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	04/09/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. Based on record review and interview, the facility failed to accommodate resident food preferences in 6 random resident interviews. The cooked hot food was not always hot/warm when they are served. (Resident 2, Resident 4, Resident 5, Resident 21, Resident 25, Resident Council)Findings include: 1. During an interview on 4/6/26 at 8:49 A.M, Resident 4 indicated the cooked food was lukewarm.2. During an interview on 04/6/26 at 9:31 A.M., Resident 2 indicated the cooked food was sometimes cold when it got to their room. 3. During an interview on 4/6/26 at 9:45 A.M., Resident 5 indicated the cooked food was cold at times.4. During an interview on 4/6/26 at 9:39 A.M., Resident 25 indicated the cooked food was sometimes cold. 5. During an interview on 4/6/26 at 10:07 A.M., Resident 21 indicated the cooked food was cold and not always cooked thoroughly if they ate in their room. 6. During a Resident Council meeting on 4/7/26 at 2:15 P.M., three anonymous residents indicated the food was not always warm if they ate in their room. During an interview on 4/9/26 at 11:15 A.M, the Dietary Manager indicated the food must be served at an adequate temperature and with palatable taste, and that resident food preferences were accommodated. On 4/9/26 at 12:48 P.M., the Administrator provided a current Food Temperatures policy, revised 5/2025. The policy indicated .all hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food.410 IAC (Indiana Administrative Code) 16.2-3.1-3(v)(1)

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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure medications were not left at bedside for a resident to self administer without completion of a self administration of medications assessment during a random observation. (Resident 2) Finding includes:During a random observation on 4/6/26 at 9:29 A.M., Resident 2 had a medication cup on her bedside table with a small white round pill with imprint 111. Resident 2 indicated she was unsure what pill it was. The medications in the medication cart for Resident 2 were reviewed at that time, the pill was determined to be exemestane 25 milligrams (mg) (steroidal drug). On 4/8/26 at 1:21 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of upper-inner quadrant of left female breast. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/5/26, indicated Resident 2 was cognitively intact and was independent for eating. Physician orders included, but were not limited to: exemestane tablet 25 mg oral once a day; Start date 10/9/23 During an interview on 4/9/26 at 11:35 A.M., the Director of Nursing (DON) indicated Resident 2 did not have a self-administration of medications assessment. On 4/9/26 at 12:48 P.M., the Administrator provided a policy titled Self Administration of Medications, revised 1/2008, that indicated The nurse at the Community must also evaluate each resident who self-administers his or her medication by completing the Self-Administration of Medication Assessment form. The nurse will approve each resident that self-administers medication to ensure safe and effective procedures are followed. 410 IAC (Indiana Administrative Code) 16.2-3.1-11(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) Assessments were completed accurately for 1 of 5 residents reviewed for medication usage (Resident 10) and 1 of 5 residents reviewed for falls (Resident 39). Findings include:1. On 4/7/26 at 8:57 A.M., Resident 10's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease and major depressive disorder.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 3/30/26, indicated Resident 10 had severe cognitive impairment and received an antidepressant during the 7-day lookback period.The clinical record lacked an active physician order for an antidepressant medication between 3/23/26 and 3/30/26. The March 2026 electronic Medication Administration Record (eMAR) lacked documentation that an antidepressant medication was administered to Resident 10 between 3/23/26 and 3/30/26.2. On 4/7/26 at 10:57 A.M., Resident 39's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/30/26, indicated Resident 39 had severe cognitive impairment and had one fall with no injury since the prior assessment on 12/29/25.The clinical record lacked documentation to indicate Resident 39 fell between 12/30/25 and 3/30/26.During an interview on 4/9/26 at 10:50 A.M., the Administrator indicated Resident 39 did not fall between 12/30/25 and 3/30/26.During an interview on 4/9/26 at 11:22 A.M., the Regional Clinical Nurse indicated that the MDS Assessments dated 3/30/26 for Resident 10 and Resident 39 were both wrong. The MDS Coordinator looked at the wrong dates for the fall and antidepressant.During an interview on 4/9/26 at 12:48 P.M., the Administrator indicated that the facility followed Resident Assessment Instrument (RAI) guidelines to code MDS Assessments.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to ensure a resident's plan of care was implemented for 1 of 1 residents observed outside. (Resident 57) Finding includes: During an observation on 4/8/26 at 1:15 P.M., Resident 57 was observed outside in his wheelchair in the facility courtyard by himself. Resident 57 was sitting in direct sunlight and did not have a drink with him. During an interview on 4/8/26 at 1:29 P.M., Resident 57 indicated staff always leave him outside unattended, he had no way to notify staff when he was ready to go back inside, stated he was not offered sunscreen, and was ready to go back inside. On 4/8/26 at 2:10 P.M., Resident 57's clinical record was reviewed. Diagnoses included, but were not limited to, paraplegia. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/16/26, indicated Resident 57 was moderately cognitively impaired, was dependent on staff (staff does all of the work) for transfers, and utilized a manual wheelchair for mobility. The current care plan included, but was not limited to: Resident likes to go outside building in unsecured area. Resident is not an elopement risk, when outside resident does not leave the facility property, resident has BIMS of 13 and has been educated on notifying staff when he is out of building and to stay on sidewalk and not in parking lot; Start date 8/15/18Interventions included, but were not limited to:Encourage resident to have drink of choice when outside, supply sunscreen to resident when outside and assist with applying when appropriate, offer assistance in/out doors. During an interview on 4/8/26 at 1:56 P.M., Registered Nurse (RN) 5 indicated there was no monitoring system or set time periods to check on Resident 57 while he was outside unattended but staff often told the resident a time limit he could be outside. RN 5 indicated Resident 57 was not wearing sunscreen because he often refused it when it was previously offered. Resident 57's physician orders lacked an order for sunscreen available to offer to the resident. On 4/9/26 at 12:48 P.M., the Administrator provided a policy titled Comprehensive Care Plan, revised 10/2025, that indicated Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each OBRA MDS assessment. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(1)410 IAC 16.2-3.1-35(b)(2)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to ensure residents were provided bathing on their scheduled days for 2 of 4 residents reviewed for bathing. (Resident 25 and Resident 18) Findings include: 1. On 4/9/26 at 10:24 A.M., Resident 25's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/13/26, indicated Resident 25 was cognitively intact and required partial assistance from staff (staff does half of the work) for bathing. A grievance form, dated 10/29/25, indicated Resident 25 was not getting her showers and was not getting her hair washed. The form indicated staff were educated on preference of shower not a complete bed bath. A shower schedule, updated 4/1/26, indicated Resident 25's shower dates were Tuesday and Friday. Shower documentation reviewed in the electronic medical record and paper shower documents indicated Resident 25 had not received a shower on the following scheduled days from 3/9/26-4/9/26: 3/10/263/27/263/31/26 2. On 4/9/26 at 8:49 A.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent admission Minimum Data Set (MDS) Assessment, dated 3/18/26, indicated Resident 18 was cognitively intact and required supervision from staff during bathing. A shower schedule, updated 4/1/26, indicated Resident 18's shower dates were Wednesday and Saturday. Shower documentation reviewed in the electronic medical record and paper shower documents indicated Resident 18 had not received a shower on the following scheduled days from 3/11/26-4/9/26:3/14/263/18/263/25/26 Shower documentation indicated Resident 18 refused a shower on 4/8/26 due to the shower being offered outside of his preferred shower time. On 4/19/26 at 12:48 P.M., the Administrator provided a policy titled Residents Rights, revised 7/2023, that indicated All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care 410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3)

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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. Based on observation, record review, and interview, the facility failed to ensure documentation of skin assessments and medication administrations were completed accurately and timely for 1 of 3 residents reviewed for activities of daily living (ADL) and 1 of 5 residents for medication administration. (Resident C, Resident G)Findings include:1. During an observation of incontinence care on 4/8/26 at 10:37 A.M., Resident C was observed to have a large purple discoloration on a large area of both right and left buttocks. Barrier cream was applied to the area. On 4/7/26 at 2:00 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, hemiplegia, and left below the knee amputation. The current Quarterly Minimum Data Set (MDS) Assessment, dated 4/1/26, indicated that Resident C was cognitively intact. Resident C needed setup assistance for eating, substantial to maximum assistance for hygiene, and was dependent on staff for dressing and transferring. A skin assessment was completed but there was no indication of skin discoloration. Physician orders included, but were not limited to the following:House barrier cream to bilateral buttocks each shift, dated 12/22/26.Weekly skin and vital sign assessments on Thursdays, dated 12/22/26. The current skin integrity care plan, dated 12/22/25, included, but were not limited to, the following interventions:Assess and document skin condition weekly and as needed. Notify MD (Medical Doctor) of abnormal findings, dated 12/22/25.House barrier cream at bedside - use as needed, dated 12/22/25. An after-visit hospital assessment, dated 12/15/25, indicated the resident had a non-blanchable purple discoloration on her buttocks. An admission nursing observation, dated 12/19/25 at 11:40 A.M., indicated the resident had no skin discolorations. A weekly nursing skin observation, dated 12/25/25 at 10:41 A.M., indicated the resident had a surgical wound but lacked documentation of any skin discolorations. The most recent skin observation, dated 4/2/26 at 8:51 A.M., indicated there were no skin discolorations noted. During an interview on 4/8/26 at 10:40 A.M., Registered Nurse (RN) 3 indicated the resident had a purple discoloration on her buttocks since admission. During an interview on 4/8/26 at 11:10 A.M., the Wound Nurse indicated the resident had purple discoloration on her buttocks since admission, but staff did not document the presence of it. 2. On 4/7/26 at 10:43 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent admission Minimum Data Set (MDS) Assessment, dated 1/15/26, indicate Resident G was moderately cognitively impaired and required setup assistance from staff for eating. Physician orders included, but were not limited to: calcitonin-salmon spray (a medication used to treat postmenopausal osteoporosis), non-aerosol; 200 unit/actuation; 1 spray by nasal, left nostril every other day; Start date 3/26/26 calcitonin-salmon spray, non-aerosol; 200 unit/actuation; 1 spray by nasal, right nostril every other day; Start date 3/27/26 A pharmacy consult report, dated 3/23/26, indicated the pharmacist noted staff were not giving calcitonin spray as ordered, and suggested staff be educated on how to properly administer the medication. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The electronic Medication Administration Record (eMAR) indicated that from 3/26/26 to 4/9/26 staff gave Resident G calcitonin in the left nostril two out of seven administrations when the order was for the right nostril, and gave calcitonin in the right nostril three out of eight administrations when the order was for the left nostril. During an interview on 4/9/26 at 9:58 A.M., the Director of Nursing (DON) indicated staff were administering calcitonin spray to Resident G as ordered, but were not documenting it correctly. On 4/9/26 at 1:09 P.M., the Administrator provided a current Documentation policy, revised 8/2025. The policy indicated for staff to accurately document in an organized manner all information related to the resident in the medical record . Weekly Skin and vital sign assessment observation (All new skin areas must be reported to the wound nurse with new skin event completed) . Wound management entries for all ulcers and for non-ulcer areas that are not healing or showing signs of improvement. This citation relates to Intake 2803351. 410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1) 410 IAC 16.2-3.1-50(a)(2)