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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE :	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPLETED	
		155290	B. WI	NG		01/31/	2023
	ROVIDER OR SUPPLIER			701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, IN 46923		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
E 0000							
Bldg	conducted by the In- accordance with 42 Survey Date: 01/31 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency I Elizabeth Healthcard substantial complian Preparedness Requir Medicaid Participation CFR 483.73	200187 155290 267300 Preparedness survey, St. e Center was found in nee with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 54.	E 00	000	The submission of this plan of correction does not indicate ar admission by St. Elizabeth HecCampus that the findings and allegations contained herein a accurate, true representation of the quality of care provided, ar the living environment provided the residents of St. Elizabeth Health campus. The facility recognizes its obligation to prolegally and medically necessal care and services to its resider in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk revior substantial compliance.	ny alth re of nd d to vide ry nts	
E 0007 SS=C Bldg	441.184(a)(3), 482 483.73(a)(3), 484. 485.68(a)(3), 485. 491.12(a)(3), 494. EP Program Patie §403.748(a)(3), §4 §441.184(a)(3), § §483.73(a)(3), §48 (3), §485.68(a)(3)	nt Population 116.54(a)(3), §418.113(a)(3), 3460.84(a)(3), §482.15(a)(3), 33.475(a)(3), §484.102(a)					

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

(X6) DATE

TITLE

Kristen Patz **Executive Director** 02/17/2023

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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155290	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/31/2023
	PROVIDER OR SUPPLIER ABETH HEALTHCA		701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD II, IN 46923	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	develop and main preparedness plar	an. The [facility] must tain an emergency n that must be reviewed, ast every 2 years. The plan ring:]			
	including, but not lead the type of service ability to provide in	nt/client] population, imited to, persons at-risk; as the [facility] has the an an emergency; and ations, including delegations accession plans.**			
	develop and main preparedness plar and updated at lea must do all of the (3) Address reside but not limited to, services the LTC to provide in an eme	The LTC facility must tain an emergency that must be reviewed, ast annually. The plan following: ent population, including, persons at-risk; the type of facility has the ability to rgency; and continuity of ing delegations of authority			
	ASC, hospice, PA RHC/FQHC, or ES Based on record rev failed to ensure the addressed resident p limited to, persons a LTC facility has the emergency; and cor including delegation plans in accordance	at risk" does not apply to: CE, HHA, CORF, CMCH, BRD facilities.] riew and interview, the facility emergency preparedness plan copulation, including, but not at-risk; the type of services the e ability to provide in an attinuity of operations, as of authority and succession with 42 CFR 483.73(a)(3). This could affect all occupants.	E 0007	The Executive Director has updated the Emergency Operations Plan and is address resident population, including, not limited to, persons at risk; type of services that St. Elizab Health Campus has the ability provide in an emergency; and continuity of operations, included legations of authority and succession plans.	but the eeth to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155290		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/31/2023	
	PROVIDER OR SUPPLIER		701 AF	ADDRESS, CITY, STATE, ZIP COD RMORY RD HI, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE
	Operations from 09 01/31/23, no documensuring the emerge addressed resident plimited to, persons a LTC facility has the emergency; and corincluding delegation plans. Based on an irreview, the Director acknowledged he wregarding the type of the ability to provide continuity of operational authority and successful conference with the Facility Support Directors on 01/31	w with the Director of Plant (38 a.m. to 10:59 a.m. on entation could be provided ency preparedness plan copulation, including, but not at-risk; the type of services the ability to provide in an atinuity of operations, as of authority and succession interview at the time of record of Plant Operations as unable to provide policies of services the LTC facility has a in an emergency; and ions, including delegations of ession plans. During the exit facility Administrator, the elector, and the Director of Plant (23 at 3:30 p.m. no additional ence could be provided cient finding.		The Executive Director was educated by Facilities Management Support on ECEP Program Patient popula The Executive Director will the Emergency Operations for EP Program Patient Popula TX per month X 12 months Results of this audit will be presented by Executive Director the QAPI committee for furt recommendations and contuntil the Quality Assurance determines substantial compliance has been achie This deficient practice could all occupants.	007 – tion. audit Plan pulation c. ector to her inue Team
E 0022 SS=C Bldg	441.184(b)(4), 482 483.73(b)(4), 485. 485.727(b)(2), 485 494.62(b)(3) Policies/Procedure §403.748(b)(4), §4 (i), §441.184(b)(4) (4), §483.73(b)(4). (2), §485.625(b)(4) §485.920(b)(3), §4 (b) Policies and pr must develop and preparedness poli on the emergency	5.54(b)(3), 418.113(b)(6)(i), 2.15(b)(4), 483.475(b)(4), 625(b)(4), 485.68(b)(2), 5.920(b)(3), 491.12(b)(2), es for Sheltering in Place 116.54(b)(3), §418.113(b)(6), , §460.84(b)(5), §482.15(b) §483.475(b)(4), §485.68(b),), §485.727(b)(2), 191.12(b)(2), §494.62(b)(3). occedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLE				
		155290	B. WI	NG		01/31	/2023
	PROVIDER OR SUPPLIER			701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, IN 46923		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	paragraph (a)(1) of communication plasection. The policible reviewed and use and use and use are [annually for minimum, the policible address the follow [(4) or (2),(3),(5),(6) place for patients, remain in the [faction of the following at a policible and process and pr	of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 r LTC facilities]. At a cies and procedures must ving:] 6)] A means to shelter in staff, and volunteers who lity]. spices at §418.113(b):] edures. are additional requirements ted inpatient care facilities and procedures must ving: elter in place for patients, es who remain in the view and interview, the facility	E 00		The Executive Director has		02/02/2023
	and procedures incl for residents, staff, the LTC facility in a 483.73(b)(4). This o occupants. Findings include: During record revie Operations from 09 01/31/23, no docum ensuring the emerge addressed sheltering at the same time as Plant Operations ag preparedness plant	ergency preparedness policies ude a means to shelter in place and volunteers who remain in accordance with 42 CFR deficient practice could affect all ew with the Director of Plant :38 a.m. to 10:59 a.m. on mentation could be provided ency preparedness plan g in place. Based on interview record review the Director of greed that the emergency lid not address a plan, a use for sheltering in place for			updated the Emergency Operations Plan to address Shelter in Place. The Executive Director was educated by Facilities Management Support on E022 Policies/Procedures for Shelte in Place. The Executive Director or designee will audit the Emerge Operations Plan for Sheltering Place 1 X per month X 12 mor Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continu until the Quality Assurance Te	ering ency in onths. or to r	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI	JILDING		COMPI	
		155290	B. WI	_		01/31	12023
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
ST ELIZA	ABETH HEALTHCA	ARE CENTER			MORY RD II, IN 46923		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
the facility. During the exit conference					compliance has been achieve		
	•	tor, the Facility Support			This deficient practice could a	iffect	
	Director, and the Director of Plant Operations on				all occupants.		
	_	m. no additional information or					
		provided contrary to this					
	SS=C 441.184(b)(6), 482.15(b)(6), 483.475(b)(6),						
E 0024							
SS=C							
Bldg							
485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5)							
		res-Volunteers and Staffing					
		416.54(b)(5), §418.113(b)(4),					
		460.84(b)(7), §482.15(b)(6),					
		83.475(b)(6), §484.102(b)(5),					
	. , , , .	85.625(b)(6), §485.727(b)(4),					
	§485.920(b)(5), §	491.12(b)(4), §494.62(b)(5).					
	[(b) Policies and p	procedures. The [facilities]					
	must develop and	l implement emergency					
	preparedness pol	icies and procedures, based					
	on the emergency	y plan set forth in paragraph					
		, risk assessment at					
		of this section, and the					
	communication pl	an at paragraph (c) of this					
		cies and procedures must					
		updated at least every 2					
		or LTC facilities]. At a					
	_ ·	icies and procedures must					
	address the follow	ving:]					
	(6) [or (4), (5), or	(7) as noted above] The use					
		n emergency or other					
		ng strategies, including the					
	1 -	for integration of State and					
		_					
Federally designated health care professionals to address surge needs during							

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an emergency.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) D.	3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING CC	MPLETED	
155290 B. WING 01	/31/2023	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER 701 ARMORY RD		
ST ELIZABETH HEALTHCARE CENTER DELPHI, IN 46923		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION PREFLY (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFLY (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATOR FOR ESCIDENTIFITING INFORMATION TAG	DATE	
*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an		
emergency and other emergency staffing		
strategies to address surge needs during an		
emergency.		
omorganay.		
*[For Hospice at §418.113(b):] Policies and		
procedures. (4) The use of hospice		
employees in an emergency and other		
emergency staffing strategies, including the		
process and role for integration of State and		
Federally designated health care		
professionals to address surge needs during		
an emergency.		
Based on record review and interview, the facility E 0024 The Executive Director has	02/02/2023	
failed to ensure emergency preparedness policies updated the Emergency		
and procedures include the use of volunteers in Operations Plan and is addressing		
an emergency or other emergency staffing strategies, including the process and role for the use of volunteers in an emergency or other emergency		
strategies, including the process and role for emergency or other emergency integration of State or Federally designated health staffing.		
care professionals to address surge needs during The Executive Director was		
an emergency in accordance with 42 CFR educated by Facilities		
483.73(b)(6). This deficient practice could affect all Management Support on E024 –		
occupants. Policies/Procedures – Volunteers		
and Staffing		
Findings include: The Executive Director or		
designee will audit the Emergency		
During record review with the Director of Plant Operations Plan for Volunteers		
Operations from 09:38 a.m. to 10:59 a.m. on and Staffing 1 X per month X 12		
01/31/23, no documentation could be provided months.		
ensuring the emergency preparedness plan Results of this audit will be		
addressed the use of volunteers in an emergency. presented by Executive Director to		
Based on interview at the time of records review, the QAPI committee for further		
the Director of Plant Operations searched through		
the plan and agreed that the plan did not address until the Quality Assurance Team		
the use of volunteers in an emergency. During the determines substantial	ĺ	
exit conference with the facility Administrator, the compliance has been achieved.		
Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional This deficient practice could affect all occupants.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155290		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING COMPLETED 01/31/2023					
NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HEALTHCARE CENTER				701 ARI	.ddress, city, state, zip cod MORY RD 1, IN 46923		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION cient finding.		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 0034 SS=C Bldg	441.184(c)(7), 482, 483.73(c)(7), 484, 485.68(c)(5), 485. 491.12(c)(5), 494. Information on Oc §403.748(c)(7), §4 §441.184(c)(7), §4 §483.73(c)(7), §48 (6), §485.68(c)(5), (5), §485.625(c)(7) §491.12(c)(5), §491.12(c	ccupancy/Needs 416.54(c)(7), §418.113(c)(7) 482.15(c)(7), §460.84(c)(7), 33.475(c)(7), §484.102(c) , §485.68(c)(5), §485.727(c) 7), §485.920(c)(7), 94.62(c)(7). Inust develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC emmunication plan must collowing: Inust develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC emmunication plan must collowing: Inust develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC emmunication plan must collowing: Inust develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC emmunication plan must collowing: Inust develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC emmunication plan must collowing: Inust develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC emmunication plan must collowing: Inust develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC emmunication plan must collowing: Inust develop and maintain eparedness communication is with Federal, State and state a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155290			JILDING	ONSTRUCTION	(X3) DATE COMPL 01/31/	ETED	
	PROVIDER OR SUPPLIEF			701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, IN 46923		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	TE	(X5) COMPLETION DATE
	failed to ensure the communication plate providing information occupancy, needs, a assistance, to the authe Incident Communication plate deficient practice of the communication plate of the communication plate of the communication plate of the communication of	wiew and interview, the facility emergency preparedness in includes a means of son about the LTC facility's and its ability to provide athority having jurisdiction or and Center, or designee in CFR 483.73(c)(7). This build affect all occupants. We with the Director of Plant 1:38 a.m. to 10:59 a.m. on by's emergency preparedness in provided did not address a information about the LTC 1/27, needs, and its ability to so the authority having incident Command Center, or interview at the time of Director of Plant Operations not address a means of son about the LTC facility's and its ability to provide the exit conference with the stor, the Facility Support irector of Plant Operations on m. no additional information or provided contrary to this	E 00	034	The Executive Director has updated the Emergency Operations Plan to include in communication plan a means providing information about the Campuses occupancy, needs it ability to provide assistance, AHJ or the Incident Command Center, or designee. The Executive Director was educated by Facilities Management Support on E03-Information on Occupancy/Ne The Executive Director or designee will audit the Emergo Operations Plan for Information Occupancy/Needs 1 X per mod X 12 months. Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieve This deficient practice could a all occupants.	of e and the f 4 - eds ency on on onth cor to r ue eam	02/02/2023
E 0041 SS=C Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power sy	(e), 485.625(e) I LTC Emergency Power tion for Participation: Id standby power systems. I implement emergency and stems based on the et forth in paragraph (a) of					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155290	l í	JILDING	NSTRUCTION	(X3) DATE COMPL 01/31	ETED
	PROVIDER OR SUPPLIER			701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, 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 B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	I IATE	(X5) COMPLETION DATE
	this section and in procedures plan s (i) and (ii) of this s	et forth in paragraphs (b)(1)					
	The [LTC facility a implement emerge systems based or	625(e) d standby power systems. and the CAH] must ency and standby power the emergency plan set (a) of this section.					
	Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA	e located in accordance with ements found in the Health de (NFPA 99 and Tentative nts TIA 12-2, TIA 12-3, TIA ad TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing					
	Emergency gener The [hospital, CAI implement the em inspection, testing requirements four	3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system I, and [maintenance] Id in the Health Care FPA 110, and Life Safety					
	Emergency gener and LTC facilities] source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency perational during the sit evacuates.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155290	B. W	ING		01/31/2023	
NAME OF P	ROVIDER OR SUPPLIER	\			ADDRESS, CITY, STATE, ZIP COD		
					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	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCT)		DATE
	*[For hospitals at 8	§482.15(h), LTC at					
	•	CAHs §485.625(g):]					
		corporated by reference in					
		pproved for incorporation by					
		Director of the Office of the					
	Federal Register i	n accordance with 5 U.S.C.					
	552(a) and 1 CFR	R part 51. You may obtain					
	the material from t	the sources listed below.					
	• •	a copy at the CMS					
		urce Center, 7500 Security					
	· ·	ore, MD or at the National					
		ords Administration					
	, ,	mation on the availability of					
		ARA, call 202-741-6030, or					
	go to:						
	•	es.gov/federal_register/code					
		ations/ibr_locations.html.					
		this edition of the Code are eference, CMS will publish a					
		ederal Register to					
	announce the cha	_					
		Protection Association, 1					
	Batterymarch Parl						
	Quincy, MA 02169						
	1.617.770.3000.	3,					
	(i) NFPA 99, Heal	th Care Facilities Code,					
		ed August 11, 2011.					
		im amendment (TIA) 12-2 to					
	NFPA 99, issued	August 11, 2011.					
	(iii) TIA 12-3 to NF	FPA 99, issued August 9,					
	2012.						
	(iv) TIA 12-4 to NF 2013.	FPA 99, issued March 7,					
	(v) TIA 12-5 to NF 2013.	PA 99, issued August 1,					
		FPA 99, issued March 3,					
		fe Safety Code, 2012					
	edition, issued Au						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155290		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/31/2023	
	PROVIDER OR SUPPLIE		701 AF	ADDRESS, CITY, STATE, ZIP COD RMORY RD HI, IN 46923	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE
K 0000	11, 2011. (ix) TIA 12-2 to N 30, 2012. (x) TIA 12-3 to NI 22, 2013. (xi) TIA 12-4 to N 22, 2013. (xiii) NFPA 110, S Standby Power S including TIAs to 2009. Based on record refailed to implement inspection, testing, found in the Health 110, and Life Safet CFR 483.73(e)(2). affect all occupants Findings include: During record revice Operations at 9:18 Reliability provide generator was date outdated. Based on review, the Director that he did not knot facility's letter or review, the Director of Plat 3:30 p.m. no additi	FPA 101, issued October FPA 101, issued October FPA 101, issued October FPA 101, issued October Standard for Emergency and systems, 2010 edition, chapter 7, issued August 6, view and interview, the facility to the emergency power system and maintenance requirements in Care Facilities Code, NFPA by Code in accordance with 42. This deficient practice could is. This deficient practice could is. This deficient practice could in accordance with 42 and on 01/31/23, the Letter of it of the facility's natural gast interview at the time of record or of Plant Operations stated when needed to update the eliability as least every other cit conference with the facility interview at the facility interview of the facility of the properties of the facility of the fa	E 0041	The Executive Director has obtained a Letter of Reliability Nipsco. The Executive Director was educated by Facilities Management Support on E04 LTC Emergency Power The Executive Director or designee will audit the Emergo Operations Plan for Letter of Reliability 1 X per month X 12 months. Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieve This deficient practice could a all occupants.	ency for to r ue eam d.
Bldg. 01	l				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155290	B. W	ING		01/31/	/2023
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					MORY RD		
ST ELIZA	ABETH HEALTHCA	ARE CENTER		DELPH	II, IN 46923		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·	DATE
	A Life Safety Code	Recertification and State	K 0	000	The submission of this plan of		
	Licensure Survey was conducted by the Indiana				correction does not indicate a		
	Department of Health in accordance with 42 CFR				admission by St. Elizabeth He	-	
	483.90(a).				Campus that the findings and		
					allegations contained herein a	re	
	Survey Date: 01/3	1/23			accurate, true representation	of	
					the quality of care provided, a	nd	
	Facility Number: (000187			the living environment provide	d to	
	Provider Number:	155290			the residents of St. Elizabeth		
	AIM Number: 100267300				Health campus. The facility		
					recognizes its obligation to pro	ovide	
	At this Life Safety	Code survey, St. Elizabeth			legally and medically necessa	ry	
	Healthcare Center	was found not in compliance			care and services to its reside	nts	
	with Requirements for Participation in				in an economic and efficient		
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),				manner. The facility hereby		
	Life Safety from Fi	re, and the 2012 edition of the			maintains it is in substantial		
	National Fire Prote	ction Association (NFPA) 101,			compliance with all state and		
	Life Safety Code (I	LSC), Chapter 19, Existing			federal requirements governin	g the	
	Health Care Occup	ancies and 410 IAC 16.2. The			management of this facility. It	is	
	500 wing, a 2018 a	ddition, was surveyed under			thus submitted as a matter of		
	LSC Chapter 18, N	ew Health Care Occupancies.			statute only. The facility respectfully requests desk rev	iow.	
	This one-story faci	lity was determined to be of			or substantial compliance.		
	I	truction and was fully			2. Sazotaman compilarico.		
		cility has a fire alarm system					
	_	on in the corridors, spaces					
		rs and hard-wired smoke					
	_	dent sleeping rooms. The					
		is connected to an Assisted					1
		Board and Care occupancy,					
	_	parated by a Fire Wall with a					
		nce Rating. The building is					
		135-kW diesel-powered					
		ility has a capacity of 64 and					
		at the time of this survey.					
		Ž					
	All areas where res	idents have customary access					
	were sprinklered. A	All areas providing facility					
	services were sprin	klered except two detached					
	_	tached storage sheds which					

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DEPARTMENT CENTERS FOI	FORM APPROVED OMB NO. 0938-039				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155290	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	X3) DATE SURVEY COMPLETED 01/31/2023
	PROVIDER OR SUPPLIE		701 AF	ADDRESS, CITY, STATE, ZIP COD RMORY RD HI, IN 46923	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ed.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0232 SS=E Bldg. 01	Quality Review con NFPA 101 Aisle, Corridor, or Aisle, Corridor or 2012 EXISTING The width of aisle unobstructed) ser at least 4 feet and convenient remove on stretchers, exc 19.2.3.4, exception 19.2.3.4, 19.2.3.5 Based on observation the clear width request an exception postates where the co- projections into the permitted for fixed the following cond (a) the fixed furnity floor or to the wall (b) the fixed furnity unobstructed corriders as permitted (c) the fixed furnity of the corridor.	Ramp Width Ramp Width es or corridors (clear or rving as exit access shall be dimaintained to provide the val of nonambulatory patients cept as modified by ons 1-5. on, the facility failed to meet uirement for 1 of 4 corridors or er 19.2.3.4(5) LSC 19.2.3.4(5) rridor width is at least 8 feet, erequired width shall be furniture, provided that all of itions are met: are is securely attached to the	K 0232	The Director of Plant Operation has removed the desk and no longer projected out into the corridor. The Hoyer lift has also been removed from the corridor restoring the width and maintaining a clear path of egroup the Director of Plant Operation was educated by the Executive Director on NFPA 101, 2012 A Corridor, or Ramp Width. The width of aisles or corridors seas an exit access shall be at least feet and maintained to provide the convenient removal of	o press. ns e xisle, rving east
	grouping does not of feet. (e) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance of at least (f) the fixed furnitude 19.2.3.4(5) (d) are distance (f) the fixed furnitude 19.2.3(6) (d) are distance (f) the fixed furnitude 19.2.3(6) (d) are distance (f) the fixed furnitude 19.2.3(6) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	are groupings addressed in LSC separated from each other by a		non-ambulatory patients on stretchers. The Director of Plant Operatio designee will audit corridor ensuring that the width of the corridor is maintained meeting requirements of NFPA 101, 2	the

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protection equipment.

(g) corridors throughout the smoke compartment

are protected by an electrically supervised

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Aisle, Corridor, or Ramp Width. 1

Results of this audit will be

x daily X 4 weeks.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155290		l í	JILDING	01	COMPL 01/31/	ETED	
	PROVIDER OR SUPPLIER			701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, 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)	ΓE	(X5) COMPLETION DATE
TAG	automatic smoke de with LSC 19.3.4, or arranged and located by the facility staff is space. (h) the smoke comp throughout by an apsprinkler system in a This deficient practistaff, and 2 visitors Findings include: Based on observation Plant Operations du 2:10 p.m. on 01/31/2 had a desk placed in nurse's station. This corridor reducing the Furthermore there we the hall from this de of the corridor to les interview at the time Director of Plant Opwas stored in the afowere not affixed to reduced the clear with 44 inches. During the facility Administrate Director, and the Di 01/31/23 at 3:30 p.m.	tection system in accordance the fixed furniture spaces are d to allow direct supervision from a nurse's station or similar			presented by Executive Direct the QAPI committee for further recommendations and continu until the Quality Assurance Te determines substantial compliance has been achieved. This deficient practice could at 18 residents, 4 staff, and 2 visif needing to exit the building.	e am d. fect	DATE
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Ex Discharge from Ex Exit discharge is a						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155290	B. W	ING		01/31	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			RMORY RD		
ST ELIZA	ABETH HEALTHCA	RE CENTER		DELPHI, IN 46923			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	·	vel walking surface meeting					
	•	7.1.7 with respect to					
	-	ion and shall be maintained					
		ns. Additionally, the exit					
	_	e a hard packed all-weather					
	travel surface.						
	18.2.7, 19.2.7	on and interview, the facility	K 0	271	The Director of Plant Operation	ne	02/01/2023
		means of egress through 1 of	~ 0	<u> </u>	The Director of Plant Operation has repaired the delayed egre		02/01/2023
		cks was readily accessible for			lock at the main dining room.	33	
		and visitors. LSC 7.2.1.6.1.1			The Director of Plant Operation	ne	
		cking Systems allows			was educated by the Executiv		
		elayed-egress locks shall be			Director on NFPA 101, 2012	•	
		alled on door assemblies			Delayed -Egress Locking Syst	em	
	-	linary hazard contents in			LSC 7.2.1.6.1.1	.0111,	
	-	throughout by an approved,			The Director of Plant Operation	ns or	
		ic fire detection system			designee will audit the		
	-	nce with Section 9.6, or an			delayed-egress lock located ir	the	
		ed automatic sprinkler system			main dining room for proper		
	installed in accorda	nce with Section 9.7, and			function 1 X per week X 8 wee	eks.	
	where permitted in	Chapters 11 through 43,			Results of this audit will be		
	provided:				presented by Executive Direct	or to	
	(1) The door leaves	shall unlock in the direction of			the QAPI committee for furthe	r	
	egress upon activati	ion of one of the following:			recommendations and continu	ie	
		rvised automatic sprinkler			until the Quality Assurance Te	am	
	*	accordance with Section 9.7			determines substantial		
	* /	one heat detector of an			compliance has been achieve	d.	
		ed automatic fire detections			This deficient practice could a		
	system in accordance				15 residents, staff, and visitors	3.	
	` '	wo smoke detectors of an					
		ed automatic fire detection					
	system in accordance						
	` '	shall unlock in the direction of					
		power controlling the lock or					
	locking mechanism						
		process shall release the lock in					
		ess within 15 seconds, or 30					
		roved by the authority having					
		pplication of a force to the					
	release device reali						•

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155290		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/31/2023	
	PROVIDER OR SUPPLIER		701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD II, IN 46923	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
TAG	the following condi (a) The force s 15 lbf (67 N). (b) The force s continuously applie (c) The initiation of activate an audible s door opening. (d) Once the door lo application of force relocking shall be b (4) A readily visible less than 1 in. (25m (3.2mm) in stroke v background that rea on the door leaf adj- the direction of egre "PUSH UNTIL AL DOOR CAN BE OI (5) The egress side delayed-egress lock emergency lighting This deficient pract residents, staff, and Findings include: Based on observation Director of Plant OI 2:29 p.m., the main delayed egress lock proper signage indicate opened in 15 second however, when the irreversible process initiated. This was a Maintenance Direct During the exit con Administrator, the I	hall not be required to exceed hall not be required to be d for more than 3 seconds. The release process shall signal in the vicinity of the ock has been released by the to the releasing device, y manual means only. e, durable sign in letters not m) high and at least 1/8 in. vidth on a contrasting ds as follows shall be located acent to the release device in ess: ARM SOUNDS. PENED IN 15 SECONDS". of the doors equipped with s shall be provided with in accordance with 7.9. ice could affect at least 15	TAG		DATE

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PRINTED: 02/28/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155290 B. WING 01/31/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 ARMORY RD ST ELIZABETH HEALTHCARE CENTER **DELPHI. IN 46923** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)K 0293 **NFPA 101** SS=E Exit Signage Bldg. 01 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility K 0293 The Director of Plant Operations 02/02/2023 failed to ensure 1 of 1 door on the 500 Hall to the placed NO EXIT signage to the outside of the facility was not mistaken as a door on the 500 hall leading to the facility exit. LSC 7.10.8.3.1 states any door, courtyard. passage, or stairway that is neither an exit nor a The Director of Plant Operations way of exit access and that is located or arranged was educated by the Executive so that it is likely to be mistaken for an exit shall Director on NFPA 101, Exit be identified by a sign that reads as follows: NO Signage, 2012 Edition, LSC EXIT. The NO EXIT sign shall have the word NO 7.10.8.3.1 in letters 2 inches high, with a stroke width of The Director of Plant Operations or 3/8ths inch, and the word EXIT below the word designee will audit the door

Findings include:

Based on observations made with the Director of Plant Operations during a tour of the facility at 1:42 p.m. on 01/31/23, the 500 Hall door to the courtyard was not posted with an EXIT sign or a NO EXIT sign. Based on an interview at the time

NO, unless such sign is an approved existing

sign. This deficient practice could affect 14

residents, 4 staff, and 2 visitors.

the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.

This deficient practice could affect

located on the 500 hall leading to

the courtyard for proper NO EXIT

signage 1 X per week X 8 weeks. Results of this audit will be

presented by Executive Director to

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155290	B. W	ING		01/31/	2023
	ROVIDER OR SUPPLIER			701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, IN 46923		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Operations stated th not an exit to the pu to get the signage th door. The signage w and the deficiency v exiting of the facilit	the Director of Plant at the door to the courtyard is blic way and went to his office at had been ordered for the vas then placed on the door, vas removed prior to my y for this survey.			14 residents, 4 staff, and 2visi	tors.	
K 0321	3.1-19(b) NFPA 101						
K 0321 SS=E Bldg. 01	Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-ho (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a do not exceed 48 if the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.					
	b. Laundries (large c. Repair, Mainten	Fired Heater Rooms er than 100 square feet) nance, and Paint Shops noms (exceeding 64					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	I	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE COMPL	
71.D I DAIN	o. condensity	155290	B. W	ING		01/31/	
	PROVIDER OR SUPPLIEF			701 AR	ADDRESS, CITY, STATE, ZIP COD		
ST ELIZA	ABETH HEALTHCA	RE CENTER		DELPH	I, IN 46923		
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
K 0324	(over 50 square feg. Laboratories (if Hazard - see K32 Based on observation failed to ensure the storage area, a storage root automatical frame. This deficien as 30 residents, 6 st dining area. Findings include: Based on observation Plant Operations du 1:42 p.m. on 01/31/kitchen storage root approximately 180 contain a self-closid was a set of double only had a manual being used for storage sand paper gool latch and a self-closid was acknowledged Operations at the time exit conference with Facility Support Di Operations on 01/3	classified as Severe 2) on and interview, the facility corridor door to 1 of 1 kitchen age room of combustible uare feet in size, was provided device which would cause the ly close and latch into the door at practice could affect as many aff, and 4 visitors in the main ons made with the Director of aring a tour of the facility at 23, the corridor door to the m, a room that measured square feet in size, did not age device. Furthermore, this doors and the second door latching device. This room was age of cardboard boxes, paper ds. The lack of an automatic sing device for these doors by the Director of Plant me of observation. During the the the facility Administrator, the rector, and the Director of Plant 1/23 at 3:30 p.m. no additional ence could be provided	K 0	321	The Director of Plant Operation will install self-closing device to the kitchen door. The Director of Plant Operation was Educated by the Executive Director on NFPA 101 — Hazardous — Areas — Enclose storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automaticall close and latch into the door frame. The Director of Plant Operation designee will audit the door located in the kitchen for propoperation of the self-closing deand for proper latching into the frame 1 X per week X 8 weeks Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieved This deficient practice could at 30 residents, 6 staff, and 4 visitors.	ons re d. A n dd y ns or er evice es s. or to r le eam d.	02/17/2023
SS=E	Cooking Facilities						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	l í	JILDING	01	COMPI	
		155290	B. W	ING		01/31	/2023
NAME OF P	ROVIDER OR SUPPLIER	,	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					MORY RD		
ST ELIZA	ABETH HEALTHCA	RE CENTER		DELPHI, IN 46923			
(X4) ID	SUMMARY	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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Cooking Facilities						
	Cooking equipmen	•					
		NFPA 96, Standard for					
		l and Fire Protection of					
		ing Operations, unless:					
		ng equipment (i.e., small					
		is microwaves, hot plates,					
	,	I for food warming or limited					
	-	ance with 18.3.2.5.2,					
	19.3.2.5.2						
	_	open to the corridor in					
	•	ents with 30 or fewer					
		rith the conditions under					
	18.3.2.5.3, 19.3.2.						
	_	in smoke compartments					
	·	atients comply with 18.3.2.5.4, 19.3.2.5.4.					
		protected according to					
		3 are not required to be					
	•	rdous areas, but shall not					
	be open to the cor						
	•	n 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5						
	•	on and interview, the facility	K 0	324	The Director of Plant Operation	ns	02/17/2023
		kitchen hood exhaust system	100	J	contacted North Mechanical to		02/17/2023
		coverage for equipment that			re-arrange the steamer and th		
		len vapors. This deficient			deep fat fryer, providing fire		
		et as many as 30 residents, 5			suppression cover to the deep	o fat	
	staff, and 2 visitors.				fryer.		
					The Director of Plant Operation	ns	
	Findings include:				and Director of Food Services	was	
					Educated by the Executive		
		ons made with the Director of			Director on NFPA 101, Cookir	ng	
	•	ring a tour of the facility at			Facilities. The kitchen hood		
	•	23, the deep fat fryer was not			exhaust system provides		
		ne hood system and the hood			complete coverage for equipm	nent	
		I the grease laden vapors as			that produces grease-laden		
		rail going up the wall as well as			vapors.		
	-	p of the streamer sitting next to			The Director of Plant Operation		
	it. Based on intervi	ew at the time of observation,			designee will audit the deep fa	at	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155290		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/31/2023			
	PROVIDER OR SUPPLIER			701 AR	DDRESS, CITY, STATE, ZIP COD MORY RD , IN 46923		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	the grease and state the cooking equipm under the hood. Due the facility Administ Director, and the Di 01/31/23 at 3:30 p.r.	t Operations acknowledged d that he would reposition all tent so that it was centered ring the exit conference with strator, the Facility Support frector of Plant Operations on m. no additional information or provided contrary to this			fryer for proper alignment to the kitchen hood exhaust system, providing coverage from the firsuppression system. Results of this audit will be presented by Executive Direction the QAPI committee for further recommendations and continuuntil the Quality Assurance Teachermines substantial compliance has been achieved This deficient practice could af 30 residents, 5 staff, and 2 visitors.	or to r e am	
K 0345 SS=C Bldg. 01	in accordance with complying with the National Electric C National Fire Alarn Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on observation failed to maintain that it had accurate accordance with the 2012 edition, Section 2010 edition 2010 edition, Section 2010 edition 2010	m is tested and maintained an approved program requirements of NFPA 70, Code, and NFPA 72, an and Signaling Code. In acceptance, maintenance adily available. FPA 70, NFPA 72 and interview, the facility refire alarm system to assure time and date information in requirements of NFPA 101-ons 19.3.4 and 9.6 and NFPA 72 ions 14.1, 14.1.1. This deficient tall residents, staff, and	K 03	45	During the time of the survey to campuses vendor for Fire Alar Inspections contractor was on-site and was able to make adjustment to the date and time the Fire Alarm Control Panel. The Director of Plant Operation was educated by the Executive Director on NFPA 101, 2012 edition, 19.3.4 and NFPA 72.2 edition, 14.1, 14.1.1	m e to ns e 2010	02/02/2023
	-	ons made with the Director of			edition, 19.3.4 and NFPA 72. 2		

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	T OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED 01/31/2023			
	PROVIDER OR SUPPLIER			701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, 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)	ΓE	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 01	Plant Operations du 2:19 p.m. on 01/31/ alarm control panel vendor happened to observation, and the re-calibrated to be e deficiency was disc the time of observat Operations indicate discrepancy stated a conducted, he would the date on the fire a correct. This deficie exiting of the facilit 3.1-19(b) NFPA 101 Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAF coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record rev	ring a tour of the facility at 23, the time and date on the fire were incorrect. The facility be on-site at the time of this etime and date were correct as soon as the overed. Based on interview at cion, the Director of Plant d he was unaware of the as inspections were d make sure that the time and calarm control panel stayed ency was removed prior to my y for this survey. - Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, citing are maintained in a red readily available. system last checked - System test - Supply source - RKS information on non-required or partial ar system.	K 0:		designee will audit Fire Alarm Control Panel. Once per week weeks. Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continu until the Quality Assurance Te determines substantial compliance has been achieved. This deficient practice could at 30 residents, 5 staff, and 2 visitors. The Director of Plant Operation has had the Sprinkler System.	or to re am d. ffect	02/02/2023

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155290		A. BUILDING B. WING	01	COMPLETED 01/31/2023
	PROVIDER OR SUPPLIER ABETH HEALTHCAI		701 AR	ADDRESS, CITY, STATE, ZIP COD RMORY RD II, 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
	been inspected and 4.6.12.1 requires and required for complia maintained in accorrequirements. Sprin maintained in accord for the Inspection, T Water-Based Fire P. 4.3.1 requires record inspections, tests, ar components and sha authority having jur requires that records performed (e.g., insy the organization that results, and the date waterflow alarm deviguarterly to verify the damage. NFPA 25, waterflow alarm deviguarterly to verify the damage. NFPA 25, waterflow alarm deviguarterly to verify the standard device, water motor gong 5.3.3.2 requires vans witch-type waterflow alarm deviguarterly to verify the standard devices and the support of the standard devices and the support available for November, and Decinterview at the time Support Director standard during that	tested for 1 of 4 quarters. LSC y device, equipment or system ance with this Code be dance with applicable NFPA akler systems shall be properly dance with NFPA 25, Standard resting, and Maintenance of rotection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the isdiction upon request. 4.3.2 a shall indicate the procedure prection, test, or maintenance), at performed the work, the .NFPA 25, 5.2.5 requires that vices shall be inspected new are free of physical 5.3.3.1 requires the mechanical vices including, but not limited gs, shall be tested quarterly. This deficient practice could staff, and visitors in the siew of the quarterly sprinkler ecords with the Director of 11:42 a.m. on 01/31/23, there sinkler system inspection the fourth quarter (October, the fourth quart		inspected by an outside contracted. The Director of Plant Operation was educated by the Executive Director on NFPA 25, Standard the Inspection, Testing and Maintenance of water-based Protection Systems. Records system design, maintenance is secure location and readily available. The Executive Director or designee will audit Quarterly Sprinkler System Inspections. 6 Months Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieve This deficient practice could a all residents, staff, and visitors	ee de for

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155290		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/31/2023		
	PROVIDER OR SUPPLIER		701 AR	ADDRESS, CITY, STATE, ZIP COD RMORY RD II, 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)	(X5) COMPLETION DATE
K 0355 SS=B Bldg. 01	the facility Adminis Director, and the Di 01/31/23 at 3:30 p.r evidence could be p deficient finding. 3.1-19(b) NFPA 101 Portable Fire Extir Portable Fire Extir Portable fire exting installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 1 of was installed in accordance with necessary accordance with service accordance with service in the service accordance with necessary accordance with necessar	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility for 1 portable fire extinguisher ordance with NFPA 10, le Fire Extinguishers, 2010 6.3 states Fire extinguishers sly located where they will be and immediately available in the erable they shall be located of travel, including exits from at practice could affect 16 and 2 visitors in the smoke ons during a tour of the facility Flant Operations, on 10/10/17 BC portable fire extinguisher lall corridor between resident on # 516 was obstructed by a on interview at the time of rector of Plant Operations	K 0355	The Director of Plant Operation has removed the Hoyer Lift, blocking the ABC Fire Extinguisher located on the 50 hall between room 514 and roo 516. The Director of Plant Operation was educated by the Executive Director NFPA 10, Standard for Portable Fire Extinguishers, 20 edition, 1-6.3. The Director of Plant Operation designee will audit all fire extinguishers to remain free of obstructions, allowing to be accessible and immediately available in the event of a fire. Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuantil the Quality Assurance Teadetermines substantial	0 pm ns e or 010 ns or

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155290	B. W	B. WING 01/		01/31/	2023
	ROVIDER OR SUPPLIER		•	701 AR	ADDRESS, CITY, STATE, ZIP COD MORY RD I, IN 46923		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID		RRECTION (X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	VIDER'S PLAN OF CORRECTION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
	extinguisher was ob	structed and moved the Hoyer			compliance has been achieved	d.	
	lift to a better location	on in the corridor. This			This deficient practice could at		
	deficiency was removed prior to my exiting of the				all 16 residents, 4 staff, and 2 visitors.		
	facility for this survey.						
	3.1-19(b)						
K 0511	NFPA 101						
SS=C	Utilities - Gas and	Electric					
Bldg. 01	Utilities - Gas and						
-	Equipment using g	gas or related gas piping					
	complies with NFF	PA 54, National Fuel Gas					
	Code, electrical wi	ring and equipment					
	complies with NFF	PA 70, National Electric					
		tallations can continue in					
	service provided n						
	18.5.1.1, 19.5.1.1,						
		on and interview the facility	K 0	511	The Executive Director has		02/16/2023
		the emergency generator had			obtained a Letter of Reliability	from	
		fuel in accordance with the			Nipsco.		
	-	PA 101 - 2012 edition, Section			The Director of Plant Operation		
		1 and NFPA 110, 2010 Edition, 1.3.1 states emergency			was educated by The Executive Director on NFPA 101 – 2012		
	generators shall be i	e ,			edition, 19.5.1.1, 19.1, 19.1.3.		
	-	dance with NFPA 110,			and NFPA 110, 2010 edition, 5		
		ency and Standby Power			LSC 9.1.3.1	J. 1.	
	_	on. Section 5.1.1 states the			The Executive Director or		
	-	urces shall be permitted to be			designee will audit the Emerge	encv	
		ncy power supply (EPS):			Operations Plan for Letter of	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	_	n products at atmospheric			Reliability 1 X per month X 12		
	pressure				months.		
	-	eum gas (liquid or vapor			Results of this audit will be		
	withdrawal)				presented by Executive Direct	or to	
	(3) Natural or synth	etic gas			the QAPI committee for further	r	
	Exception: For Leve	el 1 installations in locations			recommendations and continu	е	
	-	y of interruption of off-site			until the Quality Assurance Te	am	
		, on-site storage of an			determines substantial		
		arce sufficient to allow full			compliance has been achieved		
	-	to be delivered for the class			This deficient practice could at	fect	
	specified shall be re	quired, with the provision for			all occupants.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155290		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/31/2023			
	PROVIDER OR SUPPLIER			701 ARI	DDRESS, CITY, STATE, ZIP COD MORY RD , 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 B CROSS-REFERENCED TO THE APPROPE	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE COMPLETIO	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		from the primary energy source					
	to the alternate ener						
		ples of probability of					
	interruption could include the following: earthquake, flood damage, or a demonstrated						
	_	This deficient practice could					
	affect all residents.	This deficient practice could					
	affect aff festdents.						
	Findings include:						
	Based on record rev	view of the quarterly sprinkler					
		ecords with the Director of					
		11:34 a.m. on 01/31/23, the fuel					
		gency generator was					
	determined to be na	atural gas. Additionally, the					
	facility did have a l	etter from their natural gas					
	provider indicating	the natural gas was from a					
	reliable source, but	it was out of date being sent					
	on 05/04/2016. Thi	s finding was confirmed by the					
	Director of Plant or	perations at the time of					
	discovery. Who sta	ted that the inspection had					
		would be completed within					
	the next two weeks	. During the exit conference					
		ministrator, the Facility					
		nd the Director of Plant					
	_	1/23 at 3:30 p.m. no additional					
		ence could be provided					
	contrary to this defi	icient finding.					
	3.1-19(b)						
K 0522	NFPA 101						
SS=E	HVAC - Any Heat	ina Device					
Bldg. 01	HVAC - Any Heat						
O -		e, other than a central					
		esigned and installed so					
		rials cannot be ignited by					
		safety feature to stop fuel					
		uipment if there is					
	I	ature or ignition failure. If					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155290	B. W	B. WING0		01/31/	/2023	
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			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE	
	fuel fired, the devi	ce also:						
	* is chimney or ve	nt connected.						
	* takes air for com	bustion from outside.						
	* provides for a co	mbustion system separate						
	from occupied are 19.5.2.2	a atmosphere.						
		on and interview, the facility	K 0	522	The Director of Plant Operation	ns	02/02/2023	
		f 1 furnace room was provided			removed the block of foam blocking the outside air source for		22. 32. 2323	
		tion air from the outside for						
		iel fired equipment. This			the fuel fired furnace.			
		ould create an atmosphere rich			The Director of Plant Operatio	ns		
	with carbon monox	ide which could cause physical			was educated by the executive			
	problems for all stat	ff in the laundry room.			Director on NFPA 101, 19.5.2	.2		
	Findings include:	·			The Director of Plant Operation designee will audit the fuel fire furnace located in furnace roo	ns or ed		
	Based on observation	ons during a tour of the facility			remain free of blockage of out	side		
	with the Director of	Plant Operations, on 10/10/17			air.			
	at 2:12 p.m. the furn	nace room located in the			Results of this audit will be			
	Director of Plant Op	perations office had a fuel fired			presented by Executive Direct	or to		
	furnace in it. When	checked, this furnace room did			the QAPI committee for furthe	r		
		air source provided as it was			recommendations and continu	ıe		
		n. Based on interview at the			until the Quality Assurance Te	am		
		tion, the Director of Plant			determines substantial			
	_	ledged the foam as blocking			compliance has been achieve	d.		
		ce and removed it removing			This deficient practice could			
		deficiency was removed prior			create an atmosphere rich in			
	to my exiting of the	facility for this survey.			carbon monoxide which could			
					cause physical problems for a	II		
	3.1-19(b)				staff in the laundry room.			
K 0000								
Bldg. 02								
	A Life Safety Code	Recertification and State	K 0	000	The submission of this plan of	:		
		vas conducted by the Indiana			correction does not indicate a			
	-	th in accordance with 42 CFR			admission by St. Elizabeth He			
	483.90(a).				Campus that the findings and			
	. ,				allegations contained herein a	re		
	Survey Date: 01/31	/23			accurate, true representation			

					1		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED		
155290		B. WING		01/31/2023			
		.00200			0 1/0 1/2020		
NAME OF I	DRUAIDER UD GHDDI IEI	3		ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER			701 AF	RMORY RD			
ST ELIZABETH HEALTHCARE CENTER			DELPH	H, IN 46923			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	`		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	IAG				
		2242		the quality of care provided, a			
	Facility Number: 0			the living environment provide			
	Provider Number:	155290		the residents of St. Elizabeth			
	AIM Number: 100	267300		Health campus. The facility			
			1	recognizes its obligation to pr	rovide		
	At this Life Safety	Code survey, St. Elizabeth	1	legally and medically necess	necessary		
	-	was found not in compliance	1	care and services to its reside	- I		
	with Requirements	-	1	in an economic and efficient			
	_	, 42 CFR Subpart 483.90(a),	1	manner. The facility hereby			
				maintains it is in substantial			
	Life Safety from Fire, and the 2012 edition of the						
National Fire Protection Association (NFPA) 101,				compliance with all state and			
Life Safety Code (LSC), Chapter 19, Existing				federal requirements governing the			
	Health Care Occupancies and 410 IAC 16.2. The			management of this facility.			
	500 wing, a 2018 addition, was surveyed under			thus submitted as a matter of	Ī		
	LSC Chapter 18, N	ew Health Care Occupancies.		statute only. The facility			
				respectfully requests desk re-	view		
	This one-story facil	ity was determined to be of		or substantial compliance.			
	Type V (111) const	ruction and was fully					
	sprinklered. The fac	cility has a fire alarm system	1				
	with smoke detection in the corridors, spaces		1				
	open to the corridors and hard-wired smoke		1				
	detectors in all resident sleeping rooms. The		1				
	Healthcare Center is connected to an Assisted		1				
		Board and Care occupancy,	1				
	<u> </u>	parated by a Fire Wall with a	1				
		•	1				
		nce Rating. The building is	1				
		135-kW diesel-powered	1				
	~	lity has a capacity of 64 and	1				
	had a census of 54	at the time of this survey.					
		idents have customary access	1				
	_	ll areas providing facility	1				
	services were sprin	klered except two detached	1				
	garages and two de	tached storage sheds which	1				
	were not sprinklere	2	1				
	·						
	Quality Review cor	mpleted on 02/06/23					

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