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	02/12/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Ombudsman that residents were discharged from the facility for 3 of 3 discharged residents' records reviewed. (Residents 63, 64, and 65) Findings include:1. The clinical record for Resident 63 was reviewed on [DATE] at 11:53 A.M. The resident was admitted to the facility on [DATE]. A Progress Note, dated [DATE] at 6:07 A.M., indicated the resident experienced a change of condition and was sent to the local hospital's emergency department for evaluation.A Progress Note, dated [DATE] at 5:21 P.M., indicated the resident was admitted to the hospital. The Census section of the resident's Electronic Health Record (EHR) indicated the resident was discharged from the facility on [DATE] and the resident was not anticipated to return. The Discharge Report sent to the Ombudsman for [DATE] was provided by the Director of Nursing (DON) on [DATE] at 11:44 A.M. The report did not include Resident 63.2. The clinical record for Resident 64 was reviewed on [DATE] at 1:51 P.M. The resident was admitted to the facility on [DATE]. The resident was receiving treatment for a worsening respiratory infection in [DATE].A Progress Note, dated [DATE] at 05:21 P.M., indicated the resident's health had been declining and he passed away early that afternoon. The Census section of the resident's EHR indicated he expired on [DATE].The Discharge Report sent to the Ombudsman for [DATE] was provided by the DON on [DATE] at 11:44 A.M. The report did not include Resident 64.3. The clinical record for Resident 65 was reviewed on [DATE] at 11:22 A.M. The resident was admitted to the facility on [DATE] with plans to return to the community.A Progress Note, dated [DATE] at 11:53 A.M., indicated the resident's family arrived to take him to an Assisted Living Facility. The Census section of the resident's EHR indicated the resident was discharged from the facility on [DATE] and was not anticipated to return. During an interview, on [DATE] at 1:48 P.M., the Social Services Director (SSD) indicated she sent a report to the Ombudsman each month listing the residents that discharged from the facility. She included residents that discharged and were expected to return to the facility, residents that were at the hospital, residents that left the facility against medical advice, and residents that had received a 30-day involuntary discharge notice. She based the Ombudsman notification off a report she ran each month.The Discharge Report sent to the Ombudsman for [DATE] was provided by the DON on [DATE] at 11:44 A.M. The report did not include Resident 65.During an interview, on [DATE] at 11:28 A.M., the SSD indicated she had not been including residents that were discharged and not expected to return to the facility or expired residents on the report she sent to the Ombudsman each month.The current facility policy, titled Ombudsman Notification, dated [DATE], was provided by the DON on [DATE] at 3:05 P.M. The policy indicated, .Federal regulation F628 requires that the facility sends a copy of the Notice of Transfer/Discharge to a representative of the Office of the State Long-Term Care Ombudsman. This includes voluntary and involuntary discharges and transfers.The Director of Social Services, or designee, will send a copy of the discharge census report to the Office of the State Long-Term Care Ombudsman monthly or at least 30 days prior to issuing the involuntary discharge notice.complete the Ombudsman Notification Observation in the electronic health record as evidence that the notice was sent.Exceptions to the monthly ombudsman (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notification requirement apply with the transfer or discharge is due to the following.resident's health improves sufficiently to allow a more immediate transfer or discharge.An immediate transfer or discharge is required by the resident's urgent medical needs.If an immediate discharge due to the above reasons occurs, the Director of Social Services.will inform the .Ombudsman within 24 hours.3.1-12(a)(6)(A)(iv)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation and interview, the facility failed to follow manufacturers guidelines related to priming an insulin pen for 1 of 2 insulin pens observed. (Resident 55)Findings include: Medication administration was observed on 02/11/2026 at 11:03 A.M., with Qualified Medication Aide (QMA) 5. The QMA prepared insulin for Resident 55 using an insulin pen and indicated the resident was to receive 3 units of lispro (Humalog) insulin per the sliding scale. The QMA removed the insulin pen from the medication cart, checked the label, removed the pen cap, cleaned the end of the pen with an alcohol wipe, applied the needle, and removed the cap of the needle. She turned the pen dose selector to two units, primed the pen holding the pen tip facing parallel to the floor, squirted out the two units of insulin, turned the pen dose selector to 3 units, donned gloves, and went into the resident's room. The QMA administered the insulin into the resident's abdomen. During an interview, with QMA 5, immediately following the procedure, she indicated she was not trained on how to hold the pen when priming it. The Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) for Resident 55 was reviewed on 02/11/2026 at 2:26 P.M. The record indicated the resident had no critical blood sugar values prior to 02/11/2026. The package insert for the lispro insulin pen was provided by the Assistant Director of Nursing (ADON) on 02/11/26 at 11:30 A.M. The instructions for use indicated, .Priming your Humalog .Pen .Turn the dose knob to select 2 units .Hold the Pen with the needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top .Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows0 .A drop of insulin should be seen at the needle tip .3.1-37(a)3.1-47(a)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, that facility failed to follow a physician's order related to a blood thinning medication administration for 1 of 6 residents reviewed for unnecessary medications. (Resident 20)Findings include:The clinical record for Resident 20 was reviewed on 02/09/2026 at 11:46 A.M. An admission Minimum Data Set (MDS) assessment, dated 01/09/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hip and knee replacement and deep vein thrombosis (blood clot - DVT). A Hospital Discharge summary, dated [DATE], indicated the resident had a total right hip replacement on 12/30/2025. The resident was to be given Lovenox (blood thinning medication) 40 milligrams (mg) once a day until the resident's INR (International Normalized Ratio, a standardized blood test result that measures how long it takes for your blood to clot) level was greater than 2.0. The resident had problems with deep vein thrombosis. The resident's next INR level was to be drawn on 01/05/2026. The resident's last INR was drawn on 12/12/2025. The resident's January 2026 Electronic Medication Administration Record indicated the resident had not received the Lovenox medication on 01/04/2026 due to the medication was on hold and on 01/05/2026 because the medication was discontinued. The clinical record lacked documentation that the physician was notified of the resident's Lovenox medication being held on 01/04/2026. The clinical record lacked documentation that the Lovenox order was clarified with the physician prior to 01/05/2026.During an interview, on 02/10/2026 at 11:24 A.M., RN 2 indicated when a resident was admitted from the hospital, she would get report from the hospital nurse and put the resident's information in the facility computer system. She would transcribe the hospital discharge orders into the computer, and a second nurse would verify the medications. She would fax all the paperwork to the resident's physician and let them know the resident admitted to the facility.During an interview, on 02/10/2026 at 12:52 P.M., the Director of Nursing (DON) indicated the facility staff should transcribe the orders per the resident's hospital discharge records. During an interview, on 02/11/2026 at 11:24 A.M., the DON indicated the resident didn't get the Lovenox when she came because they were putting her at risk by giving her the Lovenox based on the INR documented in the hospital record, even though that INR level was obtained prior to the resident's surgery date. That was why they clarified the order on 01/05/2026. During an interview, on 02/11/2026 at 11:45 P.M., Nurse Practitioner 3 indicated when a resident was admitted to the facility she would have to see them within three business days. The facility should follow the orders the resident was discharged with from the hospital, she would typically make changes on her first visit with the resident if she needed to. She remembered the facility asking about the resident being on Lovenox and Coumadin (a blood thinning medication) at the same time. She explained to them that the Coumadin was not immediately effective and it took time to reach the therapeutic level, so the hospital had put the resident on on Lovenox at the same time with Coumadin. The facility should have given the Lovenox medication when the resident first came from the hospital. The current facility policy titled Medication Error Reporting with a review date of 12/17/2024, was provided by the DON on 02/11/2026 at 10:46 A.M. The policy indicated, .To identify medications given in error and expedite correction actions.3.1-48(c)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to appropriately store medications for 1 of 3 medication carts reviewed. (100 Hall Medication Cart)Findings include: On 02/09/2026 at 10:57 A.M., the 100 Hall Medication Cart was observed with RN 4 and contained the following:- A small round white pill was lying loose in the bottom of the second drawer along with dust and paper debris and- A half of a small oval green pill was lying loose in the bottom of the third drawer along with dust and paper debris.During an interview, on 02/09/2026 at 10:58 A.M., RN 4 indicated she didn't know what the pills were or who they belonged to, pills should not be loose in the medication cart. The current facility policy, titled Medication Storage dated 11/01/2022, was provided by the Director of Nursing (DON) on 02/12/2026 at 11:50 A.M. The policy indicated, .Medications must be stored under proper conditions to protect against degradation .3.1-25(o)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to transcribe a physician order on admission for 1 of 16 resident records reviewed. (Resident 20)Findings include:The clinical record for Resident 20 was reviewed on 02/09/2026 at 11:46 A.M. An admission Minimum Data Set (MDS) assessment, dated 01/09/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hip and knee replacement, hypertension, osteoporosis, malnutrition.A hospital discharge record, dated 01/27/2026, indicated the resident was to receive Coumadin (a blood thinning medication) 3 milligrams (mg) on Sunday, Monday, Wednesday, and Friday. An physician's order, with a start date of 01/27/2026, indicated the resident was to receive Coumadin 3 mg once a day on Monday, Wednesday, and Friday. During an interview, on 02/10/2026 at 11:24 A.M., RN 2 indicated when a resident was admitted from the hospital she would get report from the hospital, put the resident in the facility computer system, assess the resident, get their vital signs, and transcribe the orders into the system, and a second nurse would verify the medications. She would fax all the paperwork to the resident's physician and let them know they admitted to the facility.During an interview, on 02/10/2026 at 12:52 P.M., the Director of Nursing (DON) indicated the facility staff should transcribe the orders per the resident's hospital discharge records.During an interview, on 02/11/2026 at 11:24 A.M., the DON indicated when the resident came back from the hospital the physician's order should have been transcribed for her to receive the Coumadin on Sunday, Monday, Wednesday, and Friday and not Monday, Wednesday, and Friday. The physician changed the order on 01/30/2026. The current facility policy titled, Guidelines for Medication Orders with a review date of 12/12/2025, was provided by the DON on 02/11/2025 at 10:46 A.M. The policy indicated, .To establish uniform guidelines in the receiving and recording of medication orders.Medication orders.when recording medications orders specify: The type, route, dosage, frequency, strength of the medication.3.1-50(a)(2)