STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155742	A. BUILDING 00 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST ANDREWS HEALTH CAMPUS	1400 LAMMERS PIKE BATESVILLE, IN 47006

(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 and the Investigation of Complaint IN00419961. Complaint IN00419961 - Federal/State deficiency related to the allegations is cited at F686. Survey dates: October 30, 31, November 1, 2, 3, and 6, 2023 Facility number: 004671 Provider number: 155742 AIM number: 200538760 Census Bed Type: SNF/NF: 31 SNF: 19 Residential: 32 Total: 82 Census Payor Type: Medicare: 11 Medicaid: 24 Other: 15 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 15, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by St. Andrews Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of St. Andrews Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance as of 11/27/2023 with all state and federal requirements governing the management of this facility. The facility respectfully requests from the department a desk review for paper compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara Schamer	RN, DHS	11/21/2023

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	physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as			

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	defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify the physician for a change in a resident's condition related to weights for 1 of 5 residents reviewed for unnecessary medications. (Resident 15) Findings include: The clinical record for Resident 15 was reviewed on 11/01/23 at 10:49 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 10/01/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, hypertension, and peripheral vascular disease. The resident had taken medications that included, but was not limited to, a diuretic (water pill). The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for October and September 2023 related to the resident's weights were provided by the Scheduler on 11/03/23 at 11:38 A.M. The record indicated the resident was to be weighed weekly. The MD/NP (Nurse Practitioner) were to be notified if the resident gained three pounds or more in a week. The record included, but was not limited to, the following: - On 10/23/23, the resident gained 3.5 pounds, the record lacked the MD/NP notification. - On 10/09/23, the resident gained 4.8 pounds, the	F 0580	F580 Notification of Change 1 Resident 15 was affected by the alleged deficient practice. The provider was notified of resident's condition with no documentation prior. No adverse effects noted as a result of lack of physician's notification documentation. 2 All residents have the potential to be affected. All residents reviewed for MD notification documentation for changes in condition. Staff nurses educated on proper notification requirements for residents with change of conditions. 3 As a measure of ongoing compliance, the DHS or designee will audit 5 residents for proper MD notification on weight changes weekly x1 month , then every other week x2 months, then monthly x1 month. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	11/27/2023

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	record lacked the MD/NP notification. - On 10/02/23, the resident's weight was not obtained, no reason was documented, and the MD/NP was not notified. - On 09/18/23, the resident's weight was not obtained, no reason was documented, and the MD/NP was not notified. Vitals records for weights for September and October 2023, were provided by the Scheduler on 11/03/23 at 11:38 A.M. The record lacked documentation that the resident had been weighed on 10/02/23 or 09/18/23. A Care Plan for Nutrition was provided by the Scheduler on 11/03/23 at 11:38 A.M. The Care Plan included, but was not limited to, an intervention to, "Obtain weight as ordered/needed," with a start date of 01/04/21. Progress Notes for September and October 2023, were provided by the Scheduler on 11/03/23 at 11:38 A.M. The record lacked documentation that the MD/NP had been notified on 10/23/23 or 10/09/23, or that the resident had been weighed on 10/02/23 or 09/18/23. During an interview on 11/03/23 at 10:47 A.M., LPN (Licensed Practical Nurse) 5 indicated CNAs (Certified Nurse Aides) and nursing staff obtained residents' weights. If there was an order for a daily or weekly weight it would come up on the EMAR. Whoever was passing medications on the medication cart would document the weights in the EMAR. If the physician was to be notified it would be documented on the EMAR and staff would have to put a Progress Note in the EHR (Electronic Health Record) stating what the MD recommended.			

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	During an interview on 11/03/23 at 11:09 A.M., the DON (Director of Nursing) indicated the physician should have been notified of the resident's weight changes. The current "Guidelines for Weight Tracking" policy, with a reviewed date of 12/31/22, was provided by the Scheduler on 11/03/23 at 11:38 A.M. The policy indicated, "...Purpose...To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration...The weight should be recorded in the individual resident medical record..." The current "Physician-Provider Notification Guidelines" policy, with a reviewed date of 12/31/22, was provided by the Scheduler on 11/03/23 at 11:38 A.M. The policy indicated, "...Purpose...The ensure the resident's physician or practitioner...is aware of...change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...Attempts to notify the physician/provider and their response should be documented in the resident electronic health record..." 3.1-5(a)(2)			
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 professional standards of practice, the comprehensive person-centered care plan,			

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	and the residents' choices. Based on record review, interview, and observation, the facility failed to implement neurological checks (neurological assessments) following a fall and failed to follow appropriate guidelines for insulin pen usage for 2 of 17 residents reviewed for Quality of Care. (Residents 10 and 31) Findings include: 1. The clinical record for Resident 10 was reviewed on 11/03/23 at 2:47 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/10/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Parkinson's disease and stroke. The resident had two or more falls with no injury and two or more falls with injuries that were not major since the previous assessment, dated 06/26/23. The Progress Notes were provided by the DON (Director of Nursing) on 11/06/23 at 10:54 A.M., and included, but were not limited to, the following: - A note, dated 10/19/23 at 9:41 P.M., indicated the resident was observed on the floor in his room, lying on his left side. - An IDT (Interdisciplinary Team) note dated 10/23/23 at 8:24 A.M., indicated the resident had an unwitnessed fall in his room on 10/19/23. A Fall Event report, dated 10/19/23 at 3:45 P.M., was provided by the DON on 11/06/23 at 10:54 A.M. The report indicated the resident had an unwitnessed fall in their room and staff were to initiate the "Neuro check" order set. The event contained the initial set of vital signs and neuro	F 0684	F684 Quality of Care 1 Resident 31 was affected by alleged deficient practice. Nurse primed insulin pen with cap on it. No adverse effects were noted as a result. Resident 10 was affected by the deficient practice. Neuro checks were not completed per policy on fall. No adverse effects were noted as a result. 2 All residents have the potential to be affected. Staff nurses educated on priming insulin pens per medication insert. Staff nurses educated on fall policy and completion of neuro checks. 3 As a measure of ongoing compliance, the DHS or designee will audit 5 insulin administrations weekly x1 month ensuring staff are priming pens per manufacturer guidelines, then every other week x2 months, then monthly x1 month. As a measure of ongoing compliance, the DHS or designee will audit 5 residents weekly x1 month for neuro check completion, then every other week x2 months, then monthly x1 month 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance	11/27/2023

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	(neurological) checks only. During an interview on 11/06/23 at 10:07 A.M., RN 3 indicated when a resident had an unwitnessed fall, the staff obtained vital signs, assessed the resident for injury, assisted them to get up, and started neuro checks every 15 minutes x (times) 4, every 30 minutes x 4, every hour x 4, every 4 hours x 5; and they monitored vital signs and pain for 72 hours. During an interview on 11/06/23 at 10:11 A.M., the DON indicated neuro checks would be documented in the EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) and they would also be in the vitals record as well. Neuro checks should have been completed for the fall on 10/19/23. The EMAR/ETAR for October 2023 was reviewed on 11/06/23 at 10:30 A.M. The record lacked documentation the neuro checks had been initiated for the fall on 10/19/23. The Vital Signs record for October 2023 was provided by the DON on 11/06/23 at 10:54 A.M. The record included one set (temperature, pulse, respirations, blood pressure, and oxygen saturation) of vital signs on 10/19/23 at 3:45 P.M., and one blood pressure value documented at 8:19 P.M. No other vital signs were documented until 10/20/23 at 7:20 P.M. The current "Guidelines for Neurological Checks" policy, with a reviewed date of 12/31/22, was provided by the DON on 11/06/23 at 10:54 A.M. The policy indicated, "...Residents having a fall should be evaluated for injury...Neuro-checks for 24 hours should be completed within the Fall		Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	Event Form..." 2. Medication administration was observed on 11/01/23 at 11:49 A.M., with LPN (Licensed Practical Nurse) 2. The nurse checked Resident 31's blood sugar level and indicated the resident was to receive three units of Humalog insulin plus sliding scale insulin before meals. The resident's blood sugar level was 132 and, therefore, would only get the scheduled three units of Humalog insulin. The nurse checked the resident's order, unlocked the medication cart, retrieved the insulin pen from the cart, checked the label, cleaned the hub of the pen, applied the needle, primed the pen with two units with the white needle cap still on the pen, and holding the pen upright. The cap was not transparent. During an interview on 11/01/23 at 11:56 A.M., LPN 2 indicated the purpose of priming the insulin pen was to make sure the bubbles were out of the pen. You had to hold the pen upright. You should be able to see insulin come out of the tip of the needle, and she could not see that with the needle cap still in place. The physician's order for Humalog was provided by the DON on 11/03/23 at 2:54 P.M., and indicated the resident was to receive three units of insulin, subcutaneously, before meals. The undated pharmacy guidelines for "Preparing an Insulin Pen for Use" policy was provided by the DON on 11/03/23 at 2:54 P.M. The policy indicated, "...Remove pen cap...Wipe the rubber septum with an alcohol swab...Remove the seal from the new needle...Line the needle up straight with the pen and screw the needle on...Remove the outer needle cover and do not throw away...Dial a 2-unit prime/test dose...Hold the pen			

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	upright, lightly tap the pen reservoir so any air bubbles will rise to the top...Press the injection button all the way in to make sure insulin comes out the end of the needle..." 3.1-5(a)(2)			
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 new ulcers from developing. Based on interview, observation, and record review, the facility failed to follow the physician's orders for a dressing change to a pressure ulcer for 1 of 3 residents reviewed for wound care. (Resident 43) Findings include: During an interview on 11/02/23 at 10:47 A.M., LPN (Licensed Practical Nurse) 2 reviewed Resident 43's wound dressing change order and indicated they were to cleanse the left inner ankle area, pat dry, apply Santyl ointment (a prescription medication that removes dead tissue) to the wound bed, and cover with a foam	F 0686	F686 Pressure Ulcers 1 Resident 43 was affected by alleged deficient practice. Dressing in place on resident was dated 10/31/23. Dressing was visualized on 11/2/23. MD order states daily dressing change. Resident's wound assessed with no adverse effects noted. 2 All residents receiving treatments have the potential to be affected. All nursing staff educated on proper dressing changes. 3 As a measure of ongoing	11/27/2023

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	dressing. The dressing was to be changed daily. Wound care for Resident 43 was observed on 11/02/23 at 10:58 A.M., with LPN 2. The nurse prepared the dressing change supplies and followed appropriate infection control guidelines. The nurse removed the soft foam boot that was protecting the resident's left ankle, removed their sock, and removed the old dressing that was dated "10/31". There was a small amount of drainage on the old dressing. The wound, located on the left inner ankle bony prominence, was the size of a pencil eraser. The nurse proceeded with the dressing change and dated the dressing when finished. The nurse indicated staff were to date and initial the dressings. The resident's dressing was to be changed daily and as needed. The dressing should have been changed yesterday (11/01/23). During an interview on 11/02/23 at 11:19 A.M., the DON (Director of Nursing) indicated the resident was admitted with the wound on her inner ankle. They had a wound nurse who evaluated wounds weekly and it would be documented under Wound Management. The clinical record was reviewed on 11/02/23 at 11:37 A.M. An Admission MDS (Minimum Data Set) assessment, dated 10/04/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, and depression. The resident was at risk for pressure ulcers and had one unstageable pressure ulcer (obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough [non-viable yellow, tan, gray, green or brown tissue; usually moist] or eschar		compliance, the DHS or designee will audit 5 residents with treatment orders to ensure dressing change orders are followed per MD order weekly x1 month, then every other week x2 months, then monthly x1 month 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	[dead, black, brown, or dead tissue]), that was present on admission. The Wound Management records for the resident's ankle wound were provided by the DON on 11/03/23 at 2:52 P.M., and included, but were not limited to, the following assessments: - On 09/29/23, the wound measured 1 cm (centimeter) x (by) 0.7 cm, was unstageable, and the wound bed was covered with slough, and - On 10/30/23, the wound measured 0.4 cm x 0.3 cm, and the wound bed was covered with granulation (new connective) tissue. The Progress Notes were provided by the DON on 11/03/23 at 2:52 P.M. There were no notes indicating the dressing change had been completed on 11/01/23. The ETAR (Electronic Treatment Administration Record) was provided by the DON on 11/03/23 at 2:52 P.M., and included, but was not limited to, the following current physician's order: - Wound Care, left inner ankle, cleanse area and pat dry. Apply Santyl to wound bed. Cover with a foam dressing and change daily and as needed if soiled/dislodged. The ETAR was documented that the dressing change had been completed on 11/01/23. The current Dressing Changes policy, with a reviewed date of 12/31/22, was provided by the DON on 11/03/23 at 2:52 P.M. The policy indicated, "...To ensure measures that will promote and maintain good skin integrity while maintaining standard measures that will minimize /			

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	control contamination..." This citation relates to Complaint IN00419961. 3.1-40(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to follow a physician's order for daily weights related to edema for 1 of 2 residents reviewed for hydration. (Resident 52) Findings include: The clinical record for Resident 52 was reviewed on 11/01/23 at 10:46 A.M. An Admission MDS (Minimum Data Set) assessment, dated 10/20/23,	F 0692	F692 Nutrition Maintenance 1 Resident 52 was affected by alleged deficient practice. Failure to write order for daily weights as NP wrote in progress notes. No adverse effects were noted as a result. 2 All residents have the potential to be affected. NP notes were audited to ensure all orders	11/27/2023

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(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
	indicated the resident was cognitively intact. The diagnoses included, but were not limited to, metabolic encephalopathy, lymphedema, cardiomegaly, anxiety, and depression. An NP (Nurse Practitioner) Progress Note, dated 10/23/23, indicated the resident was being seen for post seven-day admission follow-up. The assessment and plan included but was not limited to, "...Edema: Start HCTZ (Hydrochlorothiazide) 25 mg (milligrams) daily x (times) 3 days and daily weight..." The clinical record lacked indication the resident was weighed daily from 10/24/23 through 11/03/23. During an interview on 11/03/23 at 10:47 A.M., LPN (Licensed Practical Nurse) 5 indicated CNAs (Certified Nurse Aides) and nursing staff obtained residents' weights. If there was an order for a daily or weekly weight it would come up on the EMAR. Whoever was passing medications on the medication cart would document the weights in the EMAR. If the physician was to be notified it would be documented on the EMAR and staff would have to put a Progress Note in the EHR (Electronic Health Record) stating what the MD recommended. During an interview on 11/03/23 at 9:51 A.M., the ADON (Assistant Director of Nursing) indicated the residents daily weight order from 10/23/23 was missed and should have been started on 10/24/23. The nurses would have transcribed the NP's orders the day she was in the building, but the management team should have caught the missed order the next day during their morning meeting. The current facility policy titled, "Guidelines for Weight Tracking", with a review date of 12/31/22,		written in progress notes were in place. Clinical management to review NP progress notes daily in CCM. 3 As a measure of ongoing compliance, NP progress notes will be audited for new orders by DHS or designee weekly for 4 weeks, bi-weekly for 8 weeks, and then monthly for 1 month. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	155742	A. BUILDING 00 B. WING	11/06/2023

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	was provided by the DON (Director of Nursing) on 11/03/23 at 2:52 P.M. The policy indicated, "...To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration...The weight should be recorded in the individual resident medical record..." 3.1-46(a)(1)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;			

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	§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to follow a physician's order related to a gradual dose reduction of an antipsychotic for 1 of 5 residents reviewed for unnecessary medications. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 11/01/23 at 9:56 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/06/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, non-Alzheimer dementia, Parkinson's disease, anxiety, and psychotic disorder. A Behavior Management Team Gradual Dosage Reduction Recommendation, dated 03/28/23,	F 0758	F758 Free from unnecessary psychotropic meds/ PRN use 1 Resident 26 was affected by the alleged deficient practice. Gradual dose reduction order was received to discontinue resident 26's Seroquel and the order was not discontinued on the MAR. No adverse effects noted as a result. 2 All residents have the potential to be affected. All residents with gradual dose reductions were reviewed to ensure orders were discontinued as ordered by provider. Staff nurses educated on following Gradual dose reduction orders from providers. 3 As a measure of ongoing	11/27/2023

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	indicated the resident was currently taking Seroquel (an antipsychotic medication) 12.5 mg (milligrams) every day. The consideration was given to gradual dose reduction to discontinue the Seroquel at that time. The form was signed by the Nurse Practitioner the same day. A facility Gradual Dose Reduction (GDR) Circumstance was started on 03/29/23 indication the resident Seroquel 12.5 mg every day was GDR'd. The form indicated the resident's representative was notified on 04/03/23. A Progress Note, dated 03/29/23 at 10:02 A.M., indicated the Behavior management team met on 03/28/23 for a monthly behavior meeting. The residents Seroquel 12.5 mg once a day was up for review. The Psychologist and NP decided to discontinue at the time. A Progress Note, dated 03/29/23 at 10:05 A.M., indicated the resident Seroquel was discontinued for GDR per the MD and the POA (Power of Attorney) was aware. A Progress Note, dated 03/30/23 at 12:18 A.M., indicated the resident was without concerns related to the discontinuing of Seroquel. A Progress Note, dated 03/31/23 at 12:52 A.M., indicated the resident continued a GDR of Seroquel with no adverse side effects. A Progress Note, dated 04/01/23 at 1:03 A.M., indicated the resident had no adverse effects related to the GDR of Seroquel. A Progress Note, dated 04/01/23 at 5:55 P.M., indicated the resident had no adverse side effects related to the GDR of Seroquel.		compliance, the DHS or designee will audit 5 residents weekly x1 month for accurate gradual dose reduction order completion, then every other week x2 months, then monthly x1 month 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	A Progress Note, dated 04/03/23 at 7:43 A.M., indicated the IDT (Interdisciplinary Team) reviewed the GDR event and agreed with monitoring the resident for signs and symptoms of changes in mood/behavior related to discontinuation of Seroquel. The POA was notified. The resident was without issues at the time. The resident's family was without concerns. A physician's order, dated 01/23/23 through 04/25/23, indicated the resident was to receive Seroquel 12.5 mg, every day for psychotic disorder. The March and April 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had received the medication daily from 03/28/23 through 04/24/23. During an interview on 11/01/23 at 3:09 P.M., the Social Service Director indicated behavior meetings were completed monthly and they would review the resident's charts that were up for review. If a GDR was needed, then they would discuss if it needed to be decreased or stayed the same. If the medication was going to be GDR' d, then the NP would usually agree or disagree in the meeting. A progress note would be inputted, and the order would be changed if the medication changed. During an interview on 11/01/23 at 3:23 P.M., the ADON (Assistant Director of Nursing) indicated she could not see where the resident's Seroquel had been discontinued. The medication should have changed or there should have been a progress note indicating the family refused to discontinue the medication.			

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	The current facility policy titled, "Psychotropic Medication Usage and Gradual Dose Reduction" with a review date of 12/31/22 was provided by the DON (Director of Nursing) on 11/03/23 at 2:52 P.M. The policy indicated, "...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...Efforts to reduce dosage or discontinue psychotropic medications will be ongoing, as appropriate...Gradual dose reductions will be documented on the appropriate event in the EHR [Electronic Health Record]..." 3.1-48(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed			

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	compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications appropriately related labeling medication and having unsecured loose tablets in the medication carts for 2 of 3 medication carts reviewed. (The 100 Hall Medication Cart and the 200 Hall Medication Cart) Findings include: 1. The 100 Hall Medication Cart was observed on 11/06/23 at 10:15 A.M., with RN 3. The Cart contained the following loose pills laying in the bottom of the drawers: - two small yellow oval tablets, and - one small white oval tablet, During an interview on 11/06/23 at 10:16 A.M., RN 3 indicated there should not be any loose pills in the medication cart. 2. The 200 Hall Medication Cart was observed on 11/06/23 at 9:58 A.M., with LPN (Licensed Practical Nurse) 4. The Cart contained the following: - a bottle of Refresh eye drops with no resident name and no opened date. During an interview on 11/06/23 at 9:59 A.M., LPN 4 indicated all medication in the medication cart	F 0761	F761 Label / Storage of Drugs 1 Resident 10 was affected by the alleged deficient practice. Eye drops that were ordered to be given were not dated. Unsecured medication tablets found in med cart. No adverse effects were noted as a result of eye drops not being dated and unsecured medication tablets found in med cart. 2 All residents have the potential to be affected. All medication carts were audited to ensure medications were dated. Nurses and QMAs were educated on properly labeling eye drops once opened. 3 As a measure of ongoing compliance, carts will be audited by DHS or designee for medications dated and no loose tablets weekly for 4 weeks, bi-weekly for 8 weeks, and then monthly for 1 month 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan	11/27/2023

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	should be labeled with the resident's name and have an opened date. The current facility policy titled, "MEDICATION STORAGE IN THE FACILITY" with a revised date of 11/2018 was provided by the Director of Nursing on 11/06/23 at 10:54 A.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier..." 3.1-25(m)		will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Complaint Investigation IN00419961. Complaint IN00419961 - Federal/State deficiency related to the allegations is cited at F686. Survey dates: October 30, 31, and November 1, 2, 3, and 6, 2023 Facility number: 004671 Residential Census: 32 Saint Andrews 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 November 15, 2023.	R 0000	The submission of this plan of correction does not indicate an admission by St. Andrews Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of St. Andrews Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance as of 11/27/2023 with all state and federal requirements governing the management of this	

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			facility. The facility respectfully requests from the department a desk review for paper compliance.	