STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155742	A. BUILDING -- B. WING	12/28/2022

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/28/22 Facility Number: 004671 Provider Number: 155742 AIM Number: 200538760 At this Emergency Preparedness survey, St Andrews 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 66 certified beds. At the time of the survey, the census was 57. Quality Review completed on 01/03/23	E 0000	Plan of correction for St. Andrews Health Campus, (SAHC) : The submission of this plan of correction does not indicate an admission by (SAHC) that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided by (SAHC). This 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 with the requirements of participation for comprehensive healthcare facilities. Attached you will find our plan of correction for (SAHC) for our annual life safety survey. We respectfully request paper review for this plan of correction and approval of Life Safety Code Waiver Request. If you need additional information or paperwork,, please do not hesitate to contact us at 812-934-5090 or Kevin.Craig@standrewshc.com	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kevin Craig	Executive Director	01/13/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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			Respectfully, Kevin Craig, HFA	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/28/22 Facility Number: 004671 Provider Number: 155742 AIM Number: 200538760 At this Life Safety Code survey, St Andrews Health Campus was found not in compliance with Requirements for Participation in 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 was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 66 and had a census of 57 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 01/03/23	K 0000	Plan of correction for St. Andrews Health Campus, (SAHC) : The submission of this plan of correction does not indicate an admission by (SAHC) that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided by (SAHC). This 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 with the requirements of participation for comprehensive healthcare facilities. Attached you will find our plan of correction for (SAHC) for our annual life safety survey. We respectfully request paper review for this plan of correction and approval of Life Safety Code Waiver Request. If you need additional information or paperwork,, please do not	

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			hesitate to contact us at 812-934-5090 or Kevin.Craig@standrewshc.com Respectfully, Kevin Craig, HFA	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on record review, observation and interview; the facility failed to maintain the 2-hour fire rated separation between the skilled nursing unit and the attached Assisted Living area in accordance with Section 19.1.3.4.1. This deficient practice could affect over 20 residents, staff and visitors in the main dining room. Findings include:	K 0131	Immediate Intervention: The Director of Plant Operations (DPO) has ordered two new 90 minute fire rated doors to replace the 2 non-complaint doors to the kitchen and Private dining room. The DPO has installed automatic closing hardware on the private	02/15/2023

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	Based on review of facility floor plan documentation with the Director of Plant Services (DPS) during record review from 9:25 a.m. to 11:50 a.m. on 12/28/22, a two hour fire resistance rated fire wall is in the north wall of the main kitchen. The north wall of the main kitchen is also the south wall of the main dining room. Based on observations with the DPS during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 12/28/22, the kitchen door to the main dining room is in the north wall of the kitchen and was equipped with a 45-minute fire resistance rating label affixed to the hinge side of the door. In addition, the door to the private dining room from the main dining room is also in the south wall of the main dining room. The door was equipped with a 45-minute fire resistance rating label affixed to the hinge side of the door and the door was also not self closing or automatic closing. Based on interview at the time of the observations, the DPS agreed the two doors in the 2-hour fire rated separation wall between the skilled nursing unit and the kitchen were not rated with a minimum 90-minute fire resistance rating label and the door to the private dining area was also not self closing or automatic closing. Based on review of the original blueprint documentation for the facility at 1:30 p.m. on 12/28/22, a two hour rated fire wall in the north wall of the main kitchen was confirmed by the original blueprint documentation. This finding was reviewed with the Executive Director and the DPS during the exit conference. 3.1-19(b)		dining door. See K 0131: (1), (1a), (2), (3), (4) The DPO was educated by the Executive Director on K131 NFPA 101 Multiple Occupancies - Sections of Health Care Facilities. They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. (See attachment A) The DPO will inspect the deficient doors for closing and proper operation 1x per week for 1 month then 1 times per month for 3 months. The results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. (See attachment B K0131) The Deficient practice could affect over 20 residents, staff and visitors in the main dining room	

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 2 of 7 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Director of Plant Services (DPS) during the initial walk through of the facility from 9:15 a.m. to 9:25 a.m. on 12/28/22, a plastic three drawer chest of drawers without wheels for isolation supplies was stored in the	K 0211	Immediate intervention: The three chests of drawers for isolation supplies not on wheels were replaced with chest on wheels outside room 103,113 and 312. The bed that was temporarily stored outside of soiled laundry was removed. see K211: (7), (8), (9) The DPO was educated by the Executive Director on K211 NFPA 101 Means of Egress-General. (See Attachment C) Aisles, passageway, corridors, exits discharges, exit locations and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:	12/29/2022

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	corridor outside resident Room 103, 113 and 312. In addition, a resident bed was stored in the corridor outside the Soiled Laundry room near the Breakroom. Based on observations with the DPS during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 12/28/22, the resident bed was still stored in the corridor outside the Soiled Laundry room near the Breakroom. The bed projected four- and one-half feet into the eight-foot-wide corridor. Based on interview at the time of the observations, the DPS agreed the isolation chest of drawers did not have wheels and stated the resident bed stored in the corridor is a rented bed and is not the facility's bed and the facility was awaiting pickup by the bed rental company but agreed the aforementioned means of egress were not free from obstructions. This finding was reviewed with the Executive Director and the DPS during the exit conference. 3.1-19(b)		(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following I. Equipment in use and carts in use II. Medical emergency equipment not in use III. Patient lift and transport equipment The DPO will inspect the deficient corridors for proper means of egress 1 x a week for 1 month then 1 x a month for 3 months. (see attachment B) (see K211: (2), (3), (4), (5) Results of these inspections will be presented by the Executive Director to the QA committee for further recommendations and continue until the QA Team determines substantial compliance has been achieved. The deficient practice could affect 20 residents, staff and visitors if needing to exit the facility.	

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