| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155742 | A. BUILDING 00<br>B. WING | 09/27/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST ANDREWS HEALTH CAMPUS | 1400 LAMMERS PIKE<br>BATESVILLE, IN 47006 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and investigation of Complaint IN00209649.<br><br>This visit was in conjunction with the Investigation of Complaint IN00211230.<br><br>Complaint IN00209649 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.<br><br>Complaint IN00211230 - Unsubstantiated due to lack of findings<br><br>Survey dates: September 19, 20, 21, 22, 23, 26 and 27, 2016<br><br>Facility number: 004671<br>Provider number: 155742<br>AIM number: 200538760<br><br>Census bed type:<br>SNF: 9<br>SNF/NF: 41<br>Residential: 31<br>Total: 81<br><br>Census payor type:<br>Medicare: 11 | F 0000 | September 27, 2016 St. Andrews Health Campus 1400 Lammers Pike, Batesville, Indiana 47006 Survey Event ID WBTN11. 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 and true representations of the quality of care and services provided to the residents of St. Andrews Health Campus. This facility recognized its | |

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

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| | Medicaid: 18<br>Other: 21<br>Total: 50<br><br>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed by 34233 on October 3, 2016. | | obligation to provide legally and medially necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive healthc are facilities (for Title 18/19 programs). Attached you will find our Plan of Correction for St. Andrews Health Campus for our annual survey conducted on September 27, 2016. We respectfully request paper review | |

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| | | | for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812)934-5090. Sincerely, Katrina Keck, Executive Director. | |
| F 0241 SS=D Bldg. 00 | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br>Based on observation, record review and interview, the facility failed to ensure a resident's dignity was maintained related to a resident's name visibly written on clothing for 1 resident during 4 or 4 observations. ( Resident #57)<br><br>Findings include:<br><br>On 09/21/2016 at 8:17 A.M., Resident #57 was observed sitting in the assist dining room in her wheelchair. She had on white socks with large black lettering | F 0241 | 1. Corrective Actions to be taken for those found with deficiency on res#57 socks were replaced and facility assisted in labeling to meet the dignity and respect of resident's individuality.<br>2. How others have potential to be affected by same practice will be | 10/26/2016 |

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| | on the socks with the first name and last initial of another resident.<br><br>Resident #57 was observed on 09/21/2016 at 9:34 A.M., sitting in her wheelchair by the television near the nurses' station. She was wearing white socks with large black lettering on the socks with the first name and last initial of another resident.<br><br>On 09//23/2016 at 12:02 P.M., Resident #57 was observed sitting in her wheelchair by the television near the nurses' station. The resident had a white sock on her right foot with her first initial and last name printed in large black letters.<br><br>On 09/23/2016 at 2:40 P.M., the resident's initial of her first name and last name were written on her left white sock in large black letters.<br><br>The record for Resident #57 was reviewed on 09/23/2016 at 2:57 P.M. The resident's diagnoses included, but were not limited to, dementia, downs syndrome, and anxiety.<br><br>A quarterly MDS (Minimum Data Set) Assessment, dated 08/19/2016, indicated the resident was rarely or never understood and sometimes understands, | | identified with corrective actions<br>Complete audit of residents clothing for proper labeling & ensure clothing is returned to the correct resident. No other resident's have been identified.<br>3. What measures put in place or systematic changes will be made to ensure deficient practice doesn't reoccur.<br>Inservice provided to laundry staff, Nursing (CNA, RCA, QMA, LPN, RN) to cover proper labeling and returning clothing to the correct resident.<br>4. How corrective actions will be monitored to ensure no reoccurrence<br>Weekly audits by Director of Enviromental Services &/or Administrator, Assistant Director of | |

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| | she had problems with her short and long term memory, and was severely impaired cognitively. She was an extensive assist (resident involved in activity, staff provide weight-bearing support) of two.<br><br>A care plan initiated on 01/07/2016 indicated, "I have an ADL (Activities of Daily Living) deficit of not being able to perform ADLs independently. The approaches included, but were not limited to, one assist for dressing."<br><br>On 09/26/2016 at 1:55 P.M. the resident agreement titled "Personal and other Property" was provided by Clinical Support Nurse. The agreement indicated the resident or responsible party shall label clothing as needed.<br><br>Interview with Laundry #2, on 09/23/2016 at 9:44 A.M., indicated labels were made and attached to the resident's clothing. Labels were placed on socks around the ankle so that they would be hidden by the resident's shoe.<br><br>Interview with Clinical Support Nurse, on 09/26/2016 at 1:50 P.M., indicated it was the resident's family's responsibility to label clothing.<br><br>Interview with the Director of Nursing, on 09/26/2016 at 2:20 P.M., indicated it | | Health Services, Director of Health Services of proper labeling & ensure clothing is returned to the correct resident, one time a week x 4 weeks then one time a month x 4 and reviewed by QAA monthly x 4 months. Weekly audits of proper labeling & ensure clothing is returned to the correct resident, one time a week x 4 weeks then one time a month x 4 and results of these audits will be reviewed by QAA monthly x 4 months. If any areas of concerns are identified, action plans will be developed and continue until substantial compliance is achieved.<br>5. By what date systems will be completed by 10/26 /16 | |

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| | was usually the laundry or activities department who labeled resident clothing or the family brings clothing in already labeled.<br><br>3.1-3(t) | | | |
| F 0279<br>SS=D<br>Bldg. 00 | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br>Based on interview and record review, the facility failed to ensure residents had comprehensive care plans related to psychotropic medication use for 2 of 15 | F 0279 | 1. Corrective Actions to be taken for those found with deficiency | 10/26/2016 |

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| | residents reviewed for care plans. (Resident #11 & #77)<br><br>Findings include:<br><br>1. On 09/21/2016 at 1:12 P.M., the Minimum Data Set assessment (MDS), dated 06/09/2016, indicated diagnoses included but were not limited to depression, anxiety, Parkinson's disease, chronic obstructive pulmonary disease, benign prostatic hyperplasia, hallucinations, dementia, and obstructive uropathy. Anti-anxiety, anti-depressant, and anti-psychotic medications were used for the resident in the seven day look back assessment.<br><br>On 09/23/2016 at 2:23 P.M., during an interview the MDS coordinator indicated she wrote the care plans for medications, including psychotropic medications, if the MDS assessment indicated they were to have a care plan. Residents are observed for side effects and followed by the behavior management team. The MDS coordinator indicated the psychotropic medications were not care planned for Resident #77. | | Resident # 77 & #11 had care plan completed immediately on 9/23/16.<br>2. How others have potential to be affected by same practice will be identified with corrective actions<br>No other resident's have been identified. All residents needing comprehensive care plans had the potential to be effected.<br>3. What measures put in place or systematic changes will be made to ensure deficient practice doesn't reoccur IDT to be in serviced regarding developing comprehensive care plans. All residents on psychotropic medications were audited for proper care plans and side effect monitoring monitoring.<br>4. How corrective actions | |

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| | | | will be monitored to ensure no reoccurrence<br>Complete audit will be conducted by MDS, SSD, DHS, ADHS, Nurse Manger of all residents on psychotropic medication, then all new orders to be reviewed daily in CCM for implementation of care plans. Results of these findings will be presented and reviewed monthly in QAA meetings. If any areas of concerns are identified, action plans will be developed and continue until substantial compliance is achieved.<br>5. By what date systems will be completed by 10/26 /16 | |
| F 0315 | 483.25(d) | | | |

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| SS=D<br>Bldg. 00 | NO CATHETER, PREVENT UTI, RESTORE BLADDER<br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br>Based on observation, record review and interview, the facility failed to ensure a resident received the necessary treatment and services in the care of a urinary catheter and failed to ensure the resident had a medical diagnosis for the urinary catheter for 1 of 2 resident's reviewed for urinary catheters. (Resident #116)<br><br>Findings include:<br><br>On 09/20/2016 at 12:24 P.M., Resident #116 was observed in her room sitting in her wheelchair. She had a urinary catheter flowing to gravity. The tubing of the urinary catheter was laying on the floor under the resident's wheelchair.<br><br>On 09/21/2016 at 11:30 A.M., Resident #116 was observed in the therapy room. She was sitting in her wheelchair with the urinary catheter flowing to gravity. The tubing of the catheter was laying on the | F 0315 | 1. Corrective Actions to be taken for those found with deficiency<br>Resident # 116 was observed to have urinary cath tubing on the floor on 9/20/2016 & 9/21/2016. Facility received order to discontinue catheter on resident #116 on 9/21/16.<br>Resident #116 did not have a active justifcation or diagnosis for a indwelling urinary catheter. Facility received order to discontinue catheter on resident #116 | 10/26/2016 |

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| | floor.<br><br>On 09/21/2016 at 1:22 P.M., Resident #116 was sitting in her room in her wheelchair. Her urinary catheter was flowing to gravity with the catheter tubing touching the sock on the left foot.<br><br>1. Resident #116's record was reviewed on 09/21/2016 at 12:57 P.M. The resident was admitted on 09/11/2016. Her diagnoses included, but were not limited to, acute cystitis without hematuria (urinary tract infection) and multiple sclerosis.<br><br>Interview with Unit Manager #3, on 09/20/2016 at 9:01 A.M., indicated he thought Resident #116 had a diagnosis for the catheter but he could not remember what the diagnosis was and he could not find it at this time. He then asked the MDS Nurse who indicated she had not looked into the resident's record and was not sure why she had the urinary catheter. The catheter might have been placed due to a urinary tract infection (UTI) or multiple sclerosis and it may need to be removed.<br><br>A nursing note, dated 09/20/2016 at 3:38 P.M., indicated "unable to validate diagnosis for use of catheter, was placed during hospital stay. Spoke with wound | | on 9/21/16.<br>2. How others have potential to be affected by same practice will be identified with corrective actions<br>No other resident's have been identified. All residents with foley catheters had the potential to be effected.<br>3. What measures put in place or systematic changes will be made to ensure deficient practice doesn't reoccur. Nursing in-service on policy & procedure for urinary catheters, justification of catheter & diagnosis & proper care of urinary catheter.<br>4. How corrective actions will be monitored to ensure no reoccurrence<br>Audits will be conducted by MDS, DHS, ADHS, Nurse Manger, audit all | |

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| | nurse at [name of center] and she does not feel it was medically necessary for wound management." A message was left for the physician for orders.<br><br>A nursing note, dated 09/21/2016 at 2:24 p.m., indicated new orders were received to discontinue the catheter and straight catheter if needed for no urinary output in eight hours.<br><br>Review of a hospital note, dated 09/06/2016, indicated the reason for the visit included, but was not limited to, UTI. The medical problems included, but were not limited to, UTI.<br><br>The Guidelines for the use of Indwelling Catheter Policy was provided by the Clinical Support Nurse on 09/21/2016 at 3:45 P.M. The policy indicated the purpose of urinary catheterization was to provide urinary drainage when medically necessary and to evaluate its continued use. An indwelling catheter was not to be used unless there was medical justification; an indwelling catheter for which continuing use was not medically justified was to be discontinued as soon as clinically warranted by the attending physician.<br><br>2. The "Standard Operational Policy(SOP) for Urinary Catheter Care" | | residents with urinary catheters one time a week x 4 weeks then one time a month x 4 months & all new admissions daily in CCM for diagnosis and justification of indwelling catheter.<br>Audit of 4 residents a week x 4 weeks, 3 residents a week x 4 weeks, 2 residents a week x 4 weeks to insure urinary drainage systems are bagged & not touching the floor per our policy. Results of these findings will be presented and reviewed monthly in QAA meetings. If any areas of concerns are identified, action plans will be developed and continue until substantial compliance is achieved.<br>5. By what date systems will be completed by 10/26 /16 | |

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| | was provided on 09/23/2016 at 11:05 A.M., the procedures included, but were not limited to, be sure the catheter tubing and drainage bag were kept off of the floor.<br><br>Interview with Unit Manager #3, on 09/21/2016 at 1:23 P.M., indicated the catheter tubing should not have been touching the resident's foot and should not have been on the floor.<br><br>Interview with CNA #4, on 09/23/2016 at 1:59 A.M., indicated the catheter tubing should not be touching the floor.<br><br>3.1-41(a)(1)<br>3.1-41(a)(2) | | | |
| F 0323 SS=D Bldg. 00 | 483.25(h)<br>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview and record review, the facility failed to ensure residents were free from accidents related to call lights for 1 of 30 residents reviewed for accidents. (Resident #B) | F 0323 | 1. Corrective Actions to be taken for those found with deficiency<br>Call light in restroom where accident occurred | 10/26/2016 |

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| | Findings include:<br><br>During an interview on 09/20 /2016 at 12:29 P.M., Unit Manager #3 indicated Resident #B had a fall on 09/08/2016 that resulted in an injury and partial amputation of her little finger on her left hand. Resident #B was under the supervision of Physical Therapy at the time being assisted to the bathroom. Resident #B requested privacy while in the bathroom and therapy had honored that request. The resident told him (Unit Manager) that she got her finger stuck in the over flow drain hole in the sink when grabbing the sink as she fell backwards. The resident's finger was found on a shelf unit in the bathroom.<br><br>During an interview on 09/21/2016 at 10:17 A.M., the Therapy Manager indicated Resident #B requested to use the bathroom during a therapy session and was assisted by Physical Therapy Assistant (PTA) #13 to the bathrooms across the hall from the therapy room. When the resident requested privacy, PTA #13 instructed the resident to use the call light when finished and waited outside the bathroom door. PTA #13 then heard commotion in the bathroom, opened the door, and found the resident lying on the floor. The call light had been pulled half way down but had not | | was changed out 9/21/16.<br>2. How others have potential to be affected by same practice will be identified with corrective actions<br>No other resident's have been identified. All residents have the potential to be effected.<br>3. What measures put in place or systematic changes will be made to ensure deficient practice doesn't reoccur. An audit of all call lights completed for proper functioning.<br>No other call light issues have been identified. A all staff in service on importance of ensuring all call lights are within reach of all residents at all times.<br>4. How corrective actions will be monitored to ensure no reoccurrence | |

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| | activated the system. The resident called out for help after the fall as the therapist was entering the bathroom. The Therapy Manager indicated Resident #B, at that time, was in Occupational Therapy (OT) working on being more independent in the bathroom, in Physical Therapy (PT) for balance training and strengthening to improve the symptoms of foot drop, and had a brace on her right leg for foot drop. Prior to the fall the resident had shown signs of improvement.<br><br>During an interview on 09/21/2016 at 1:31 P.M., the Administrator indicated since it was fairly evident what had happened a root cause analysis was not completed; the resident did mention the sink but staff found no issues. She further indicated the shelf was tested and one could have gotten their finger stuck behind the shelf. It did seem the shelf could have been the problem. She further indicated the testing of the shelf and sink were not documented and part of the resident's finger was found on the shelf.<br><br>During an interview on 09/21/2016 at 3:30 P.M., the Maintenance Director indicated he was in the bathroom within the hour following Resident #B's fall on 09/08/2016. He had checked the call station on the wall and it was working. He moved the wire shelf rack away from | | Audits will be conducted by Maintenace Director, housekeeping. All call lights to be audited once a week x 4 weeks, one time a month x 4 months to insure all call lights are in proper working order & functioning per manufacturers guidelines. Results of these findings will be presented and reviewed monthly in QAA meetings. If any areas of concerns are identified, action plans will be developed and continue until substantial compliance is achieved.<br>5. By what date systems will be completed<br>10/26/16 | |

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| | the sink to the opposite wall.<br><br>During an interview on 09/21/2016 at 3:40 P.M., PTA #13, who was assisting Resident #B with toileting on 09/08/2016, indicated the resident was lying on the floor with her head close to the door and her feet near the commode. The shelf unit was pulled away from the wall and the walker was over next to the commode between the commode and the sink. When she first came into the bathroom, blood was near the resident's head and she thought the blood was coming from the resident's head. PTA #13 then saw the tip of the resident's pinky was bleeding and realized that was where the blood was coming from. PTA #13 then called for help without leaving the resident. As she was comforting and waiting with the resident, she realized the tip of the resident's finger was hanging on the shelf.<br><br>During an observation of the bathroom on 09/21/2016 at 2:00 P.M., the call light was able to be pulled part of the way down without activating the call system and the over flow drain hole in the sink was noted to have a sharp edge.<br><br>During an observation of the bathroom with the Maintenance Director on 09/21/2016 at 3:45 P.M., the call light | | | |

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| | was able to be pulled part of the way down without activating the call system.<br><br>During an observation on 09/22/2016 at 9:12 A.M., Resident #B was in her room sitting in a wheelchair. Resident #B indicated she needed to go to the bathroom and could not find her call light. The resident was assisted by one staff member, Certified Nurse Aide (CNA) #14, to the bathroom. When brought out of the bathroom, CNA #14 picked the call light up off the floor, discovered it would not reach the resident, unwound the cord that was wrapped around a jacket that was on the floor between the recliner and the bed, and hooked the call light to the resident's bed within reach of the resident.<br><br>During an interview on 09/22/2016 at 9:23 A.M., CNA #14 indicated residents who need assistance should always have their call lights in reach.<br><br>The clinical record was reviewed on 09/21/2016 at 10:20 A.M. The quarterly MDS (Minimum Data Set) assessment, dated 08/29/2016, indicated the resident was mildly cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 11, had diagnoses including, but not limited to, anxiety and depression, and needed the assistance for toileting. | | | |

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| | The current "Accident and Incident Reporting Guidelines" were provided by the Executive Director on 09/21/2016 at 1:25 P.M. and reviewed at that time. The policy indicated, "...The administrative staff shall complete the investigation...identifying the 'root cause' and review interventions started to prevent another occurrence..."<br><br>This Federal tag relates to complaint IN00209649.<br><br>3.1-45(a)(1)<br>3.1-45(a)(2) | | | |
| F 0371 SS=E Bldg. 00 | 483.35(i)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br>Based on observation, interview and record review, the facility failed to ensure food was stored in a sanitary manner related to open dating and disposing of expired food. This deficient practice had | F 0371 | 1. Corrective Actions to be taken for those found with deficiency<br>All food items were | 10/26/2016 |

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| | the potential to affect 50 of 50 residents who were provided food by the facility kitchen.<br><br>Findings include:<br><br>On 09/19/2016 at 10:09 A.M. during the initial observation in the walk-in refrigerator the following was noted: one package of meat, with an opened date of 8/30/16 and a use by date of 9/2/16, and one package of shredded mozzarella cheese, with an opened date of 9/14/16 and a use by date of 10/30/16.<br><br>On 09/21/2016 at 1:22 P.M. during an observation of the walk-in refrigerator the shredded mozzarella cheese with an opened date of 9/14/16 and a use by date of 10/30/16 remained.<br><br>On 09/21/2016 at 1:26 P.M. during an interview, the Dietary Manager (DM) indicated the shredded mozzarella cheese use by date should have been dated 30 days after being opened. She disposed of the package of meat with the use by date of 9/2/16 after our first observation.<br><br>On 09/26/2016 at 10:55 A.M. during an interview, the DM indicated she labeled the food items when they were delivered and the cooks labeled food items when they were opened, including the use by | | discarded that were past use by/expiration dates or unlabeled. DFS and ADFS immediately re-inspected items and appropriate labeling was completed.<br>2. How others have potential to be affected by same practice will be identified with corrective actions<br>No other resident's have been identified. All residents have the potential to be affected.<br>3. What measures put in place or systematic changes will be made to ensure deficient practice doesn't reoccur<br>DFS & Dietary staff to be educated by DFS support on food storage and labeling.<br>4. How corrective actions will be monitored to ensure no reoccurrence<br>Audits will be conducted | |

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| | dates. The DM indicated she arrives in the mornings, looks through the walk-in, and "cleans out" the expired foods. When she was not available the cooks were to check the dates.<br><br>The current "Food Dating Guide" was provided by the DM, on 09/21/2016 at 1:28 P.M. and reviewed at that time. The guide indicated cheese expired seven days after being opened and deli meat expired 72 hours after being opened.<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | by DFS, ADFS, ED, or designee to insure adequate and proper labeling & storage of all food items. Audits will be completed twice a day x a week for 4 weeks, twice a day 5 times a week for 4 weeks, twice a day 3 x a week x 4 weeks, daily x 4 weeks. Results of these findings will be presented and reviewed monthly in QAA meetings. If any areas of concerns are identified, action plans will be developed and continue until substantial compliance is achieved.<br>5. By what date systems will be completed<br>10/26 /16 | |
| F 0428<br>SS=D | 483.60(c)<br>DRUG REGIMEN REVIEW, REPORT | | | |

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| Bldg. 00 | IRREGULAR, ACT ON<br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br>Based on record review and interview, the facility failed to ensure Pharmacy recommendations were carried out in a timely manner for 1 of 5 residents reviewed for unnecessary medications. (Resident #38)<br><br>Findings include:<br><br>The record for Resident #38 was reviewed on 09/21/2016 at 3:32 P.M. Her diagnosis included, but was not limited to, gastro-esophageal reflux disease.<br><br>Review of the Medication Administration History from 09/01/2016 to 09/22/2016 indicated the resident had received Omeprazole 20 mg (milligrams) twice a day (BID) everyday except on 09/12/2016.<br><br>A Pharmacy recommendation, dated 06/28/2016, indicated the following: the resident had been receiving Omeprazole 20 mg BID for GERD (gastro-esophageal reflux disease). "This classification of | F 0428 | 1. Corrective Actions to be taken for those found with deficiency<br>Resident #38 pharmacy recommendation reviewed with MD and new order obtained on 10/ 7 /16<br>2. How others have potential to be affected by same practice will be identified with corrective actions<br>No other resident's have been identified. All residents have the potential to be affected.<br>3. What measures put in place or systematic changes will be made to ensure deficient practice doesn't reoccur | 10/26/2016 |

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| | medication had been associated with reduced absorption of iron and calcium as well as an increase risk of pneumonia and C. Diff infections [bacterial infection]. Please consider a reduction to 20 mg every day in an attempt to utilize the lowest effective dose."<br><br>A Pharmacy recommendation dated 08/23/2016, indicated the following: the resident had been receiving Omeprazole 20 mg BID for GERD. "This classification of medication had been associated with reduced absorption of iron and calcium as well as an increase risk of pneumonia and C. Diff infections (bacterial infection). Please consider a reduction to 20 mg every day in an attempt to utilize the lowest effective dose."<br><br>An interview with the Director of Nursing, on 09/23/2016 at 2:00 p.m., indicated the facility had a problem with Physician compliance in responding to Pharmacy recommendations. They had tried faxing the recommendations and walked them over to the Physician's office. She indicated these recommendations had not been acted upon.<br><br>3.1-25(J) | | DHS will review recommendations monthly & ensure they are addressed by physician or by Medical Director prior to next pharmacy review.<br>4. How corrective actions will be monitored to ensure no reoccurrence<br>Monthly audit of Pharmacy Recommendations by DHS, ADHS. Results of these findings will be presented and reviewed monthly in QAA meetings. If any areas of concerns are identified, action plans will be developed and continue until substantial compliance is achieved.<br>5. By what date systems will be completed<br>10/26 /16 | |

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| F 0441 SS=D Bldg. 00 | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens | | | |

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| | Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br>Based on observation, record review and interview, the facility failed to ensure infection control practices were maintained related to glove use, hand washing, isolation precautions, and Nebulizer storage for 3 of 8 resident care observations. (Residents #57, #8, and #77)<br><br>Findings include:<br><br>1. Incontinence care was observed for Resident #57 on 09/23/2016 at 1:03 a.m. Certified Nurse Aide (CNA) #4 and CNA #20 washed their hands and then put on gloves. The CNAs explained to the resident what they were going to do and what they wanted her to do. CNA #20 helped with positioning. CNA #4 cleaned the residents peri area with a cloth using soap and water, then used a second cloth to rinse off the soap, and a third cloth to dry the resident. The two CNAs rolled the resident side to side to remove the resident's dirty brief. CNA #4 put the dirty brief in the trash bag after it was removed and a new brief was placed on the resident. CNA #20 went to the resident's dresser and removed a clean gown. CNA #20 and CNA #4 assisted the resident in changing her gown. CNA | F 0441 | 1. Corrective Actions to be taken for those found with deficiency immediate in service provided to activity assistant on contact isolation precautions per DHS.<br>2. How others have potential to be affected by same practice will be identified with corrective actions<br>No other resident's have been identified. All residents have the potential to be affected.<br>3. What measures put in place or systematic changes will be made to ensure deficient practice doesn't reoccur in service for all nursing staff LPN, RN, QMA, CNA, RCA on hand hygiene, hand washing, nebulizer | 10/26/2016 |

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| | #4 then adjusted the resident's oxygen tubing by the side of the bed. She then raised the head of the resident's bed and adjusted the resident's oxygen tubing around her cheek and ear. CNA #20 removed her gloves and took the trash out of the room. CNA #4 removed her gloves and washed her hands.<br><br>Interview with CNA #4, on 09/23/2016 at 1:59 a.m., indicated after peri care you should remove gloves and wash hands. She indicated she did not do this prior to adjusting the resident's oxygen tubing and replacing her gown and she should have.<br><br>Interview with the clinical Support Nurse, on 09/23/2016 at 11:45 A.M., indicated standard precautions should be used for glove changing and hand washing when peri care was being provided.<br><br>A "Guideline for Handwashing/Hand Hygiene" was was provided by the Clinical Support Nurse on 09/23/2016 at 11:45 A.M. The policy indicated, "Handwashing is the single most important factor in preventing transmission of infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF(Long Term Care Facilities). Implementation of PROPER | | storage, Isolation precautions and gloves.<br>All staff in service for hand washing and isolation precautions.<br>4. How corrective actions will be monitored to ensure no reoccurrence<br>Audit of Hand hygiene 5 random employees a week x 4 weeks then 4 random employees a week x 4 weeks then 3 random employees a week x 2 by DHS, ADHS, Medical Records, MDS, Clinical Managers. Results of these findings will be presented and reviewed monthly in QAA meetings. If any areas of concerns are identified, action plans<br>In service all nurses (RN, LPN) on Nebulizer Administration and Storage Demonstration & Return Demonstration. | |

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| | handwashing practices has interrupted outbreaks in many settings. The procedures included, but were not limited to, Health Care Workers shall wash hands at times such as: ...Before/after having direct physical contact with residents. after removing gloves , worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc." | | Audit of Nebulizer administration & storage. Observe 3 Nebulizer Administrations a week x 4 weeks, then 2 Nebulizer Administrations x 4 weeks, then 1 Nebulizer Administration a week x 4 weeks by DHS, ADHS, Medical Records, MDS, Clinical Managers. Results of these findings will be presented and reviewed monthly in QAA meetings. If any areas of concerns are identified, action plans<br>5. By what date systems will be completed<br>10/26 /16 | |
| F 9999<br><br>Bldg. 00 | 3.1-14 PERSONNEL<br>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using | F 9999 | 1. Corrective Actions to be taken for those found with deficiency<br>No residents were identified in this | 10/26/2016 |

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| | the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intramural tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of indurating with the date given, date read, and by whom administered.<br>The tuberculin skin test must be read prior to the employee starting work.<br>The facility must assure the following:<br>(1)At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and non-paid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) moths, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br><br>This rule is not met as evidenced by:<br><br>Based on record review and | | deficiency statement.<br>All Staff at this time has completed PPD screening.<br>2. How others have potential to be affected by same practice will be identified with corrective actions<br>No other resident's have been identified. All residents have the potential to be affected.<br>3. What measures put in place or systematic changes will be made to ensure deficient practice doesn't reoccur<br>An audit of all staff PPD was completed to insure that all employees have completed the required tuberculin policy with PPD annuals and upon hire with 2 step protocol.<br>4. How corrective actions will be monitored to ensure no reoccurrence | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST ANDREWS HEALTH CAMPUS | 1400 LAMMERS PIKE<br>BATESVILLE, IN 47006 |

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| | interview, the facility failed to ensure each employee had appropriate tuberculin testing. This affected 3 of 10 staff members reviewed for employee records. (CNA #9, CNA #10, and CNA #11)<br><br>Findings include:<br><br>Employee records were reviewed on 09/27/2016 at 9:15 A.M.<br><br>1. The "Tuberculin Testing for Employees" form for Certified Nursing Assistant (CNA) #9 was provided by the DON (Director of Nursing) on 09/27/2016 at 10:45 A.M. and was reviewed at the time. The form indicated CNA #9 received her first step tuberculin test on 06/22/2016. Employee records indicated the CNA started working on the floor on 05/31/2016.<br><br>2. The "Tuberculin Testing for Employees" form for CNA #10 was provided by the DON on 09/27/2016 at 10:45 A.M. and was reviewed at that time. The form indicated CNA #10 received her first-step tuberculin test on 07/19/2016. Employee records indicated the CNA started working on the floor on 07/15/2016.<br><br>3. The "Tuberculin Testing for | | Audits will be conducted by AP, BOM DHS, ADHS, ED, Nurse Manager or designee a minimum of 15 staff members files a month x 3 months then quarterly there after. Results of these findings will be presented and reviewed monthly in QAA meetings. If any areas of concerns are identified, action plans will be developed and continue until substantial compliance is achieved.<br>5. By what date systems will be completed<br>10/26/16 | |

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| | Employees" form for CNA #11 was provided by the DON on 09/27/2016 at 10:53 A.M. and was reviewed at that time. The form indicated CNA #11 received her first-step tuberculin test on 08/09/2016. Employee records indicated the CNA started working on the floor on 07/18/2016.<br><br>During an interview on 09/27/2016 at 10:41 A.M., the DON indicated employee tuberculin testing was supposed to be done before the employee started working on the floor.<br><br>The current facility policy, titled "Guidelines for TB Results Summary Documentation: Staff" and dated 05/11/2016, was provided by the DON on 09/27/2016 at 1:16 P.M. and was reviewed at that time. The policy indicated, "...Upon hire each employee shall receive a Two Step Mantoux PPD test to ensure they are free of tuberculosis..."<br><br>3.1-14(t)(1) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. | R 0000 | September 27, 2016<br>St. Andrews Health | |

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| | Residential Census: 31<br>Sample: 7<br><br>These State findings are cited in accordance with 410 IAC 16.2-5. | | Campus 1400 Lammers Pike, Batesville, Indiana 47006 Survey Event ID WBTN11. 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 and true representations of the quality of care and services provided to the residents of St. Andrews Health Campus. This facility recognized its obligation to provide legally and medially necessary care and | |

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| | | | services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive healthc are facilities (for Title 18/19 programs). Attached you will find our Plan of Correction for St. Andrews Health Campus for our annual survey conducted on September 27, 2016. We respectfully request paper review for this plan of correction. If you need any information | |

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| | | | or paperwork, please do not hesitate to contact us at (812)934-5090. Sincerely, Katrina Keck, Executive Director. | |
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.<br>Based on observation, interview and record review, the facility failed to ensure food was stored in a sanitary manner related to open dating and disposing of expired food. This deficient practice had the potential to affect 31 of 31 residents who were provided food by the facility kitchen.<br><br>Findings include:<br><br>On 09/19/2016 at 10:09 A.M. during the initial observation in the walk-in refrigerator the following was noted: one package of meat, with an opened date of 8/30/16 and a use by date of 9/2/16, and one package of shredded mozzarella cheese, with an opened date of 9/14/16 | R 0273 | 1. Corrective Actions to be taken for those found with deficiency<br>All food items were discarded that were past use by/expiration dates or unlabeled. DFS and ADFS immediately re-inspected items and appropriate labeling was completed.<br>2. How others have potential to be affected by same practice will be identified with corrective actions | 10/26/2016 |

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| | and a use by date of 10/30/16.<br><br>On 09/21/2016 at 1:22 P.M. during an observation of the walk-in refrigerator the shredded mozzarella cheese with an opened date of 9/14/16 and a use by date of 10/30/16 remained.<br><br>On 09/21/2016 at 1:26 P.M. during an interview, the Dietary Manager (DM) indicated the shredded mozzarella cheese use by date should have been dated 30 days after being opened. She disposed of the package of meat with the use by date of 9/2/16 after our first observation.<br><br>On 09/26/2016 at 10:55 A.M. during an interview, the DM indicated she labeled the food items when they were delivered and the cooks labeled food items when they were opened, including the use by dates. The DM indicated she arrives in the mornings, looks through the walk-in, and "cleans out" the expired foods. When she was not available the cooks were to check the dates.<br><br>The current "Food Dating Guide" was provided by the DM on 09/21/2016 at 1:28 P.M. and reviewed at that time. The guide indicated cheese expired seven days after being opened and deli meat expired 72 hours after being opened. | | No other resident's have been identified. All residents have the potential to be affected.<br>3. What measures put in place or systematic changes will be made to ensure deficient practice doesn't reoccur<br>DFS & Dietary staff to be educated by DFS support on food storage and labeling.<br>4. How corrective actions will be monitored to ensure no reoccurrence<br>Audits will be conducted by DFS, ADFS, ED, or designee to insure adequate and proper labeling & storage of all food items. Audits will be completed twice a day x a week for 4 weeks, twice a day 5 times a week for 4 weeks, twice a day 3 x a week x 4 weeks, daily x 4 weeks. Results of these | |

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| | | | findings will be presented and reviewed monthly in QAA meetings. If any areas of concerns are identified, action plans will be developed and continue until substantial compliance is achieved.<br>5. By what date systems will be completed<br>10/26 /16 | |