STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155290	A. BUILDING -- B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST ELIZABETH HEALTHCARE CENTER	701 ARMORY RD DELPHI, IN 46923

(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: 05/13/25 Facility Number: 000187 Provider Number: 155290 AIM Number: 100267300 At this Emergency Preparedness survey, St. Elizabeth Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 64 certified beds. At the time of the survey, the census was 52. Quality Review completed on 05/14/25	E 0000		
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: 05/13/25 Facility Number: 000187 Provider Number: 155290 AIM Number: 100267300 At this Life Safety Code survey, St. Elizabeth	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Monique Augustine	ED	05/29/2025

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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	Healthcare Center 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. The 500 wing, a 2018 addition, was surveyed under LSC Chapter 18, New Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. 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 Center is connected to an Assisted Living, Residential Board and Care occupancy, from which it is separated by a Fire Wall with a 2-hour Fire Resistance Rating. The building is fully protected by a 135-kW Natural Gas-powered generator. The facility has a capacity of 64 and had a census of 52 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached garages and two detached storage sheds which were not sprinklered. Quality Review completed on 05/14/25			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and Interview, the facility failed to ensure 5 of over 8 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states that an irreversible process shall release the lock in the direction of	K 0222	The submission of this plan of correction does not indicate any admission by St Elizabeth Health Care that the findings and allegations contained herein are	06/13/2025

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	egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 35 residents in the Walnut Grove hall and Chestnut hall Findings include: Based on observation and interview with the Director of Plant Operations (DPO) and Regional Facilities Support person (FS) on 05/13/25, the following exit doors, equipped with a 15 second delayed egress, failed to initiate the irreversible process to release the lock. A) At 12:14 pm, the Chapel Exit door. B) At 12:10 pm, the front Main entrance door could not be tested. The staff was unable to override the timed locking mechanism in order to test the delayed egress. C) At 12:20 pm, the Activities Room Exit Door with 15 second delayed egress lacked signage indicating the door was so equipped. D) At 12:45 pm, the Exit Door near RR#522. The DPO stated the door had been worked on but was warped/bent and would need to be replaced before the delayed egress feature would work properly. E) At 1:15 pm, the Exit Door from the dining area.		accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at Lafayette. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance K222 Compliance Date: 6/13/25 Immediate Intervention The Director of Plant Operations was educated on 6/10/25 by the Executive Director on NFPA 101-2012 edition sections; 19.2.2.2, 7.2.1.5.10, and 7.2.1.6. The Director of Plant Operations has contacted the vendor to repair Walnut Hall and Chestnut Hall in which they were present in campus on 6/13/25 with quote given. The Director of Plant Operations will audit the functionality of both doors 2x per week x4 weeks. The results of these inspections will be presented by the Executive	

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	When the panic hardware was pushed the delayed egress feature failed to activate. When the door was pushed near the top, the feature would engage. The DPO stated the door would need attention. This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the DPO and RS each present. 3.1-19(b)		Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect 35 residents in the facility	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of over 8 exit discharges had a level walking surface and was free of obstructions. This deficient practice could affect 15 residents and staff. Findings include: Based on observation and interview with the Director of Plant Operations (DPO) and Regional Facilities Support person (FS) on 05/13/25 at 12:27 pm, the exit discharge from the exit near RR# 306, was uneven and had a curb of approximately 7 inches in order to arrive at the paved surface. Based on interview at the time of observation, the DPO acknowledged that the exit discharge was not level to the public way or parking lot and stated that a concrete ramp would need to be installed. This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the DPO and RS each present. 3.1-19(b)	K 0271	The submission of this plan of correction does not indicate any admission by St Elizabeth Health Care that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at Lafayette. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance K271 Discharge from exits.	06/13/2025

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			Immediate intervention The contractor has been contacted to quote the removal of the 7-inch drop at the point of termination. Compliance date 6/13/25 The Director of plant operations was educated by Regional Support on NFPA 101 as regards to discharge of exits and providing a hard packed all - weather travel surface in accordance with 7.7, 7.1.7, 18.2.7, 19.2.7. The Executive Director will present the results of the work performed to the QAPI committee for further recommendations and will continue until the QAPI team determines substantial compliance has been achieved.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were separated from other spaces by smoke resisting partitions and provided with self-closing devices. This deficient practice could affect more than 20 residents, as well as staff and visitors in the dining area. Findings include: Based on observation and interview with the Director of Plant Operations (DPO) and Regional Facilities Support person (FS) on 05/13/25 at 1:17 pm. the Kitchen Storage area, off the dining room,	K 0321	The submission ofthis plan of correction does not indicate any admission by St Elizabeth Health Care that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at Lafayette. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.	06/13/2025

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	greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and several large and small cardboard boxes. The double doors to this storage room were louvered and when in the closed position had a ¾ to 1 inch gap between the two doors, conditions which cause the doors to not resist the passage of smoke and did not self-close and latch into the door frame. The DPO and FS stated that the doors would need to be replaced and a closer added to the new doors. This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the DPO and RS each present. 3.1-19(b)		The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance K321 ¿azardous Areas - Enclosure Immediate Intervention: Director of plant operations has replaced doors in private dining storage. Compliance date 6/13/25 Director of plant operations was educated by Executive director on K321 NFPA 101 hazardous areas enclosure doors. Corridor doors and doors to rooms that contain flammable devices, or combustible materials must have positive latching hardware and fire rated doors. The Executive Director will present the results of inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1. Based on observation and interview, the facility	K 0324	The submission of this plan of	06/13/2025

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	failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 6 staff. Findings include: Based on observation and interview with the Director of Plant Operations (DPO) and Regional Facilities Support person (FS) on 05/13/25 at 1:17 pm, the gas griddle and grease fryer located on the cooking line under the hood in the kitchen were not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the DPO the facility was not aware an approved method should be provided to		correction does not indicate any admission by St Elizabeth Health Care that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at Lafayette. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance K324- Cooking Facilities Compliance Date 6/13/25 Immediate Intervention The Director of Plant Operations ordered Dormont PS Safety Positioning System to ensure cooking appliances return where they were when kitchen hood extinguishing equipment was designed. The Director of Plant Operations and Director of Food Services was Educated by the Executive Director on NFPA 101, Cooking Facilities. The kitchen hood	

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	ensure that the appliances were returned to an approved design location after maintenance or cleaning. 2. Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 20 residents in the dining room. Findings include: Based on observation and interview with the Director of Plant Operations (DPO) and Regional Facilities Support person (FS) on 05/13/25 at 1:25 pm, the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Day Cook was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied, grab an extinguisher and put it out. The employee failed to indicate activating the UL 300 hood extinguishing system and using the correct fire extinguisher for a hood grease fire. The DPO acknowledged the Cooks response and stated kitchen staff will be informed on proper response. These findings were acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		exhaust system provides complete coverage for equipment that produces grease-laden vapors. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 20 residents, Kitchen staff.	

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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Director of Plant Operations (DPO) and Regional Facilities Support person (FS) on 05/13/25 at 11:30 a.m., 8 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted at on unexpected and unpredictable days. This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the DPO and RS each present. 3.1-19(b)	K 0712	The submission of this plan of correction does not indicate any admission by St Elizabeth Health Care that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at Lafayette. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance K-712-Fire Drills Compliance Date - 6/13/25 Immediate Intervention The Director of Plant Operations has conducted a fire drill for each shift The Director of Plant Operations was educated by the Executive Director on K712, Fire drills, NFPA 101, Fire Drills are held at expected and unexpected times under varying conditions, at least	06/13/2025

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			quarterly on each shift. The Executive Director will audit/review each fire drill with the Director of Plant Operations 1 X Month X 3 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all staff and residents.	
K 0000 Bldg. 02	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: 05/13/25 Facility Number: 000187 Provider Number: 155290 AIM Number: 100267300 At this Life Safety Code survey, St. Elizabeth Healthcare Center 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. The	K 0000		

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	500 wing, a 2018 addition, was surveyed under LSC Chapter 18, New Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. 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 Center is connected to an Assisted Living, Residential Board and Care occupancy, from which it is separated by a Fire Wall with a 2-hour Fire Resistance Rating. The building is fully protected by a 135-kW Natural Gas-powered generator. The facility has a capacity of 64 and had a census of 52 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached garages and two detached storage sheds which were not sprinklered. Quality Review completed on 05/14/25			
K 0712 SS=C Bldg. 02	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Director of Plant Operations (DPO) and Regional Facilities Support person (FS) on 05/13/25 at 11:30 a.m., 8 of 12 quarterly fire drills were conducted	K 0712	The submission of this plan of correction does not indicate any admission by St Elizabeth Health Care that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at Lafayette. The facility recognizes its obligation to provide legally and medically necessary care and	06/13/2025

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	near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted at on unexpected and unpredictable days. This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the DPO and RS each present. 3.1-19(b)		services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance K-712-Fire Drills Compliance Date - 6/13/25 Immediate Intervention The Director of Plant Operations has conducted a fire drill for each shift The Director of Plant Operations was educated by the Executive Director on K712, Fire drills, NFPA 101, Fire Drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The Executive Director will audit/review each fire drill with the Director of Plant Operations 1 X Month X 3 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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			This deficient practice could affect all staff and residents.	