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	09/29/2022

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: September 22, 23, 26, 27, 28, and 29, 2022 Facility number: 003342 Provider number: 155712 AIM number: 200403740 Census Bed Type: SNF/NF: 38 SNF: 15 Residential:10 Total: 63 Census Payor Type: Medicare: 10 Medicaid: 27 Other: 16 Total: 53 These deficiencies reflect/reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 5, 2022.	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 9/29/2022. We respectfully request desk review in lieu of a post survey review. Please accept this Plan of Correction as the provider's credible allegation of compliance as of 10/24/2022.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

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

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow the physician's orders related to hypoglycemia, to complete neurological assessments related to falls, and to initiate monitoring of a wound for 1 of 14 residents reviewed for quality of care. (Resident 45) Findings include: 1a. During an observation on 09/23/22 at 9:56 A.M., Resident 45 was lying in her bed, awake. The clinical record for Resident 45 was reviewed on 09/26/22 at 11:52 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/23/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, diabetes, seizure, anxiety, depression, bipolar, and schizophrenia. An open-ended physician's order, with a start date of 12/14/21, indicated the nursing staff were to check the resident's blood sugar (blood glucose) once a day, from 1:00 A.M. to 3:00 A.M. An open-ended physician's order, with a start date of 12/16/21, indicated if the resident's blood sugar was 50 to 69, the nursing staff were to give the resident a 15-gram carbohydrate oral feeding four times a day as needed, and wait 15 minutes and recheck blood sugar. If the blood sugar was less than 70, staff were to repeat the 15-gram of carbohydrate snack. The 15-gram carbohydrate, oral feeding, included one of the following: - 1 tube of glucose gel, - 4 ounces of any juice without adding sugar,	F 0684	**F 684 Quality of Care** It is the practice of this provider to follow physician's orders related to hypoglycemia, to complete neurological assessments related to falls, and to initiate monitoring of wounds. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident # 45 – 1a) Resident did not have any ill affects from failure to follow hypoglycemic interventions related to blood sugar results. 1b) Resident has no ill affects suffered from missed neurological checks following a fall. 1c) Area noted to resident's toe has a skin event open and wound management event open and is improving. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All like residents have the potential to be affected by the alleged deficient practice.	10/24/2022

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	- 4 ounces of regular soda pop, or - 8 ounces of low-fat/non-fat milk. The July and September 2022 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had the following blood sugars: - 07/31/22, a blood sugar of 57, - 09/25/22, a blood sugar of 58, and - 09/26/22, a blood sugar of 56. The resident's clinical record lacked any documentation that the resident had received a snack or that the MD was notified of the blood sugars. During an interview on 09/28/22 at 2:22 P.M., RN 7 indicated if a resident had an out of range vital, such as blood sugar, she would notify the MD and document any new orders as appropriate. Resident 45 was a brittle diabetic. The facility had a protocol if a residents' blood sugar was 60 or below the nurse was to follow the instructions on the order and call the MD for further orders. She would also notify the family. During an interview on 09/28/22 at 3:06 P.M., the DON (Director of Nursing) indicated the resident had an order to monitor the blood sugar in the middle of the night to monitor for hypoglycemia. If the resident had a low blood sugar the nurse should offer her a snack or follow the hypoglycemic protocol. If the resident was coherent, they would offer oral measures. If the resident's blood sugar was below 60 the nurses should document in the EMAR/ETAR, or a progress note the type of intervention that was		· Review all residents with orders for hypolglycemic intervention protocol · Conduct 100% skin sweep for all current residents 10/13/2022· Review all residents at high risk or with recent falls to ensure that all interventions have been updated and are in place· Education of all nursing staff related to following blood glucose monitoring interventions and the documentation of interventions will ensure that all residents affected will be addressed. · 1a) Physician Orders have been updated to prompt nurses to answer that intervention has been completed related to insulin orders. 1b) 100% skin audit and education of staff related to identifying and reporting any new skin areas coinciding with assigned shower days, weekly skin assessments and monthly skin sweeps. 1c) Monitor through audit tool to ensure compliance. Fall events will not be closed until neurological checks are completed as indicated. · Skin sweeps will be conducted to ensure all areas and any new areas of skin impairment are properly identified and treatments are implemented or updated as needed. **4: How the corrective action will be monitored to ensure the**	

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	used. The resident had not suffered ill effects and did not have to be sent to the hospital due to the low blood sugars. The current facility policy, titled "Hyper/Hypoglycemia", with a review date of 03/18/22, was provided by the DON on 809/29/22 at 9:10 A.M. The policy indicated, "...To ensure appropriate medical treatment is provided to residents experiencing hyper/hypoglycemic episodes..." 1b. During an observation and interview on 09/23/22 at 9:56 A.M., Resident 45 was lying in her bed, awake. She indicated she had a sore on the top of one of her right toes. She was unsure what happened to it and had noticed it was bleeding a few days prior. The nursing staff would come in and check on it. There currently was no dressing on the toe. There was a pencil eraser size area to the toe that was pink in color. During an observation on 09/26/22 at 10:27 A.M., Resident 45 was lying in her bed. Her call light was in reach. She was awake and alert. The resident's right foot was without a sock. Her forth toe was dark in color. The clinical record lacked any indication the resident had an area to her right forth toe. During an interview on 09/29/22 at 9:31 A.M., RN 10 indicated the resident had a spot on one of her right toes that had been there for a few weeks. They were applying skin prep to the toe and covering it with a band aid. When a resident had a new skin area, the nurse would open an event. The event would talk about the wound and the size. If the resident had an area that was just red and not open, then they wouldn't create an event		**deficient practice will not recur i.e. what quality assurance program will be put into place?** The DNS/designee will be responsible for auditing the care plan/interventions for residents with blood glucose monitoring orders to ensure proper interventions have been provided; residents at risk for wound development or with any new skin areas to ensure appropriate interventions are in place. They will also be responsible for ensuring that neurological checks are conducted as indicated on all residents with a fall . These residents will be reviewed during CAR meeting 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 CQI committee overseen by the ED. !--[if="" !supportannotations]--="">	

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	for it. They would have an order to monitor it each shift. The resident did not have an order to monitor the toe. During an observation and interview on 09/29/22 at 9:46 A.M., the resident was sitting in her wheelchair in the bathroom. She gave permission for the ADON (Assistant Director of Nursing) to observe her toe. The ADON washed her hands and donned gloves. She removed the resident's sock and band aid to the right forth toe. The resident had a blister that was dark purple in color. The ADON indicated she was unaware of the area and if a resident had a new skin condition the nurse would create an event or progress note. The resident should have had an event and monitoring of the toe. A Skin Integrity Event, dated 09/29/22 at 10:07 A.M., indicated the resident had a blister the right forth toe. The area measured 1 cm (centimeter) X (by) 1 cm. A treatment was in place for skin prep to the blister and cover with a band aid. The Nurse Practitioner was notified. The current facility policy titled "Bruise, Rash, Lesion, Skin Tear, Laceration Assessment", with a most recent revision date of 05/10/16, was provided by the DON on 09/29/22 at 10:25 A.M. The policy indicated, "...May complete Skin Tear/Laceration Event in EHR (Electronic Health Record)...if the Skin Tear/Laceration warrants documentation due to the extent and/or location...One weekly follow-up assessment may be completed to ensure...in the process of healing...If further follow-up is needed, documentation may be placed in a progress note..." 1c. During an observation on 09/28/22 at 12:40			

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	P.M., Resident 45 was sitting in the dining room with her family member. There were no concerns observed. During an interview on 09/28/22 at 2:22 P.M., RN 7 indicated when a resident had a fall, she would assess the resident for injuries. If the resident was able to be moved, then they would be assisted up. If the resident's fall was unwitnessed or if they hit their head the nurse would complete neurological assessments for 24 hours. The nurse would initiate an immediate intervention and then the management team would either agree or disagree with the intervention. During an interview on 809/28/22 at 3:06 P.M., the DON (Director of Nursing) indicated when a resident had a fall the nurse would complete their assessment, open a fall event, and notify the family and MD. The nurse would implement an immediate intervention. The IDT (Interdisciplinary Team) would review the fall and either agree or disagree with the intervention. If they had disagreed with the immediate intervention a new intervention would be initiated immediately. The neurological checks would be initiated for 24 hours if a resident's fall was unwitnessed, or if they hit their head. A Fall Event, dated 04/12/22 at 12:25 A.M., indicated the resident had an unwitnessed fall in the bathroom. There were no injuries noted. The resident had neurological checks completed for the first hour after the fall. A Fall Event, dated 04/13/22 at 3:08 A.M., indicated the resident had an unwitnessed fall in the bathroom. The resident had obtained a skin tear to the left forearm. The resident had neurological checks completed for the first hour			

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	after the fall. The clinical record lacked documentation the neurological checks were completed for 24 hours after the falls. During an interview on 09/29/22 at 11:01 A.M., the DON indicated the resident should have neurological checks completed for 24 hours after each unwitnessed fall. The current facility policy titled, "Guidelines for Neurological Checks", with a revised date of 03/16/22, was provided by the DON on 09/29/22 at 11:15 A.M. The policy indicated, "...to evaluate the level of consciousness, evaluate pupil response, motor function, and vital signs that may alert staff for potential for head injury or seizure activity...Neuro-checks for 24 hours should be completed within the Fall Event Form... 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent			

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	new ulcers from developing. Based on interview, observation, and record review, the facility failed to prevent the formation of a pressure ulcer and an increase in the stage (severity) of a pressure ulcer for 1 of 3 residents reviewed. (Resident 41) Findings include: During an interview on 09/22/22 at 1:10 P.M., Resident 41 indicated the wound on his foot bothered him sometimes. During an interview on 09/27/22 at 11:28 A.M., the DON (Director of Nursing) indicated the resident was admitted from another facility, was a type 1 diabetic, and had several ulcers to both heels and toes. He started being seen at the wound clinic while a resident at this facility. If the facility saw that a wound was not healing well, they would get an outside opinion from a specialist. He admitted to this facility with a stage 2 (partial thickness skin loss with exposed dermis) pressure ulcer to his left heel. The wound had eschar (dry, dead) tissue now and it was an unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] and/or eschar [tan, black or brown] in the wound bed) pressure ulcer. He currently had a Podus (pressure relieving foam) boot in place. They had gotten an order to take the Podus boot off at night due to the resident obtaining stage 1(intact skin with non-blanchable redness of a localized area) pressure ulcers to the top of his foot and lateral ankle from the boot. His skin was very fragile. They had a wound nurse, the ADON (Assistant Director of Nursing) assessed the wounds weekly, measured them, and notified the physician if the wounds had gotten worse. They were required to get an order from the physician in	F 0686	**F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer** It is the practice of this facility to prevent the formation of a pressure ulcer and an increase in the stage of a pressure ulcer. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · The area to resident #41's left ankle continues to improve and is being monitored weekly with dressing being performed as ordered. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · Conduct 100% skin sweep 10/13/2022. · Review all residents with area of impaired skin integrity to ensure that proper treatments and interventions are in place. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · All residents will be assessed upon admission, with weekly skin assessments and on shower days to ensure their skin is being monitored for at risk or impaired skin and they have	10/24/2022

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	order to send a resident to the wound clinic. When asked what happened between 07/05/22 and 07/26/22 the DON indicated they may have opened up a new wound management record due to the change in the stage of the wound. During an interview on 09/27/22 at 3:15 P.M., RN 7 indicated the resident had been non compliant related to his diabetes for a long time. During an interview on 09/28/22 09:46 AM., CNA (Certified Nurse Aide) 6 indicated the resident could scoot himself around in bed but required staff assistance with turning. The resident's wounds on his left lower extremity were observed on 09/28/22 at 10:19 A.M., with the DON and the ADON. The resident was lying in bed wearing his protective foam boot. The staff removed the boot, unwrapped the foot and ankle and took off the foam protective pads that had been held in place by the gauze wrap. The wound on the resident's left ankle was closed and had a thin red/pink line that was healing. The wound on the resident's heel was a dime size wound with a black wound bed. The surrounding skin was pink and healing. No odor or drainage was observed on the dressing. An Admission MDS (Minimum Data Set) assessment, dated 06/10/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, type I diabetes, thyroid disorder, and dementia. The resident required extensive assistance of two staff members for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident was at risk for pressure ulcers and had unhealed pressure ulcers, one stage 2 pressure ulcer and one unstageable pressure ulcer that were present		individual care plans related to wound prevention/treatment in place as needed · **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · The DNS/designee will be responsible for auditing residents with a change of condition or new area of impaired skin, the care plan for residents at risk for wound development to ensure appropriate interventions are in place and that interventions are reviewed and updated as needed. At risk residents and residents with new area of impaired skin will be reviewed during CAR meeting 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 CQI committee overseen by the ED.	

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	on admission. A Discharge MDS assessment, dated 08/08/22, indicated the discharge was not anticipated. An Entry MDS assessment, dated 08/11/22, indicated the resident returned to the facility from an acute hospital stay. The Wound Management Log for the resident's pressure ulcers (PU) was provided by the DON on 09/27/22 at 1:42 P.M., and included, but was not limited to, the following: 1. Left ankle PU (not present on admission, developed in-house on 07/26/22): - dated 07/26/22, stage 2 PU, 0.7 cm (centimeters) x (by) 1 cm, (no measurable depth noted), - dated 08/02/22, stage 3 PU (full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed), 0.5 cm x 0.7 cm x 0.2 cm deep, and - dated 09/22/22, no stage identified, 0.3 cm x 0.3 cm (no measurable depth noted). 2. Left Heel PU (present on admission, 06/03/22): - On 07/05/22, stage 2 PU, 2 cm x 1 cm (no measurable depth noted), - On 07/20/22, stage 3 PU, 2.5 cm x 2.5 cm x 0.1 cm deep, and - On 09/22/22, unstageable, 1 cm x 1.8 cm (no measurable depth noted). The clinical record lacked documentation the			

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	wound was assessed and measured between 07/05/22 and 07/20/22. The EMAR/ETAR (Electronic Medication Administration Record / Electronic Treatment Administration Record for July 2022, was provided by the DON 09/27/22 at 3:21 P.M. The physician's order indicated the resident was to have a weekly skin assessment: , once a day on Saturday, with the start date of 06/03/22, and a discontinued date 08/08/22. The assessment was to be documented as 0 = (equals)no impairment, 1 = new impairment, 2 = old impairment. The assessments were completed on 07/09/22 and 07/16/22 and were documented with "0", indicating the resident had no current skin impairments. The physician's order indicated the resident was to wear Podus boots at all times for both heels as a preventative measure, with a start date of 07/21/22 (after the resident's pressure ulcer on his heel progressed to a stage 3), and a discontinued date 08/08/22, when the resident was discharged to the hospital. A lab results report, dated 08/23/22, was provided by the DON on 09/27/22 at 3:21 P.M., and indicated the resident had a left lower extremity venous ultrasound. The vessels demonstrated normal blood flow. A Care Plan, with a start date of 06/16/22, was provided by the DON on 09/27/22 at 3:21 P.M., and indicated the resident had multiple pressure ulcers on the left lower extremity. Interventions included, but were not limited to, weekly skin assessments, measurement, and observation of			

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	the ulcers and record. The current "Guidelines for Weekly Skin Observations" policy, with a reviewed date of 03/16/22, was provided by the DON on 09/28/22 at 11:25 A.M. The policy indicated, "...The nurse completing the weekly skin check shall indicate the appropriate number (0,1, 2) medication note..." The current "Pressure/Stasis/Arterial/Diabetic Wound Guidelines" policy, with a reviewed date of 11/15/21, was provided by the DON on 09/28/22 at 11:25 A.M. The policy indicated, "PURPOSE...To provide weekly documentation of wound measurements and condition..." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to follow and intervention after a fall for 1 of 3 residents reviewed for accidents. (Resident 45) Findings include: The clinical record for Resident 45 was reviewed on 09/26/22 at 11:52 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/23/22,	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** It is the practice of this provider to update and implement interventions after a fall. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient**	10/24/2022

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	155712	A. BUILDING 00 B. WING	09/29/2022

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

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	indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, diabetes, seizure, anxiety, depression, bipolar, and schizophrenia. A Fall Event, dated 02/28/22 at 10:04 P.M., indicated the resident slid out of bed while attempting to transfer. There were no injuries noted. An IDT (Interdisciplinary Team) note, dated 03/02/22 at 8:21 A.M., indicated the root cause of the fall was the resident had slid off her low air loss mattress. A new intervention was to remove the low air loss mattress. A Fall Event, dated 03/14/22 at 3:50 A.M., indicated the resident had rolled out of bed. There was a low air loss mattress in place. There were no injuries noted. An IDT note, dated 03/14/22 at 2:59 P.M., indicated the root cause was that the resident had slid out of bed. The immediate intervention was to remove the low air loss mattress. During an interview on 09/28/22 at 2:22 P.M., RN 7 indicated when a resident had a fall, she would assess the resident for injuries. If the resident was able to be moved, then they would be assisted up. If the resident's fall was unwitnessed or they hit their head the nurse would complete neurological assessments for 24 hours. The nurse would initiate an immediate intervention and then the management team would either agree or disagree with the intervention. During an interview on 809/28/22 at 3:06 P.M., the DON (Director of Nursing) indicated when a resident had a fall the nurse would complete their		**practice?** · Care plans reviewed for resident #45 to ensure that proper interventions are currently in place to prevent falls. Resident room reviewed to ensure that all interventions were as ordered. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · Review all current residents at high risk or with recent falls to ensure proper care plan and interventions are in place to prevent further falls. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · DNS/designee will conduct an in-service with all nursing regarding updating Care Plans and interventions and ensuring that all interventions are put in place. Audit of falls will be conducted to ensure interventions are in place and appropriate. · During CCM review of falls, review to ensure that duplicate intervention does not occur. DHS and/or designee will update the CRCA care sheets in system to ensure staff aware of fall interventions.	

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	assessment, open a fall event, and notify the family and MD. The nurse would implement an immediate intervention. The IDT would review and either agree or disagree with the intervention. If they had disagreed with the immediate intervention a new intervention would be initiated immediately. The neurological checks would be initiated for 24 hours if a resident's fall was unwitnessed, or they hit their head. The resident's low air loss mattress should have been removed when she had the fall on 02/28/22. The current facility policy titled, "Fall Management Program Guidelines" with a review date of 03/16/22, was provided by the DON on 09/29/22 at 9:10 A.M. The policy indicated, "...to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...should the resident experience a fall the attending nurse shall complete the "Fall Event", this includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions...Discuss risks and interventions with resident and/or responsible party and communicate interventions during shift report..." 3.1-45(a)(1) 3.1-45(a)(2)		**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The DNS/designee will be responsible for updating care plan, implementing, and visualizing that interventions are in place with each new fall weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 months 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 CQI committee overseen by the ED	
F 0712 SS=D Bldg. 00	483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for			

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	the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. Based on interview and record review, the facility failed to ensure a resident received a regulatory physician's visit every 60 days for 1 of 14 residents reviewed. (Resident 10) Findings include: The clinical record for Resident 10 was reviewed on 09/26/22 at 11:14 A.M. The resident was admitted to the skilled nursing department of the facility on 08/30/21. Prior to 08/30/21, the resident resided in the assisted living area of the facility. A Quarterly MDS (Minimum Data Set) assessment, dated 09/09/22, indicated the resident had short term memory problems and was moderately cognitively impaired for daily decision making. The diagnoses included, but were not limited to, dementia, stroke, malnutrition, and dysphasia. During an interview on 09/28/22 at 10:18 A.M., LPN (Licensed Practical Nurse) 9 indicated the	F 0712	**F 712 Physician Visits-Frequency/Timeliness** It is the practice of this provider to ensure a resident received a regulatory physician's visit every 60 days. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · The physician for the resident cited has been notified of the regulation for the resident to be seen every 60 days. The family transports resident and they are also aware of the regulation. **2: How other residents having the potential to be affected by the same deficient practice will**	10/24/2022

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	resident's family member took her to her doctor appointments. The resident would see her doctor in his office, he did not see her in the facility. The resident did not see the Nurse Practitioner that came into the facility. Her family member took her to the doctor every 3 months or so. The Physician notes from the resident's in-office visits were provided by Clinical Support Nurse 8 on 09/28/22 at 11:44 A.M. and included the following: - The resident went to her physician's office and had an annual wellness visit on 01/25/22. Physician's notes indicated the resident should follow up in 4 months or as needed for her Atrial Fibrillation diagnosis. - A referral form dated 05/23/22 indicated the resident was seen in the office by her physician. A progress note indicated the resident's chronic condition appeared to be stable. The resident's next appointment was in 4 months. - A referral form dated 09/23/22 indicated the resident was seen in the office by her physician. A progress note indicated the resident's family member reported the resident was overall stable but had experienced some weight loss. The resident was to continue her current medications. The resident's next appointment was in 4 months. The resident's clinical record lacked a physician's visit at least one every 30 days for the first 90 days after admission and one every 60 days thereafter. The current facility policy, titled "Guidelines for Physicians Services" was provided by Clinical Support Nurse 8 on 09/28/22 11:25 A.M. at 11:25		**be identified and what corrective action will be taken.** All residents that choose to utilize an outside provider have potential to be affected. · Upon admission or as desired by current residents, to utilize an outside primary care physician, that physician will be notified of regulation for the resident to be seen every 60 days. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · Any new admission or current resident that chooses an outside primary care provider, that physician will be provided with the requirement for physician visits while residing in Long Term Care setting. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The DNS/designee will be responsible for ensuring that residents are seen by outside provider every 60 days monthly times 6 months and then quarterly. The results of these audits will be reviewed by the CQI committee overseen by the ED.	

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	A.M. The policy indicated, "...To provide care and treatment of residents under the supervision of a licensed physician...Physician visits, frequency of visits...are provided in accordance with current OBRA regulations and campus policy..." 3.1-22(d)(1)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to			

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	address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on observation, interview, and record review, the facility failed to address the pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications. (Resident 44) Findings include: Resident 44 was observed in his room on 09/27/22 at 11:01 A.M. The resident was in bed but indicated he would be getting up and going to lunch soon. The resident was pleasant and denied any concerns. The resident's clinical record was reviewed on 09/26/22 at 1:46 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/21/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Parkinson's disease, hypertension, and Non-Alzheimer's dementia. The resident was receiving hospice services. The resident's medication orders were reviewed and included an order from the resident's neurologist, with a start date of 10/27/21, for Aricept (a cognition enhancing medication, used to treat Alzheimer's disease) 5 mg (milligrams)	F 0756	**F 756 Drug Regimen Review, Report Irregular, Act on** It is the practice of this provider to address the pharmacy recommendations related to unnecessary medications. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · The Neurologist for the resident cited responded to the pharmacy recommendation on 9/29/2022 and did not agree to decrease medication. The Neurologist continued the Aricept as ordered. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice.	10/24/2022

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	daily. That order was discontinued on 05/09/22, and a current, open ended order, with a start date of 05/10/22, for Aricept 10 mg daily began. The resident received the medication daily as ordered. A Pharmacy Recommendation Event, dated 06/08/22, indicated the following: - At the top of the recommendation was a highlighted area that requested the recommendation be sent to the resident's neurologist and included his name and phone number. The recommendation went on to say that the resident's most recent MDS assessment indicated he was severely cognitively impaired. The American Geriatric Society found that de-prescribing medications like Aricept was not associated with negative effects to the resident and would likely help reduce the risk of falls and fractures in older nursing home residents with dementia. The pharmacist recommended they consider discontinuing the Aricept medication at that time. - The Pharmacy Recommendation Event was closed on 06/20/22 by the ADON (Assistant Director of Nursing). The evaluation notes indicated there were no new physician's orders. There was no indication that the physician agreed or disagreed with the recommendation, those questions were marked "NA". The resident's clinical record lacked any other documentation related to the pharmacy recommendation. During an interview on 09/29/22 at 12:08 P.M., the DON (Director of Nursing) indicated the ADON usually handled pharmacy recommendations. The recommendation would be forwarded to the prescribing physician. The physician's response, whether they agreed with the recommendation or		· Review all current Pharmacy recommendations for the last 90 days to ensure proper follow-up has occurred. · All licensed nursing staff will be educated related to procedure for opening events for pharmacy recommendations. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · Pharmacy recommendation events will not be closed until response from MD/NP is received. If a specialty physician has not responded to a recommendation, then Medical Director/On call MD/NP will be contacted for review. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · The DNS/designee will be responsible for the ensuring completion of pharmacy recommendations and that recommendations are reviewed 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	

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	if they declined the recommendation would be documented in the resident's clinical record. The physician would provide rationale if they declined the pharmacy recommendation. During an interview on 09/29/22 at 11:36 A.M., Clinical Support Nurse 8 indicated the facility could not provide a specific policy for pharmacy recommendations. 3.1-25(i)		the CQI committee overseen by the ED.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 22, 23, 26, 27, 28, and 29, 2022 Facility number: 003342 Residential Census: 10 Covered Bridge Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on October 5, 2022.	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 9/29/2022. We respectfully request desk review in lieu of a post survey review. Please accept this Plan of Correction as the provider's credible allegation of compliance as of 10/24/2022.	