STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155712	A. BUILDING 00 B. WING	12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COVERED BRIDGE HEALTH CAMPUS	1675 W TIPTON ST SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: November 27, 28, 29, 30, December 1, and 4, 2023 Facility number: 003342 Provider number: 155712 AIM number: 200403740 Census Bed Type SNF/NF: 37 SNF: 15 Residential: 17 Total: 69 Census Payor Type: Medicare: 5 Medicaid: 27 Other: 20 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 10, 2023.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Recertification Survey conducted 12/4/2023. We are requesting a Desk Review for our Plan of Correction for this survey. Please accept this Plan of Correction as the provider's credible allegation of compliance as of 12/22/2023.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Short	Executive Director	12/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin 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 disclo 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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	injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation and interview, the facility failed to report the misappropriation of money for 1 of 1 resident reviewed for personal property. (Resident 16) Findings include: During an observation and interview on 11/27/23 at 1:54 P.M., Resident 16 was sitting in his room on his wheelchair. The resident indicated on Thanksgiving Eve (11/22/23) he had $1,024.00 missing from his fanny pack. He had gone to the bathroom, located in his room, to get cleaned up and placed the fanny pack in his recliner with a blanket over it. The next morning, he realized the money was missing. He reported it to a nurse, and	F 0609	F609 - Reporting of Alleged Violations It is the practice of this practice of this provider that all allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknow source and misappropriation of resident property are immediately reported. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Staff Educated	12/22/2023

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	she called the police. He had not talked to the Administrator as she had been off work. During an interview on 11/28/23 at 2:50 P.M., RN 4 indicated on the morning of 11/23/23, Resident 16 came to her saying he was missing $900.00. She had him recount his money just to make sure and she sent a message to the DON (Director of Nursing). She didn't hear anything back from the DON, so she called the police, and they came and talked to the resident. During an interview on 11/29/23 at 1:47 P.M., the Administrator indicated she had interviewed all of the staff and other residents. She could not confirm that staff had taken the resident's money as he had lots of outside visitors. The resident had been educated to not have large sums of money on him and he had been offered to place his money in a trust with the business office. He had since gotten a safe and was putting his money in there. Law enforcement was still involved and it was an open case. She should have been contacted immediately when the resident reported the missing money on 11/22/23. She was not notified until 11/27/23. She reported the incident as soon as she was notified. The current facility policy titled, "Abuse and Neglect Procedural Guideline" with a revised date of 08/29/2019, was provided by the Administrator on 11/29/23 at 3:02 P.M. The policy indicated, "...Reporting/response...Any staff member, resident, visitor or resident representative may report known or suspected abuse, exploitation, neglect, or misappropriation to local or state agencies. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property,		regarding proper reporting per the Abuse Policy. All staff will be educated to ensure they speak directly to the Executive Director/DHS when there is a need to report an allegation of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Staff were educated the appropriate reporting guidelines with residents residing in the campus concentrating on reporting immediately to the ED/DHS when an alleged abuse accusation occurs. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ED/Designee will interview 10% of staff to ensure they are aware of the abuse reporting guidelines. Anyone requiring additional education will have it provided at the time of review. The ED/DHS/designee will be responsible for ensuring that staff are interviewed weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive	

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	are reported immediately, but no later than 2 hours after the allegation is made..." 3.1-13(g)(1)		quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? The results of audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will past 6 months if warranted until 100% compliance is met.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs			

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	listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to label and store medications appropriately for 1 of 2 medications carts (200 Hall) and 1 of 1 medication rooms (Health Care Medication Room) observed. Findings include: 1. The 200 Hall Medication Cart was observed on 12/04/23 at 9:08 A.M., with RN 6 and contained the following: - a Lispro insulin pen for Resident 108, containing 100 units of insulin, with no open date, - an unopened Basalgar insulin pen for Resident 108 with a sticker that indicated to refrigerate until opened. The pen was in the same package as an opened Basalgar pen for the resident. The RN indicated the one pen was not opened and should have been in the refrigerator, - a Lantus insulin pen for Resident 40, containing about 30 units of insulin, with no open date, and - a Novolog insulin pen for Resident 37, containing 200 units of insulin, with no open date. RN 6 indicated the insulin pens were good for 28 days after they were opened and should have all been labeled with an open date. The current "Humalog Insulin Lispro Instruction	F 0761	F /Store Drugs and Biologicals p paraid="648387853" paraeid="{7f888df0-7263-4a1e-9349-9126997b71c7}{134}" >It is the practice of this provider to ensure that the labeling and storage of Drugs and Biologicals used in the facility are labeled in accordance with currently accepted professional include the appropriate accessory and cautionary instructions and the expiration date when applicable. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Licensed nursing on the proper labeling Insulin vials/pens and TB solution when opened. 2 be identified and what corrective action will be taken? All residents that have ordered insulin or TB injection have the	12/22/2023

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	for Use" was provided by the DON (Director of Nursing) on 12/04/23 at 9:53 A.M. The instructions indicated, "...Opened Humalog vials, prefilled pens, and cartridges must be thrown away 28 days after first use, even if they still contain insulin..." The current "Basaglar Instructions for Use" was provided by the DON on 12/04/23 at 9:53 A.M. The instructions indicated, "...Store unused pens in the refrigerator..." The current "Lantus Package Insert" with a revision date of December 2020, was provided by the DON on 12/04/23 at 9:53 A.M. The insert indicated, "...Shelf life after first use of the pen...The medicinal product may be stored for a maximum of 4 weeks..." The current " Novolog Instructions for Use" with a revised date of December 2012, was provided by the DON on 12/04/23 at 9:53 A.M. The instructions indicated, "...Store the FlexPen you are currently using out of the refrigerator...for up to 28 days..." 2. During an observation and interview of the Health Care Medication Room with RN 7 the refrigerator contained a vial of Tuberculin Serum. The bottle was 1/4 full. The bottle was undated. RN 7 indicated the serum was good for 30 days after it was opened. During an interview on 12/04/23 at 9:53 A.M., the DON indicated the TB serum was delivered from the pharmacy on 10/16/23. There was no way to determine when the serum was opened. The current "Apisol Package Insert" was provided by the DON on 12/04/23 at 9:53 A.M.		potential to be affected by the alleged deficient practice. All insulin pens and TB solution audited for dates when opened. Any not dated discarded and reordered from the pharmacy. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DHS/designee will be responsible for auditing med carts and refrigerators for insulin or TB solution not dated when opened weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 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 QAPI committee overseen by the ED. 4: How be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? The results of audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6	

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	The package insert indicated, "...Vials in use for more than 30 days should be discarded..." 3.1-25(j) 3.1-25(k)(6)		months to ensure substantial compliance is maintained. Ongoing monitoring will past 6 months if warranted until 100% compliance is met.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: November 27, 28, 29, 30, December 1, and 4, 2023 Facility number: 003342 Residential Census: 17 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 10, 2023.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Recertification Survey conducted 12/4/2023. We are requesting a Desk Review for our Plan of Correction for this survey. Please accept this Plan of Correction as the provider's credible allegation of compliance as of 12/22/2023.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of			

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	medication staff. Based on record review and interview, the facility failed to follow a physician's order related to hold parameters for 1 of 7 residents reviewed for pharmacy services. (Resident 204) Findings include: The clinical record for Resident 204 was reviewed on 12/04/23 at 12:06 P.M. The diagnoses included, but were not limited to, dementia and stroke. A physician's order, dated 11/22/22 through 12/04/23, indicated the resident was to take Eliquis (a blood thinning medication), 5 mg (milligrams), twice a day, for history of a stroke. A current physician's order, dated 12/01/23, indicated the resident was start Eliquis, 2.5 mg, twice a day, for history of a stroke, on 12/03/23. A Nurse Practitioner visit note, dated 12/01/23, indicated a new order to hold "Eliquis today and tomorrow then restart Sunday (12/03/23) at 2.5 mg P.O. (by mouth) BID (twice a day)." The December 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had received both Eliquis 5 mg and Eliquis 2.5 mg (for a total of 7.5 mg) on the following dates and times: - On 12/03/23 from 6:00 A.M. to 10:00 A.M. - On 12/03/23 from 6:00 P.M. to 10:00 P.M. - On 12/04/23 from 6:00 A.M. to 10:00 A.M. The facility failed to discontinue the order for Eliquis 5 mg twice a day.	R 0296	R296 It is the practice of this provider to follow the physician's order when the residents. p paraid="2050694413" paraeid="{f622f5ce-1946-4ef4-a0fe-12f3dd872ff6}{37}" >1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident cited did not have any adverse reactions. was clarified with . ·Educate all licensed nursing staff on the on the proper process of discontinuation of meds within the MAR, not utilizing the HOLD option for meds needing discontinued. 2 be identified and what corrective action will be taken? Education of all licensed nursing staff will all residents residing in the facility. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	12/22/2023

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	During an interview on 12/04/23 at 12:06 P.M., LPN (Licensed Practical Nurse) 8 indicated the Eliquis 5 mg order should have been discontinued on 12/03/23. The current facility policy titled, "AL - Physician's Orders Guidelines", with a reviewed date of 03/24/22, was provided by the Assistant Director of Nursing on 12/04/23 at 12:28 P.M. The policy indicated, "...To provide guidelines for obtaining and follow through of physician orders..."		All medication changes will be reviewed by the DHS/Designee in CCM to ensure physician's orders are accurate on the MAR. ·The DHS/designee will be responsible for monitoring medication changes are properly documented in the MAR in times 4 weeks, bi-monthly times 2 months, monthly times 4 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 QAPI committee overseen by the ED. 4: How be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? The results of audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will past 6 months if warranted until 100% compliance is met.	

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R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interview, the facility failed to label medications appropriately for 1 of 1 medication room observed. Findings included: During an observation and interview of the Assisted Living Medication Room on 12/04/23 at 10:38 A.M., with LPN (Licensed Practical Nurse) 5 the following was observed: - a tuberculin serum vial that contained 1/4 solution with no open date. During an interview on 12/04/23 at 10:40 A.M., LPN (Licensed Practical Nurse) 5 indicated the serum was good for 30 days and should have had an open date on it. The current "Apisol Package Insert" was provided by the DON on 12/04/23 at 9:53 A.M.	R 0301	p paraid="318692580" paraeid="{f622f5ce-1946-4ef4-a0fe-12f3dd872ff6}{191}" >It is the practice of this provider to ensure that the labeling and storage of Drugs and Biologicals used in the facility are labeled in accordance with currently accepted professional include the appropriate accessory and cautionary instructions and the expiration date when applicable. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Licensed nursing staff were educated on the proper labeling of	12/22/2023

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	The package insert indicated, "...Vials in use for more than 30 days should be discarded..."		TB solution when opened. ul class="BulletListStyle1 SCXW177207000 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" No residents were affected by the alleged deficient practice. 2 be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All med carts and refrigerators were inspected by the DHS or for any other TB solutions opened and not dated. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DHS/designee will be responsible for auditing med carts and refrigerators for insulin or TB solution not dated when opened times 4 weeks, bi-monthly times 2 months, monthly times 4 and then	

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			quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? The results of audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will past 6 months if warranted until 100% compliance is met.	