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	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covered Bridge Health Campus	1675 W Tipton St Seymour, IN 47274

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34232 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) 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, 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38769 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 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 effectiveness of intervention for 72 hours . 3.1-45(a)(2)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38769 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 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 . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current facility policy titled, Eye Drop Administration, with a revised date of 11/2018, 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)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38239 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 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 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 34232 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. 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)