

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER St Andrews Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Lammers Pike Batesville, IN 47006	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>34232</p> <p>Based on record review and interview, the facility failed to provide prescribed medications for 1 of 6 residents reviewed for pharmacy services. (Resident 40)</p> <p>Findings include:</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> - 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. <p>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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>3.1-25(g)(3)</p> <p>3.1-37(a)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38239</p> <p>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)</p> <p>Findings include:</p> <p>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:</p> <ul style="list-style-type: none"> - 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. <p>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.</p> <p>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, .Food or Beverage items are to be properly Labeled and Date marked, stored and discarded, in conjunction with the facilities Date [NAME] and labeling [Policy and Procedure] P&P .</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 .</p> <p>3.1-21(i)(3)</p>		