STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155273		(X2) MULTIPLE (A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/29/2023		
NAME OF	PROVIDER OR SUPPLIE	R		TADDRESS, CITY, STATE, ZIP COD MEDWELL DR	
CYPRES	S GROVE REHAE	BILITATION CENTER		3URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DN (X5) BE COMPLETION PRIATE DATE
0000					
Bldg. 00	This visit was for 1 IN00421148.	the Investigation of Complaint	F 0000	Deficiency ID: F _ 0000 Completion Date: 12/18/20 Plan of Correction for Cypr	
	Complaint IN00421148: Deficiencies related to the allegations are cited at F690.			Grove Rehabilitation Center F000	r
	Survey dates: Nov	ember 28 & 29, 2023		By submitting the enclosed material, we are not admitti truth or accuracy of any spo	ing the
	Facility number: 0			findings or allegations. We	reserve
	Provider number:			the right to contest the find	ings or
	AIM number: 100			allegations as part of any proceedings and submit the	ese
	Census Bed Type: SNF/NF: 83			responses pursuant to our	facility
	Total: 83			regulatory obligations. The requests that the plan of correction be considered of	
	Census Payor Typ	e:		allegation of compliance ef	fective
	Medicare: 3			December 18, 2023.	
	Medicaid: 38				
	Other: 42			This provider respectfully re	
	Total: 83			that this 2567 Plan of Corre	
				be considered the Letter of	
	This deficiency real accordance with 4	flects State Findings cited in 10 IAC 16.2-3.1.		Credible Allegation of Com and requests a desk review of a post survey review on	v in lieu
	Quality review con	mpleted on December 5, 2023.		December 18, 2023.	
[:] 0690 SS=E Bldg. 00	§483.25(e) Incom §483.25(e)(1) Th resident who is c bowel on admiss assistance to ma or her clinical com	icontinence, Catheter, UTI tinence. e facility must ensure that ontinent of bladder and ion receives services and intain continence unless his ndition is or becomes such s not possible to maintain.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE	E'S SIGNATURE	(X6) DATE	
Brandon P Burns	Executive	Director	12/20/2023
Any defiencystatement ending with an asterisk (*) denotes a deficency which the ir	nstitution may be excused from	a correcting providing it is determin	

Any defended sufficient ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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	DENTIFICATION NUMBER A. BUILDING <u>00</u>				LETED	
	ROVIDER OR SUPPLIE S GROVE REHAE	R BILITATION CENTER	_	4255 N	address, city, state, zip cod 1EDWELL DR URGH, IN 47630			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	incontinence, bas comprehensive a ensure that- (i) A resident who an indwelling cat unless the reside demonstrates that necessary; (ii) A resident wh indwelling cathet one is assessed as soon as possi clinical condition catheterization is (iii) A resident wh receives appropri- to prevent urinary restore continence, bas comprehensive a ensure that a resident a resident function as possi Based on observat review, the facility catheter care was p measures were ma development of ur residents reviewed catheter tubing wa	sed on the resident's assessment, the facility must o enters the facility without heter is not catheterized ant's clinical condition at catheterization was o enters the facility with an er or subsequently receives for removal of the catheter ble unless the resident's demonstrates that necessary; and no is incontinent of bladder iate treatment and services y tract infections and to be to the extent possible. r a resident with fecal sed on the resident's assessment, the facility must ident who is incontinent of ppropriate treatment and re as much normal bowel ble. ion, interview, and record r failed to ensure routine provided and infection control intained to prevent the inary tract infections for 3 of 4 for catheter care. Routine nonthly catheter changes were dered by a physician and s observed on the floor during survey. (Resident C, Resident D,	F 00	590	Residents D, F & G have been reviewed and catheter ba were replaced and tubing are of the floor. Catheter care has also been provided as ordered. Resident C no longer resides a the facility All residents who require catheter care have the potentia be affected by the alleged defice practice. All residents with catheters have been reviewed a	off o t I to iient	12/18/202	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDIC					-	MB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155273	A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/29/2023	
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4255 MEDWELL DR				
CIFRE	33 GROVE REHAD			INEVID	URGH, IN 47630			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE COM	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Resident C's diagno limited to dementia sepsis, hydroureter	eview on 11/28/23 at 11:20 A.M., oses included, but were not a, urinary tract infection, severe , type II diabetes, obstructive y, and chronic kidney disease.			their tubing & catheter bags a the floor. All residents with catheter bags have been revi to ensure catheters are chan per physician orders.	iewed		
	Data Set) assessme resident had severe an indwelling catho Resident C's physic not limited to; Fole (started 6/4/19) and Monday of every n Resident C's care p limited to; resident prophylactic antibi- infections (started 2	cian orders included, but were by catheter care every shift d change Foley catheter first month (started 5/15/20). Idan included, but was not has history of taking otic for chronic urinary tract 3/28/18), resident requires an			Education provided to nu staff related to catheter care. to audit catheter documentati during daily clinical meeting to ensure catheter care being provided as ordered. Staff to educated to check for cathete and tubing to be always off fluc Re-education to be provided nursing staff related to cathete care as needed. DNS/Design round each shift to ensure catherter bags/tubing are not touching the floor.	IDT ion o be er oor. to ter nee to		
	reflux uropathy. Re apart and opens bay and floor. Resident breakdown. (started interventions includ change catheter per tubing or any part of the floor, and provi catheter care. Resident C's medic treatment administr	indwelling urinary catheter for obstructive and reflux uropathy. Resident often pulls catheter apart and opens bag at times, spilling urine on bed and floor. Resident is at risk for infection and skin breakdown. (started 11/27/16). Care plan interventions included, but were not limited to change catheter per physician order, do not allow tubing or any part of the drainage system to touch the floor, and provide assistance with Foley			The DNS/designee will be responsible for the completio an Catheter Care QA Tool we times 4 weeks, bi-monthly tim months, monthly times 4 and quarterly until continued compliance is maintained for consecutive quarters. The re of these audits will be review the QAPI committee oversee the ED. If threshold of 100% achieved, an action plan will developed. Deficiency in this	eekly nes 2 then 2 esults ed by n by is not be		

following orders were not documented as administered on the following dates: Foley catheter care every shift (started 6/4/19) was not provided on 7/2/23 (night shift), 7/8/23 (night shift), 8/21/23 (night shift), 8/25/23 (night shift),

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

Event ID:

R45F11

Facility ID: 000173

employee.

If continuation sheet

practice will result in disciplinary

action up to and including

termination of responsible

Page 3 of 8

PRINTED: 12/28/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/29/2023 155273 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4255 MEDWELL DR CYPRESS GROVE REHABILITATION CENTER NEWBURGH, IN 47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 8/27/23 (night shift), and 9/1/23 (night shift). Change Foley catheter first Monday of every month (started 5/15/20) was not completed on 8/7/23 and 10/2/23. Resident C's progress notes from 7/1/23 through 10/25/23 included the following: 8/5/23 - Resident on antibiotic for UTI 10/12/23 - Resident not responding to staff and will not take anything by mouth. Orders received for stat labs and urinary analysis. 10/12/23 - Orders received to send to hospital. Resident C's hospital discharge summary, dated 10/17/23, included that Resident C's admitting diagnoses included UTI and sepsis. A discharge diagnosis included UTI associated with indwelling urethral catheter. The "Hospital Course" included, "He was sent to the emergency department where he was noted to have significant urinary tract infection. Urine is very dark with considerable sediment and strong odor... Workup in [Emergency Room] shows white count of 13.8, temp 100.8° (degrees Fahrenheit), pulse of 92 with a lactate of 1.3. However given his altered mental status and worsening kidney function, patient does meet criteria for severe sepsis..." 2. During an observation on 11/29/23 at 9:25 A.M., Resident D was sitting in a wheelchair in his room on the West hall. The resident's catheter bag was clipped to the bottom of his wheelchair and the tubing was resting on the floor. During an observation on 11/29/23 at 9:45 A.M., Resident D was wheeling himself in his wheelchair from the West hall to the East hall to a common TV area in front of the East hall nurse's station. Resident D's catheter tubing was dragging the hall Event ID: R45F11 Facility ID: 000173 Page 4 of 8 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

12/28/2023

PRINTED:

1 LIG I O	FERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-03	
	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155273		A. 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/29/2023	
		LITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4255 MEDWELL DR NEWBURGH, IN 47630					
		EITATION OENTER						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO		(X5)	
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TAG	REGULATORY OR floor as he wheeled	LSC IDENTIFYING INFORMATION himself.	TAG		DEFICIENCY)		DATE	
	During an observati A.M., QMA 5 prov. D. Following the co assisted Resident D clipped the resident of the wheelchair. T on the resident's roo During record revie Resident D's diagno limited to chronic k dysfunction of blad overactive bladder. Resident D's most r Data Set) assessmer resident had an indv Resident D's physic not limited to cather excessive intake and Resident D's care pl limited to; Resi catheter due to reter neuromuscular dysf risk for infection (st interventions includ part of the drainage provide assistance v Resident D's medica	 an of care on 11/29/23 at 10:15 add catheter care to Resident ompletion of care, QMA 5 back to his wheelchair and 5's catheter bag to the bottom The catheter tubing was resting om floor. w on 11/29/23 at 10:20 A.M., oses included, but were not idney disease, neuromuscular der, retention of urine, and ecent annual MDS (Minimum nt, dated 8/18/23, indicated the welling catheter. ian orders included, but were ter care every 4 hours due to d output (started 3/20/23). an included, but was not dent requires a supra pubic ntion of urine due to function of bladder and is at tarted 9/29/21). Care plan led, do not allow tubing or any system to touch the floor, and 						
	care every 4 hours (provided on 10/1/23 A.M. and 9:00 A.M	(started 3/20/23) was not (started 3/20/23) (started 3/20) was (started 3/20) (started 3/20) (starte						

SUMMARY : (EACH DEFICIEN REGULATORY OR /20/23 (9:00 A.M 00 A.M.), 11/4/2 M.), 11/6/23 (9:00 /17/23 (9:00 A.M /20/23 (9:00 P.M M.) and 11/27/23 During an observ sident F was lyin	LITATION CENTER STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIC .), 10/27/23, (9:00 A.M.), 11/ 3 (1:00 P.M.), 11/5/23 (1:00) A.M.), 11/11/23 (9:00 P.M.) .), 11/19/23 (9:00 A.M.), .), 11/21/23 (9:00 A.M. and 9 (9:00 A.M.). ation on 11/29/23 at 9:30 A.M g in bed in his room. The	L DN /3/23), :00	4255 M	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP EDWELL DR JRGH, IN 47630 PROVIDERS PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	COD COD	TE SURVEY IPLETED 29/2023 (X5) COMPLETI DATE
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During an observ sident F was lyin ident's catheter b	ation on 11/29/23 at 9:30 A.M g in bed in his room. The	Л.,				
sident F was lyin ident's catheter b	g in bed in his room. The	Л.,				
ident's catheter b	-					
	17.12 1.2					
e floor next to the	ag and tubing were lying on					
	bed.					
ring record revie	w on 11/29/23 at 10:03 A.M.,					
-	ses included, but were not					
nited to neuromus	cular dysfunction of bladder					
d multiple scleros	is.					
sident F's most re	cent significant change MDS					
licated the reside	nt had an indwelling catheter.					
sident F's physic	an orders included, but were					
•	pubic catheter care every shift	ft				
arted 6/4/19).						
sident F's care pl	an included, but was not					
-		.ct				
ection (UTI) recu	rrent with supra pubic cathete	er				
-	-					
		,				
th catheter care.	nosi, una provide assistance					
sident F's medica	tion administration (MAR) /					
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/29/2023 155273 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4255 MEDWELL DR CYPRESS GROVE REHABILITATION CENTER NEWBURGH, IN 47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE treatment administration record (TAR) was reviewed from 10/1/23 through 11/29/23. Supra pubic catheter care every shift (started 6/4/19) was not provided on 10/1/23 (day shift), 10/11/23 (night shift), 11/6/23 (night shift), and 11/13/23 (day shift). 4. During a random observation on 11/28/23 at 12:25 P.M., Resident G was sitting in a wheelchair in her room. The resident's catheter tubing was resting on the room floor. During an interview on 11/29/23 at 9:50 A.M., RN 2 indicated staff should ensure that residents with a catheter have their catheter bags and tubing up off of the floor to help prevent UTI's. During an interview on 11/29/23 at 10:15 A.M., QMA 5 indicated catheter care should be charted each shift or more often if ordered, and that staff should document if a resident refuses catheter care. During an interview on 11/29/23 at 10:45 A.M., CNA 6 indicated staff should clean the residents catheters every day and empty the catheter drainage bag every shift. On 11/29/23 at 2:30 P.M., the facility administrator supplied a facility policy titled, Nursing, dated 6/2023. The policy included, "Policy: The nursing staff shall follow infection control guidelines to prevent the spread of infection... 2. Resident Care equipment: a. Licensed nursing staff is responsible for the insertion/removal of medical devices, including but not limited to, indwelling urinary catheters... b. Urinary catheters should have a catheter bag cover over them or a wash basin underneath them as a barrier to prevent catheter bag or tubing from touching the ground." R45F11 Event ID: Facility ID: 000173 Page 7 of 8 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

12/28/2023

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			SURVEY		
AND PLAN	LAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING		ILDING	00 COMPLI		ETED.			
		155273	B. WING		11/29/2023				
	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD EDWELL DR JRGH, IN 47630	-			
CIFRES	CYPRESS GROVE REHABILITATION CENTER								
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMI		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE		
	This citation relates 3.1-41(a)(2)	to complaint IN00421148.							

R45F11 Facility ID: 000173 If continuation sheet Page 8 of 8