| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155290 | A. Building<br>B. Wing | 05/07/2025 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>52091<br><br>Based on interview and record review, the facility failed to ensure resident council concerns and grievances were resolved for 3 of 5 residents reviewed for resident council concerns. (Resident 28, 37 and B)<br><br>Findings include:<br><br>A meeting with the resident council was conducted on 5/5/25 at 10:01 a.m. The residents in attendance indicated call light wait times had been an ongoing concern.<br><br>The resident council meeting minutes were reviewed and indicated:<br><br>a. On 2/24/25, the residents indicated the call light waiting time was long.<br><br>b. On 3/19/25, the residents indicated the call light response time remained untimely. The call light concerns from 2/24/25 were included with no resolution.<br><br>c. On 4/21/25, the residents indicated there were concerns with the call lights being answered in a timely manner. The call light concerns from 3/19/25 were included with no resolution.<br><br>1. During an interview, on 4/30/25 at 10:34 a.m., Resident B indicated she had laid in her feces and urine before and there had been times when Resident B waited over an hour before someone cleaned her up. It could take anywhere from 30 minutes to over an hour for someone to answer the call light and provide care. The call lights continued to be an ongoing issue.<br><br>2. During an interview, on 5/5/25 at 10:01 a.m., Resident 28 indicated call lights could take up to 30 minutes before being answered and had been an issue for a while now.<br><br>3. During an interview, on 5/5/25 at 10:02 a.m., Resident 37 indicated call light wait times were an ongoing problem.<br><br>During an interview, on 5/1/25 at 3:00 p.m., the Clinical Support Nurse provided a general form which indicated the names of the residents who had filled out a grievance, but no evidence of specific concerns or resolution. The Clinical Support Nurse indicated the grievances/concerns forms were filled out in a program on the computer and she could not print an individual form from the program with the information.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155290 | A. Building<br>B. Wing | 05/07/2025 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on 5/5/25 at 10:05 a.m., the Activity Director indicated she helped the residents fill out grievances/concerns forms. Management reviewed the concerns. Management has been invited to resident council meetings to address the concerns.<br><br>44598<br><br>During an interview, on 5/8/25 at 3:03 p.m., the Director of Nursing (DON) indicated the facility had completed call light audits. Call light audits from 4/1/25 to 4/29/25 were the only audits the facility could provide.<br><br>A current facility policy, titled Resident Council, dated 6/2/16 and received from Director of Nursing (DON) 5/7/25 at 4:30 p.m., indicated .The Resident Council structure and process including staff liaison designation will be established with the residents .Residents are informed of council meetings and are encouraged to utilize the complaint resolution process .Minutes of the meeting will be recorded and maintained for a least 2 years. Minutes will not disclose specific individuals who voice concerns about the Campus. The group facilitator will determine the prevalence 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<br><br>A current facility policy, titled Resident Concern Process, dated 11/13/19 and received from DON on 5/7/25 at 4:30 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<br><br>A current policy, titled Your Rights and Protections as a Nursing Home Resident, not dated and received from the 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<br><br>This citation relates to Complaint IN00452657.<br><br>3.1-3(l) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155290 | A. Building<br>B. Wing | 05/07/2025 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>49891<br><br>Based on interview and record review, the facility failed to ensure the written reason for discharge and the bed hold policy with cost information was provided to the resident and resident's representative for 4 of 4 residents reviewed for hospitalization . (Resident 2, F, 23 and 27)<br><br>Findings include:<br><br>1. The clinical record for Resident 2 was reviewed on 5/1/25 at 11:49 a.m. The diagnoses included, but were not limited to, cervical spina bifida, pressure ulcer, type 2 diabetes mellitus, paraplegia, hydrocephalus, cerebral palsy, major depressive disorder, anxiety disorder, neuromuscular dysfunction of the bladder, and mood affective disorder.<br><br>A notice of transfer discharge, dated 4/30/25, indicated the reason for the discharge and the bed hold policy was included. The notice did not include any indication of the charges for holding the bed while the resident was discharged . The notice did not indicate Resident 2 was provided with a written copy of the notice or the bed hold policy information.<br><br>A nursing progress note, dated 4/30/25 at 3:47 p.m., indicated the resident was taken to the hospital by emergency medical service (EMS) at 3:40 p.m., for suicidal ideation. The nursing note did not indicate any transfer or bed hold information given to Resident 2 by the facility.<br><br>A nursing progress note, dated 4/30/25 at 3:23 p.m., indicated the resident notified staff of thoughts of suicide. The staff verbally notified the resident and resident's family of the plan to discharge to the hospital.<br><br>During an interview, on 5/5/25 at 2:44 p.m., Resident 2 indicated he did not remember receiving a copy of the discharge information or bed hold policy.<br><br>44598<br><br>2. The clinical record for Resident F was reviewed on 5/1/25 at 11:46 a.m. The diagnoses included, but were not limited to, congestive heart failure, pulmonary edema, hypertension, diabetes mellitus, chronic kidney disease, dementia, depression, atrial fibrillation, and fibromyalgia.<br><br>Resident F was transferred from the facility to the hospital on 1/2/25, 1/10/25 and 1/22/25. The documentation did not indicate a bed hold policy was given to the resident or responsible party.<br><br>3. The clinical record for Resident 23 was reviewed on 5/1/25 at 1:54 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, diabetes mellitus, chronic obstructive pulmonary disorder, hypertension, depression, epilepsy, major depressive disorder, cardiomegaly, congestive heart failure, and dementia.<br><br>Resident 23 was transferred from the facility to the hospital on 10/22/25, 3/25/25 and 4/22/25. The documentation did not indicate a bed hold policy was given to the resident or responsible party.<br><br>(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<br>B. Wing | 05/07/2025 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 52091<br><br>4. The clinical record for Resident 27 was reviewed on 5/6/25 at 11:03 a.m. The diagnoses included, but were not limited to, displaced intertrochanteric fracture of left femur, pneumonitis due to inhalation of food and vomit, diabetes type 2, hypertension, depression, anxiety, dysphagia, pain, heart attack, stroke, and myalgia.<br><br>A progress note, dated 4/29/25 at 11:35 a.m., indicated Resident 27 was sent to the emergency room for symptoms of a stroke.<br><br>The record did not contain documentation to indicate Resident 27 or the resident's representative were given information in writing regarding the reason for the resident's transfer to the hospital or the facility's bed hold policy, including the facility's charge to hold a bed.<br><br>During an interview, on 5/5/25 at 1:42 p.m., the Director of Nursing (DON) indicated the discharge paperwork was usually printed and sent to the hospital with the resident, but there was no specific indication in the chart the transfer form and the bed hold policy with charges were given to the residents and the residents' representative.<br><br>During an interview, on 5/5/25 at 2:46 p.m., the Clinical Support Nurse indicated there was no documentation in the electronic health record to indicate the residents or the residents' representatives were given the bed hold policy.<br><br>A current facility policy, titled Discharge/Transfer Notification Process Communicating Unplanned Discharges, dated 2/8/22 and received from the DON on 5/5/25 at 2:56 p.m., indicated .This communication must occur within 24 hours of receiving a 30-day notice, and/or PRIOR to conversation with families regarding internal service line transfers .If the campus is requesting a move out or choosing to change a resident's service level, communication must be sought<br><br>A current facility policy, titled Bed Hold Policy, dated 2/1/11 and received from Director of Nursing on 5/5/25 at 11:00 a.m., indicated .the campus will properly inform residents in advance of their option to make bed-hold payments as well as the amount of the facility's charge to hold a bed .<br><br>3.1-12(a)(6)(A)(ii)<br><br>3.1-12(a)(6)(A)(iii)<br><br>3.1-12(a)(26) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155290 | A. Building<br>B. Wing | 05/07/2025 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>44598<br><br>Based on interview and record review, the facility failed to ensure staff obtained a follow-up weight to determine if a significant weight loss or gain had occurred and to document if a resident refused for 1 of 3 residents reviewed for nutrition. (Resident B)<br><br>Findings include:<br><br>The clinical record for Resident B was reviewed on 5/1/25 at 1:44 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, diabetes mellitus, morbid obesity, hypertension, major depressive disorder, post-traumatic stress disorder, major depressive disorder, panic disorder, bipolar disorder, anxiety disorder, and chronic pain.<br><br>Resident B had the following weights:<br><br>1. On 11/2/24, the weight was 322.6 pounds.<br><br>2. On 12/16/24, the weight was 246.3 pounds.<br><br>Resident B had a 23.65 % weight loss in 1 month.<br><br>3. On 1/1/25, the weight was 314.0 pounds.<br><br>Resident B had a 27.49 % weight gain in 1 month.<br><br>There was no documentation, between 11/1/24 to 5/7/25, of the significant gain or loss, no indication the resident was re-weighed, and no indication the physician, dietician, or family representative were notified.<br><br>During an interview, on 5/6/25 at 2:39 p.m., the Clinical Support Nurse indicated the resident had refused some weights. The staff should attempt multiple times to obtain a resident's weight.<br><br>During an interview, on 5/7/25 at 2:40 p.m., Licensed Practical Nurse (LPN) 11 indicated any staff member could weigh a resident. When a resident refused to be weighed, staff would attempt 1 or 2 more times to obtain the weight. Resident B was a mechanical lift weight. If the resident refused 3 times, management would be told.<br><br>During an interview, on 5/7/25 at 2:41 p.m., Certified Nursing Assistant (CNA) 12 indicated when a resident refused to be weighed, she would inform the nurse, and the nurse would let management know. The nurse would normally get the resident to agree to be weighed, Resident B liked to be weighed before breakfast and CNA 12 did not know of anytime the resident refused.<br><br>During an interview, on 5/7/25 at 2:46 p.m., Qualified Medical Assistant (QMA) 13 indicated Resident B did not normally refuse to be weighed. Resident B had never refused care when she asked. If a resident refused to be weighed, she would attempt multiple times and then inform management.<br><br>(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<br>B. Wing | 05/07/2025 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on 5/7/25 at 2:48 p.m., QMA 14 indicated she would attempt 2 or 3 times to obtain a weight. If a resident refused, she would tell management.<br><br>During an interview, on 5/7/25 at 2:55 p.m., the Clinical Support Nurse indicated the facility did not have a documentation policy and they followed the state guidelines.<br><br>A current facility policy, titled Guidelines for Weight Tracking, dated 12/17/24 and received from the Clinical Support Nurse on 5/6/25 at 2:39 p.m., indicated .Residents who have a weight that seem out of normal range shall be re-weighed to determine the accuracy of the original weight .The physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. (Unless on a planned weight loss or gain program)<br><br>A current facility policy, titled Clinical Services-Weight Management, dated 12/20/24 and received from the Clinical Support Nurse on 5/6/25 at 2:39 p.m., indicated .Review of error weights, daily, in CCM .Re-weights as needed .Correct weights as needed .Invalidate weights as needed<br><br>3.1-46(a)(1) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155290 | A. Building<br>B. Wing | 05/07/2025 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>49891<br><br>Based on interview and record review, the facility failed to ensure staff had documented training prior to administering 2 step Mantoux skin tests for tuberculosis (TB) and all parts of the procedure were documented to ensure accuracy for 1 of 5 employees and 3 of 7 residents reviewed for infection control. (CNA 16, Resident 2, 20, and 50)<br><br>Findings include:<br><br>1. A facility tuberculin testing for employees' form indicated CNA 16 was given a second step Mantoux test on 4/10/24 and read on 4/12/24. There was no documentation to indicate the time the second step test was given or read to ensure there was a 48-hour lapse before reading the test.<br><br>2. The clinical record for Resident 2 was reviewed on 5/1/25 at 11:49 a.m. The diagnoses included, but were not limited to, spina bifida with hydrocephalus, type 2 diabetes mellitus, paraplegia, cerebral palsy, major depressive disorder with psychotic symptoms, anxiety disorder, and neuromuscular dysfunction of bladder.<br><br>A TB skin test record, dated 2/2/24, indicated LPN 3 administered the skin test.<br><br>There was no documentation to indicate LPN 3 was trained to administer TB tests.<br><br>3. The clinical record for Resident 20 was reviewed for 5/2/25 at 9:47 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, chronic diastolic congestive heart failure, dementia, and schizoaffective disorder bipolar type.<br><br>A first step TB skin test record indicated the skin test was administered on 2/20/25 at 8:23 p.m., by RN 8. The skin test was read on 2/22/25 with no time recorded to indicate the time the second step test was read to ensure there was a 48-hour lapse before reading the test.<br><br>There was no documentation to indicate RN 8 was trained to administer TB tests.<br><br>A second step TB skin test record indicated the skin test was administered on 3/7/25 at 11:54 p.m., by RN 9. The skin test was read on 3/8/25 with no time recorded. The test was read before the 48 hours.<br><br>There was no documentation to indicate RN 9 was trained to administer TB tests.<br><br>4. The clinical record for Resident 50 was reviewed on 5/1/25 at 2:26 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy, Parkinson's disease, dementia, delirium, delusional disorders, major depressive disorder, anxiety disorder, depression, visual hallucinations, and hydrocephalus.<br><br>A physician's order, dated 4/16/25, indicated to administer Aplisol (TB) solution intradermally (into the skin) on 4/16/25.<br><br>(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<br>B. Wing | 05/07/2025 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Medication Administration Record (MAR) indicated the skin test was administered late on 4/17/25 at 2:41 a.m., by RN 9. The skin test was read on 4/18/25. 48 hours had not passed before the test was read.<br><br>There was no documentation to indicate RN 9 was trained to administer TB tests.<br><br>During an interview, on 5/7/25 at 1:54 p.m., the Infection Prevention Nurse indicated 2 step TB tests should be completed upon admission for all residents. The test should be read between 48 and 72 hours after administration. The clinical record should have included the time the test was administered. The nurses who administer and read the tests must be trained.<br><br>During an interview, on 5/7/25 at 1:54 p.m., the Director of Nursing (DON) indicated 2 step TB tests were required upon admission and should have been read within the 48-to-72-hour window to be considered valid. She indicated LPN 2, LPN 3, RN 5, LPN 6, RN 7, RN 8, and RN 9 did not have the required training to give or read TB tests. The facility could not verify if LPN 4 was certified because she was no longer in their system.<br><br>A current facility policy, titled Mantoux Test Procedure, dated 12/16/24 and provided by the Clinical Support Nurse on 5/6/25 at 10:02 a.m., indicated .Record administration of Mantoux Test (date, time .) . Read the Mantoux Test results in 48-72 hours<br><br>A current facility policy, titled Guidelines for TB Control Plan for Residents-Indiana, dated 4/2/24 and provided by the DON on 5/5/25 at 2:56 p.m., indicated .tuberculin skin test .administered by persons having documentation of training from a department approved program .Upon admission a baseline two-step TST shall be completed<br><br>3.1-18(e)<br><br>3.1-18(h) |