STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155333	A. BUILDING -- B. WING	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/12/24 Facility Number: 000226 Provider Number: 155333 AIM Number: 100267730 At this Emergency Preparedness survey, Paoli Health and Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 109 certified beds, with a current census of 95. Quality Review completed on 03/15/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/12/24 Facility Number: 000226 Provider Number: 155333 AIM Number: 100267730 At this Life Safety Code survey, Paoli Health and	K 0000	March 28, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marquetta Motsinger		03/28/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Living Community Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (111) 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 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 95 at the time of this survey. 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. Quality Review completed on 03/15/24		Event ID: C77X21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on March 12, 2024. This letter is to inform you that the plan of correction attached is to serve as Paoli Health & Living Community credible allegation of compliance. We allege substantial compliance on March 29th, 2026. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 812-723-2595 Sincerely, Marquetta Motsinger, HFA Administrator Paoli Health and Living Submission of this plan of correction in no way constitutes an admission by Paoli Health and Living or its management company that the allegations	

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			contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0200 SS=D Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 2 of 2 egress doors from the two public rest rooms, were not equipped with a locking device that would require the use of a key to unlock from the outside in the case of fire or other emergencies in accordance with LSC 7.1.10.1. This deficient practice could affect two residents, staff or visitors. Findings include:	K 0200	**K 200** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The 2 public restroom doors are equipped with a thumb turn dead bolt and a	03/21/2024

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	Based on observations on 03/12/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Maintenance Supervisor and Regional Director, the public rest room near the front entrance and the public rest room near the center nurse's station were both equipped with deadbolt locking devices that required the use of a key to open from the outside. Based on interview at the time of each observation, the Maintenance Supervisor and Regional Director agreed the deadbolt locks on the two rest room doors could not be unlocked from the outside without the use of a key if locked. This finding was reviewed with the Administrator, Regional Director, and Maintenance Supervisor during the exit conference. 3.1-19(b)		latching door handle. The thumb turn dead bolt has a key to unlock them. The latching door handle is non locking. At the time of survey, a key was not available for review. The Maintenance Supervisor has since obtained keys for the 2 doors in question. The keys are kept at each nurse station and med carts. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff that use the restrooms could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is a new TELS task for the Maintenance Supervisor to verify the restroom keys are at the nurse station and med carts. See attached every 3-month task Labeled “Paoli TELS Bathroom Key Inspection” **IV The facility will monitor the corrective action by implementing the following**	

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			measures. CarDon Corporate Facilities will audit the restroom keys during the annual site visit inspections. **V. Plan of Correction completion date.** Plan of Completion date is March 21st, 2024.	
K 0222 SS=D Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to			

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	release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure 1 of 11 delayed egress locking arrangements were installed in accordance with	K 0222	**K 222** **I. The corrective actions to be**	03/29/2024

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	LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect at least 13 residents, staff, and visitors in the 500 hall. Findings include: Based on observation on 03/12/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Maintenance Supervisor and Regional Director, the outside exit door leading into the 500 hall was equipped with delayed egress. When the panic bar on the door was pushed for 15 seconds several times the door did not release from the magnetic hold located at the top of the door. However, the magnetic hold did release the door when the code was pushed on the keypad located next to the door. Based on interview at the time of observation, the Maintenance Supervisor and Regional Director acknowledged and agreed this exit door did not release when the panic bar was pushed for 15 seconds several times. This finding were reviewed with the Administrator, Regional Director, and		**accomplished for those residents found to have been affected by the deficient practice.** Observation A- The marked exit door on the 500 Hall did not automatically unlock when the delayed egress was activated. Circuit Masters has replaced the electronic mag lock since the previous one was not repairable. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is a new TELS task for the Maintenance Supervisor to inspect all exterior doors to ensure the functionality and delayed egress works. See attached weekly task Labeled "Paoli Delayed Egress Door Inspection." **IV The facility will monitor the corrective action by implementing the following**	

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	Maintenance Supervisor during the exit conference. 3.1-19(b)		**measures.** CarDon Corporate Facilities will inspect all exit doors during the annual site visit inspections to ensure the delayed egress function on all doors work. **V. Plan of Correction completion date.** Plan of Completion date is March 29th, 2024.	
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 1 of 1 battery backup lights that were tested monthly for 30 seconds during 12 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having	K 0291	**K 291** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The community failed to ensure that the battery powered emergency light that was located at the generator had been tested for 30 seconds monthly and 90 minutes annually. The Maintenance Supervisor has been re educated that this needs to be completed. He has created a clipboard that will hang in the sprinkler riser room to document	03/21/2024

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	jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 03/12/24 between 9:30 a.m. and 12:45 p.m. with the Maintenance Supervisor and Regional Director present, the facility did not have a preventative maintenance (PM) report that the battery powered emergency light located on the outside wall next to the emergency generator was tested monthly for 30 seconds during the past 12 month period. Furthermore, there was no documentation available to show the battery powered emergency light was tested annually for 90 minutes during the past 12 month period. Based on an interview at the time of record review, this was confirmed by the Maintenance Supervisor and Regional Director. During a tour of the facility with the Maintenance Supervisor and Regional Director between 12:45 p.m. and 2:45 p.m., the facility was equipped with one emergency battery powered light unit near the emergency generator. This finding was reviewed with the Administrator, Regional Director, and Maintenance Supervisor during the exit conference. 3.1-19(b)		this. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is a new TELS task for the Maintenance Supervisor to test the generator emergency light every month and annually for 90 minutes. See attached every month task Labeled “Paoli TELS Generator Emergency Light TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the task and clipboard during the annual site visit inspections. **V. Plan of Correction completion date.**	

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			Plan of Completion date is March 21st, 2024.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure complete documentation was available for the sensitivity testing of all hard wired smoke detectors, and to show what testing instrument was used to test all smoke detectors for sensitivity. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method.	K 0345	**K 345** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the every 24 month sensitivity test dated 6/28/22 had the correct information on it. The Maintenance Supervisor has contacted Safecare to come perform a new building wide sensitivity test. See attached new sensitivity test. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	03/21/2024

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	(2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 03/12/24 between 9:30 a.m. and 12:45 p.m. with the Maintenance Supervisor and Regional Director present, there was documentation available to show a smoke detector sensitivity test of all smoke detectors was performed on 06/28/22 by the facility's fire alarm system inspection vendor, however, the report did not include the Alarm Point at which individual smoke detector was tested at. Furthermore, the 06/28/22 report did not include the name of the manufacturer's calibrated sensitivity test instrument. This was confirmed by the Maintenance Supervisor and Regional Director at the time of record review. This finding was reviewed with the Administrator, Regional Director, and Maintenance Supervisor during the exit conference.		All Residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** CarDon Corporate Facilities will audit the sensitivity test after completion to ensure it includes all the proper information. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the sensitivity test after completion to ensure it includes all the proper information. **V. Plan of Correction completion date.** Plan of Completion date is March 21st, 2024	

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K 0351 SS=E Bldg. 01	3.1-19(b) NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure only one type of sprinkler head, i.e. quick response or standard sprinklers were installed in 1 of 8 smoke compartments. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect at least 20 residents, staff, and visitors.	K 0351	**K 351** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The community failed to ensure that all sprinkler compartments had the same type of sprinkler heads. The front lobby had 2 quick response heads while the others around had standard	04/01/2024

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	Findings include: Based on observations on 03/12/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Maintenance Supervisor and Regional Director, the front lounge near the entrance to the 300 hall was open to the front lobby. The front lounge was equipped with two quick response sprinkler heads and the remainder of the sprinkler heads in the front lobby were standard response sprinkler heads. Based on interview at the time observation, this was acknowledged by the Maintenance Supervisor and Regional Director, and they both agreed there were a mixture of different type sprinkler heads within this compartmented space. This finding was reviewed with the Administrator, Regional Director, and Maintenance Supervisor during the exit conference. 3.1-19(b)		response. The Maintenance Supervisor has contacted with the sprinkler contractor to replace the 2 heads. The heads have been measured and ordered. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent fix to the violation so no further follow up will be needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the sprinkler heads within the community during the annual site visit inspections. **V. Plan of Correction completion date.** Plan of Completion date is April	

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	155333	A. BUILDING 01 B. WING	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			1st, 2024.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff,	K 0353	**K 353** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The community failed to ensure and document that a sprinkler control valve inspection was done weekly while doing the gauge testing. The Maintenance Supervisor has added the valve inspection to his current gauge testing tracking sheet. The	03/15/2024

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	and visitors in the facility. Findings include: Based on review of the sprinkler system inspection records on 03/12/24 between 9:30 a.m. and 12:45 p.m. with the Maintenance Supervisor and Regional Director present, there was no sprinkler control valve inspection documentation available for the past 12 month period. Based on interview at the time of record review, the Maintenance Supervisor said the sprinkler system control valves are visually inspected at least once a week, but not documented. This finding was reviewed with the Administrator, Regional Director, and Maintenance Supervisor during the exit conference. 3.1-19(b)		tracking sheet is on a clip board in the sprinkler riser room. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is a TELS task to inspect the fire sprinkler system weekly. We have added a control valve inspection to this current task. See attached TELS task labeled “Paoli TELS Gauge and valve inspection Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit this task and clipboard during their annual site inspections. **V. Plan of Correction completion date.**	

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			Plan of Completion date is March 15th, 2024.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a	K 0511	**K 511** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The community failed to ensure that all the outlets on the dining room counter top near the sink were GFCI protected. The Maintenance Supervisor has rewired receptacle to existing receptacle with a GFCI receptacle. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff in the dining room could be affected by this deficient practice.	03/15/2024

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	branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect mostly kitchen staff.		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- The rewiring of the outlet to GFCI is a permanent fix to this violation so no further follow up is needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all electrical outlets that should be GFCI protected during their annual inspection. **V. Plan of Correction completion date.** Plan of Completion date is March 15th, 2024.	

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	Findings include: Based on observations on 03/12/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Maintenance Supervisor and Regional Director, the right half of the wall mounted quad electric receptacle furthest to the right of the sink behind the dining room steam table was not provided with GFCI protection. This receptacle was within five feet of the sink. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Supervisor and Regional Director agreed the previously mentioned receptacle was not properly GFCI protected. This finding was reviewed with the Administrator, Regional Director, and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure electrical wiring was protected in 1 of 8 smoke barriers. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect mostly kitchen staff. Findings include: Based on observation on 03/12/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with			

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	the Maintenance Supervisor and Regional Director, the wall mounted electrical receptacle just above the sink behind the dining room steam table had a loose receptacle cover and hanging out from the wall about a half inch. Based on interview at the time of observation, the Maintenance Supervisor and Regional Director acknowledged the loose electrical receptacle on the wall behind the dining room steam table and said it would be fixed by the end of the day. This finding was reviewed with the Administrator, Regional Director, and Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0531 SS=D Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke			

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	detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation, and interview; the facility failed to ensure documentation was provided for the testing of 1 of 1 elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect up to two residents and staff while using the elevator to the Physical Therapy gym. Findings include: Based on record review on 03/12/24 between 9:30 a.m. and 12:45 p.m. with the Maintenance Supervisor and Regional Director present, there was no documentation available for the monthly firefighter recall test for the elevator for the past 12 months and prior. Based on interview at the time of record review, the Maintenance Supervisor and Regional Director said they were not sure if the elevator was equipped with a firefighter recall, and said there was no documentation available for the testing of a firefighter recall for the elevator. Based on observation on 03/12/24 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Maintenance Supervisor and Regional Director the elevator was equipped with a firefighter recall key operation. This was confirmed by the Maintenance Supervisor and Regional Director at the time of observation. This finding was reviewed with the Administrator, Regional Director, and Maintenance Supervisor	K 0531	**K 531** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The community failed to document that the monthly fire fighter recall was being tested on the elevator. The Maintenance Supervisor has contacted Murphy Elevator to show and educate him on how to safely do this. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is a current monthly TELS task to test the	03/15/2024

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	during the exit conference. 3.1-19(b)		firefighter recall on the elevator. See attached task labeled “Paoli Fire Fighter Recall TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the firefighter recall paperwork to ensure that it is being completed and documented. **V. Plan of Correction completion date.** Plan of Completion date is March 15th, 2024.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held at varied times	K 0712	**K 712**	03/15/2024

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	and varied dates for all shifts and quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 03/12/24 between 9:30 a.m. and 12:45 p.m. with the Maintenance Supervisor and Regional Director present, the following was noted: a. 11 of 12 fire drills conducted during the past 12 month period were held during the last three days of each month. b. 3 of 4 third shift fire drills during the past 12 month period were held between 4:48 a.m. and 5:15 a.m. Based on interview at the time of record review, the Maintenance Supervisor and Regional Director acknowledged the times and dates of all fire drills conducted during the past 12 month period and agreed they were not varied enough by time or date. This finding was reviewed with the Administrator, Regional Director, and Maintenance Supervisor during the exit conference. 3.1-19(b) 3.1-51(c)		**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The community failed to ensure that the monthly fire drills did not vary enough between time and date. The Maintenance Supervisor has been re educated that fire drills cannot occur at the end of every month. CarDon Corporate Facilities has laid out a time and date map to help ensure this does not happen again. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated that fire drills cannot occur at the end of every month. CarDon Corporate Facilities has laid out a time and	

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			date map to help ensure this does not happen again. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the fire drill documentation and logs to ensure they vary each month. **V. Plan of Correction completion date.** Plan of Completion date is March 15th, 2024.	