

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
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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 PERCEDED 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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F0000	<p>This visit was for Investigation of Complaint IN00098234.</p> <p>Complaint IN00098234 - Substantiated. No deficiencies cited</p> <p>Survey dates: 10/21 and 10/24/11</p> <p>Facility number: 000226 Provider number: 155333 AIM number: 100267730</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF: 15 SNF/NF: 85 Total: 100</p> <p>Census payor type: Medicare: 17 Medicaid: 69 Other: 14 Total: 100</p> <p>Sample: 3</p> <p>Paoli Health and Living Community was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2.</p>	F0000		
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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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	Quality review 11/01/11 by Suzanne Williams, RN			
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