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	12/16/2024

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. Survey dates: December 9, 10, 11, 12, 13, and 16, 2024 Facility number: 004671 Provider number: 155742 AIM number: 200538760 Census Bed Type: SNF/NF: 33 SNF: 22 Residential: 32 Total: 87 Census Payor Type: Medicare: 16 Medicaid: 25 Other: 14 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 20, 2024.	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 an 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 substantial compliance as of 01/03/2025 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 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to provide prescribed medications for 1 of 6 residents reviewed for pharmacy services. (Resident 40) Findings include:	F 0755	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? -Resident 40 had head-to-toe assessment completed by	01/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sierra Orr	Assistant Director of Health Services	01/03/2025

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	The clinical record for Resident 40 was reviewed on 12/11/24 at 11:24 A.M. An Admission Minimum Data Set (MDS) assessment, dated 10/02/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Parkinson's disease, anxiety, and macular degeneration. The physician's orders were reviewed on 12/11/24 at 11:29 A.M., and included, but were not limited to, the following current order: - Brimonidine eye drops (used to lower fluid pressure in the eyes), one drop in the left eye three times a day at 7:30 A.M., 2:00 P.M., and 10:00 P.M., with a start date of 09/29/24. The November Electronic Medication Administration Record (EMAR) indicated the medication was not given and documented as "unavailable" on the following dates and times: - 11/24/24 at 10:00 P.M., - 11/25/24 at 7:30 A.M. and 2:00 P.M., - 11/26/24 at 7:30 A.M., 2:00 P.M., and 10:00 P.M., - 11/27/24 at 10:00 P.M., - 11/28/24 at 7:30 A.M., 2:00 P.M., and 10:00 P.M., and - 11/29/24 at 7:30 A.M. and 2:00 P.M. During an interview on 12/11/24 at 1:56 P.M., Qualified Medication Aide (QMA) 3 indicated staff could peel a sticker off of the eye drop bottles and inhalers and fax the order to the pharmacy or they could press the reorder button on the EMAR. During an interview on 12/11/24 at 1:57 P.M., the Assistant Director of Nursing (ADON) indicated when pressing the reorder button on the EMAR		licensed nurse with no findings. Brimonidine drops had been reordered by the time of the survey. No adverse effects noted. 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. EMAR compliance reviewed to ensure that all medications are available at this time. Education and training were provided for licensed staff regarding the available medications policy. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -As a measure of ongoing compliance, the DHS or designee will audit the EMAR compliance report on 5 residents three times weekly x 4 weeks, then 3 residents three times a week x 4 weeks, then 1 resident three times a week x 4 weeks, then 1 resident a month x 3 months. 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? - The results of these audits will	

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	before 7:00 P.M. on weekdays, or 3:00 P.M. on weekends, the medication should be delivered to the facility in less than 24 hours. Medications usually came in after midnight of the day they were ordered. During an interview on 12/13/24 at 10:18 A.M., RN 4 indicated they had called the pharmacy, and the pharmacy indicated they had sent the eye drops. When medications came in, the nurse on duty would sign the list saying they were received. They had checked the other medication carts and could not find the eye drops. When staff ordered medications, they usually would arrive at the facility that same night. During an interview on 12/13/24 at 2:39 P.M., the ADON indicated they could use any of the local pharmacies if they needed a medication they were having difficulty getting from the primary pharmacy. The current "UNAVAILABLE MEDICATIONS" policy, with a revised date of "11/18", was provided by the ADON on 12/13/24 at 3:02 P.M. The policy indicated, "...The facility must make every effort to ensure that medications are available to meet the needs of each resident..." 3.1-25(g)(3) 3.1-37(a)		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. 5. Date of completion: 01/03/2025	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to maintain residents' snack refrigerator related to unlabeled items for 1 of 1 resident snack refrigerators reviewed. (Health Center snack refrigerator)	F 0812	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? -No residents were affected by the	01/03/2025

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	Findings include: The nourishment area in the Health Center was observed with Qualified Medication Aide (QMA) 2 on 12/16/24 at 9:17 A.M. The snack refrigerator contained the following: - Three lidded bowls that contained what looked like oats and milk that were labeled as belonging to a current resident in the facility. There were instructions for reheating the contents of the bowls. The bowls were not dated and QMA 2 was not sure when the items were brought into the facility. - A bag from a fast-food restaurant with a container of dried out french fries and a wrapped sandwich. The bottom of the bag was discolored from grease. A resident's nickname was written on the bag, but the bag was not labeled with a received-on date. - A white plastic bag from a fast-food restaurant with a half-eaten burrito bowl inside. The bag was not labeled in any way. - A Styrofoam cup of milk with a lid labeled with a resident's first name. The cup was dated 12/07/24. QMA 2 removed the cup and poured the milk out. During an interview on 12/16/24 at 9:20 A.M., QMA 2 indicated food items brought in by family should be labeled with the resident's name and the date it was received. The current facility policy, titled "Food Brought Into Facility", dated 01/2023, was provided by the Assistant Director of Nursing (ADON) on 12/16/24 at 1:57 P.M. The policy indicated,		alleged deficient practice. All unlabeled items were wasted. 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. All items were audited to ensure label in place and are discarded if expired. Education provided to culinary team and nursing staff related to labeling items and discarding expired items. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -As a measure of ongoing compliance, the Director of Food Services (DFS) will round for completion of labeling, dating, and disposal of expired items, weekly x4 weeks, then every other week x2 months, then monthly x3 months. 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? -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	

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	"...Food or Beverage items are to be properly Labeled and Date marked, stored and discarded, in conjunction with the facilities Date Mark and labeling [Policy and Procedure] P&P..." The current facility policy, titled "Food Labeling and Dating Policy", dated 01/2024, was provided by the ADON on 12/16/24 at 1:57 P.M. The policy indicated, "...Any food product...must have a label that contains the following...Date and Time the food was labeled...Use by date..." 3.1-21(i)(3)		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. 5. Date of completion: 01/03/2025	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: December 9, 10, 11, 12, 13, and 16, 2024 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.	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 an 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 substantial compliance as of 01/03/2025 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.	