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	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Elizabeth Healthcare Center	701 Armory Rd Delphi, IN 46923

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 44598 Based on interview and record review, the facility failed to ensure resident council concerns and grievances were addressed and the resolutions to the concerns/grievances were documented in the meeting minutes for 4 of 12 months reviewed for resident council meeting minutes. (July 2023, January 2024, February 2024, March 2024. Finding includes: During the resident council meeting, on 4/17/24 at 10:00 a.m., the residents indicated the call lights continued to be an ongoing concern. The resident council meeting minutes were reviewed and indicated the following: a. On 7/14/23, there were concerns voiced with the call light response times. The resident council meeting minutes, dated 8/14/23, did not indicate the call light concerns from 7/14/23 were discussed and no resolution was included in the meeting minutes. b. On 1/15/24, there were concerns voiced about the call light response times at night being extended. c. On 2/19/24, there were concerns voiced about the call lights in the evening. The minutes did not include the call light concerns from 1/15/24 were reviewed or resolved. d. On 3/18/24, 1 of 2 residents indicated there were still concerns about the call lights. The minutes did not include the call light concerns from 2/19/24 were reviewed or resolved. e. On 4/15/24, the minutes did not include the call light concerns from 3/18/24 were reviewed or resolved. During an interview, on 4/17/24 at 10:09 a.m., Resident 28 indicated she had to put her call light on several occasions for her roommate. The call light would stay on for an hour or more. The call lights have continued to be an ongoing issue. During an interview, on 4/17/24 at 10:11 a.m., Resident 41 indicated the call lights would stay on for 30 minutes to 1 hour before they were answered. There were times the lights were not answered, and she would provide her own care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/17/24 at 10:20 a.m., Resident 3 indicated during several resident council meetings the call lights concerns were discussed. The resident considered his call light as his lifeline and there were times the staff would exit the room without making sure the call light was within his reach. During an interview, on 4/18/24 at 10:39 a.m., the Activity Director indicated she helped the residents fill out the grievances when they had a concern, and she did not know why the call light concerns had not been addressed. During an interview, on 4/18/24 at 3:10 p.m., the Director of Nursing Services (DNS) indicated she did not have documentation call light audits were completed. A current policy, titled Resident Council, dated 6/2/16 and received from Executive Director on 4/19/24 at 4:53 p.m., indicated .Patients are informed of council meetings and are encouraged to utilize the complaint resolution process .The group facilitator will determine the pervious of the concerns/recommendations voiced to determine appropriate follow-up. The group's grievances and recommendations will be brought to the attention of the Executive Director who will forward the concerns to the appropriate department leader for attention and response. Responses regarding resolutions will be documented, reviewed by the Executive Director, and kept with Resident Council minutes .Actions taken and/or considerations given to issues will be reported back to the Resident Council at the next meeting. A current policy, titled Your Rights and Protections as a Nursing Home Resident, not dated and received from Executive Director at entrance indicated .Make Complaints: You have the right to make a complaint to the staff of the nursing home, or any other person, without fear of punishment. The nursing home must address the issue promptly A current policy, titled Resident Concern Process, dated 11/13/19 and received from Executive Director on 4/19/24 at 4:59 p.m., indicated .To provide a process of handling, tracking and resolving customer concerns to provide excellence in customer service .The facility staff will follow these basic steps in responding to a complaint: Listen to the concern without interruption .Take steps to correct the problem. Make the problem their own by following up to make sure it is resolved and stays resolved .Concerns are reviewed in morning meeting, noting new entries and assigning them for follow up and resolution .The Executive Director will review and manage the follow up of the concerns .The QAPI team will review the trends of the concerns and the action plans to resolve concerns on a monthly basis 3.1-3(l)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 36454 Based on interview and record review, the facility failed to ensure the Notice of Medicare Non-Coverage was given 48 hours prior to the Medicare benefits ending date for 2 of 3 residents reviewed for beneficiary notices. (Resident 38 and 101) Findings include: 1. The Notice of Medicare Non-Coverage (NOMNC) for Resident 38 indicated the Medicare services would end on 3/13/24 and Medicare probably would not pay for Skilled Nursing and Therapy after 3/13/24. Resident 38 signed the NOMC on 3/12/24. This was only a 24-hour notice prior to the end of the Medicare covered services. 2. The NOMNC for Resident 101 indicated the Medicare services would end on 3/5/24 and Medicare would probably not pay for Skilled Nursing and Therapy after this date. Resident 101 signed the NOMNC on 3/4/24. This was only a 24-hour notice prior to the end of the Medicare covered services. During an interview, on 4/19/24 at 12:43 p.m., the Executive Director (ED) indicated the staff who completed the notices was out of the facility on leave and was not able to be interviewed. The ED did not know the reason the notices were only given with a 24-hour notice instead of the 48-hour notice required. A current policy, titled NOMNC Completion SOP [Standard Operating Procedure], dated last reviewed on 12/31/23 and received from the ED on 4/19/24, indicated .In order to streamline communication for completion of Notice of Medicare Non-Coverage [NOMNC] .this SOP outlines the expectations for completion .For residents being notified of discontinuation of their Medicare coverage, the NOMNC is required to be issued 2 calendar days prior to the actual discharge from Medicare 3.1-4(f)(3)

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	155290	A. Building B. Wing	04/19/2024

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 44598 Based on interview and record review, the facility failed to ensure a revised Preadmission Screen and Resident Review (PASARR) level I was completed after psychotropic medications were prescribed for 1 of 5 residents reviewed for PASARR. (Resident 40) Finding includes: The clinical record for Resident 40 was reviewed on 4/16/24 at 4:39 p.m. The diagnoses included, but were not limited to, depression, anxiety disorder, dementia, congestive heart failure, and hypertension. A PASARR level I, dated 3/1/24, indicated the resident did not require a level II. The PASARR level I indicated the resident was not taking any mental health medications and did not have a mental health diagnosis. The level I screen indicated if changes occurred or new information refuted these findings a new screen must be submitted. A physician's order, dated 3/27/24, indicated duloxetine delayed release (an antidepressant) 30 milligram (mg), give one capsule twice a day for depression. A care plan, dated 3/27/24, indicated the resident was at risk for developing adverse effects from the use of antidepressant medications. The approaches included, but were not limited to, administering medication per the physician's order. During an interview, on 4/18/24 at 3:34 p.m., the Executive Director indicated the Social Service Director was on vacation and she would have to look at the resident's PASARR information. During an interview, on 4/18/24 at 4:57 p.m., the Clinical Support Nurse indicated the level I was completed on 3/1/24 and the medication was not started until 3/27/24. The facility policy indicated the facility had a total of 14 days to complete a new PASARR level I and they were beyond 14 days. A new PASARR level I should have been completed. The facility did not have a PASARR policy. The facility used the Indiana PASARR Standard Operating Procedure Revenue [NAME] & Collections. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36454 Based on observation, interview and record review, the facility failed to assess and document the progress of a non-pressure skin wound, to assess and document the skin condition of a resident with a splint in place, to notify the physician when blood sugar readings were elevated, failed to follow the physician's orders for medications and to notify the physician per the physician's order for 5 of 5 residents reviewed for quality of care. (Resident 23, 37, 31, 29 and 16) Findings include: 1. During an observation, on 4/16/24 at 11:13 a.m., Resident 23 had a bandage on her right and left elbows and another bandage on her left forearm. She indicated the bandages on the elbows were used as a preventative. She had an area of open skin on the left forearm. The clinical record for Resident 23 was reviewed on 4/17/24 at 11:40 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, depression, chronic obstructive pulmonary disease, and congestive heart failure. A progress note, dated 2/25/24 at 7:33 p.m., indicated the resident had an open area on her left arm which measured 3.1 centimeter (cm) in length and 2 cm in width. A physician's order, dated 2/26/24, indicated to clean the left forearm skin tear with cleanser or normal saline, apply skin prep to the peri wound, apply aquacel AG (an antimicrobial wound dressing) to the wound bed and to cover with a foam dressing every 5 days. The electronic health record (EHR) had no documentation of the open skin area since 2/25/24. During an interview, on 4/17/24, the Director of Nursing Services (DNS) indicated the resident had a skin issue which was caused from a hospitalization . She was not sure if the EHR had any documentation about the skin area after the initial measurements were entered on 2/25/24. During an interview, on 4/19/24 at 2:41 p.m., the DNS indicated she measured the left forearm wound two days ago and put in a late note. The wound should have been assessed and measured weekly since 2/25/24 when it was identified, and it had not been measured. 2. During an observation, on 4/16/24 at 12:04 p.m., Resident 37 had a left hand/wrist splint device in place which was wrapped with an elastic bandage. The resident's left wrist, hand and fingers were swollen. The resident indicated she broke her hand, and it was hurting. During an observation, on 4/17/24 at 11:25 a.m., the resident's left hand and fingers remained swollen. The clinical record for Resident 37 was reviewed on 4/18/24 at 2:09 p.m. The diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance and hypertensive heart disease with heart failure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 4/8/24, indicated to monitor for blanching, color and odor related to the non-removable splint/cast three times a day. The electronic health record (EHR) did not have any documentation of edema for the resident's left wrist, hand, and fingers. During an interview, on 4/18/24 at 3:11 p.m., the Executive Director (ED) indicated the resident had self-ambulated in the hallway, had an unwitnessed fall, and sustained a fracture of the left radius (one of two bones of the forearm). During an interview, on 4/19/24 at 3:04 p.m., the DNS indicated the resident was followed by the orthopedic physician. She could not find documentation about the resident's swollen fingers and hand. The facility did not have any notes from the orthopedic physician. There was no care plan in place for the resident's fracture. During an observation with the DNS, on 4/19/24 at 3:27 p.m., the resident was lying in bed in her room. The resident's left hand and left fingers were very swollen. There was an open area on the left hand near the thumb which was about the size of a dime. The DNS indicated an edema event should have been initiated in the EHR and the open skin should have been measured and documented in the EHR. The DNS could not find any documentation in the EHR about the swelling. 49891 3a. The clinical record for Resident 31 was reviewed on 4/18/24 at 12:22 p.m. The diagnoses included, but were not limited to, pneumonia, type 2 diabetes mellitus, chronic anemia, dementia, pleural effusion, atelectasis (partial collapse or closure of part of the lung), and diastolic congestive heart failure. A care plan for Resident 31, dated 3/27/24, indicated the resident was at risk for hypo/hyperglycemia related to diabetes mellitus. A long-term goal indicated the resident would be free of symptoms of hypo/hyperglycemia through the next review. A physician's order, dated 3/8/24, indicated insulin Aspart U-100 per sliding scale and to call MD if blood sugar was greater than 400 mg/dL. A progress note, dated 3/8/24 at 5:20 p.m., indicated Resident 31 had a blood glucose level of 591 prior to dinner. The physician was called and gave a new order for NovoLog 6 units now and to recheck the blood glucose in 2 hours. If the repeat blood sugar was in normal range, the nurse did not need to call the provider. A vitals record, dated 3/8/24 at 4:49 p.m., indicated a blood sugar of 591 mg/dL. A vitals record, dated 3/8/24 at 7:52 p.m., indicated a blood sugar of 460 mg/dl. The listed acceptable (normal) range was 45-300 mg/dl. A vitals record dated 3/8/24 at 9:18 p.m. indicated a blood sugar of 460 mg/dl. The listed acceptable (normal) range was 45-300 mg/dl. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The electronic medical record did not contain any physician notifications for the repeat blood sugars. During an interview, on 4/18/24 at 1:30 p.m., the Clinical Support Nurse indicated the facility could not provide any documentation of the physician notification of the abnormal repeat blood sugars of 460 mg/dL. 3b. A physician's order, dated 2/29/24 and discontinued 3/8/24, indicated Novolin 70-30 FlexPen (insulin nph and regular human) give 8 units subcutaneous each morning and 3 units each evening. A physician's order, dated 3/8/24 and discontinued 3/19/24, indicated Levemir FlexPen (insulin detemir u-100) insulin pen give 10 units subcutaneous twice a day. The electronic medical record did not contain hold orders for the Novolin 70-30 or the Levemir. A vitals record, dated 3/7/24 at 10:57 a.m., indicated a blood sugar of 349 mg/dL. The acceptable range listed was 45-300 mg/dL. A vitals record, dated 3/7/24 at 4:38 p.m., indicated a blood sugar of 286 mg/dL. The Medication Administration Record (MAR) for Resident 31 indicated the Novolin 70-30 insulin was held on 3/7/24 in the morning and the evening due to poor intakes. The MAR for Resident 31 indicated the Novolin 70-30 insulin was held on 3/8/24 in the morning due to poor intakes. The electronic medical record did not contain any physician notifications for the held insulin. During an interview, on 4/19/24 at 12:02 p.m., LPN 1 indicated she was not sure when or if 70/30 or Levemir should be held if there was not a specific order. She would look it up with her resources or ask the physician before holding it. The physician should be notified if a medication was held. During an interview, on 4/18/24 at 1:30 p.m., the Clinical Support Nurse indicated the facility could not provide any documentation of the physician notification for the held insulin. The endocrinology textbook chapter by [NAME] J Rushakoff, MD in Inpatient Diabetes Management (01/07/19) from https://www.ncbi.nlm.nih.gov/books/NBK278972/, accessed on 04/19/24, indicated basal insulin, such as Novolin 70-30 and Levemir, was needed even when a patient was not eating. 4. The clinical record for Resident 29 was reviewed on 4/16/24 at 3:52 p.m. The diagnoses included, but were not limited to, type 2 diabetes with diabetic chronic kidney disease, acute kidney failure, and atrophy (wasting away) of the kidney. A physician's order, with a start date of 5/23/23 and an end date of 7/26/23, indicated the resident received insulin glargine (insulin which works over a longer period of time) 12 units before breakfast. Hold the insulin if the blood sugar was less than 150. Resident 29's MAR (Medication Administration Record) indicated the following blood sugars: (continued on next page)

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	155290	A. Building B. Wing	04/19/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 7/3/24, the blood sugar was 139. Insulin was administered. b. On 7/4/24, the blood sugar was 124. Insulin was administered. c. On 7/7/24, the blood sugar was 138. Insulin was administered. d. On 7/8/24, the blood sugar was 146. Insulin was administered. e. On 7/11/24, the blood sugar was 112. Insulin was administered. f. On 7/13/24, the blood sugar was 148. Insulin was administered. g. On 7/14/24, the blood sugar was 137. Insulin was administered. h. On 7/15/24, the blood sugar was 148. Insulin was administered. During an interview, on 4/18/24 at 10:47 a.m., the DHS (Director of Health Services) indicated they should not have administered the insulin. 5a. The clinical record for Resident 16 was reviewed on 4/17/24 at 9:42 a.m. The diagnoses included, but were not limited to, long term current use of insulin, bradycardia (slow heart rate), paroxysmal atrial fibrillation, ventricular premature depolarization, and type 2 diabetes mellitus. A physician's order, dated 7/9/21, indicated digoxin tablet (used to treat heart failure and heart rhythm problems), give 125 micrograms (mcg) every other day, with special instructions to hold the medication if her pulse was less than 60 and to notify the physician. The Medication Administration Record (MAR) indicated, on 3/19/24, Resident 16's pulse was 51 and the digoxin tablet was given. The MAR indicated, on 4/12/24, Resident 16's pulse was 56 and the digoxin tablet was given. The MAR indicated the digoxin was held due to a pulse rate less than 60 on 3/23/24, 3/31/24, and 4/14/24. The clinical record did not indicate the provider was notified of the pulse rate less than 60 or when the digoxin was given and not given according to the physician's order. During an interview, on 4/18/24 at 10:27 a.m., LPN 1 indicated staff would call or notify the physician in person for an abnormal vital sign, blood sugar, or if a medication was held. The staff should notify the provider as soon as they could. During an interview, on 4/18/24 at 1:30 p.m., the Clinical Support Nurse indicated the facility could not provide any documentation of the physician notification of the heart rate or the medication being held. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. A physician's order, dated 1/15/24, indicated insulin aspart U-100 insulin pen, give 5 units subcutaneous prior to meals, with special instructions to hold if the blood sugar was less than 110 mg/dL. The MAR, dated 3/19/24, indicated 5 units of insulin were given at breakfast with a blood sugar of 105 at 7:05 a.m. The MAR, dated 3/26/24, indicated 5 units of insulin were given at breakfast with a blood sugar of 83 at 7:17 a.m. The MAR, dated 3/27/24, indicated 5 units of insulin were given at breakfast with a blood sugar of 108 at 7:48 a.m. A current policy, titled Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines, dated as revised on 5/10/16 and received from the Executive Director on 4/19/24 at 4:00 p.m., indicated .One weekly follow-up assessment may be completed to ensure rash/lesion is resolved, healing, or becomes a chronic skin condition. If further follow-up is needed, documentation may be placed in a progress note A current policy, titled Medication Administration- General Guidelines, dated as revised on 11/2018 and received from the Clinical Support Nurse on 4/18/24 at 1:30 p.m., indicated .Medications are administered in accordance with written orders of the prescriber A current policy, titled Physician-Provider Notification Guidelines, dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 4/18/24 at 1:30 p.m., indicated .To ensure the resident's physician or practitioner .is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care Attempts to notify the physician/provider and their response should be documented in the resident electronic medical record 3.1-37(a)

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	155290	A. Building B. Wing	04/19/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 36454 Based on observation, interview and record review, the facility failed to ensure oxygen tubing was dated, oxygen canisters were filled, and the oxygen was set on the flow liter as ordered by the physician for 3 of 4 residents reviewed for respiratory care. (Resident 23, 31 and 20) Findings include: 1. During an observation, on 4/16/24 at 11:06 a.m., Resident 23's oxygen (02) was set at 3 liters per minute by nasal cannula and there was no date on the tubing. The resident indicated her 02 was supposed to be set at 3 liters per minute. During an interview, on 4/16/24 at 11:08 a.m., Qualified Medication Aide (QMA) 2 indicated the oxygen tubing was not dated. During an observation, on 4/18/24 at 3:31 p.m., with the Clinical Support Nurse, Resident 23's 02 was set at 1.5 liters. During an interview, on 4/18/24 at 4:02 p.m., the Clinical Support Nurse indicated the resident's 02 was to be set at 2 liters during the day and 3 liters at night. The 02 should have been set at 2 liters instead of the 1.5 liters or 3 liters. The clinical record for Resident 23 was reviewed on 4/17/24 at 11:40 a.m. The diagnoses included, but were not limited to, chronic congestive heart failure, chronic obstructive pulmonary disease, chronic respiratory failure, shortness of breath, sarcoidosis (an inflammatory disease which affects the lungs), cerebral infarction, and dependence on supplemental oxygen. A care plan, dated 3/26/24 and last reviewed on 4/16/24, indicated the resident had a potential for shortness of breath related to the chronic obstructive pulmonary disease and required supplemental oxygen to maintain 02 saturations. The approaches included, but were not limited to, administer 02 as ordered by the medical doctor. A care plan, dated 3/26/22 and last reviewed on 3/28/24, indicated the resident had a potential for complications related to congestive heart failure. The approaches included, but were not limited to, oxygen as ordered by the medical doctor. A physician's order, dated 1/19/23 and open ended, indicated to change the 02 tubing monthly on the first day of the month. A physician's order, dated 3/8/23 and open ended, indicated 02 at 3 liters during the night. A physician's order, dated 4/16/24 and open ended, indicated 02 at 2 liters per nasal cannula continuous. 49891 (continued on next page)

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	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation, on 4/15/24 at 12:45 p.m., Resident 31 was wearing oxygen tubing connected to an empty portable oxygen tank. During an interview, on 4/15/24 at 12:49 p.m., CNA 10 indicated the portable tank was empty and the resident relied on supplemental oxygen. CNA 10 indicated she would fill up the tank. During an observation, on 4/16/24 at 10:28 a.m., the portable oxygen tank for Resident 31 was empty and the flow rate dial was set on 2.5 liters while he was sitting in the activities room in his reclining wheelchair (Broda chair). The nurse was notified. LPN 9 took the portable oxygen tank off Resident 31's Broda chair and refilled tank. LPN 9 returned the refilled portable oxygen tank to Resident 31 and reconnected the oxygen tubing. The flow rate remained at 2.5 liters of oxygen. During an observation, on 4/16/24 at 3:53 p.m., the oxygen tubing was not dated, and the flow rate was set at 3 liters. During an observation, on 4/17/24 at 3:31 p.m., Resident 31 was in bed, the oxygen tubing was not dated, and the flow rate was set at just under 3 liters of oxygen. During an observation, on 4/18/24 at 10:07 a.m., Resident 31 was asleep in his Broda chair in the activities room with the portable oxygen tank dial set at a flow rate of 2.5 liters. During an observation, on 4/18/24 at 2:36 p.m., Resident 31 was asleep in his room with the oxygen set on a flow rate of 2.5 liters. The clinical record for Resident 31 was reviewed on 4/18/24 at 12:22 p.m. The diagnoses included, but were not limited to, pneumonia, type 2 diabetes mellitus, chronic anemia, dementia, pleural effusion, atelectasis (partial collapse or closure of part of the lung), and diastolic congestive heart failure. A physician's order, dated 3/26/24, indicated 2 liters of continuous oxygen. A care plan, dated 4/16/24, indicated the resident required supplemental oxygen to maintain oxygen saturation. Interventions included, but were not limited to, administering oxygen per the physician's order. During an interview, on 4/18/24 at 10:23 a.m., LPN 1 indicated Resident 31 was on 2 to 3 liters of oxygen, only the nurses were allowed to adjust the oxygen flow rate, and the rate was to be set on the flow rate ordered by the physician. 3. During an observation, on 4/16/24 at 10:04 a.m., Resident 20's oxygen was at a flow rate of 5 liters with extended tubing which was not labeled with a date. During an observation, on 4/16/24 at 4:15 p.m., Resident 20 was wearing oxygen at a flow rate of 4 liters via nasal canula tubing which was not labeled with a date. During an observation, on 4/17/24 at 10:10 a.m., Resident 20 was wearing oxygen at a flow rate of 5 liters. (continued on next page)

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	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 4/17/24 at 3:28 p.m., Resident 20 continued to wear oxygen at a flow rate of 5 liters. During an interview, on 4/17/24 at 10:10 a.m., Resident 20 indicated he would ask staff to turn up his oxygen when he was having trouble breathing, which happened a lot. The clinical record for Resident 20 was reviewed on 4/17/24 at 4:56 p.m. The diagnoses included, but were not limited to, type 2 diabetes, morbid obesity, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), paroxysmal atrial fibrillation, anxiety, cardiomegaly, dependence on continuous supplemental oxygen, pneumonia, pulmonary edema, and anemia. A profile care guide in the resident's care plan, dated 7/21/23, indicated an intervention of oxygen at 3 liters. A physician's order, dated 4/7/24, indicated 3 liters of continuous oxygen. During an interview, on 4/18/24 at 10:23 a.m., LPN 1 indicated Resident 20's oxygen order prior to his last hospital visit was for 3 to 5 liters for his comfort. LPN 1 indicated she did not realize it had changed to 3 liters. A current policy, titled Administration of Oxygen, dated as approved on 5/2018 and received from the Clinical Support Nurse on 4/18/24 at 1:30 p.m., indicated .Verify physician's order for the procedure .Date the tubing for the date it was initiated .Adjust the oxygen delivery device so that .the proper flow of oxygen is administered 3.1-47(a)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46961 Based on observation, interview and record review, the facility failed to ensure expired medications were removed from the medication cart and medications were labeled for 1 of 3 medication carts reviewed for medication storage. (500 back hall medication cart) Finding includes: During an observation, on 4/18/24 at 11:08 a.m., the 500 back hall medication cart had a partial bottle of Robitussin DM with an expiration date of 2/22/24, and a partial bottle of Geri tussin Liquid 100/5 with an expiration date of 3/18/24. The bottom drawer contained a partial bottle of Tums unlabeled, 2 tubes of Diclofenac sodium topical gel 1% unlabeled, and a partial bottle of Childrens Tylenol with a resident's name in marker and not labeled. During an interview, on 4/18/24 at 11:30 a.m., QMA 11 indicated she did not know what resident(s) were receiving the Tums and Diclofenac gel. The expired medications should have been removed. She took expired medications to the Director of Nursing Services for destruction. A current policy, titled Medication and Storage in the facility, received from the Clinical Support Nurse on 4/19/24 at 9:30 a.m., indicated .outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or with secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal A current policy, titled Medication Administration-General Guidelines, dated 11/2018 and received from the Clinical Support Nurse on 4/18/24 at 1:30 p.m., indicated .label, container and contents are checked for integrity, and compared against the medication administration record by reviewing the 5 rights .prior to administration of any medication, the medication and dosage schedule on the resident's medication administration record are compared with the medication label 3.1-25(l)(1) 3.1-25(o)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48525 Based on observation, interview and record review, the facility failed to ensure staff followed infection control standards related to handwashing during food service, following enhanced barrier precautions during wound care, during incontinence care, for urinary catheters, for storing linens and clothes in rooms, and disposing of soiled linens for 6 of 6 staff and 3 of 3 residents randomly observed for infection control practices. (Assistant Food Director, Guest Relations 5, Director of Health Services, RN 6, QMA 2, Resident 40, Resident 5, Resident 149 and CNA7) Findings include: 1. During an observation, on 4/15/24 at 12:12 p.m., the Assistant Food Director served a plate of food to a resident without washing his hands between serving plates. During an observation, on 4/15/24 at 12:15 p.m., the Assistant Food Director served a plate of food to a resident without washing his hands between serving plates. During an observation, on 4/15/24 at 12:17 p.m., the Assistant Food Director served a plate of food to a resident without washing his hands between serving plates. During an observation, on 4/15/24 at 12:21 p.m., the Assistant Food Director served a plate of food to a resident without washing his hands between serving plates. During an observation, on 4/18/24 at 12:19 p.m., Guest Relations 5 was waving her apron towards her face as a fan and scratched her arm while she was waiting to serve food. During an observation, on 4/18/24 at 12:23 p.m., Guest Relations 5 served a plate of food to a resident without washing her hands. During an interview, on 4/18/24 at 12:28 p.m., the Assistant Food Director indicated he did notice he was not washing his hands between serving plates and he should have been washing his hands. Staff should also not touch their arms or surfaces before delivering trays. 2. During an observation, on 4/18/24 at 2:43 p.m., the DHS (Director of Health Services) and RN 6 went to complete wound care for Resident 2 who had a stage 3 or 4 pressure wound, a urinary catheter, and was in enhanced barrier precautions. The DHS and RN 6 walked into the room and put on gloves. They completed wound care and then changed the resident's brief, handling the resident's catheter tubing in the process. The DHS and RN 6 did not have a gown on during wound care. The clinical record for Resident 2 was reviewed on 4/18/24 at 3:00 p.m. The diagnoses included, but were not limited to, stage 3 pressure ulcer of the left buttocks, unstageable pressure ulcer of the sacral region, paraplegia, and osteomyelitis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, with a start date of 4/1/24, indicated staff were to use enhanced barrier precautions, wearing gloves and a gown at a minimum during high-contact care activities. During an interview, on 4/18/24 at 3:06 p.m., the DHS indicated they should have put on gowns on for enhanced barrier precautions. 36454 3. During an observation of incontinence care for Resident 21, on 4/15/24 at 1:43 p.m., Qualified Medication Aide (QMA) 2 wiped the resident's peri-area with a disposable wipe. QMA 2 did not remove her gloves. She then pulled up the resident's blankets and tucked them in around her neck and chest area and handed the resident her touch pad call light. She had touched the blankets and the call light with the same gloves she used to wipe the resident's peri-area. During an interview, on 4/15/24 at 1:53 p.m., QMA 2 indicated she did not realize she had left the same gloves on and touched the resident's blankets and call light. The DNS was present and QMA 2 and the DNS walked away and did not go back into the resident's room to sanitize the touch pad call light. 44598 4. During an observation, on 4/15/24 at 11:32 a.m., Resident 40's catheter bag was laying on the floor. During an interview, on 4/15/24 at 11:38 a.m., the Executive Director indicated the catheter bag was not to be on the floor and she would get someone to assist the resident. 5. During an observation, on 4/15/24 at 11:49 a.m., Resident 5 had two pillows, a blanket, and one blue sock on the floor next to the bed. In the recliner next to the resident's bed, there were folded linen sheets, a quilt, a shirt, a gown, a blanket and two blue cushions. During an interview, on 4/15/24 at 11:54 a.m., CNA 8 indicated the pillows, the blanket, and the sock should not be on the floor and the other items should not be stored on the chair. 6. During an observation, on 4/15/24 at 11:58 a.m., Resident 149 had a soaked brief laying on the resident's bed. During an interview, on 4/15/24 at 11:47 a.m., the Minimum Data Set (MDS) Coordinator indicated she did not know why the brief was on the resident's bed. The resident was dependent on all incontinence care and the dirty brief should not have been left on the resident's bed. 7. During an observation, on 4/15/24 at 3:08 p.m., CNA 7 exited room [ROOM NUMBER] carrying a large amount of rolled up linen not in a bag down the 500 hall. The linen was touching the staff's left side while she carried the linen. CNA 7 then entered room [ROOM NUMBER] and left the room with the linen in a trash bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 4/15/24 at 3:10 p.m., CNA 7 indicated she had just finished changing a resident and forgot to put the linen in a trash bag and she probably should not be carrying dirty linens down the hall without being in a trash bag. A current policy, titled Enhanced Barrier Precautions (EBP) Standard Operating Procedure, dated as approved 4/1/24 and received from the Clinical Support Nurse on 4/18/24 at 5:00 p.m., indicated .Enhanced Barrier Precautions (EBP) will be in place during high-contact care activities for residents with the following conditions: a. Residents at an increased risk of MDRO acquisition which include i. All Residents with chronic wounds, including but not limited to, pressure ulcers .All residents with indwelling medical devices 1. Includes but not limited to: catheters .At minimum, staff shall wear gloves and gowns during high-contact care activities A current policy, titled Preserving Dignity with Indwelling Catheter, dated as revised 4/19/24 and received from the Executive Director on 4/19/24 at 4:55 p.m., indicated .Urinary drainage bags and catheter tubing should be kept from touching the floor surface A current policy, titled Guidelines for Handwashing/Hand Hygiene, dated as revised 2/9/17 and received from the Executive Director on 4/19/24 at 4:55 p.m., indicated .All health care workers shall utilize hand hygiene frequently and appropriately .Health Care Workers (HCW) shall utilize hand hygiene at times such as: Reporting to work; before/after eating .Before/after preparing/serving meals, drinks, tube feedings, etc . before/after having direct physical contact with residents .After removing gloves worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes A current policy, titled Perineal Care for Incontinence, dated as revised 11/9/17 and received from the Executive Director on 4/16/24 at 10:38 a.m., indicated .Residents may be cleaned using washcloths, wet wipes or dry wipes .Pay particular attention to infection prevention and control techniques when performing peri care, to prevent introduction of contamination that may lead to a urinary tract infection 3.1-18(b)(1) 3.1-18(l)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44598 Based on observation, interview and record review, the facility failed to ensure resident rooms and hallways were in good repair and rooms were free of odors for 5 of 28 rooms observed for environment on the 500 hall. (room [ROOM NUMBER], 512, 517, 518 and 519). Findings include: 1. During an observation, on 4/15/24 at 11:20 a.m., the doorway of room [ROOM NUMBER] was missing approximately 18 inches of carpet. The hall between rooms [ROOM NUMBERS] had two gold floor plates which were missing pieces of carpet around them. During an interview, on 4/15/24 at 3:37 p.m., the Maintenance Director indicated there were no purchase orders for the carpet in room [ROOM NUMBER] or the 500 hall. 2 During an observation, on 4/15/24 at 3:37 p.m., room [ROOM NUMBER]'s bed was very loud when moving up and down. During an interview, on 4/15/24 at 3:38 p.m., the Maintenance Support and the Maintenance Director indicated there were approximately 50 beds like room [ROOM NUMBER]'s bed. The Maintenance Support indicated the bed sounded like it was getting ready for take-off. The reason the bed made loud noises was the grease on the bottom of the bed frame dried. They would spray WD 40 (a type of lubricant) on the bed frame to correct the loud noise. The beds were old. The company who manufactured the beds was no longer in business. 3. During an observation, on 4/15/24 at 12:27 p.m., room [ROOM NUMBER], 518 and 519 had a strong urine odor. The odor was carried out into the hallway. During an interview, on 4/15/24 at 12:30 p.m., Certified Nursing Assistant (CNA) 8 indicated the 500 hall always had a strong odor. room [ROOM NUMBER] had a really bad smell, and they did not know why. During an interview, on 4/15/24 at 12:50 p.m., the Assistant Director of Nursing Services (ADNS) indicated she did not know what was being done about the strong odors on the 500 Hall. During an interview, on 4/15/24 at 3:41 p.m., the Maintenance Support indicated the facility changed all the exhaust fans in room [ROOM NUMBER] and there was still an odor. room [ROOM NUMBER] had a strong urine odor, and the facility thought it was because a resident used a urinal and would spill urine on the carpet. At the time of the exit conference, the facility did not provide an environmental policy. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy, titled Resident Rights, dated as reviewed on 4/18/21 and received from the Executive Director (ED) on 1/4/23 at 1:00 p.m., indicated .The resident has a right to a safe, clean, comfortable and Homelike environment, including but not limited to receiving treatment and supports for daily living 3.1-19(f)(5)