

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 08/07/2013
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K010000	<p>A 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: 08/07/13</p> <p>Facility Number: 000226 Provider Number: 155333 AIM Number: 100267730</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Paoli Health and Living Community 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 (111) construction and 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 500 halls,</p>	K010000		
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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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	<p>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 93 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. 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 by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/08/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide an automatic sprinkler system which provided complete coverage in 1 of 7 smoke compartments. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main line power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect up to 10 residents, as well as staff and visitors while in the Physical Therapy room which was in the same smoke compartment as the elevator equipment room.</p>	K010056	<p>I. All residents who participate in therapy on the lower level have the potential to be affected by the deficient practice. An outside vendor was contacted in order to correct the deficient practice.</p> <p>II. Any resident receiving therapy in the lower level has the potential to be affected by the deficient practice.</p> <p>III. A sprinkler head in the elevator equipment room with a shunt trip breaker will be installed in the lower level elevator equipment room, in order to correct the deficient practice.</p> <p>IV. The corrective action will be monitored quarterly to ensure the new shunt valve and sprinkler head continue to meet standards. The findings will be reviewed quarterly at the</p>	09/06/2013			

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	<p>Findings include:</p> <p>Based on observation on 08/07/13 at 1:40 p.m. during a tour of the facility with the current Maintenance Supervisor and the Maintenance Supervisor Trainee, the elevator equipment room in the lower level was not provided with sprinkler coverage. This was acknowledged by the current Maintenance Supervisor and the Maintenance Supervisor Trainee at the time of observation.</p> <p>3.1-19(b)</p>		<p>Community's Quality Assurance Meeting. The Maintenance Director or designee will be responsible for the quarterly audits.</p> <p>V. The corrective actions will be completed by 9/6/13</p>		