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	01/23/2025

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: January 15, 16, 17, 21, 22, and 23, 2025 Facility number: 003342 Provider number: 155712 AIM number: 200403740 Census Bed Type SNF/NF: 38 SNF: 14 Residential: 21 Total: 73 Census Payor Type: Medicare: 6 Medicaid: 34 Other: 12 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quaity review completed on January 28, 2025.	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 s prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of non compliance cited during the Annual Recertification Survey conducted 1/23/25. We are requesting Desk Review for our Plan of Correction for this survey. Correction as the provider's credible allegation of compliance as of 2/9/25	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview, and record review, the facility failed to follow the physician's orders related to the treatment for a pressure ulcer for 1 of 2 residents reviewed for pressure ulcer treatments. (Resident 47)	F 0686	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Resident 47s wound	02/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela	Short	02/07/2025

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	Findings include: During an observation on 01/21/25 at 11:06 A.M., Resident 47's dressing change was observed. The resident's pressure wound, located on her right upper buttock, was observed with the Assistant Director of Nursing (ADON) and the Minimum Data Set (MDS) Coordinator. The ADON and MDS Coordinator donned gowns and gloves prior to entering the resident's room. The ADON indicated the current treatment was to cleanse the wound with wound cleanser, apply collagen powder, then Anasept gel (an antimicrobial), and cover the wound with a border dressing. The staff members entered the room, raised the bed, pulled the covers back, pulled the resident's brief down, then rolled the resident to her left side. The resident's wound was uncovered and open to air. The ADON removed her gloves and washed her hands. The wound was quarter sized and had a dark red wound bed with a measurable depth. The ADON donned clean gloves, cleansed the wound using a spray bottle of cleanser, patted the wound dry with gauze, applied collagen powder to the wound bed using a sterile swab, applied the Anasept gel to the wound bed using a sterile swab, then covered the wound with a border gauze dressing that was dated. The staff reattached the resident's brief, put her pants back on, and applied the resident's shoes. The clinical record for Resident 47 was reviewed on 01/21/25 at 2:18 P.M. A Quarterly MDS assessment, dated 01/01/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, dementia and malnutrition. The resident was at risk for pressure ulcers and had one unhealed Stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia,		showed no worsening or signs of infection due to skin prep not being applied per order. **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 with pressure wounds have the potential to be affected by said deficiency. All orders for residents with pressure wound dressing changes were reviewed for accuracy and dressing change observed for appropriate execution of the physician order. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed Nursing Staff, including the ADHS, were Educated regarding following physician's orders related to the treatment of pressure ulcers including the General Guidelines for Administration of Medication policy. DHS/Designee will observe wound dressing changes to ensure that staff are following physician's orders related to wound care 3 times a	

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	muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed) pressure ulcer. The current physician's order, with a start date of 01/01/25, indicated the treatment for the resident's right buttock was to cleanse the wound with Anasept spray, gently pat dry with sterile gauze, apply Skin Prep (a skin toughening agent) to the outside edge of the wound, apply collagen powder to the wound bed, apply Anasept gel, and cover with a bordered dressing. During an interview on 01/21/25 at 3:04 P.M., the ADON indicated the resident was admitted over a year ago and had the Stage 4 pressure wound. At the time of admission, the wound was big enough to put your fist in it and bone was visible. Healing had been a slow process, and the wound had worsened following a hospital stay. The wound was improving. The current treatment was to cleanse with Anasept spray, pat dry with sterile gauze, apply collagen powder to the wound bed, apply Anasept gel, and cover with a border dressing. Skin Prep was used to keep the area around the wound from becoming macerated (the softening and breaking down of skin resulting from prolonged exposure to moisture). The Skin Prep should have been applied to the outside edges. The current "GENERAL GUIDELINES FOR ADMINISTRATION OF MEDICATION" policy, with an effective date of 12/01/22, was provided by the Administrator on 01/22/25 at 10:31 A.M. The policy indicated, "...The nurse must clearly understand all medication orders before carrying them out..." 3.1-40(a)(2)		week for 4 weeks, 1 time a week for 4 weeks, monthly for 4 months 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 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?** DHS/ADHS/designee will be responsible for monitoring wound dressing changes according to the physician's order for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on record review, observation, and interview, the facility failed to ensure fall preventative devise interventions were in place as ordered for 1 of 3 residents reviewed for accident hazards. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed on 01/21/25 at 9:23 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/13/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, hypertension, and malnutrition. A "Fall" Care Plan, with a start date of 07/12/24 and a revised date of 01/23/25, included but was not limited to, the following intervention: Highlighter tape to wheelchair brakes with a start date of 09/08/24. A Progress Note, dated 09/09/24 at 4:02 A.M., indicated the resident had a fall while trying to transfer herself into her wheelchair to go to the bathroom. The left side wheelchair brake was not locked upon inspection. The resident had no injuries. An Interdisciplinary Team (IDT) Note, dated 09/09/24 at 1:36 P.M., indicated the immediate intervention to prevent further falls was to apply highlighter tape to the resident's wheelchair brake handles. A Progress Note, dated 12/16/24 at 9:00 A.M., indicated the nurse walked into the resident's	F 0689	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Resident 27's Highlighter tape was immediately placed on the wheelchair brakes and remains in place at this time. **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 with falls have the potential to be affected.- All Residents with fall interventions in place will be audited to ensure that all fall interventions are initiated and 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?** Staff educated related to ensuring interventions are in place per care plan and as indicated on profile care guide including the Fall management Program Guidelines.	02/09/2025

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	room to administer her medications. When the resident went to sit in her wheelchair, she had forgotten to lock her brakes and the chair rolled out from underneath her. During an observation on 01/21/25 at 9:07 A.M., Resident 27 was sitting in her wheelchair in her room. Her call light was in reach. Her wheelchair brakes lacked any highlighter tape to them. During an observation on 01/21/25 at 2:31 P.M., Resident 27 was sitting in the common area using a cell phone. There was no highlighter tape to the resident's wheelchair brakes. During an observation and interview on 01/21/24 at 2:54 P.M., the Director of Nursing (DON) indicated after a resident had a fall they would be assessed by a nurse and the nurse would complete the appropriate paperwork. The management staff would review the fall and would try to determine a root cause of the fall. They would then determine an appropriate intervention for the fall. The Care Plan would be updated. If there was a need to alter the resident's environment, then the nurse working the floor or the IDT would make those changes. The resident should have had highlighter tape to the wheelchair brakes if she was care planned for it. The resident was sitting in the common area with no highlighter tape to the wheelchair brakes. The current facility policy titled, "Fall Management Program Guidelines", with a review date of 12/17/24, was provided by the DON on 01/22/25 at 12:06 P.M. The policy indicated, "...to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...Nursing staff will monitor and document continued resident response and		DHS/Designee will observe residents and their environment to ensure fall interventions are in place per plan of care 3 residents daily 3 times a week for 4 weeks, 2 residents daily 3 times a week for 4 weeks, 1 resident daily 3 times a week for 4 months, then 1 resident monthly for 3 months 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 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?** DHS/ADHS/designee will be responsible for monitoring wound dressing changes according to the physician's order for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less	

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	effectiveness of intervention for 72 hours..." 3.1-45(a)(2)		than 6 months.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to have a medication error rate of less than 5% for 2 of 32 medication administrations observed. (Resident 3) Findings include: During an observation on 01/22/25 at 9:36 A.M., RN 6 prepared Resident's 3 morning medications. She placed all of Resident 3's morning prescribed (14) different medications in one medication cup. The resident's morning dose of Buprenorphine, 2 mg, was to be administered by sublingual (placing a drug under the tongue to dissolve and be absorbed directly into the bloodstream) administration. The RN retrieved the resident's prescribed eye drops, refresh tears and brimonidine, from the medication cart. The nurse took the prepared cup of medications, and the two types eye drops to the therapy gym where the resident requested to take the medications. The resident was given the cup of medications and took them whole with sips of her drink. The nurse then administered the eyes drops to the resident, one after the other, with no wait time in between. The resident's Buprenorphine was not administered by the prescribed sublingual route and all eye drops were administered with no delay in time. During an interview on 01/22/25 at 10:13 A.M., RN 6 indicated if a resident's medication was ordered	F 0759	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Resident 3 did not have any adverse effects due to said deficient practice. **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 that receive medication by the nursing staff have potential to be affected. Residents with multiple eye drops at the same time of day have instructions added to their orders for wait times in between eye drops. Residents with sublingual medications have listed in special instructions to give sublingual to draw attention to the route. **3: What measures will be put into place or what systemic changes will be made to**	02/09/2025

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	sublingually, then it should be placed under their tongue. She should have told the resident the medication was sublingual, and explained it to the resident. She should have waited 5 to 10 minutes between administering the two eye drop medications. The clinical record for Resident 3 was reviewed on 01/22/25 at 10:05 A.M. An Annual Minimum Data Set (MDS) assessment, dated 08/23/24, indicated the resident was cognitively intact. The current, open-ended physician's order, with a start date of 08/25/24, indicated the staff were to administer buprenorphine (a pain medication), sublingually, once a day. The current, open-ended physician's order, with a start date of 12/10/24, indicated the staff were to administer brimonidine (an eye drop), one drop in each eye, twice a day. The current, open-ended physician's order, with a start date of 08/18/24, indicated the staff were to administer refresh tears (an eye drop), one drop in each eye, three times a day. The current facility policy titled, "General Guidelines for Administration of Medications", with an effective date of 12/01/22 and was provided by the Administrator on 01/22/25 at 10:31 A.M. The policy indicated, "...When administering a medication, the following steps should be followed: a. Check the physician's order to verify dosage specifics. b. Make note of the [five rights], to assure the proper administration of medication...right route of administration..." The current facility policy titled, "Eye Drop Administration", with a revised date of 11/2018,		**ensure that the deficient practice does not recur?** Licensed staff, including RN 6, were reeducated regarding the 5 rights of medication administration using the General Guidelines for Administration of Medication policy and Eye Drop Administration using the Specific Medication Administration Procedure guidelines. The DHS/designee will be responsible for monitoring medication administration by observing medication pass for 3 residents a week for 4 weeks, 2 residents a week for 4 weeks, then 1 resident monthly for 4 weeks 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 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?** DHS/ADHS/designee will be responsible for monitoring wound dressing changes according to the physician's order for 6 months.	

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	was provided by the Director of Nursing on 01/22/25 at 12:06 P.M. The policy indicated, "...If another drop of the same or different medication is prescribed for administration in the same eye at the same time, wait 10 minutes, then repeat..." 3.1-25(b)(9)		The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to urinary catheter care for 2 of 3 residents reviewed for infection control. (Residents 10 and 15) Findings include: 1. On 01/16/25 at 1:40 P.M., Resident 10 was observed in her room sitting in a recliner. The resident's urinary catheter drainage bag was hanging from a pocket on the recliner, with two inches of the bottom of the bag resting on the floor. On 01/16/25 at 3:29 P.M., the resident was observed in her room sitting in the recliner. The resident's catheter drainage bag was hanging from the chair with two inches of the bottom of the bag resting on the floor. On 01/17/25 at 1:43 P.M., the resident was observed in bed. The bed was in a low position	F 0880	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Residents' 10 and 15 had no adverse effects from said deficient practice. Resident 10's catheter tubing was removed from the floor and a basin placed underneath. Catheter care performed again on resident number 15 with the proper changing of gloves and using EBP precautions.	02/09/2025

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	and the catheter bag was hanging on the left side of the bed. An inch of the bag was resting on the floor. Qualified Medication Aide (QMA) 2 observed the bag and indicated it shouldn't be touching the floor; it was probably because the bed was so low. She indicated she would adjust the position of the bag. On 01/22/25 at 10:34 A.M., the resident was observed in her recliner. The resident's catheter drainage bag was hanging from the side of the chair, with at least two inches of the bottom of the bag resting on the floor. Certified Nurse Aide (CNA) 4 observed the bag and indicated it shouldn't be touching the floor. During an observation on 01/22/25 at 10:41 A.M., CNA 3 and CNA 4 entered the resident's room to provide catheter care. The resident was sitting in her recliner. The resident was in Enhanced Barrier Precautions (EBP) and staff were to wear a gown and gloves when they provided catheter care. The CNAs donned gowns, entered the resident's room, washed their hands, and donned gloves. CNA 3 brought supplies from the bathroom to the resident's bedside, moved items from the nightstand, and then placed the supplies on the nightstand. CNA 3 then went to the other side of the resident's bed, pulled the string to shut the blinds, pulled the cord to turn on the light above the resident's bed, and used the bed remote to adjust the position of the bed. CNA 3 and CNA 4 went over to the resident in her chair. CNA 3 picked up the catheter drainage bag that was laying on the end of the recliner, removed a blanket from the resident, and then, with CNA 4's assistance, helped the resident move from the chair to the bed. CNA 3 hung the drainage bag on the side of the bed. The CNAs got the resident into a laying position, pulled the resident's pants		**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. Residents with catheters were observed for proper placement of tubing. Residents with catheters were assessed for symptoms of urinary infection with none showing symptoms. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Care Staff , including CNA 3 and CNA 4, educated on proper use/changing of gloves during urinary catheter care, proper placement of catheter tubing, EBP, and Standard Precautions. The DHS/designee will be responsible for auditing catheter positioning and catheter care for 3 residents a week for 4 weeks, 2 residents a week for 4 weeks,	

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	down, and opened the resident's brief. CNA 3, wearing the same gloves, removed a wet washcloth from the basin, applied cleanser to the washcloth, and began cleansing the resident. CNA 3 washed, rinsed, and dried the resident's perineal area, then cleansed the urinary catheter tubing. During an interview on 01/22/25 at 10:56 A.M., CNA 3 indicated she should have removed her gloves, washed her hands, and put on new gloves before she provided perineal/catheter care. The resident's clinical record was reviewed on 01/17/25 at 1:54 P.M. An Admission Minimum Data Set (MDS) assessment, dated 11/11/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, stroke, malnutrition, and neurogenic bladder. The resident had an indwelling urinary catheter. 2. During an interview and observation on 01/15/25 at 1:16 P.M., Resident 15 indicated he had an indwelling urinary catheter because he had trouble emptying his bladder. The catheter tubing was visible and contained cloudy yellow urine. Catheter care for Resident 15 was observed on 01/22/25 at 9:59 A.M., with CNA 4. The CNA donned a gown and gloves from an isolation cart located in the hallway outside of the resident's room, entered the room, went into the bathroom, and prepared pan of warm water, using her gloved hands to turn the water on and off. The CNA proceeded to close the window blind, pull the privacy curtain, then clean the resident's suprapubic catheter tubing that extended out of the resident's abdomen. The CNA failed to changer her gloves after touching items and before starting the procedure.		then 1 resident monthly for 4 months 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 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?** DHS/ADHS/designee will be responsible for monitoring wound dressing changes according to the physician's order for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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	The resident's clinical record was reviewed on 01/21/25 at 2:20 P.M. A Quarterly MDS assessment, dated 11/14/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure and obstructive uropathy. The resident had not had a Urinary Tract Infection (UTI) in the previous 30 days. The resident had an indwelling catheter and was always continent of bowel. During an interview on 01/22/25 at 1:49 P.M., the DON indicated the resident was admitted to the facility with the suprapubic urinary catheter. The resident had the catheter placed due to retention issues. He just recently had a stent placed to help with the retention. He was on an antibiotic prophylactically (as a preventative measure) following the procedure. The current "Urinary Catheter Care" policy, with a reviewed date of 12/16/24, was provided by the DON on 01/22/25 at 12:06 P.M. The policy indicated, "...To prevent infection of the resident's urinary tract...Be sure the catheter tubing and drainage bag are kept off the floor...Prior to beginning the procedure...Close the room entrance door...Pull the privacy curtain...Close drapes...close blinds...Wash and dry hands thoroughly...Put on gloves...Wash the resident's genitalia and perineum thoroughly...Place soiled linen into designated container...Remove gloves and discard...Wash and dry your hands thoroughly...Put on clean gloves..." 3.1-18(l)			
R 0000 Bldg. 00				

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	01/23/2025

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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	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 15, 16, 17, 21, 22, and 23, 2025 Facility number: 003342 Residential Census: 21 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 January 28, 2025.	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 s prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of non compliance cited during the Annual Recertification Survey conducted 1/23/25. We are requesting Desk Review for our Plan of Correction for this survey. Correction as the provider's credible allegation of compliance as of 2/9/25	