

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

PRINTED: 04/11/2023
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155290 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 03/28/2023 | |
| NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HEALTHCARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 701 ARMORY RD DELPHI, IN 46923 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| {F 000} | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on January 12, 2023. This visit included a PSR to the Investigation of Complaints IN00381691, IN00381305, IN00390095, IN00381685, and IN00388615 completed on January 12, 2023.</p> <p>Complaint IN00381305- Corrected.</p> <p>Complaint IN00390095- Corrected.</p> <p>Complaint IN00381685- Corrected.</p> <p>Complaint IN00381691- Corrected.</p> <p>Complaint IN00388615- Corrected.</p> <p>Survey dates: March 24, 27, and 28, 2023</p> <p>Facility number: 000187 Provider number: 155290 AIM number: 100267300</p> <p>Census Bed Type: SNF/NF: 40 SNF: 5 Residential: 26 Total: 71</p> <p>Census Payor Type: Medicare: 9 Medicaid: 31 Other: 31 Total: 71</p> <p>St. Elizabeth Healthcare Center was found to be</p> | | | {F 000} | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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| {F 000} | Continued From page 1 in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaints IN00381691, IN00381305, IN00390095, IN00381685, and IN00388615. Quality review completed on April 3, 2023. | {F 000} | | | |