STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155290	A. BUILDING -- B. WING	01/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/31/23 Facility Number: 000187 Provider Number: 155290 AIM Number: 100267300 At this Emergency Preparedness survey, St. Elizabeth Healthcare Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 64 certified beds. At the time of the survey, the census was 54. Quality Review completed on 02/06/23	E 0000	The submission of this plan of correction does not indicate any admission by St. Elizabeth Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of St. Elizabeth Health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance.	
E 0007 SS=C Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3) EP Program Patient Population §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.73(a)(3). This deficient practice could affect all occupants. Findings include:	E 0007	The Executive Director has updated the Emergency Operations Plan and is addressing resident population, including, but not limited to, persons at risk; the type of services that St. Elizabeth Health Campus has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	02/02/2023

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	During record review with the Director of Plant Operations from 09:38 a.m. to 10:59 a.m. on 01/31/23, no documentation could be provided ensuring the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. Based on an interview at the time of record review, the Director of Plant Operations acknowledged he was unable to provide policies regarding the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding.		The Executive Director was educated by Facilities Management Support on E007 – EP Program Patient population. The Executive Director will audit the Emergency Operations Plan for EP Program Patient Population 1 X per month X 12 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants.	
E 0022 SS=C Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), 483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: During record review with the Director of Plant Operations from 09:38 a.m. to 10:59 a.m. on 01/31/23, no documentation could be provided ensuring the emergency preparedness plan addressed sheltering in place. Based on interview at the same time as record review the Director of Plant Operations agreed that the emergency preparedness plan did not address a plan, a policy, or a procedure for sheltering in place for	E 0022	The Executive Director has updated the Emergency Operations Plan to address Shelter in Place. The Executive Director was educated by Facilities Management Support on E022 – Policies/Procedures for Sheltering in Place. The Executive Director or designee will audit the Emergency Operations Plan for Sheltering in Place 1 X per month X 12 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial	02/02/2023

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	the facility. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding.		compliance has been achieved. This deficient practice could affect all occupants.	
E 0024 SS=C Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or 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.			

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	*[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. *[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 failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: During record review with the Director of Plant Operations from 09:38 a.m. to 10:59 a.m. on 01/31/23, no documentation could be provided ensuring the emergency preparedness plan addressed the use of volunteers in an emergency. Based on interview at the time of records review, the Director of Plant Operations searched through the plan and agreed that the plan did not address the use of volunteers in an emergency. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided	E 0024	The Executive Director has updated the Emergency Operations Plan and is addressing the use of volunteers in an emergency or other emergency staffing. The Executive Director was educated by Facilities Management Support on E024 – Policies/Procedures – Volunteers and Staffing The Executive Director or designee will audit the Emergency Operations Plan for Volunteers and Staffing 1 X per month X 12 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants.	02/02/2023

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	contrary to this deficient finding.			
E 0034 SS=C Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident			

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	Command Center, or designee. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: During record review with the Director of Plant Operations from 09:38 a.m. to 10:59 a.m. on 01/31/23, the facility's emergency preparedness communication plan provided did not address a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee. Based on interview at the time of records review, the Director of Plant Operations agreed the plan did not address a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding.	E 0034	The Executive Director has updated the Emergency Operations Plan to include in the communication plan a means of providing information about the Campuses occupancy, needs and it ability to provide assistance, the AHJ or the Incident Command Center, or designee. The Executive Director was educated by Facilities Management Support on E034 – Information on Occupancy/Needs The Executive Director or designee will audit the Emergency Operations Plan for Information on Occupancy/Needs 1 X per month X 12 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants.	02/02/2023
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of			

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	this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.			

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	*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.			

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	(viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: During record review with the Director of Plant Operations at 9:18 a.m. on 01/31/23, the Letter of Reliability provided for the facility's natural gas generator was dated May 4th, 2016 and was very outdated. Based on interview at the time of record review, the Director of Plant Operations stated that he did not know he needed to update the facility's letter or reliability as least every other year. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding.	E 0041	The Executive Director has obtained a Letter of Reliability from Nipsco. The Executive Director was educated by Facilities Management Support on E041 - LTC Emergency Power The Executive Director or designee will audit the Emergency Operations Plan for Letter of Reliability 1 X per month X 12 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants.	02/16/2023
K 0000 Bldg. 01				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/31/23 Facility Number: 000187 Provider Number: 155290 AIM Number: 100267300 At this Life Safety Code survey, St. Elizabeth Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The 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 diesel-powered generator. The facility has a capacity of 64 and had a census of 54 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	K 0000	The submission of this plan of correction does not indicate any admission by St. Elizabeth Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of St. Elizabeth Health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance.	

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	155290	A. BUILDING 01 B. WING	01/31/2023

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	were not sprinklered. Quality Review completed on 02/06/23			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of 4 corridors or met an exception per 19.2.3.4(5) LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised	K 0232	The Director of Plant Operations 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 egress. The Director of Plant Operations was educated by the Executive Director on NFPA 101, 2012 Aisle, Corridor, or Ramp Width. The width of aisles or corridors serving as an exit access shall be at least 4 feet and maintained to provide the convenient removal of non-ambulatory patients on stretchers. The Director of Plant Operations or designee will audit corridor ensuring that the width of the corridor is maintained meeting the requirements of NFPA 101, 2012 Aisle, Corridor, or Ramp Width. 1 x daily X 4 weeks. Results of this audit will be	02/02/2023

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	automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8 This deficient practice could affect 18 residents, 4 staff, and 2 visitors if needing to exit the facility. Findings include: Based on observations made with the Director of Plant Operations during a tour of the facility at 2:10 p.m. on 01/31/23, the overflow unit corridor had a desk placed in it for nurses to use as a nurse's station. This desk projected out into the corridor reducing the clear width therein. Furthermore there was a Hoyer lift directly across the hall from this desk that reduced the clear width of the corridor to less than 44 inches. Based on interview at the time of the observation, the Director of Plant Operations confirmed furniture was stored in the aforementioned corridor which were not affixed to the floor or to the wall and reduced the clear width of the corridor to less than 44 inches. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 18 residents, 4 staff, and 2 visitors if needing to exit the building.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with			

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	7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.1 Delayed-Egress Locking Systems allows approved, listed, delayed-egress locks shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (1) The door leaves shall unlock in the direction of egress upon activation of one of the following: (a) Approved, supervised automatic sprinkler system installed in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detections system in accordance with section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3) An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of	K 0271	The Director of Plant Operations has repaired the delayed egress lock at the main dining room. The Director of Plant Operations was educated by the Executive Director on NFPA 101, 2012 Delayed -Egress Locking System, LSC 7.2.1.6.1.1 The Director of Plant Operations or designee will audit the delayed-egress lock located in the main dining room for proper function 1 X per week X 8 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 15 residents, staff, and visitors.	02/01/2023

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	the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4) A readily visible, durable sign in letters not less than 1 in. (25mm) high and at least 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". (5) The egress side of the doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with 7.9. This deficient practice could affect at least 15 residents, staff, and visitors. Findings include: Based on observations made on 01/31/23 with the Director of Plant Operations during the tour at 2:29 p.m., the main dining area was provided with delayed egress lock and was provided with the proper signage indicating the doors can be opened in 15 seconds by pushing on the door, however, when the doors were pushed, the irreversible process to release the lock was not initiated. This was acknowledged by the Maintenance Director at the time of observations. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at			

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	3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage 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 failed to ensure 1 of 1 door on the 500 Hall to the outside of the facility was not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 14 residents, 4 staff, and 2 visitors. 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	K 0293	The Director of Plant Operations placed NO EXIT signage to the door on the 500 hall leading to the courtyard. The Director of Plant Operations was educated by the Executive Director on NFPA 101, Exit Signage, 2012 Edition, LSC 7.10.8.3.1 The Director of Plant Operations or designee will audit the door 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 the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect	02/02/2023

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	of the observations, the Director of Plant Operations stated that the door to the courtyard is not an exit to the public way and went to his office to get the signage that had been ordered for the door. The signage was then placed on the door, and the deficiency was removed prior to my exiting of the facility for this survey. 3.1-19(b)		14 residents, 4 staff, and 2visitors.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms			

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	(exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 kitchen storage area, a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect as many as 30 residents, 6 staff, and 4 visitors in the main dining area. 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 corridor door to the kitchen storage room, a room that measured approximately 180 square feet in size, did not contain a self-closing device. Furthermore, this was a set of double doors and the second door only had a manual latching device. This room was being used for storage of cardboard boxes, paper cups and paper goods. The lack of an automatic latch and a self-closing device for these doors was acknowledged by the Director of Plant Operations at the time of observation. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)	K 0321	The Director of Plant Operations will install self-closing device to the kitchen door. The Director of Plant Operations was Educated by the Executive Director on NFPA 101 – Hazardous – Areas – Enclosed. A storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. The Director of Plant Operations or designee will audit the door located in the kitchen for proper operation of the self-closing device and for proper latching into the frame 1 X per week X 8 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 30 residents, 6 staff, and 4 visitors.	02/17/2023
K 0324 SS=E	NFPA 101 Cooking Facilities			

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Bldg. 01	Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed ensure 1 of 1 kitchen hood exhaust system provided complete coverage for equipment that produces grease-laden vapors. This deficient practice could affect as many as 30 residents, 5 staff, and 2 visitors. Findings include: Based on observations made with the Director of Plant Operations during a tour of the facility at 2:33 p.m. on 01/31/23, the deep fat fryer was not completely under the hood system and the hood was not catching all the grease laden vapors as they was a grease trail going up the wall as well as collecting on the top of the streamer sitting next to it. Based on interview at the time of observation,	K 0324	The Director of Plant Operations contacted North Mechanical to re-arrange the steamer and the deep fat fryer, providing fire suppression cover to the deep fat fryer. The Director of Plant Operations and Director of Food Services was Educated by the Executive Director on NFPA 101, Cooking Facilities. The kitchen hood exhaust system provides complete coverage for equipment that produces grease-laden vapors. The Director of Plant Operations or designee will audit the deep fat	02/17/2023

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	the Director of Plant Operations acknowledged the grease and stated that he would reposition all the cooking equipment so that it was centered under the hood. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		fryer for proper alignment to the kitchen hood exhaust system, providing coverage from the fire suppression system. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 30 residents, 5 staff, and 2 visitors.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations made with the Director of	K 0345	During the time of the survey the campuses vendor for Fire Alarm Inspections contractor was on-site and was able to make adjustment to the date and time to the Fire Alarm Control Panel. The Director of Plant Operations was educated by the Executive Director on NFPA 101, 2012 edition, 19.3.4 and NFPA 72. 2010 edition, 14.1, 14.1.1 The Director of Plant Operations or	02/02/2023

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	Plant Operations during a tour of the facility at 2:19 p.m. on 01/31/23, the time and date on the fire alarm control panel were incorrect. The facility vendor happened to be on-site at the time of this observation, and the time and date were re-calibrated to be correct as soon as the deficiency was discovered. Based on interview at the time of observation, the Director of Plant Operations indicated he was unaware of the discrepancy stated as inspections were conducted, he would make sure that the time and the date on the fire alarm control panel stayed correct. This deficiency was removed prior to my exiting of the facility for this survey. 3.1-19(b)		designee will audit Fire Alarm Control Panel. Once per week X 6 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 30 residents, 5 staff, and 2 visitors.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to provide written documentation or other	K 0353	The Director of Plant Operation has had the Sprinkler System	02/02/2023

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	evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review of the quarterly sprinkler system inspection records with the Director of Plant Operations at 11:42 a.m. on 01/31/23, there was no quarterly sprinkler system inspection report available for the fourth quarter (October, November, and December) of 2022. During an interview at the time of record review, the Facility Support Director stated that the facility changed vendors during that time period, and the new vendor could not schedule an inspection until the		inspected by an outside contracted. The Director of Plant Operations was educated by the Executive Director on NFPA 25, Standard for the Inspection, Testing and Maintenance of water-based Protection Systems. Records of system design, maintenance in a secure location and readily available. The Executive Director or designee will audit Quarterly Sprinkler System Inspections. 1 X 6 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff, and visitors.	

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	155290	A. BUILDING 01 B. WING	01/31/2023

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	following quarter. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0355 SS=B Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguisher was installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice could affect 16 residents, 4 staff, and 2 visitors in the smoke compartment. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations, on 10/10/17 at 2:12 p.m., the ABC portable fire extinguisher located in the 500 Hall corridor between resident room #514 and room # 516 was obstructed by a Hoyer lift. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned fire	K 0355	The Director of Plant Operations has removed the Hoyer Lift, blocking the ABC Fire Extinguisher located on the 500 hall between room 514 and room 516. The Director of Plant Operations was educated by the Executive Director NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, 1-6.3. The Director of Plant Operations or 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 to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial	02/02/2023

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	extinguisher was obstructed and moved the Hoyer lift to a better location in the corridor. This deficiency was removed prior to my exiting of the facility for this survey. 3.1-19(b)		compliance has been achieved. This deficient practice could affect all 16 residents, 4 staff, and 2 visitors.	
K 0511 SS=C Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for	K 0511	The Executive Director has obtained a Letter of Reliability from Nipsco. The Director of Plant Operations was educated by The Executive Director on NFPA 101 – 2012 edition, 19.5.1.1, 19.1, 19.1.3.1 and NFPA 110, 2010 edition, 5.1. LSC 9.1.3.1 The Executive Director or designee will audit the Emergency Operations Plan for Letter of Reliability 1 X per month X 12 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants.	02/16/2023

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	automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could affect all residents. Findings include: Based on record review of the quarterly sprinkler system inspection records with the Director of Plant Operations at 11:34 a.m. on 01/31/23, the fuel source for the emergency generator was determined to be natural gas. Additionally, the facility did have a letter 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. This finding was confirmed by the Director of Plant operations at the time of discovery. Who stated that the inspection had been scheduled and would be completed within the next two weeks. During the exit conference with the facility Administrator, the Facility Support Director, and the Director of Plant Operations on 01/31/23 at 3:30 p.m. no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If			

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	fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 furnace room was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations, on 10/10/17 at 2:12 p.m. the furnace room located in the Director of Plant Operations office had a fuel fired furnace in it. When checked, this furnace room did not have an outside air source provided as it was blocked off by foam. Based on interview at the time of the observation, the Director of Plant Operations acknowledged the foam as blocking the outside air source and removed it removing the deficiency. This deficiency was removed prior to my exiting of the facility for this survey. 3.1-19(b)	K 0522	The Director of Plant Operations removed the block of foam blocking the outside air source for the fuel fired furnace. The Director of Plant Operations was educated by the executive Director on NFPA 101, 19.5.2.2 The Director of Plant Operations or designee will audit the fuel fired furnace located in furnace room to remain free of blockage of outside air. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could create an atmosphere rich in carbon monoxide which could cause physical problems for all staff in the laundry room.	02/02/2023
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/31/23	K 0000	The submission of this plan of correction does not indicate any admission by St. Elizabeth Health Campus that the findings and allegations contained herein are accurate, true representation of	

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	Facility Number: 000187 Provider Number: 155290 AIM Number: 100267300 At this Life Safety Code survey, St. Elizabeth Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The 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 diesel-powered generator. The facility has a capacity of 64 and had a census of 54 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 02/06/23		the quality of care provided, and the living environment provided to the residents of St. Elizabeth Health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance.	