STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Grove Rehabilitation Center	4255 Medwell Dr Newburgh, IN 47630

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on observation, interview, and record review, the facility failed to maintain a resident's dignity for 1 of 1 residents viewed during a random observation. (Resident 75) Finding includes: During an observation on 5/17/24 at 8:58 A.M., Resident 75's bedroom door was fully opened and Resident 75 was observed laying in bed and body was fully exposed. Resident 75 was not wearing pants, an incontinence brief, or covered with a bedsheet. QMA (Qualified Medication Aide) 22 was standing at the medication cart directly across the hall from Resident 75's room. She then took the medication cart towards the opposite end of the hall. At 9:01 A.M., CNA (Certified Nurses Aide) 15 responded to Resident 75's call light and placed an incontinence brief on Resident 75. On 5/15/24 at 11:07 A.M., Resident 75's clinical record was reviewed. Resident 75 was admitted on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, dysphagia, pneumonitis due to inhalation of food and vomit, and sepsis. The most recent Admission MDS (Minimum Data Set) Assessment, dated 3/25/24, indicated Resident 75 was cognitively intact, was completely dependent on staff for toileting, bathing, and transfers, and was receiving nutrition through a feeding tube. During an interview on 5/17/24 9:53 A.M., RN (Registered Nurse) 11 indicated residents should not be left exposed and CNA's should come get a nurse to pause feedings before performing incontinence care. On 5/17/24 at 10:51 A.M., a current policy titled Resident's Rights, dated 11/15, was provided by the Administrator and indicated Residents shall be assured of at least visual privacy in multi-bed rooms. Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs. Residents have the right to be suitably dressed at all times. 3.1-3(t)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on interview, observation, and record review, the facility failed to ensure residents who required assistance with Activities of Daily Living (ADLs) received showers for 6 of 7 residents reviewed for ADLs. (Resident 40, Resident 46, Resident 20, Resident 12, Resident 19, Resident 75) Findings include: 1. On 5/13/24 at 2:04 P.M., Resident 40 indicated he only got a shower once a week, but he would prefer to take a shower three times a week. At that time, Resident 40 was observed to have dandruff on his shirt. On 5/16/24 at 9:39 A.M., Resident 40's clinical record was reviewed. Diagnoses included, but were not limited to, primary hypertension and overactive bladder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 4/30/24, indicated Resident 40 had mild cognitive impairment, had no behaviors, and required partial to moderate assistance (staff does less than half) of staff for bathing. A current ADL (Activities of Daily Life) care plan, dated 11/14/19, included an intervention to offer showers two times per week and that the resident preferred showering in the evening. A January 2024 Point of Care (POC) (a charting system for CNAs [Certified Nurse Aide]) history indicated Resident 40 received a shower on 1/4/24, 1/14/24, 1/18/24, and 1/28/24. There were no complete bed baths documented in January. Resident 40 refused his shower on 1/9/24, 1/10/24, and 1/13/24. A February 2024 POC history indicated Resident 40 received a shower on 2/4/24, 2/8/24, 2/11/24, 2/22/24, and 2/29/24. There were no complete bed baths documented in February. Resident 40 refused his shower on 2/15/24 and 2/18/24. A March 2024 POC history indicated Resident 40 received a shower on 3/3/24, 3/10/24, 3/14/24, 3/24/24, and 3/28/24. There were no complete bed baths or refusals documented in March. An April 2024 POC history indicated Resident 40 received a shower on 4/4/24, 4/7/24, 4/19/24, 4/21/24, and 4/25/24. There were no complete bed baths documented in April. Resident 40 refused his shower on 4/11/24 and 4/28/24. A May 2024 POC history indicated Resident 40 received a shower on 5/5/24 and 5/16/24. There were no complete bed baths or refusals documented in May. A Shower assignment sheet, updated 5/14/24, indicated Resident 40 received showers on Thursday and Sunday during the day. 2. On 5/13/24 at 11:50 A.M., Resident 46 indicated she rarely got showers, but was supposed to get them twice a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/24 at 2:51 P.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, major depressive disorder, and anxiety disorder. The most current Significant Change MDS Assessment, dated 2/27/24, indicated Resident 46 had mild cognitive impairment, had no behaviors, and required substantial/maximal assistance (staff does more than half) of staff for bathing. A current ADL care plan, dated 7/24/23, included an intervention to offer showers two times per week and that the resident preferred showering in the evening. A January 2024 POC history indicated Resident 46 received a shower on 1/3/24, 1/6/24, 1/20/24, 1/24/24, and 1/31/24. There were no complete bed baths documented in January. Resident 46 refused her shower on 1/14/24. A February 2024 POC history indicated Resident 46 received a shower on 2/10/24, 2/18/24, and 2/26/24. There were no complete bed baths or refusals documented in February. A March 2024 POC history indicated Resident 46 received a shower on 3/3/24, 3/13/24, and 3/16/24. Resident 26 received a complete bed bath on 3/27/24. There were no refusals documented in March. An April 2024 POC history indicated Resident 46 received a shower on 4/3/24. There were no complete bed baths documented in April. Resident 46 refused her shower on 4/13/24. A May 2024 POC history indicated Resident 46 received a shower on 5/4/24. There were no complete bed baths or refusals documented in May. A shower assignment sheet, updated 5/14/24, indicated Resident 46 received showers on Monday and Thursday during the day. 46758 3. During an interview on 5/15/24 at 2:30 P.M., Resident 20 indicated showers were not received on a regular basis. On 5/16/24 at 10:24 A.M., Resident 20's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia, without behavioral disturbance, and vascular dementia. A current Quarterly MDS Assessment, dated 5/10/24, indicated Resident 20 was moderately cognitively impaired and needed set up assistance with bathing and dressing. Current physician orders included, but were not limited to: Activity level of resident - up ad lib (as desired) with walker, dated 12/8/21. The current ADL care plan, dated 12/8/21, indicated the resident required help with the ADL. Interventions included, but were not limited to, assist with bathing as per resident preference, offer showers two times a week, in the evenings. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 at 2:00 P.M., Human Resources (HR) 4 provided a copy of the weekly shower sheets for [Unit Name] which indicated the resident received evening showers on Tuesdays and Fridays. On 5/15/24 at 3:00 P.M., the POC charting in Resident 20's EMR (Electronic Medical Records) indicated that, on the following days, Resident 20 received showers from January 2024 to May 2024: January 2, 6, 9, 13, and 20. The POC only recorded one refusal on 1/30/24. February 13, 20, 23, and 27. The POC only recorded one refusal on 2/2/24. March 5,12, and 5 April 9, 14, and 26 May 3 ,7, and 10 48057 4. On 5/15/24 at 8:09 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia, osteoarthritis, and osteoporosis. The most recent Quarterly MDS Assessment, dated 2/16/24, indicated Resident 12 was severely cognitively impaired, was dependent on staff for transfers, and required maximal assistance from staff for toileting. A care plan included, but was not limited to: (Resident) requires assistance with ADL's; Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Start date: 3/29/22. On 5/17/24 at 10:52 A.M., Resident 12's shower record from 1/1/24 to 5/17/24 indicated Resident 12 received a complete bed bath or shower for that time period, with one refusal of care documented on 2/28/24, for the following dates: January: 1/4, 1/11, 1/25, 1/31 February: 2/4, 2/7, 2/8, 2/11, 2/13, 2/25 March: 3/6, 3/10, 3/31 April: 4/15, 4/17, 4/21 May: 5/5, 5/12, 5/15 5. On 5/14/24 at 2:42 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side and chronic pain. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent Significant Changes MDS Assessment, dated 4/22/24, indicated Resident 19 was cognitively intact, was dependent on staff for bathing and toileting, and required maximal assistance for transfers. A care plan included, but was not limited to: Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Start date: 6/4/19. Hospice Aide visits three times per week to provide ADL's, nursing facility will provide scheduled Hospice care in the event Hospice unable to make visit. Start date: 4/16/24. On 5/17/24 at 10:29 A.M., Resident 19's shower record from 1/1/24 to 5/17/24 indicated Resident 19 received a complete bed bath or shower for that time period, with no refusal of care documented, for the following dates: January: 1/18, 1/22, 1/30 February: 2/3, 2/19, 2/22, 2/26 March: 3/1, 3/15, 3/18, 3/20, 3/22, 3/25, 3/27 April: 4/1, 4/3, 4/5, 4/27 May: 5/6, 5/9 6. On 5/15/24 at 11:07 A.M., Resident 75's clinical record was reviewed. Resident 75 was admitted on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, dysphagia, pneumonitis due to inhalation of food and vomit, and sepsis. The most recent Admission MDS Assessment, dated 3/25/24, indicated Resident 75 was cognitively intact, was completely dependent on staff for toileting, bathing, and transfers, and was receiving nutrition through a feeding tube. A care plan included, but was not limited to: Assist with bathing as needed per resident preference. Offer showers (prefers complete bed baths) two times per week, partial bath in between. Start date: 3/19/24. On 5/17/24 at 11:07 A.M., Resident 75's shower record from 3/19/24 to 5/17/24 indicated Resident 19 received a complete bed bath or shower for that time period, with no refusal of care documented, for the following dates: March: none April: 4/14, 4/17, 4/22 May: none (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 at 2:53 P.M., the Director of Nursing (DON) indicated residents received a shower or complete bed bath 2 days a week. Partial bed baths were not an acceptable substitution because every resident received a partial bed bath during morning care every day. Some residents preferred showers three times a week which would be accommodated and documented in the care plan. Showers, complete bed baths, and refusals should be documented in the POC. She indicated shower sheets were to be used as a communication tool between the aide and nurse and did not necessarily need to be filled out. On 5/17/24 at 10:06 A.M., the Administrator indicated the QAPI (Quality Assurance and Performance Improvement) committee was aware there was an issue with residents getting their showers. They had been working on that issue for at least a year and it had improved. Now that they had staff documenting in POC, they needed to work on the accuracy of the documentation. At that time, he indicated there was no policy related to ADL care or showers. On 5/17/24 at 10:51 A.M., the Administrator provided a current Resident Care/ADL Sheet policy, dated 11/15, that indicated The Daily Living Flow Chart shall be used to document resident's daily care provided. On 5/17/24 at 11:21 A.M., the Administrator indicated that the facility did not have daily living flow charts. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-38(b)(2) 3.1-38(b)(3)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on observation, record review, and interview, the facility failed to ensure physician orders were followed and resident's nutritional feedings were administered for 2 of 2 residents reviewed for tube feedings. (Resident 75, Resident 68) Findings include: 1. During an observation on 5/17/24 at 8:58 A.M., Resident 75's bedroom door was fully opened and Resident 75 was observed laying in bed and body was fully exposed. Resident 75's feeding pump was running at a rate of 75 mL (milliliters) per hour, and the bottle containing the nutritional formula was dated 5/16/24 6:00 A.M. The gauze surrounding the base of the feeding tube was dated 5/15. On 5/15/24 at 11:07 A.M., Resident 75's clinical record was reviewed. Resident 75 was admitted on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, dysphagia, pneumonitis due to inhalation of food and vomit, and sepsis. The most recent Admission MDS (Minimum Data Set) Assessment, dated 3/25/24, indicated Resident 75 was cognitively intact, was completely dependent on staff for toileting, bathing, and transfers, and was receiving nutrition through a feeding tube. Current physician orders included, but were not limited to: Elevate HOB (head of bed) 30 degrees at all times every shift; start date 3/19/24. Cleanse G-tube (feeding tube) site with soap and water, pat dry, and apply gauze every shift; start date 3/19/24. Continuous feeding x22 hours formula: Jevity 1.5 mL per hour: 75 mL; twice a day 5/9/24. During an interview on 5/17/24 9:53 A.M., RN (Registered Nurse) 11 indicated CNA's (Certified Nursing Aide) should alert a nurse to pause feedings before laying a resident flat to perform incontinence care, and that she had not been notified to pause Resident 75's feeding during that day. During an interview on 5/17/24 at 9:55 A.M., CNA 15 stated she had paused the continuous feeding machine herself while performing incontinence care for Resident 75. 48147 2. On 5/13/24 at 10:04 A.M., Resident 68 was observed in her room laying on her bed with enteral nutrition running through a feeding tube at 38 mL/hr (milliliters per hour). The head of the bed was flat, and the nutrition was not labeled or dated. On 5/14/24 at 10:15 A.M., the enteral nutrition was observed turned off in Resident 68's room. Resident 68 was not in her room at that time. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 1:24 P.M., Resident 68 was observed in the Gardens lounge in her wheelchair and was not hooked up to enteral nutrition. On 5/15/24 at 2:06 P.M., Resident 68 was observed in the main lounge with a family member and was not hooked up to enteral nutrition. On 5/13/24 at 1:29 P.M., Resident 68's clinical record was reviewed. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, dysphagia, Barrett's esophagus, and profound intellectual disabilities. The most current Quarterly MDS Assessment, dated 3/21/24, indicated Resident 68 was rarely or never understood, was dependent on staff for eating and bed mobility, did not have weight loss, and received 51% or more of calories through a feeding tube. A current enteral feeding care plan, dated 6/28/23, included interventions to elevate the head of the bed and give tube feedings as ordered. Physician orders included, but were not limited to: Continuous Feeding Jevity 1.5 (a calorically dense liquid food) - 38 mL per hour x 22 hours, turn off daily between 2:00 A.M. and 4:00 A.M., dated 9/02/23. Elevate HOB 30 degrees at all times, dated 6/27/23. The MAR (Medication Administration Record) and TAR (Treatment Administration Record) for May did not include documentation of the Jevity 1.5 being turned on or off except for as it was ordered at 2:00 A.M. and 4:00 A.M. The clinical record lacked documentation that the enteral nutrition was turned off outside off the times ordered by the physician. On 5/16/24 at 11:50 A.M., Licensed Practical Nurse (LPN) 7 indicated that when the nutrition got turned off during the day it should be documented in the progress notes. On 5/17/24 at 10:57 A.M., the Administrator provided a current Enteral Therapy policy, revised 1/2016, that indicated a licensed nurse will take, note, and implement physician orders for enteral therapy. 3.1-44(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48147 Based on interview and record review, the facility failed to ensure routine medications were available and dispensed according to physician's orders for 1 of 5 residents reviewed for unnecessary medications. (Resident 71) Finding includes: On 5/15/24 at 8:45 A.M., Resident 71's clinical record was reviewed. Diagnosis included, but was not limited to, gastro-esophageal reflux disease (GERD). The most current Admission Minimum Data Set (MDS) Assessment, dated 2/14/24, indicated Resident 71 had mild cognitive impairment, had no behaviors, and required setup assistance for eating. A current GERD care plan, dated 2/16/24, included an intervention to administer medications as ordered. Physician's orders included, but were not limited to: omeprazole (medication to treat acid reflux) capsule, delayed release (DR) 20 mg (milligrams) orally once a day, dated 5/10/24. pantoprazole (medication to treat acid reflux) tablet, DR 40 mg orally once a day, dated 5/10/24. The May 2024 MAR (Medication Administration Record) indicated omeprazole and pantoprazole was not administered from 5/12/24 through 5/16/24 because the drug was unavailable. A review of the order administration indicated omeprazole and pantoprazole was reordered from the pharmacy on 5/10/24. A list of medications in the EDK (Emergency Drug Kit) indicated the following drugs were available: omeprazole DR, 20 mg - 15 available pantoprazole DR, 40 mg - 5 available On 5/16/24 at 11:50 A.M., Licensed Practical Nurse (LPN) 7 indicated medications ordered usually arrived on the same day because pharmacy came to the facility twice daily. If the medication didn't come, then staff should call the pharmacy. If the medication was in the EDK, it should be given from the EDK. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 2:53 P.M., the Director of Nursing (DON) indicated if a medication was unavailable, it should be given from the EDK. Staff should document why the medication was unavailable and should follow up with the pharmacy if it was not received by the next day. At that time, she indicated documentation related to the unavailability of Resident 71's omeprazole and pantoprazole was not in the clinical record like it should have been. On 5/17/24 at 10:52 A.M., the Administrator provided a current Reordering, Changing, and Discontinuing Orders policy, revised 1/1/22, that indicated facility staff should review the transmitted re-orders for status and potential issues and Pharmacy response. 3.1-25(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to maintain accurate medical records for 1 of 5 residents reviewed for unnecessary medications and 1 of 2 residents reviewed for tube feeding. (Resident 14 and Resident 75) Findings include: 1. On 5/16/24 at 10:01 A.M., Resident 14's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's, anxiety disorder, and recurrent depressive disorders. The most recent Significant Change MDS (Minimum Data Set) Assessment, dated 3/12/24, indicated Resident 14 was mildly cognitively impaired, required partial assistance with toileting and transfers, and was receiving antianxiety and antidepressant medications during the seven day lookback period. A social service note dated 2/21/24 12:16 P.M., indicated (Resident) participated in psychotherapy that day. During an interview on 5/17/24 08:47 A.M., Social Services indicated Resident 14 was in the hospital from 2/18/24 through 2/23/24, and the psychotherapy visit was documented in error. 2. On 5/15/24 at 11:07 A.M., Resident 75's clinical record was reviewed. Resident 75 was admitted on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, dysphagia, pneumonitis due to inhalation of food and vomit, and sepsis. The most recent Admission MDS (Minimum Data Set) Assessment, dated 3/25/24, indicated Resident 75 was cognitively intact, was completely dependent on staff for toileting, bathing, and transfers, and was receiving nutrition through a feeding tube. On 5/17/24 at 9:52 A.M., the DON (Director of Nursing) provided procedure documents that indicated Resident 75 was out of the building from 9 A.M. to 2:30 P.M. on 5/15/24 for an endoscopy, and from 9:15 A. M. to 2:30 P.M. on 5/16/24 for a colonoscopy. The clinical record from 5/15/24 to 5/17/24 lacked documentation of the departure from the facility and arrival back to the facility for Resident 75 on 5/15/24 and 5/16/24. On 5/17/24 at 10:52 A.M., the Administrator provided a document titled Documentation Guidelines for Nursing, revised date 6/23, that indicated the purpose: (is) to accurately document in an organized manner all information related to the resident in the medical record. On 5/17/24 at 10:52 A.M., the Administrator provided a document titled Leave of Absence, revised date 6/19, that indicated The licensed nurse will document resident status upon leave from the facility and upon return from leave, and any other pertinent information. 3.1-50(a)(2)