STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155290	A. BU B. WI		-		COMPLETED 05/13/2025	
			<u> </u>	_	ADDRESS, CITY, STATE, ZIP COD	l		
NAME OF F	PROVIDER OR SUPPLIER				MORY RD			
ST ELIZA	ABETH HEALTHCA	RE CENTER		DELPHI	I, IN 46923			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
E 0000	REGULATORT OR	LESC IDENTIFTING INFORMATION		IAG			DATE	
Bldg	An Emarganay Dran	norodnoss Survey vos	E 00	.00				
		paredness Survey was diana Department of Health in CFR 483.73.	E 00	100				
	Survey Date: 05/13	2/25						
	Facility Number: 00 Provider Number: 1002 AIM Number: 1002	155290						
	Elizabeth Healthcar compliance with En Requirements for M	Preparedness survey, St. e Center was found in nergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR						
	The facility has 64 of the survey, the cens	certified beds. At the time of us was 52.						
	Quality Review con	npleted on 05/14/25						
K 0000								
Bldg. 01								
i biug. V I	Licensure Survey w	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 00	000				
	Survey Date: 05/13	2/25						
	Facility Number: 00 Provider Number: 1002	155290						
	At this Life Safety (Code survey, St. Elizabeth						
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE	
Monique A	ugustine			ED			05/29/2025	

Any defiency statement 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 disclosed 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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	of correction X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155290	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/13/2025	
	PROVIDER OR SUPPLIER ABETH HEALTHCARE CENTER	701 AF	STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0222 SS=E Bldg. 01	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 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 at admission by St Elizabeth Heat Care that the findings and allegations contained herein a	ny alth	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155290	B. W	ING		05/13/	2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
OT 51.174	ADETH HEALTHOA	DE OENTED			MORY RD		
SI ELIZA	ABETH HEALTHCA	RE CENTER		DELPH	I, IN 46923		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	egress within 15 sec	conds, or 30 seconds where			accurate, true representation	of	
	approved by the aut	chority having jurisdiction,			the quality of care provided, a		
	upon application of a force to the release device				the living environment provide		
	required in 7.2.1.5.10 under all of the following				the residents of The Springs a		
	conditions:				Lafayette. The facility recogniz		
	(a) The force shall not be required to exceed 15 lbf				its obligation to provide legally		
	(67 N).				medically necessary care and		
	(b) The force shall not be required to be				services to its residents in an		
	continuously applied for more than 3 seconds.				economic and efficient manne	r.	
	(c) The initiation of the release process shall				The facility hereby maintains i		
	activate an audible signal in the vicinity of the				in substantial compliance with		
	door opening.				state and federal requirements		
	(d) Once the lock has been released by the				governing the management of		
	application of force to the releasing device,				facility. It is thus submitted as		
		y manual means only. This			matter of statute only. The fac		
	_	ould affect 35 residents in the			respectfully requests desk rev	-	
	Walnut Grove hall a				or substantial compliance	1011	
	Findings include:				K222 Compliance Date: 6/13/2	25	
					·		
	Based on observation	on and interview with the			Immediate Intervention The		
	Director of Plant Op	perations (DPO) and Regional			Director of Plant Operations w	as	
	Facilities Support p	erson (FS) on 05/13/25, the			educated on 6/10/25 by the		
	following exit doors	s, equipped with a 15 second			Executive Director on NFPA		
	delayed egress, faile	ed to initiate the irreversible			101-2012 edition sections;		
	process to release th				19.2.2.2, 7.2.1.5.10, and 7.2.1	.6.	
	A) At 12:14 pm, t	he Chapel Exit door.			,		
		he front Main entrance door			The Director of Plant Operatio	ns	
		The staff was unable to			has contacted the vendor to re		
		ocking mechanism in order to			Walnut Hall and Chestnut Hall	•	
	test the delayed egre				which they were present in		
		he Activities Room Exit Door			campus on 6/13/25 with quote	;	
		yed egress lacked signage			given.		
	indicating the door				ľ		
	-	he Exit Door near RR#522. The			The Director of Plant Operatio	ns	
	DPO stated the door had been worked on but was				will audit the functionality of bo		
	warped/bent and would need to be replaced before the delayed egress feature would work				doors 2x per week x4 weeks.		
	properly.				The results of these inspection	าร	
		e Exit Door from the dining area.			will be presented by the Execu		
l l	- 1	<i>6</i> ·····	ı		I		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155290	B. W	ING		05/13/	2025
NAME OF B	DOLUBER OR CLIRRI IER			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				MORY RD		
ST ELIZA	ABETH HEALTHCA	RE CENTER		DELPH	II, IN 46923		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION dware was pushed the	+	TAG	Director to the QAPI committe		DATE
	-	are failed to activate. When			further recommendations and	6 101	
	, ,	d near the top, the feature			continue until the Quality		
		DPO stated the door would			Assurance Team determines		
	need attention.				substantial compliance has be	en	
					achieved.		
	This finding was acl	knowledged by the DPO at the					
	_	nd again at the exit conference			This deficient practice had the		
	with the DPO and R	S each present.			potential to affect 35 residents		
					the facility		
	3.1-19(b)						
K 0271	NFPA 101						
SS=E	Discharge from Ex	kits					
Bldg. 01	3						
	Based on observation	on and interview, the facility	K 0	271	The submission of this plan of		06/13/2025
	failed to ensure 1 of	over 8 exit discharges had a			correction does not indicate a	าy	
	level walking surfac	ce and was free of			admission by St Elizabeth Hea	alth	
		eficient practice could affect			Care that the findings and		
	15 residents and star	ff.			allegations contained herein a		
	E 1 1 1 1				accurate, true representation		
	Findings include:				the quality of care provided, a		
	D1				the living environment provide		
		on and interview with the			the residents of The Springs a		
	-	perations (DPO) and Regional erson (FS) on 05/13/25 at 12:27			Lafayette. The facility recognize its obligation to provide legally		
		ge from the exit near RR# 306,			medically necessary care and		
	-	l a curb of approximately 7			services to its residents in an		
		rive at the paved surface.			economic and efficient manne	r	
		at the time of observation, the			The facility hereby maintains i		
		I that the exit discharge was			in substantial compliance with		
	_	lic way or parking lot and			state and federal requirements		
	•	e ramp would need to be			governing the management of		
	installed.				facility. It is thus submitted as		
					matter of statute only. The fac		
	This finding was acl	knowledged by the DPO at the			respectfully requests desk rev	-	
	_	nd again at the exit conference			or substantial compliance		
	with the DPO and R	S each present.			·		
					K271 Discharge from exits.		
	3.1-19(b)						

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PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155290	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/13/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 ARMORY RD DELPHI, IN 46923				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Immediate intervention The contractor has been contacted quote the removal of the 7-inc drop at the point of termination	h		
				Compliance date 6/13/25 The Director of plant operation was educated by Regional Support on NFPA 101 as regated to discharge of exits and proving a hard packed all - weather transurface in accordance with 7.77, 11.7, 11.2.7, 19.2.7.	ards iding avel		
				The Executive Director will protect the results of the work perform to the QAPI committee for furt recommendations and will continue until the QAPI team determines substantial compliance has been achieve	ned her		
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure					
	failed to ensure 1 of such as storage roof spaces by smoke re with self-closing de could affect more the staff and visitors in Findings include: Based on observation Director of Plant Operations	on and interview, the facility Fover 10 hazardous area doors, ms, were separated from other sisting partitions and provided vices. This deficient practice nan 20 residents, as well as the dining area. on and interview with the perations (DPO) and Regional erson (FS) on 05/13/25 at 1:17	K 0321	The submission ofthis plan of correction does not indicate at admission by St Elizabeth Heat Care that the findings and allegations contained herein a accurate, true representation the quality of care provided, at the living environment provided the residents of The Springs at Lafayette. The facility recognizits obligation to provide legally medically necessary care and services to its residents in an	alth ire of nd id to it zes y and		
	pm. the Kitchen St	orage area, off the dining room,	1	economic and efficient manne	r.		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 05/13/2025		
	PROVIDER OR SUPPLIEI ABETH HEALTHCA		701 AF	ADDRESS, CITY, STATE, ZIP COD RMORY RD HI, IN 46923	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	combustible items, several large and sr double doors to this and when in the clo gap between the tw cause the doors to r smoke and did not door frame. The D doors would need t added to the new do	knowledged by the DPO at the nd again at the exit conference		The facility hereby maintains in substantial compliance with state and federal requirement governing the management of facility. It is thus submitted as matter of statute only. The fact respectfully requests desk revor substantial compliance K321 ¿azardous Areas - Enclosure Immediate Intervention: Direct plant operations has replaced doors in private dining storage Compliance date 6/13/25 Director of plant operations we educated by Executive director K321 NFPA 101 hazardous at enclosure doors. Corridor door and doors to rooms that contaflammable devices, or combust materials must have positive latching hardware and fire rate doors. The Executive Director will protect the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieve	all s f this a illity iew tor of as or on reas rs iin stible ed esent gh r
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities				
Diag. 01	1. Based on observe	ation and interview, the facility	K 0324	The submission of this plan of	06/13/2025

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155290		JILDING	01	COMPL 05/13/	ETED
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD MORY RD		
ST ELIZA	ABETH HEALTHCA	RE CENTER			I, IN 46923		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		approved method for		TAG			DATE
	-	ppliances to where they were			correction does not indicate ar admission by St Elizabeth Hea	-	
		ood extinguishing equipment			Care that the findings and	11111	
		establed for 1 of 1 kitchen hood			allegations contained herein a	re	
	-	n. NFPA 96 Standard for			accurate, true representation of		
		and Fire Protection of			the quality of care provided, ar		
	Commercial Cookir	ng Operations Section 2011			the living environment provide		
	Edition Section 12.1.2.2* Cooking appliances				the residents of The Springs a	t	
	requiring protection shall not be moved, modified,				Lafayette. The facility recogniz	zes	
	or rearranged without prior re-evaluation of the				its obligation to provide legally	and	
	fire-extinguishing system by the system installer				medically necessary care and		
	or servicing agent, unless otherwise allowed by				services to its residents in an		
	the design of the fire extinguishing system.				economic and efficient manne		
	Section 12.1.2.3 The fire-extinguishing system				The facility hereby maintains it		
	shall not require reevaluation where the cooking appliances are moved for the purposes of				in substantial compliance with		
	maintenance and cle				state and federal requirements		
		ned to approved design			governing the management of facility. It is thus submitted as		
		oking operations, and any			matter of statute only. The fac		
	-	ctinguishing system nozzles			respectfully requests desk revi	-	
		iances are reconnected in			or substantial compliance	CW	
		manufacturer's listed design			or substantial somplianes		
		1.2.3.1 An approved method			K324- Cooking Facilities		
		at will ensure that the					
	appliance is returne	d to an approved design			Compliance Date 6/13/25		
	location. The defici	ient practice affected 6 staff.					
					Immediate Intervention The		
	Findings include:				Director of Plant Operations		
					ordered Dormont PS Safety		
		on and interview with the			Positioning System to ensure		
		perations (DPO) and Regional			cooking appliances return whe	ere	
		erson (FS) on 05/13/25 at 1:17			they were when kitchen hood		
		and grease fryer located on der the hood in the kitchen			extinguishing equipment was		
		with an approved method that			designed.		
	_				The Director of Plant Operation	ns	
	would ensure that the appliance was returned to an approved design location after it had been		The Director of Plant Operations and Director of Food Services was				
		ance and cleaning. Based on			Educated by the Executive		
		OPO the facility was not aware			Director on NFPA 101, Cooking	ıg	
		d should be provided to			Facilities. The kitchen hood	_	
			1		İ		1

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155290	JILDING	onstruction 01	(X3) DATE COMPL 05/13 /	ETED
	PROVIDER OR SUPPLIEF		701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, IN 46923		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TC	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		IE .	DATE
TAG	ensure that the appl approved design loc cleaning. 2. Based on observation of the UL 300 hood sy 96, 11.1.4 states insoperating the fire exposted conspicuous reviewed with employeement practice of and 20 residents in Findings include: Based on observation Director of Plant Of Facilities Support p	iances were returned to an cation after maintenance or ation and interview, the facility of were instructed in the use of extern in 1 of 1 Kitchen. NFPA structions for manually extinguishing system shall be layin the kitchen and shall be loyees by management. This could affect staff in the kitchen	140	exhaust system provides complete coverage for equipm that produces grease-laden vapors. Results of this audit will be presented by the Executive Director to the QAPI committe further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved. This deficient practice could at 20 residents, Kitchen staff.	e for	DAIL
	and a K-class fire e instructions. Based was asked; what is was a grease fire ur employee replied, g out. The employee	xtinguisher with posted on interview, the Day Cook the correct response if there aderneath the hood. The trab an extinguisher and put it failed to indicate activating the				
	correct fire extingui DPO acknowledged	guishing system and using the isher for a hood grease fire. The I the Cooks response and will be informed on proper				
	Maintenance Direct again at the exit con	e acknowledged by the tor at the time of discovery and afterence with the Maintenance tive Director present.				
	3.1-19(b)					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155290	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/13/2025
	ROVIDER OR SUPPLIER		701 AF	ADDRESS, CITY, STATE, ZIP COD RMORY RD HI, IN 46923	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills				
Bidg. UT	failed to conduct question of the month. These codrills to be conducted unpredictable days. Findings include: Based on records redirector of Plant Operation of Plant Operation of Plant Operation of the month. These codrills to be conducted unpredictable days.	d at unexpected times under This deficient practice could staff and visitors in the facility. Eview and interview with the perations (DPO) and Regional erson (FS) on 05/13/25 at 11:30 rly fire drills were conducted month, around the 30th day of onditions do not allow fire ed at on unexpected and knowledged by the DPO at the and again at the exit conference	K 0712	The submission of this plan correction does not indicate admission by St Elizabeth H Care that the findings and allegations contained herein accurate, true representation the quality of care provided, the living environment provided the residents of The Springs Lafayette. The facility recognits obligation to provide legal medically necessary care an services to its residents in an economic and efficient mannormal the facility hereby maintains in substantial compliance with state and federal requirement governing the management facility. It is thus submitted a matter of statute only. The face respectfully requests desk resor substantial compliance. K-712-Fire Drills Compliance Date - 6/13/25 Immediate Intervention The Director of Plant Operations conducted a fire drill for each was educated by the Execut Director on K712, Fire drills, NFPA 101, Fire Drills are he expected and unexpected tirunder varying conditions, at	any ealth are n of and ded to at nizes illy and nd ner. at it is th all nts of this as a acility eview has h shift cions cive eld at mes

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 155290		ILDING	01	COMPL 05/13/	ETED
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 ARMORY RD				
ST ELIZA	BETH HEALTHCAI	RE CENTER		DELPHI	, IN 46923		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
K 0000					quarterly on each shift. The Executive Director will audit/review each fire drill with Director of Plant Operations 1 Month X 3 Months Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuuntil the Quality Assurance Teadetermines substantial compliance has been achieved. This deficient practice could affall staff and residents.	or to e am	
Bldg. 02	Licensure Survey w Department of Healt 483.90(a). Survey Date: 05/13 Facility Number: 06 Provider Number: 1 AIM Number: 1002 At this Life Safety C Healthcare Center w with Requirements t Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L	200187 155290 267300 Code survey, St. Elizabeth vas found not in compliance	K 00	000			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	02	COMPLETED	
		155290	B. W	ING		05/13/	2025
	ROVIDER OR SUPPLIER			701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, IN 46923		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	T	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	_	ldition, was surveyed under ew Health Care Occupancies.					
	Type V (111) constricts sprinklered. The fact with smoke detection open to the corridor detectors in all resident Healthcare Center is Living, Residential from which it is sep 2-hour Fire Resistar fully protected by a generator. The facil had a census of 52 at All areas where resident were sprinklered. A services were sprinklered.						
K 0712 SS=C Bldg. 02	NFPA 101 Fire Drills						
)	failed to conduct question unexpected days and varying conditions. affect all residents, affect all residents. Findings include: Based on records red Director of Plant Of Facilities Support por	riew and interview, the facility arterly fire drills on d at unexpected times under This deficient practice could staff and visitors in the facility. view and interview with the perations (DPO) and Regional erson (FS) on 05/13/25 at 11:30 rly fire drills were conducted	K 0	712	The submission of this plan of correction does not indicate ar admission by St Elizabeth Heat Care that the findings and allegations contained herein a accurate, true representation of the quality of care provided, are the living environment provide the residents of The Springs at Lafayette. The facility recognizits obligation to provide legally medically necessary care and	ny alth re of nd d to t zes	06/13/2025

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155290	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE COMPI 05/13	
NAME OF I	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP CO	DD	
ST ELIZ	ABETH HEALTHCA	RE CENTER		HI, IN 46923		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
	near the end of the the month. These codrills to be conduct unpredictable days. This finding was according to the conduct that the conduct the conduct that th	month, around the 30th day of conditions do not allow fire ed at on unexpected and cknowledged by the DPO at the and again at the exit conference		services to its residents economic and efficient in The facility hereby main in substantial compliance state and federal require governing the management facility. It is thus submitt matter of statute only. The respectfully requests do or substantial compliance in the compliance of	manner. Itains it is the with all thements thement of this thed as a the facility the review the second of the se	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLII		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED	
	155290		B. WING			05/13/2025	
NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 701 ARMORY RD DELPHI, IN 46923			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		I	PREFIX (EACH CORRECTIVE ACTION SHOULD	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					This deficient practice could at all staff and residents.	fect	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: $GXSP21 \quad \ \ Facility ID: \quad 000187$ If continuation sheet Page 13 of 13