STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155712	A. BUILDING -- B. WING	02/04/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/04/25 Facility Number: 003342 Provider Number: 155712 AIM Number: 200403740 At this Emergency Preparedness survey, Covered Bridge Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 78 certified beds. At the time of the survey, the census was 57. Quality Review completed on 02/05/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Certification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/04/25 Facility Number: 003342 Provider Number: 155712 AIM Number: 200403740 At this Life Safety Code survey, Covered Bridge Health Campus was found in substantial	K 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 in the Statement of Deficiency. The Plan of Correction is 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 noncompliance cited during the Life Safety Survey	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela	Short	02/14/2025

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	155712	A. BUILDING 01 B. WING	02/04/2025

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	compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to corridor, and all resident rooms. The facility has a capacity of 78 and had a census of 57 at the time of the survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/05/25		conducted 2/4/25. 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 2/21/25.	
K 0324 SS=B Bldg. 01	NFPA 101 Cooking Facilities Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood exhaust system was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 7.8.2.1(8) requires rooftop terminations to be arranged with or provided with a hinged upblast fan supplied with flexible weatherproof electrical cable and service hold-open retainer to permit inspection and cleaning that is listed for commercial cooking equipment. This deficient practice could affect mostly kitchen staff. Findings include:	K 0324	K 324 **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** A work order for the repairs was in progress at the time of survey. The fan wiring was corrected on 2/7/25. The vent hinge is scheduled to be installed 2/18/25. **2: How other residents having the potential to be affected by the same deficient practice will**	02/21/2025

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	155712	A. BUILDING 01 B. WING	02/04/2025

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	Based on record review on 02/04/25 between 9:45 a.m. and 12:00 p.m. with the Director of Plant Operations and Regional Facility's Support present, the kitchen range hood cleaning report dated 12/27/24 from the facility's range hood inspection vendor indicated "Need Fan Hinges" and "Exhaust Fan Wiring" both checked under "Noticed Areas of Concerns/Deficiencies". Furthermore, in the Notes section of the report it stated "Fan wiring for dish hood switch is ran through hood. Dish fan also needs hinge kit." When asked, the Director of Plant Operations said he has been in contact with the vendor about the issues, but they have not been fixed to date. This finding was reviewed with the Executive Director, Director of Plant Operations, and Regional Facility's Support during the exit conference. 3.1-19(b)		**be identified and what corrective action will be taken.** All residents in the facility could have been affected. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Completion of rewiring and vent hinge replacement will correct the area cited. **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?** All outside vendor service reports will be reviewed and a Tels order will be entered for any recommended repairs or changes. This will be reviewed weekly by DPO and/or designee to ensure proper follow up on recommendations. The DPO and/or designee will review all vendor service reports to ensure proper follow up continues to be put in place. Any recommendations will be entered into the Tels system for proper tracking. The Tels system will be audited daily for 4 weeks; Bi-weekly for 4 weeks; and monthly for 4 months. The results of audit observations will be reported, reviewed, and	

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			trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	