent to the hospital. She indicated his blood sugar had been very high that morning.</p> <p>The resident had been hospitalized from 10/15/13 through 10/23/13 for unresponsiveness and high blood sugar. Orders upon return from the hospital were to check and record blood sugar three times daily before meals. The resident was ordered to receive Novolog insulin according to a sliding scale. For blood sugars from 351 to 400, he was to receive 10 units. The resident's blood sugars were high on 10/23 and 10/24/13. On 10/24/13, the blood sugar was 490 at 8:00 a.m. New orders were obtained as follows: "Increase sliding scale high end to include if level 400 or greater give 10 units of Novolog and recheck in 1 hr., if level 500 or greater give 20 units and recheck in one hour. Follow sliding scale for levels under 400. Contact MD for concerns and questions that are urgent." Blood sugars and sliding scale insulin were</p> | | <p>with AV Fistula grafts are to have Thrill and Bruit checked daily and post dialysis with the new results now documented daily on the Treatment Administration Record. 3. A "Directed In-service" will be given to the professional staff on the policy and procedure for Diabetic Care to ensure diabetic care is completed to control blood sugars. A "Directed in-service" will be conducted with the professional staff on the facilities policy and procedure to ensure dialysis care which includes but is not limited to checking the Thrill and Bruit daily and post-dialysis . 4. Medication Administration Records will be audited daily by the Director of Nursing or Designee to ensure documentation of insulin administration per physician order. In addition, an audit will be completed weekly by the Director of Nursing/Designee with the use of the "Clinical Systems Review – Diabetic Quality Assurance Review Form". These audits will be completed weekly for 4 weeks, then twice a month for 3 months, then monthly for 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be re-viewed in QA monthly times 6 months and quarterly times 2 quarters thereafter. Audits will be done daily of the Treatment Administration Record by the</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| | <p>not documented as given for 11/1/13 at 11:30 a.m. and 11/4/13 at 11:30 a.m.</p> <p>The resident also had orders for Levimir 100 Units per milliliter, inject 5 units subcutaneously every morning and Levimir 4 units subcutaneously every bedtime. The morning dose was not documented as given on 10/25, 10/26, 10/29, 10/31, 11/1, 11/3, 11/4, or 11/5/13. The evening dose was not documented as being given on 10/26, 10/27, 10/29, 10/31, or 11/4/13.</p> <p>Nurses' notes included, but were not limited to, the following: 10/29/13 1700 [5:00 p.m.] "Accu ck. [accu-check blood glucose check] at 1630 [4:30 p.m.] result 39 given Glucagon [injectable glucose] 1 mg [milligram] Rt [right] thigh. Pt. taken to dinning [sic] rm [room] and food presented. Pt. taking po [oral] food." 10/29/13 1730 [5:30 p.m.] "Accu ck 200. Nepro [supplement] given." 10/29/13 2300 [11:00 p.m.] "HS [bedtime] snack given." 10/30/13 03:20 [3:20 a.m.] "Resident c/o's [complains of] 'not feeling right'; dizziness, lightheadedness tremors; accu ck registered 'Hi' X 2 on glucometer. Novolog 15 units given instead of 20 U per resident request."</p> | | <p>Director of Nursing/Designee to ensure the Thrill and bruit are Palpated, auscultated and recorded on the Treatment Administration Record and that the Post Dialysis assessment is completed. These audits will be conducted daily for 4 weeks times 1 month, then 2 times a week for 3 months, then monthly for 6 months. Identified non-compliance will result in 1:1 education up to and including termination. Identified trends will be reviewed in QA monthly times 6 months and quarterly times 2 quarters thereafter.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>10/30/13 05:30 [5:30 a.m.] Accu ck 467; [no] c/o's; Novolog insulin given per sliding scale."</p> <p>11/2/13 3:45 a.m. "...No diabetic distress noted @ this time..."</p> <p>11/2/13 1500 [3:00 p.m.] "...Blood sugar continues to be elevated but resident is asymptomatic [sic]. Will monitor."</p> <p>11/2/13 4:20 p.m., "Faxed physician line to report elevated blood glucose reading..."</p> <p>11/2/13 6:00 p.m., "Order received to send to the ER [emergency room]...Resident is refusing to go..."</p> <p>11/5/13 8:30 a.m., "Found on floor unresponsive, BP 220/100 P [pulse] 110 R [respirations] 16 T [temperature] 99.4 BS [blood sugar] 479. would not respond to stimuli, with the assist of two lifted to bed. Called Dr. [name] triage and received order for transfer to [local hospital]. Call [local emergency services]..."</p> <p>Blood sugars recorded for November, 2013, were as follows: 11/1/13 6:30 a.m., 483 11/1/13 11:30 a.m., blank 11/1/13 4:30 p.m., 473 11/2/13 6:30 a.m., 457 11/2/13 11:30 a.m., "Hi" 11/2/13 4:30 p.m., "Hi" 11/3/13 6:30 a.m., 155 11/3/13 11:30 a.m., 407</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/05/2013 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>11/3/13 4:30 p.m., 211 11/4/13 6:30 a.m., "Hi" 11/4/13 11:30 a.m., blank 11/4/13 4:30 p.m., 372 11/5/13 6:30 a.m., 524</p> <p>2. During initial tour of the facility on 11/4/13 at 8:35 a.m., Agency Nurse #1 indicated Resident #114 received dialysis on Monday, Wednesday, and Friday of each week.</p> <p>An observation on 11/5/13 at 9:10 a.m., indicated Resident #114 to be lying in bed. Resident #114 indicated he had a graft for dialysis which was recently inserted in his left upper arm. Resident #114 indicated the dialysis unit used a port which was located in his right chest for dialysis.</p> <p>The clinical record for Resident #114 was reviewed on 11/4/13 at 11:23 a.m. Resident #114 had a diagnosis including, but not limited, ESRD (End Stage Renal Disease.)</p> <p>A "Hemodialysis Plan of Care," indicated Resident #114 had an intervention for monitoring the dialysis access site. The dialysis care plan indicated the AV (arteriovenous)</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>graft/fistula function is to be checked by palpating for a thrill and listening for a bruit daily and recorded on the TAR (treatment administration record.)</p> <p>A form titled , "Dialysis Center Communication Record," indicated the thrill or bruit had not been checked upon return from dialysis for Resident #114 on 11/1/13,10/30/13, 10/22/13, or 10/19/13.</p> <p>During an interview on 11/4/13 at 3:52 p.m., RN #2 indicated Resident #114 received a graft to the left arm in mid-September.</p> <p>Interview with the DoN (Director of Nursing) on 11/4/13 at 4:00 p.m., indicated the staff only checked for a thrill and bruit upon the return of the resident from dialysis. The DoN indicated he assumed the dialysis unit checked the graft site when the resident was receiving dialysis but he was not sure. Upon query, the DoN indicated the staff did not usually check for a thrill or bruit when the graft is not used.</p> <p>During an interview with the DoN on 11/5/13 at 10:00 a.m., the DoN indicated he had checked every resident with a graft last evening for a</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>thrill and a bruit. The DoN indicated he had inserviced the nursing staff regarding grafts and it would be documented on each dialysis resident.</p> <p>3.1-37(a)</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/05/2013 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F000314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. | F000314 | 1. Treatment orders were reviewed and treatments applied as ordered for Resident #4 2. 100% skin assessment of all residents was completed to ensure areas of skin impairment are identified. The interdisciplinary team reviewed all records of residents identified to ensure there are appropriate treatment orders and that Skin grids are completed, and appropriate treatment orders are transcribed to the Treatment Administration Record and carried out as ordered. 3. A "Directed In-service" will be held with the professional staff on the facility's policy and procedures concerning wound management. 4. Audits will be done daily by the Director of Nursing/Designee of the Treatment Administration Records to ensure treatments are being carried out according to the physicians' orders. Audits will be conducted daily for 4 weeks, then | 12/02/2013 | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>Based on observation, interview and record review, the facility failed to ensure 1 of 4 residents with pressure sores, in a total sample of 12, received treatment and services to promote healing and prevent infection, in that all areas were not monitored; and treatments were not done as ordered. (Resident #4)</p> <p>Finding includes:</p> <p>Resident #4 was observed to be seated in a reclining geri-chair in the hallway across from the nurses' station on 11/4/13 at 3:00 p.m. The resident was observed to have a cast on his left lower leg. The left large toe was deep purple in color on the</p> | | <p>2 times a week for 3 months, then monthly for 6 months. Skin assessments of all residents will be carried out monthly times 4 months by the Director of Nursing /Designee to ensure all areas of skin impairment have treatment orders as appropriate and orders have been transcribed to the Treatment Administration Record and appropriate documentation to ensure treatments are completed is in place. Identified non-compliance will result in 1:1 education up to and including termination. Identified trends will be reviewed in the QA monthly meetings times 6 months and quarterly times 2 quarters.</p> | |

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/05/2013 | |
| NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>distal aspect.</p> <p>Resident #4's clinical record was reviewed at 3:30 p.m. on 11/4/13. The record indicated he was being weighed on 9/29/13; they heard popping sounds from his lower leg and he fell. Fractures were found in his left tibia (lower leg bone) and ankle. A cast was placed on the resident following the fractures.</p> <p>On 10/23/13 at 4:30 p.m., the resident returned from an appointment at the orthopedic physician. the following orders were received: "1) dc [discontinue] (L) [left] leg cast. 2) Rsd [resident] to be non weight bearing to (L) LE [lower extremity]. 3) Rsd to have brace to (L) knee. May remove for cleaning [and] skin [check]. [Check] for skin integrity Q [every] shift."</p> <p>The following orders were also received: "1) Skin prep to (L) heel ankle area sore [with] Allevyn [foam dressing] change every other day. 2) Skin prep to (L) ball of foot near big toe then cover area [with] Allevyn every other day. 3) Skin prep to (L) little toe every other day.</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>4) Skin prep to (L) big toe every other day."</p> <p>There were two "Skin Grid - Pressure/Venous Insufficiency Ulcer/Other" forms available for review. Both indicated each area was identified on 10/23/13 as follows: Left back of heel, type of wound indicated "other, cast friction," length 3.0 centimeters (cm), width 3.2 cm, depth 0.3 cm, color black. Left inner foot at toe, "other, cast friction," length 2.2, width 2.3, depth 0.0, color pink</p> <p>On 10/29/13, the areas were documented as follows: Left back of heel, stage N/A (not applicable), length 3.0 cm, width 3.2 cm, depth 0.1 cm, color red/yellow, "area improving. Beginning to seal over. [No] s/s [signs/symptoms] infection." Left inner foot at toe, stage N/A, length 2.2, width 2.3, depth 0.0, color red/yellow, [no] s/s infection.</p> <p>There were no skin grids for the left little toe or the left big toe areas.</p> <p>A clinical review note, dated 11/1/13, indicated the following, "[Clinical Review] r/t [related to] fall 10/30/13 [no time]. Res. [resident] seated in</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>w/c [wheelchair] [and] for unknown reason tipped forward from w/c onto his knee. Suspected re-injury of (L) leg fx [fracture] led to res. being sent to ER [Emergency Room] for eval. [evaluation]. Res. returned with cast to (L) LE. To follow up with ortho MD r/t leg. At this time, res. seating has been [changed] to recliner with pressure-reducing cushion (Geri-chair). Due to wound that developed under previous cast, attempt to expedite change to better cast with possible....Transport arranged for [local transportation company] to take pt. to [local orthopedic office] urgent care today. [Name of Occupational Therapist] to accompany resident."</p> <p>Review of the November, 2013 Treatment Record indicated the treatments dated 10/23/13 had been continued into November. All treatments to the pressure areas were documented as done on 11/1/13. None were documented for 11/3/13. In the space for 11/4/13, illegible writing was observed on the treatment record.</p> <p>RN #3 was interviewed at 4:30 p.m. on 11/4/13. She indicated she had been at the facility on 11/1/13 when the resident returned with the cast.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>She indicated there were windows cut into the cast so the areas could be treated. She indicated she "wasn't sure if everyone knew it or not," but she thought RN #1 knew it. She proceeded to do the treatments to the areas at that time.</p> <p>The ball of the left foot was observed, after a piece of the cast was removed, to have a round area, 2.5 by 2.0 cm, dark brown in color, eschar. A dry dressing was removed from the area; no date was on the dressing. The large toe was observed to be dark purple-black in color 2.5 cm in diameter. The little toe had a 0.5 cm blackened area on the side of it. The left heel was observed after a piece of the cast was removed. It was a larger dark brown area, 3.0 to 3.5 cm in diameter. There was some redness around the area at that time.</p> <p>On 11/5/13 at 8:15 a.m., the lack of tracking of all areas, and the lack of treatment over the past weekend was reviewed with the Administrator and Corporate Nurse Consultant. At 8:35 a.m. the Director of Nurses (DoN) and Nurse Consultant were observed removing the cast windows and dressings to assess the areas.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2013 |
|--|---|--|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>At 11:00 a.m. on 11/5/13, RN #1 was queried as to what the illegible writing on the Treatment Record on 11/4/13 said. She indicated she had written it and it said "checked cast." She further indicated she could not see the area on the ball of the foot because of the cast, but the area on the heel had a window and she had treated it on 11/4/13. She was unaware of the cast window over the ball of the foot.</p> <p>The DoN indicated on 11/5/13 at 4:45 p.m., he had not seen skin grids for the large toe and the small toe areas.</p> <p>The skin grid form had a form date of 07/13. The instructions included, but were not limited to, "one site per page," and "complete weekly."</p> <p>3.1-40(a)(2)</p> | | | |