

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  11/19/2015
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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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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00186741.</p> <p>Complaint IN00186741 - Substantiated Federal/State deficiencies related to the allegations are cited at F504.</p> <p>Survey date: November 19, 2015</p> <p>Facility number: 000173 Provider number: 155273 AIM number: 100290920</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 10 Medicaid: 44 Other: 15 Total: 69</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on</p>	F 0000	<p><b>Plan of Correction for Cypress Grove Rehabilitation Center 2015 Annual Survey</b></p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit on December 11, 2015</p>	

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

TITLE

(X6) DATE

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

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F 0504 SS=D Bldg. 00	<p>November 24, 2015.</p> <p>483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician.</p> <p>Based on interview and record review, the facility failed to ensure laboratory services were obtained as ordered by the physician, for 1 of 3 residents reviewed with lab orders, in a sample of 3. Resident C</p> <p>Findings include:</p> <p>The closed clinical record of Resident C was reviewed on 11/19/15 at 11:00 A.M.</p> <p>A Physician's order, undated, indicated, "Hgb A1 C, Lipid Pro, CMP on 10-14-15. Fax to [name of physician]...."</p> <p>Lab results from 10/14/15 were not found in the clinical record, nor a reason for not obtaining the lab.</p> <p>On 11/19/15 at 2:05 P.M., during an</p>	F 0504	<p><b>F504 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident C no longer resides in the facility.</p> <p><b>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> All residents having physician orders to have labs completed have the potential to be affected by the alleged deficient practice. A review was completed by the DNS/designee of physician orders to ensure all lab orders are documented in the lab tracking log and have been completed per the physician's orders.</p> <p><b>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p>	12/11/2015

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	<p>interview with Medical Records Staff # 1, she indicated she was unable to find the lab results from 10/14/15. She indicated she phoned the hospital lab, and there was no record of the lab being drawn.</p> <p>On 11/19/15 at 2:15 P.M., during an interview with the Director of Nursing (DON), she indicated, "I think we just missed it."</p> <p>On 11/19/15 at 3:35 P.M., the DON provided the current facility policy, "Guidelines for Lab Tracking," undated. The policy included: "Suggest one person be assigned to track labs in the facility. Set up a lab tracking binder with a list for: Daily labs, Weekly labs, Monthly labs...Set up the binder with a lab tracking from [sic] for each day of the year...Review MD orders and place in tracking binder at time order reviewed...."</p> <p>This Federal tag relates to Complaint IN00186741.</p> <p>3.1-49(f)(1)</p>		<p>Licensed staff will be in-serviced by 12/11/15 by Clinical Education Coordinator (CEC)/designee on "Guidelines for Lab Tracking". The DNS/designee will add all new lab orders to the lab tracking system during daily clinical review. The Director of Nursing Services (DNS)/designee will monitor lab tracking daily to ensure labs are drawn and the results are maintained on the clinical record. <b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</b> To ensure compliance the DNS/designee is responsible for the completion of the Lab/Diagnostic CQI tool weekly X 4 weeks, monthly X 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. <b>5. Date of compliance:</b> December, 11 2015</p>		

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