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	01/08/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident had orders from the attending practitioner for oxygen therapy use and maintenance of equipment. A resident documented as using oxygen therapy had no physician orders for use. (Resident B) Finding includes: On 1/7/26 at 9:14 a.m., Resident B's clinical record was reviewed. Diagnoses included, but was not limited to, nontraumatic acute subdural hemorrhage, chronic obstructive pulmonary disease, morbid (severe) obesity due to excess calories, and obstructive sleep apnea. An admission Minimum Data Set (MDS) dated [DATE] was not coded for oxygen therapy. Resident B had been discharged to the hospital on 1/4/26. Care plans were reviewed and included, but were not limited to:The resident has potential for impaired gas exchange related to: Head elevated while in bed to alleviate shortness of breath while lying flat, related to diagnosis of COPD (chronic obstructive pulmonary disease), and sleep apnea. Approaches included but were not limited to: Administer oxygen as ordered, start date 11/14/25. Progress notes were reviewed and included, but were not limited to: 11/13/25 at 11:28 a.m., This nurse recieved (sic) report from [name of nurse]. Resident is a max 2 assist stand pivot transfer. O2 on 3 liters . 11/17/25 at 12:14 a.m., .Cardiac/ Respiratory Assessment: Breath sounds clear throughout, Resident uses Bi-Pap or C-Pap, Respirations are even and easy, Resident requires/uses oxygen (device/LPM) 2 L (liters) pr NC (nasal cannula) . 1/4/26 at 12:28 p.m., .resident on 2 L o2 via NC . The following dates were documented in progress notes that Resident B had oxygen on per nasal cannula: 11/13/2511/14/2511/15/2511/17/2511/21/2511/21/2511/22/2511/24/2511/26/2511/27/2511/29/2512/1/2512/3/ orders for November and December 2025, January 2026, were reviewed. No orders for oxygen therapy to be applied or maintenance of equipment were in the clinical record. On 1/8/26 at 9:20 a.m., CNA 2 indicated Resident B had been on continuous O2 therapy per nasal cannula, CNA's filled the oxygen tank when needed, O2 was put on the resident when staff got him out of bed. On 1/8/26 at 9:27 a.m., LPN 3 indicated Resident B was on O2 when he was admitted , he used a C-Pap at night, she believed he was weaned off oxygen therapy, and was supposed to just use a C-Pap On 1/8/26 at 9:28 a.m., the DON indicated she would have to check Resident B's record, but was almost positive he was on continuous O2 therapy, and thinks it was an admission order. On 1/8/26 at 11:44 a.m., the DON indicated the facility did not have a policy on oxygen therapy; they follow the policy from the medical service they use to obtain supplies. This citation relates to Intake 2707908. 3.1-47(a)(6)

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