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	03/11/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure alternative food choices were offered to residents who chose to receive meals in their room for 3 of 3 residents reviewed for resident rights. (Resident 4, 40 and 41)Findings include:During an interview, on 3/5/26 at 2:04 p.m., Resident 4 indicated the alternative food choices offered on the menu were not available to residents who chose to eat their meals in their rooms. During an interview, on 3/9/26 at 11:47 a.m., Resident 40 indicated she chose to eat in her room and not eat in the dining room. She had to go to the dining room to pick up her meal and bring it back to the room herself in order receive food from the alternative menu. Resident 40 indicated this was a recent new change and she had not always had to do that.During an interview, on 3/9/26 at 11:51 a.m., Resident 41 indicated a new policy had recently been put in place and he was unable to receive food choices from the alternative menu unless he went to the dining room to eat for meals.During an interview, on 3/9/26 at 3:04 p.m., the Director of Nursing (DON) indicated the facility had a corporate policy titled All Day Dining. There was a corporate policy which indicated the residents, who chose to eat in their room, could not have the option for alternative menu choices. The corporate policy had been put in place about a year ago and this facility had activated it in January.During an interview, on 3/10/26 at 11:00 a.m., the Administrator indicated residents who chose to eat in their rooms could not receive an alternative to the meal unless they physically went to the dining room and picked up the alternative. If they were unable to propel themself to the dining room, someone would have to take them, or their family could obtain the alternate for the resident. The Administrator indicated there was no facility policy which indicated this process.During an interview, on 3/10/26 at 2:00 p.m., the Corporate Support Nurse indicated she had contacted their corporation and there was no dining policy in place related to the residents who chose to eat in their room not receiving the alternative menu options.During an interview, on 3/10/26 at 3:37 p.m., the Corporate Support Nurse indicated there was no policy related to not being able to receive a selection from the alternative menu if the residents chose to eat in their room. The process should not have been in place and needed to be fixed.A facility admission agreement, provided upon entrance to the facility, indicated the resident had the right to be free of interference, coercion, discrimination, and reprisal from the facility and had the right to make choices about aspects of his or her life in the facility that are significant to the resident.A policy related to alternative menu selections was not provided by the facility.410 IAC (Indiana Administrative Code) 16.2-3.1-3(a)(2)(c)410 IAC (Indiana Administrative Code) 16.2-3.1-3(t)410 IAC (Indiana Administrative Code) 16.2-3.1-3(u)(3)

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 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. Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed when the resident had a new mental health diagnosis added for 1 of 5 residents reviewed for PASARR. (Resident 24)Findings include:The clinical record for Resident 24 was reviewed on 3/6/26 at 10:20 a.m. The diagnoses included, but were not limited to, post-traumatic stress disorder (PTSD), bipolar disorder, cognitive communication deficit, borderline personality disorder, and anxiety disorder. A PASARR level II, dated 6/19/22, had the diagnosis of post-traumatic stress disorder (PTSD) handwritten on the document. During an interview, on 3/9/26 at 3:15 p.m., the Director of Nursing (DON) indicated Resident 24 had a diagnosis of PTSD. During an interview, on 3/11/26 at 10:40 a.m., the PASARR help desk indicated they did not have any records of Resident 24 having a diagnosis of PTSD on the PASARR level II, dated 6/19/22. Whenever a resident had a new mental health diagnosis added, a new PASARR level I needed to be completed, and it was not. The facility should have a new PASARR complete as soon as possible.During an interview, on 3/11/26 at 12:20 p.m., the Social Service Director (SSD) indicated when a resident had a new mental health diagnosis or mental health medication added, a new PASARR level I needed to be completed. The resident did not have a diagnosis of PTSD on her PASARR level II, dated 6/19/22, and she did not know why PTSD was handwritten on the PASARR. An Indiana PASARR document indicated .Change in status and Level II follow up .Social Services ensures paperwork is submitted. They will print out the outcome letter and upload.A PASARR policy was not provided by the facility prior to exit. 410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)(1)(A)410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)(1)(B)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure a comprehensive person-centered care plan was developed and implemented for 1 of 2 residents reviewed for care plans. (Resident 24)Findings include:The clinical record for Resident 24 was reviewed on 3/6/26 at 10:20 a.m. The diagnoses included, but were not limited to, post-traumatic stress disorder (PTSD), bipolar disorder, cognitive communication deficit, borderline personality disorder, and anxiety disorder. A PASARR level II, dated 6/19/22, had a diagnosis of PTSD handwritten on the document. The clinical record indicated the diagnosis of post-traumatic stress disorder was added to the resident's diagnoses list on 5/5/24.There was no care plan located in Resident 24's electronic record related to post-traumatic stress disorder.During an interview, on 3/9/26 at 3:15 p.m., the Director of Nursing (DON) indicated the resident had a diagnosis of PTSD. During an interview, on 3/11/26 at 12:20 p.m., the Social Service Director (SSD) indicated Resident 24 did not have a care plan for PTSD and should have one. A current facility policy, titled Trauma Informed Care, dated 10/24/24 and received from the Clinical Support Nurse on 3/10/26 at 2:01 p.m., indicated .Facility will ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice to eliminate or mitigate triggers that may cause re-traumatization of the resident .Social services will update the care plan and resident profile with any trauma and cultural needs 410 IAC (Indiana Administrative Code) 16.2-3.1-35(a)410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure a resident received a medication timely according to the scheduled administration time and to ensure a resident had a physician's order in place for a non-pressure skin impairment for 2 of 3 residents reviewed for quality of care. (Resident 24 and 56) Findings include: 1. During an interview, on 3/5/26 at 10:21 a.m., Resident 24 indicated she did not always receive her medication on time. She had to turn her call light on, ask for her pills, and would have to wait a very long time. The clinical record for Resident 24 was reviewed on 3/6/26 at 10:20 a.m. The diagnoses included, but were not limited to, post-traumatic stress disorder (PTSD), osteoarthritis of the left shoulder, bipolar disorder, cognitive communication deficit, borderline personality disorder, and anxiety disorder. A care plan, dated 6/3/24, indicated Resident 24 had the potential for cardiovascular distress. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 2/28/25, indicated to administer one half a tablet of isosorbide dinitrate (a nitrate medication used to prevent and manage chronic chest pain by relaxing the blood vessels) 30 milligrams (mg) twice a day. A Medication Administration Record (MAR) indicated the medication was scheduled to be administered at 8:00 a.m., and 6:00 p.m. The MAR indicated the medication was administered later than the scheduled administration time on the following dates and times: a. On 1/1/26, the 8:00 a.m. dose was administered at 9:52 a.m. The 6:00 p.m. dose was administered at 11:25 p.m. b. On 1/2/26, the 6:00 p.m. dose was administered at 8:23 p.m. c. On 1/3/26, the 6:00 p.m. dose was administered at 8:23 p.m. d. On 1/4/26, the 8:00 a.m. dose was administered at 11:39 a.m. The 6:00 p.m. dose was administered at 7:12 p.m. e. On 1/5/26, the 6:00 p.m. dose was administered at 8:08 p.m. f. On 1/6/26, the 6:00 p.m. dose was administered at 7:28 p.m. g. On 1/7/26, the 6:00 p.m. dose was administered at 7:49 p.m. h. On 1/10/26, the 6:00 p.m. dose was administered at 9:10 p.m. i. On 1/13/26, the 6:00 p.m. dose was administered at 9:02 p.m. During an interview, on 3/9/26 at 10:33 a.m., the Director of Nursing (DON) indicated the facility had an extended medication pass for most medications. If the resident had a medication scheduled at a certain time, the nurse would have one hour before and one hour after the pill was scheduled to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer the medication. During an interview, on 3/11/26 at 11:17 a.m., the Clinical Support Nurse indicated the nurse could administer a medication one hour before or after the scheduled medication time. During an interview, on 3/11/26 at 12:37 p.m., Registered Nurse (RN) 8 indicated the facility normally used an extended medication pass time. When a pill had a scheduled time assigned, the nurse would have one hour before and after to administer the medication. During an interview, on 3/11/26 at 12:43 p.m., the Assistant Director or Nursing (DON) indicated the facility used an extended medication pass. When a medication had a designated time, the nurse had one hour before and one hour after to administer the medication. 2. During an observation, on 3/5/26 at 11:09 a.m., Resident 56 had a one-inch white island dressing (a highly absorbent, non-adherent central pad surrounded by a breathable adhesive border) on her right temple which was initialed and dated 3/2/26. Old blood was visible through the dressing. During an observation, on 3/6/26 at 2:32 p.m., Resident 56 had a one-inch white island dressing on her right temple, dated 3/6/26. The dressing was clean. During an observation, on 3/9/26 at 11:35 a.m., Resident 56 had a one-inch white island dressing on her right temple, dated 3/8/26. During an observation, on 3/10/26 at 10:37 a.m., Resident 56 had a Band-Aid on her right temple. The resident indicated she did not like the island dressing and liked the Band-Aid better. The clinical record for Resident 56 was reviewed on 3/6/26 at 11:34 a.m. The diagnoses included, but were not limited to, myocardial infarction, pulmonary disease, long term use of anticoagulants, and adult failure to thrive. A care plan, dated 2/6/26, indicated the resident was at risk for skin breakdown. Interventions included, but were not limited to, treatments when ordered. A physician's order, initiated on 2/21/26 with an end date of 3/2/26, indicated to cleanse the temple wound with wound cleanser or normal saline, pat dry, apply skin prep and cover with a border dressing as needed if dislodged or soiled. The clinical record for Resident 56 did not contain a current physician's order related to the treatment of the right temple wound after 3/2/26. During an interview, on 3/9/26 at 10:24 a.m., the Director of Nursing (DON) indicated the wound care order was discontinued, on 3/2/26, and there was no current physician's order for treatment. During an interview, on 3/9/26 at 2:02 p.m., the DON indicated she removed Resident 56's dressing and had replaced it with a Band-Aid at Resident 56's request. She felt Resident 56 needed a treatment order continued and needed to contact the physician. A current facility policy, titled Dressing Changes, dated 12/16/24 and received from the DON on 3/10/26 at 9:25 a.m., indicated .Follow doctor's recommendations for treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review, the facility failed to ensure a comprehensive assessment, person-centered care plan, and physician's orders were implemented for the use of an assistive device with transfers for 1 of 1 resident reviewed for range of motion and mobility. (Resident 44)Findings include:The clinical record for Resident 44 was reviewed on 3/5/26 at 2:19 p.m. The diagnoses included, but were not limited to, displaced spiral fracture of the shaft of the right femur, venous insufficiency, moderate protein-calorie malnutrition, history of falls, fracture of the shaft of the left tibia and left fibula, difficulty walking, osteoporosis, disorders of bone density and structure, and osteoarthritis.A nursing progress note, dated 12/11/25 at 3:20p.m., indicated Resident 44 had returned to the facility from a hospital stay for a right femur fracture.A therapy recommendation, dated 12/12/25, indicated a slide board was placed in Resident 44's room. The recommendation indicated the slide board was to be used for transfers with two people and a gait belt. The slide board was to be placed towards the good leg (left).A quarterly Minimum Data Set (MDS) assessment, dated 12/31/25 at 2:21 p.m., indicated Resident 44 used a wheelchair and was dependent on staff for mobility and transfers.A quarterly MDS assessment, dated 2/20/26 at 8:00 p.m., indicated Resident 44 used a wheelchair and was dependent on staff for mobility and transfers.During an observation, on 3/9/26 at 2:02 p.m., Certified Nursing Assistant (CNA) 6 and Qualified Medication Aide (QMA) 7 transferred Resident 44 from a wheelchair to the bed using a gait belt and a slide board.The electronic medical record did not contain a physician's order or a comprehensive person-centered care plan for the use of a slide board for transfers.During an interview, on 3/9/26 at 2:43 p.m., the Director of Nursing (DON) indicated there was no physician's order or care plan in place for the use of a slide board with transfers.A current facility policy, titled Comprehensive Care Plan Guidelines, dated as last reviewed 5/22/18 and received from the Social Service Director on 3/11/26 at 12:22 p.m., indicated .to ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines .A comprehensive care plan will be developed.Comprehensive care plans need to remain accurate and current 410 IAC (Indiana Administrative Code) 16.2-3.1-42(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-42(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a physician's order for the use of oxygen was implemented for 1 of 1 resident reviewed for respiratory care. (Resident 62) Findings include:During an observation, on 3/6/26 at 10:03 a.m., Resident 62's oxygen concentrator (a device used to provide supplemental oxygen therapy) was set on 3 liters per minute (L). During an observation, on 3/6/26 at 9:38 a.m., the resident was receiving 2 L of oxygen. The clinical record for Resident 62 was reviewed on 3/6/26 at 10:03 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), Alzheimer's disease, major depressive disorder, and hypertension.A care plan, dated 6/18/24, indicated Resident 62 received oxygen therapy. Interventions included, but were not limited to, monitor oxygen saturation, monitor signs and symptoms of respiratory distress, and administer oxygen by nasal cannula as ordered.A physician's order was not implemented until after Resident 62 was observed receiving oxygen therapy.The physician's order, dated 3/6/26, indicated Resident 62 was to receive 2 L of oxygen continuously and staff could titrate to ensure oxygen saturations remained greater than 90% but not to exceed 4 liters without physician notification.During an interview, on 3/5/26 at 10:25 a.m., Resident 62's family indicated the resident had been on oxygen since being admitted to the facility on [DATE]. The resident had been short of breath and needed oxygen. During an interview, on 3/6/25 at 9:40 a.m., the Director of Nursing (DON) indicated the facility had noticed Resident 62 did not have an oxygen order and the liter flow was confirmed today. The resident had been on oxygen therapy since she was admitted to the facility on [DATE] and did not have an order. The resident needed a physician's order if the resident received oxygen therapy.A current facility policy, titled Administration of Oxygen, dated as last reviewed 12/13/24 and received from the DON on 3/6/26 at 9:47 a.m., indicated .Guidelines to properly Administering Oxygen and any Respiratory procedure .Verify physician's order for the procedure.410 IAC (Indiana Administrative Code) 16.2-3.1-47(a)(6)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on interview and record review, the facility failed to ensure the care strategies to meet the individual needs of a resident who had a history of post-traumatic stress disorder (PTSD) were documented and implemented for 1 of 1 resident reviewed for post-traumatic stress disorder. (Resident 24)Findings include:The clinical record for Resident 24 was reviewed on 3/6/26 at 10:20 a.m. The diagnoses included, but were not limited to, post-traumatic stress disorder (PTSD), panic disorder, major depressive disorder, bipolar disorder, cognitive communication deficit, borderline personality disorder, and anxiety disorder. The clinical record indicated post-traumatic stress disorder was added to the resident's diagnoses list on 5/5/24.The clinical record did not contain a care plan related to post-traumatic stress disorder, the root cause, the triggers to watch for, or the interventions to implement in response to a trigger.Resident 24's profile care guide indicated Cultural Preferences and Trauma Triggers: There was no documentation after the statement to indicate what the cultural preferences or trauma triggers were. The care guide indicated the resident was care in pairs and male staff to remain out of the room if possible due to staffing.A care plan, dated 5/7/24, indicated Resident 24 was cognitively intact and was alert and oriented.A care plan, dated 5/13/24, indicated Resident 24 was at risk for adverse consequences related to receiving an antipsychotic medication for bipolar disorder. The care plan did not include the diagnosis or root cause of the post-traumatic stress disorder.A care plan, dated 5/16/24, indicated Resident 24 demonstrated inappropriate behaviors including: false accusations towards staff and stating staff did not administer medications. The care plan did not indicate if the inappropriate behaviors were related to the resident's diagnosis or root cause of the post-traumatic stress disorder.A care plan, dated 5/16/24, indicated Resident 24 had a diagnosis of bipolar and borderline personality disorder which was treated with antipsychotic medication. The care plan did not include the diagnosis or root cause of the post-traumatic stress disorder.A care plan, dated 5/16/24, indicated Resident 24 had a diagnosis of bipolar disorder and demonstrated altered mood, affect, and behaviors. The care plan did not include the diagnosis or root cause of the post-traumatic stress disorder.A care plan, dated 6/10/24, indicated Resident 24 demonstrated inappropriate behaviors including: sexually inappropriate talk or comments to staff. The care plan did not indicate if the inappropriate behaviors were related to the resident's diagnosis or root cause of the post-traumatic stress disorder.A care plan, dated 7/8/24, indicated Resident 24 demonstrated inappropriate behaviors including: having family bring in supplements, keeping them in her room, and not telling clinical staff. The care plan did not indicate if the inappropriate behaviors were related to the resident's diagnosis or root cause of the post-traumatic stress disorder.A care plan, dated 7/8/24, indicated Resident 24 demonstrated inappropriate behaviors including: repetitive complaints, refusal of care, negative statements, and only allowing certain staff in the room or to provide care. The care plan did not indicate if the inappropriate behaviors were related to the resident's diagnosis or root cause of the post-traumatic stress disorder.A care plan, dated 9/16/24, indicated Resident 24 demonstrated inappropriate behaviors including: self-determination of care, refusal to get out of bed, non-compliance with diet, non-compliance of medications, and refusal to let some staff enter her room to perform care. The care plan did not indicate if the inappropriate behaviors were related to the resident's diagnosis or root cause of the post-traumatic stress disorder.A care plan, dated 9/16/24, indicated Resident 24 demonstrated verbally abusive behaviors. The care plan did not indicate if the verbally abusive behaviors were related to the resident's diagnosis or root cause of the post-traumatic stress disorder.A care plan, dated 1/24/25, indicated Resident 24 demonstrated altered behaviors including visual hallucinations. The care plan did not indicate if the altered behaviors including visual hallucinations were related to the resident's diagnosis or root cause of the post-traumatic stress (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorder.A care plan, dated 2/10/25, indicated Resident 24 demonstrated inappropriate behaviors including: refusing to allow staff to round at night and did not want to be woken to be changed. The care plan did not indicate if the behaviors were related to the resident's diagnosis or root cause of the post-traumatic stress disorder.A trauma screening tool was not completed until at least 9 months after the post-traumatic stress disorder was added to Resident 24's diagnosis list.The trauma screening tool, dated 2/21/25, indicated the resident had experienced a potential traumatic experience of PTSD. The screening indicated Resident 24 did not exhibit a substance abuse issue, an eating disorder, and was not fearful of others. She did not have overwhelming guilt or shame, did not have irritability, anger outbursts, or aggressive behavior, was not easily startled, frightened or fearful, and did not appear to be on guard for danger. No triggers or cultural trauma were voiced or identified. A referral was recommended but the resident denied services. The form indicated a care plan was implemented and included the trauma identified and the triggers which might re-traumatize the resident.During an interview, on 3/11/26 at 12:20 p.m., the Social Service Director indicated a trauma screening was not completed for Resident 24 prior to 2/21/25. During an interview, on 3/11/26 at 12:28 p.m., the Clinical Support Nurse indicated the facility was not trained on the trauma informed information until June of 2024.During an interview, on 3/11/26 at 12:29 p.m., the Social Service Director indicated a trauma screening was not completed when the resident's diagnosis was first added. A current facility policy, titled Trauma Informed Care, dated 10/24/24 and received from the Clinical Support Nurse on 3/10/26 at 2:01 p.m., indicated .will ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice to eliminate or mitigate triggers that may cause re-traumatization of the resident .This includes identifying triggers that may be stressors or cause re-traumatization to the resident .Information can be gathered by speaking with resident, family, POA, staff, and information provided by previous provider .Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being .Social services will complete the social history observation upon admission, annually, and with significant change which incorporates identifying trauma, triggers, and cultural preferences .Social services will update the care plan and resident profile with any trauma and cultural needs 410 IAC (Indiana Administrative Code) 16.2-3.1-43(a)(2)