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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to store food items for residents appropriately related to expired foods for 1 of 2 kitchen observations. This deficient practice had the potential to affect 57 of 57 resident that reside in the facility. Findings include:During the initial kitchen tour and interview with the Dietary Manager (DM), on 01/08/2026 at 10:30 A.M., the following was observed: -Two plastic packages of sliced turkey deli meat with an expiration date of November 2025, were laying on the top shelf of a wheeled cart. The DM indicated it had been frozen and was recently thawed. They were going to use it for lunch. There was no date on the packages as to when the packages of turkey were thawed. The DM threw both packages in the garbage can, -The top white plate in the plate warmer had a large splatter of off-white colored debris with green specks on the surface of the plate, the DM placed it in the dirty dish area. The dry storage room contained the following: -One square plastic tub of quinoa labeled with a use by date of 03/18/2025,-One square plastic tub of rice labeled with a use by date of 06/08/2025,-One square plastic tub of dry pasta labeled with a use by date of 09/26/2025,-One square plastic tub of dry beans labeled with a use by date of 06/09/2025,-One square plastic tub of split peas labeled with a use by date of 06/08/2025,-A one gallon jug of [NAME] wine for cooking labeled with a use by date of 10/29/2024,-A one gallon jug of [NAME] wine for cooking labeled with a use by date of 02/22/2025, that had the Corporate Dining Support Services name on it, who used to be the DM in the facility up until two months ago. The current DM indicated inventory was assessed two times a week. The items in the dry storage room had not been used recently. During an interview, on 01/15/2026 at 11:55 A.M., the DM indicated food items were labeled and disposed of when they reached the date on the label. During an interview, on 01/15/2026 12:20 PM., the Assistant Director of Nursing (ADON) indicated all the residents in the facility received foods from the facility kitchen. The current Storage Procedures policy for Culinary Services, with a revised date of 07/10/2025, was provided by the Director of Nursing on 01/14/2026 at 1:05 P.M. The policy indicated, .Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value, and appearance.Open packages are labeled, dated, and stored in closed containers.Stock is dated and rotated so that the oldest items are used first. 3.1-21(i)(3)

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

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review, interview, and observation, the facility failed to follow physician's orders related to hold parameters for medications and identify skin impairments in a timely manner for 3 of 17 residents reviewed for Quality of Care. (Residents 8, 52, and 43)Findings include:1.The clinical record for Resident 8 was reviewed on 01/09/2026 at 1:15 P.M. An Annual Minimum Data Set (MDS) assessment, dated 10/10/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, hypertension, dementia, anxiety, and depression. The Electronic Medication Administration Record (EMAR) for November and December 2025, were provided by the Director of Nursing (DON) on 01/14/2026 at 1:05 P.M. The record indicated the resident had the following current physician's order: -Losartan, a cardiovascular medication, 25 milligrams (mg) once a day, between 6:00 A.M. and 10:00 A.M. The special instructions for the medication indicated the medication was to be held, not given, if the resident's systolic (top number) blood pressure (b/p) was 120 or less, per hospice. The medication was given, not held, on the following dates: -On 11/02/2025, the resident's b/p was 116/69. -On 11/05/2025, the resident's b/p was 111/68. -On 11/06/2025, the resident's b/p was 115/72. -On 11/07/2025, the resident's b/p was 110/64. -On 11/10/2025, the resident's b/p was 118/66. -On 11/11/2025, the resident's b/p was 116/65. -On 11/12/2025, the resident's b/p was 110/69. -On 11/16/2025, the resident's b/p was 118/69. -On 11/19/2025, the resident's b/p was 118/74. -On 11/23/2025, the resident's b/p was 95/55. -On 12/01/2025, the resident's b/p was 107/59. -On 12/30/2025, the resident's b/p was 118/68. -On 12/31/2025, the resident's b/p was 118/69. The Progress Notes for November and December 2025 were reviewed on 01/09/2026 at 1:36 P.M. The record lacked documentation the physician was notified of the medication being outside of the hold parameters or a reason the medication was given. (continued on next page)

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Care Plan for Potential for cardiovascular distress related to diagnoses of hypotension and hypertension was provided by the DON on 01/14/2026 at 1:05 P.M. An Approach, with a start date of 07/28/2023, indicated staff were to, .Obtain vital signs as ordered and needed . 2. The clinical record for Resident 52 was reviewed on 01/12/2026 at 11:45 AM. An admission MDS assessment, dated 11/14/2025, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension and Parkinson's disease. An open-ended physician's order, with a start date of 11/10/2025, indicated the staff were to administer amlodipine 10 mg, once a day. The staff were to hold the medication if the resident's blood pressure was less than or equal to 110/60 or the pulse was less than or equal to 60. The November and December 2025, and January 2026, EMAR indicated the resident had received the medication when the pulse was less than or equal to 60 on the following dates and times: -On 11/11/2025 when the resident's pulse was 57. -On 11/12/2025 when the resident's pulse was 58. -On 11/18/2025 when the resident's pulse was 53.-On 11/23/2025 when the resident's pulse was 59.-On 11/24/2025 when the resident's pulse was 54.-On 11/29/2025 when the resident's pulse was 52.-On 11/30/2025 when the resident's pulse was 59.-On 12/02/2025 when the resident's pulse was 60. -On 12/03/2025 when the resident's pulse was 56.-On 12/04/2025 when the resident's pulse was 56. -On 12/10/2025 when the resident's pulse was 60. -On 12/13/2025 when the resident's pulse was 59.-On 12/20/2025 when the resident's pulse was 60.-On 12/23/2025 when the resident's pulse was 60. -On 12/24/2025 when the resident's pulse was 60.-On 01/09/2025 when the resident's pulse was 60. -On 01/10/2025 when the resident's pulse was 59. During an interview, on 01/13/2025 at 10:54 A.M., RN 5 indicated if a resident's medication had hold parameters, then she would obtain the vital signs before giving the medication. If the vital sign values were not within the parameters to give the medication, she would hold (not give) the medication. She would document in the EMAR that the medication was not administered due to the resident's condition. The current MEDICATION ADMINISTRATION GENERAL GUIDELINES policy, with a revised date of 11/2018, was provided by the Director of Nursing (DON) on 01/14/2026 at 1:05 P.M The policy indicated, .Medications are administered in accordance with written orders of the prescriber . 3. During an observation and interview, on 01/08/2026 at 12:50 P.M., Resident 43 was sitting in her room. She had on a pair of capri style pants. On her right lower leg there was a dime size, dark scab. The resident indicated she was unsure what had happened. During an observation, on 01/12/2026 at 1:39 P.M., Resident 43 was sitting in the doorway to her room. She had on capri style pants. On her right lower leg there was a dime size, dark scab. The clinical record for Resident 43 was reviewed on 01/13/2026 1:14 P.M. A Quarterly MDS assessment, dated 10/09/2025, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, senile degeneration of the brain, heart failure, hypertension, diabetes, non-Alzheimer's dementia, anxiety, and depression. During an interview, on 01/13/2026 at 10:50 A.M., RN 5 indicated the resident mostly cared for herself but needed assistance at times. If a resident had new skin impairments, the nurse would assess the (continued on next page)

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area and open a skin event in the electronic clinical record. The resident had told her about the scab on her leg the day before. She had not opened a skin event and was just keeping an eye on it to make sure it didn't bust open. During an interview, on 01/13/2026 at 1:56 P.M., the ADON indicated if a Nurse or Certified Nurse Aide (CNA) found a new skin impairment then it should be documented in the clinical record. The nurses document in a progress note and the CNA's document in their CNA charting. The nurse would also need to notify the physician and get new orders. During an interview, on 01/13/2025 at 2:06 P.M., the ADON indicated she was unaware of the scab to the resident's leg. The resident did like to pick at her skin but that wasn't an excuse, and the staff should have documented that the resident had an area to her leg. The resident's clinical record lacked any documentation related to the skin impairment to the right lower leg until the afternoon of 01/13/2025. The current facility policy titled, Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines, with a review date of 11/19/2025, was provided by the DON on 01/14/2025 at 9:24 A.M. The policy indicated, .Utilize to describe and monitor.If skin alterations occur post admission.Complete Skin Tear/Laceration Incident in EHR [Electronic Health Record].IDT [Interdisciplinary Team] should review this timely and wound nurse or designee complete an assessment in wound management or Wound Zoom . Continue to monitor weekly in wound management. 3.1-37(a)

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines related to indwelling urinary catheters for a resident with a Urinary Tract Infection (UTI) for 1 of 2 residents reviewed for urinary catheters / UTIs. (Resident 38)Findings include: On 01/13/2026 at 8:59 A.M., Resident 38 was observed in his room sitting in his recliner. The resident's indwelling urinary catheter tubing and drainage bag were hanging on the side of a waste basket next to the resident's chair. During an interview, on 01/13/2026 at 1:42 P.M., RN 12 indicated the resident currently had a UTI and would begin taking an antibiotic that day. On 01/13/2026 at 1:47 P.M., the resident was observed in his room sitting in his recliner. The resident's catheter tubing and drainage bag were laying on the floor near the resident's feet. On 01/13/2026 at 3:31 P.M., the resident was observed in his room sitting in his recliner. The resident's catheter tubing and drainage bag were laying on the floor near the resident's feet. On 01/13/2026 at 3:50 P.M., Certified Nurse Aide (CNA) 4 entered the resident's room and observed the resident's catheter bag and tubing laying on the floor. The CNA picked up the catheter bag and hung it on the side of the waste basket near the resident's chair. The CNA indicated it was normal to hang the bag on the waste basket. He probably should have hung the bag on the other side of the resident's chair and not on the waste basket. It might have been an infection control issue. The resident's record was reviewed on 01/12/2026 at 11:02 A.M. A Quarterly Minimum Data Set assessment, dated 11/17/2025, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, renal insufficiency, and neurogenic bladder. The resident had an indwelling urinary catheter.The resident's current Care Plans were reviewed, and included, but were not limited to, a Care Plan, with a start date of 01/13/2026, that indicated the resident had an active diagnosis of a urinary tract infection. Interventions included, but were not limited to, an intervention to use proper infection control precautions as indicated and per policy when providing toileting, incontinence care, or catheter care.The resident's current physician's orders included, but were not limited to an order, with a start date of 01/13/2026 for Macrobid (an antibiotic) 100 milligrams twice a day until 01/20/2026 for a UTI.The current facility policy, titled Urinary Catheter Care, with a reviewed-on date of 12/16/2024, was provided by the Director of Nursing on 01/14/2026 at 2:50 P.M. The policy indicated, .To prevent infection of the resident's urinary tract.Be sure catheter tubing and drainage bag are kept off the floor.3.1-41(a)(2)

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to have medications available for a resident for 1 of 17 residents reviewed for pharmacy services. (Resident 4)Findings include:The clinical record for Resident 4 was reviewed on 01/09/2026 at 2:42 P.M. An admission Minimum Data Set (MDS) assessment, dated 12/12/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, pressure ulcer, heart failure, hypertension, wound infection, diabetes, non-Alzheimer's dementia, malnutrition, and vascular dementia.A physician's order, dated 12/09/2025 through 12/10/2025, indicated the resident was to receive Lovenox (enoxaparin), 30 mg subcutaneously (an injection administered just under the skin), every 12 hours. The resident's December 2025 Electronic Medication Administration Record (EMAR) indicated the resident did not receive the medication on 12/09/2025, between 6:00 A.M. and 10:00 A.M., due to the medication being unavailable. A physician's order, dated 12/10/2025 through 12/25/2025, indicated the resident was to received enoxaparin, 90 mg subcutaneously (an injection administered just under the skin), every 12 hours. The resident's December 2025 EMAR indicated the resident did not receive the medication on 12/22/2025, between 6:00 A.M. and 10:00 A.M., and on 12/22/2025, between 6:00 P.M. and 10:00 P.M., due to the medication not being available. The clinical record lacked indication the physician was notified the medication was unavailable. During an interview, on 01/13/2025 at 1:50 P.M., the Assistant Director of Nursing (ADON) indicated when a resident was due for more medications the nurse would just hit the resupply button on the EMAR. If it was a recurrent order, the resident's medications came every Thursday for a week's worth of medications. If it was a new order, then the medication would come the next day. If they needed a medication sooner, they would call the pharmacy, and the medication would arrive at the facility in about four hours. If a resident was missing a medication, the physician should be notified, and it should be documented in the EMAR or a progress note. For syringe medications, like the resident's Lovenox, it should be reordered when there were only five doses left. The current facility policy titled Medication Orders, with a revised date of 11/2018, was provided by the Director of Nursing (DON) on 01/14/2025 at 9:24 A.M. The policy indicated, .The prescriber is contacted by facility personnel for direction when delivery of a medication will be delayed or the medication is not or will not be available.3.1-25(a)

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to prevent a significant medication error related to an anticoagulant (blood thinner) medication for 1 of 7 residents reviewed for unnecessary medications. (Resident 4)Findings include:The clinical record for Resident 4 was reviewed on 01/09/2026 at 2:42 P.M. An admission Minimum Data Set (MDS) assessment, dated 12/12/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, pressure ulcer, heart failure, hypertension, wound infection, diabetes, non-Alzheimer's dementia, malnutrition, and vascular dementia. A Hospital Discharge summary, dated [DATE], indicated the resident was to receive Lovenox (enoxaparin), 90 milligrams (mg), subcutaneously (an injection administered just under the skin), every 12 hours. A physician's order, dated 12/09/2025 through 12/10/2025, indicated the resident was to receive enoxaparin, 30 mg every 12 hours.A Progress Note, dated 12/10/2025 at 7:37 A.M., indicated there was a transcription error noted. The resident's Lovenox order was updated to include the correct dosing. The physician and Power of Attorney were updated of the medication transcription error. The resident had no adverse side effects at that time. Staff education was provided and monitoring would continue. There were no new orders at that time. The resident's December 2025 Electronic Medication Administration Record (EMAR) indicated the resident had received the Lovenox medication, 30 mg, twice, once on 12/09/2025 between 6:00 P.M. and 10:00 P.M., and once on 12/10/2025, between 6:00 A.M. and 10:00 A.M. During an interview, on 01/13/2025 at 10:54 A.M., RN 5 indicated when a resident admitted to the facility from the hospital the nurse would transcribe the physician's orders into the resident's electronic clinical record and a second nurse would verify the orders were correct before the resident's medications could be administered.During an interview, on 01/13/2025 at 1:50 P.M., the Assistant Director of Nursing (ADON) indicated when the resident readmitted from the hospital in December (2025) there was a medication transcription error. The resident's Lovenox was transcribed for 30 mg and should have been 90 mg. At that time, she educated the nurse that made the error and the nurse that verified the medications. The current facility policy titled Medication Orders, with a revised date of 11/2018, was provided by the Director of Nursing (DON) on 01/14/2025 at 9:24 A.M. The policy indicated, .Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe.To facilitate effective communication, documentation, and aid in prevention of medication errors, medication orders should be clear and concise.The current facility policy titled, Guidelines for Medication Error Reporting, with a review date of 12/12/2025, was provided by the DON on 01/14/2025 at 9:24 A.M. The policy indicated, .To identify medications given in error and expedite correction actions.3.1-48(c)(2)

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to follow infection control guidelines related to Enhanced Barrier Precautions (EBP) for 2 of 3 observations of high-contact resident care activities. (Residents 58 and 2) Findings include:1. Resident 58's clinical record was reviewed on 01/12/2026 at 11:00 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/05/2025, indicated the resident was severely cognitively impaired. The resident was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, Alzheimer's dementia, diabetes, and stroke. The resident was at risk for pressure ulcers and had a Stage 3 (Full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue was often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss) pressure ulcer that was present on admission/re-entry. The resident's current physician's orders included an open-ended order, with a start date of 12/08/2025, indicated staff were to apply Santyl (an enzymatic ointment) to the resident's sacral wound once a day. During an observation, on 01/12/2026 at 1:35 P.M., RN 12 entered the resident's room to provide wound care. There was no sign on the door that indicated the resident was in EBP. RN 12 washed her hands, donned gloves, and approached the resident's bedside. The bed was in a low position. The RN got down on her knees on the floor next to the bed and proceeded to change the dressing on the resident's sacral wound. The RN leaned on the side of the bed and rested her right arm/elbow on the mattress multiple times during the procedure. The RN did not wear a gown when she administered the wound treatment. During an interview, on 01/12/2026 at 3:34 P.M., RN 3 indicated residents with open wounds, feeding tubes, and catheters were in EBP. If staff were administering wound treatments or dealing with any tubing, staff were to wear gowns and gloves. During an interview, on 01/14/2026 at 9:51 A.M., The Assistant Director of Nursing (ADON) indicated the resident's current pressure ulcer on her sacrum was first identified in November 2025. The current facility sign for EBP was provided by the Director of Nursing on 01/14/2026 at 2:50 P.M. The sign indicated staff were to STOP and the resident was in ENHANCED BARRIER PRECAUTIONS. Providers and staff were to wear gloves and a gown for High-Contact Resident Care Activities, including, but not limited to, wound care (any skin opening requiring a dressing) and device care or use (central line, urinary catheter, feeding tube, and tracheostomy). 2. During an observation, on 01/12/2026 at 2:54 P.M., RN 12 prepared a medication, Warfarin two milligrams, for Resident 2 to be administered via the resident's gastrointestinal tube (G-tube). The G-tube was to be flushed with 30 cubic centimeters (cc's) of water before and after the medication was administered. The RN crushed the medication and dissolved it in 10 cc's of water in a small medication cup while standing at the medication cart in the hallway. The resident's room door had a sign posted on the outside indicating the resident was in Enhanced Barrier Precautions (EBP). The RN entered the resident's room with her supplies and the medication. She sat the items down, entered the bathroom, and washed her hands. The RN donned gloves, checked the placement of the G-tube using her stethoscope, placing it on the resident's abdomen, flushed the G-tube with water, administered the medication, and flushed the G-tube with water again. The RN failed to don a gown (continued on next page)

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to managing the administration of the medication via the resident's G-tube. The clinical record for Resident 2 was reviewed on 01/13/2026 at 3:24 P.M. An Annual MDS assessment, dated 10/16/2025, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke and heart failure. The resident had a feeding tube and was on a mechanically altered diet. The physician's orders included, but were not limited to, the following: -Warfarin two milligrams, once a day via gastric tube, and -Staff to use enhanced barrier precautions, wearing a gown and gloves at minimum during high-contact care activities. The resident's Care Plan included, but was not limited to, Resident requires enhanced barrier precautions (EBP) during high-contact care related to presence of: feeding tube. An Approach, with a start date of 04/01/2024, indicated staff were to utilize a gown and gloves per EBP policy during indwelling device care .feeding tube . The current Enhanced Barrier Precautions (EBP) Standard Operating Procedure policy, with an Approved date of 04/01/2024, was provided by the DON on 01/14/2026 at 1:05 P.M. The policy indicated, .EBP .will be in place during high contact care activities for residents with the following conditions .All residents with .pressure ulcers .All residents with indwelling medical devices .feeding tubes . 3.1-18(b)(2)

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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Health Campus	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)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, the facility failed to ensure staff met the requirement of completing three hours of annual dementia training for 1 of 10 Nurse Aide/employee records reviewed. (Qualified Medication Aide/CNA 6)Findings include:The employee records were provided by the Employee Experience Manager (EXM) on 01/15/2026. The following staff member failed to have the required number of hours of annual dementia training:- QMA 6 was hired on 11/12/2021 and failed to have any current annual dementia training in her file for 2025. During an interview, on 01/15/2026 at 11:23 A.M., the Director of Nursing indicated the corporation recently changed training management systems. The facility could provide no documentation that indicated QMA 6 completed the annual dementia training in 2025.The current, undated facility policy, titled Training (Required/Personal Development) was provided by the EXM on 01/15/2026 at 11:12 A.M. The policy indicated, .Mandatory trainings are assigned annually to employees based on their role in the organization in order to comply with State and Federal regulations for senior care.3.1-14(u)