

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/01/2015
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NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN 47454
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K 0000 Bldg. 01	<p>A Short form Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/01/15</p> <p>Facility Number: 000226 Provider Number: 155333 AIM Number: 100267730</p> <p>At this Life Safety Code survey, Paoli Health and Living Community Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement was determined to be of Type V (000) construction and was sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in resident sleeping rooms in the 400 and</p>	K 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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K 0047 SS=E Bldg. 01	<p>500 halls, furthermore, battery operated smoke detectors were located in all other resident sleeping rooms. The facility has a capacity of 109 and had a census of 106 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached wood sheds and one metal shed used for facility storage, plus the elevator equipment room in the lower level.</p> <p>Quality Review completed 09/03/2015-AK</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 3 of over 20 exit signs were continuously illuminated over 1 of 10 exit doors and over 1 of 6 sets of smoke barrier doors. LSC 19.2.10.1 refers to 7.10. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect up to 26 residents, as well as staff and visitors</p>	K 0047	An electrician corrected the problem. All exit lights are functioning and are monitored monthly by the Environment Director during preventive maintenance checks. The Environmental Director will audit monthly and the Administrator will monitor for compliance. Completion date: 9/25/15	09/25/2015

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K 0050 SS=C Bldg. 01	<p>in the 300 hall.</p> <p>Findings include:</p> <p>Based on observations on 09/01/15 at 11:00 a.m. during a tour of the facility with the Maintenance Director, the exit signs on each side of the smoke barrier doors between the 300 hall and front lobby and the exit sign over the 300 hall exit door were not illuminated. This was acknowledged by the Maintenance Director at the time of observation, furthermore, the Maintenance Director said he was aware the exit signs were not illuminating and had an electrician coming to fix the problem.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters.</p>	K 0050	All fire drills will be logged to assure that times are varied per shift to ensure that the deficient practice is corrected. The logged will be the Environmental Director	09/25/2015	

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	<p>This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Life Safety Book on 09/01/15 at 10:30 a.m. with the Maintenance Director present, the following was noted:</p> <ul style="list-style-type: none"> a. three of four first shift (day) fire drills were performed between 9:35 a.m. and 10:15 a.m. b. three of four second shift (evening) fire drills were performed between 2:08 p.m. and 3:02 p.m. c. four of four third shift (night) fire drills were performed between 3:55 a.m. and 5:10 a.m. <p>During an interview at the time of record review, the Maintenance Director acknowledged the times the first, second and third shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p>		<p>and Administrator to assure that all drills per shifted are varied and conducted to meet the requirement. Completion date: 9/25/15</p>		