Marquetta

PRINTED: 04/03/2024 FORM APPROVED OMB NO. 0938-039

03/28/2024

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155333		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/12/2024	
	PROVIDER OR SUPPLIER		559 W	ADDRESS, CITY, STATE, ZIP COD LONGEST ST IN 47454	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg	conducted by the In accordance with 42  Survey Date: 03/12  Facility Number: 0  Provider Number: 1002  At this Emergency I Health and Living Compliance with En Requirements for M Participating Provided 483.73	00226 155333	E 0000		
	0 11: 7	1 . 1 . 00/15/04			
	Quality Review con	npieted on 03/15/24			
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 03/12  Facility Number: 0 Provider Number: 1002	00226 155333	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 Complian	се
I ADODATOR	V DIDECTORIS OF PROV	/IDED/CHIDDHED DEDDECENTATIVES OF	I GNIATUDE	TITLE	(VA) DATE
LABORATOR	CT DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATUKE	TITLE	(X6) DATE

Any defiency statement 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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Motsinger

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155333	B. WI	NG		03/12/2	2024
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	ER			LONGEST ST		
PAOLLE	IEALTH AND LIVIN				IN 47454		
TAOLIT	LALIII AND LIVIN	NG COMMONT I		I AOLI,	111 47454		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		y Inc. was found not in			Event ID: C77X21		
	•	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,				Dear Mrs. Buroker:		
					Please find enclosed the Plan		
	I	(LSC), Chapter 19, Existing			Correction for the State Licens		
	Health Care Occup	pancies and 410 IAC 16.2.			Survey conducted on March 1		
					2024. This letter is to inform	/ou	
	This one story fac			that the plan of correction			
	determined to be o			attached is to serve as Paoli			
	was sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in				Health & Living Community		
					credible allegation of complian		
					We allege substantial complia		
	resident sleeping rooms in the 400 and 500 halls,				on March 29th, 2026. We are		
		ry operated smoke detectors			requesting paper compliance	for	
		other resident sleeping rooms.			this plan of correction.		
	1	capacity of 109 and had a			l		
	census of 95 at the	e time of this survey.			If you have any further question		
		21 1			please do not hesitate to cont	act	
		sidents have customary access			me at 812-723-2595		
	_	and all areas providing facility					
	_	nklered, except two detached			Sincerely,		
		ne metal shed used for facility					
	storage.				Name of the Marketin was 1150		
	Ovality Daview or	ompleted on 03/15/24			Marquetta Motsinger, HFA Administrator		
	Quality Keview Co	ompleted on 03/13/24					
					Paoli Health and Living		
					Submission of this plan of		
					correction in no way constitute	25	
					an admission by Paoli Health		
					Living or its management		
					company that the allegations		
l	1		- 1		1		

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155333	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/12/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 559 W LONGEST ST PAOLI, IN 47454				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION DATE DATE		
K 0200 SS=D Bldg. 01	Means of Egress List in the REMAR Section 18.2 and requirements that provided K-tags, k information, along Safety Code or NI should be included 18.2, 19.2 Based on observation failed to ensure 2 of public rest rooms, v locking device that to unlock from the other emergencies in 7.1.10.1. This deforms that the other emergencies is 7.1.10.1. This deforms the other emergencies is 7.1.10.1.	Requirements - Other Requirements - Other RKS section any LSC 19.2 Means of Egress are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567.  on and interview, the facility find egress doors from the two overe not equipped with a would require the use of a key outside in the case of fire or on accordance with LSC citent practice could affect two sitors.	K 0200	contained in the survey repetrue and accurate portrayal provision of nursing care of services provided in this father Plan of Correction is pland executed solely becaute required by Federal and Statew.  This statement of deficient plan of correction will be reat the Monthly Quality Assurance/Assessment Committee meeting.  K 200 I. The corrective actions accomplished for those residents found to have be affected by the deficient practice.  Observation A- The 2 publications are equipped.	I of the r other acility. I orepared use it is state  Sies and eviewed  103/21/2024  10 be  10 ic ed with		
	Findings include:		1	a thumb turn dead bolt and	da I		

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NAME OF PROVIDER OR SUPPLIER  PAOLI HEALTH AND LIVING COMMUNITY  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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, and Maintenance Supervisor during the exit conference.  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.  Supervisor and Regional Director, and Maintenance Supervisor during the exit conference.  All Residents and staff that use the restrooms could be affected by this deficient practice.		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155333		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/12/2024	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Based on observations on 03/12/24 between 12:45 p.m. and 2:45 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.  PREFIX TAG  PREFIX TAG  PREFIX TAG  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				559 W	LONGEST ST		
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	(X4) ID PREFIX	Based on observation p.m. and 2:45 p.m. the Maintenance S Director, the public entrance and the pure locking devices the open from the outs time of each observation of a key if locked.  This finding was re Regional Director, during the exit contribution of the contr	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  Tons on 03/12/24 between 12:45 during a tour of the facility with upervisor and Regional c rest room near the front ablic rest room near the center the both equipped with deadbolt at required the use of a key to ide. Based on interview at the vation, the Maintenance gional Director agreed the the two rest room doors could om the outside without the use  eviewed with the Administrator, and Maintenance Supervisor	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)  latching door handle. The turn dead bolt has a key to them. The latching door han non locking. At the time of survey, a key was not avail review. The Maintenance Supervisor has since obtain keys for the 2 doors in questively are kept at each station and med carts.  II. The facility will identify other residents that may potentially be affected by deficient practice.  All Residents and staff that the restrooms could be affet this deficient practice.  III. The facility will put intended the following system changes to ensure that the deficient practice does not recur.  Observation A- There is an TELS task for the Maintena Supervisor to verify the reskeys are at the nurse static med carts. See attached easimonth task Labeled "Pace Bathroom Key Inspection"  IV The facility will monit the corrective action by	thumb unlock andle is lable for ned stion. nurse  ty the  t use ected by  to matic ne ot new ance stroom on and every bli TELS  tor	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155333	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURY  COMPLETED  03/12/202	D	
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD				
PAOLI H	EALTH AND LIVING	G COMMUNITY	559 W LONGEST ST PAOLI, IN 47454				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	ECTION DULD BE PROPRIATE  CO	(X5) MPLETION DATE	
K 0222 SS=D Bldg. 01	be equipped with requires the use of egress side unless special locking are CLINICAL NEEDS LOCKING Where special locking are used, only one lock permitted on each be made for the raby: remote control locks or keys carrother such reliable staff at all times.  18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special locks are pering met. In a great side of the Clinical or Section 1.00 are being met. In a great side of the such reliable staff at all times.	king arrangements for the eds of the patient are cking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the		measures.  CarDon Corporate Faci audit the restroom keys annual site visit inspect  V. Plan of Correction completion date.  Plan of Completion date 21st, 2024.	during the ions.		

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Event ID:

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA			ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>01</u> CO		COMPL	ETED	
		155333	B. W	ING		03/12/	/2024	
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD			
DAGLLI		C COMMUNITY			LONGEST ST			
PAULI H	EALTH AND LIVING	3 COMMUNITY		PAULI,	IN 47454			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	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							
		(or is constantly monitored						
		ation 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							
		g low and ordinary hazard						
		gs protected throughout by						
		ervised automatic fire						
		or an approved, supervised						
	automatic sprinkle							
	18.2.2.2.4, 19.2.2.	-						
	ACCESS-CONTR							
	LOCKING ARRAN							
		d Egress Door assemblies						
		lance with 7.2.1.6.2 shall						
	be permitted.	ianoc with 1.2.1.0.2 Stidii						
		2.4						
	18.2.2.2.4, 19.2.2.	3Y EXIT ACCESS						
	LOCKING ARRAN							
		t access door locking in						
		7.2.1.6.3 shall be permitted						
		es in buildings protected						
		approved, supervised						
		ection system and an						
		sed automatic sprinkler						
	system.	0.4						
	18.2.2.2.4, 19.2.2.			222	14.000		02/20/2024	
		on and interview, the facility	K 0	222	K 222		03/29/2024	
		f 11 delayed egress locking						
	arrangements were	installed in accordance with			I. The corrective actions to b	e		

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CENTERS FOR	NTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155333	B. W.	ING		03/12/	/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 559 W LONGEST ST PAOLI, IN 47454					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE	
TAG	LSC 7.2.1.6.1(3) where process shall release egress within 15 section approved by the authorn application of required in 7.2.1.5.1 conditions:  (a) The force shall reference in the force shall recontinuously applies (c) The initiation of activate an audible adoor opening.  (d) Once the lock he application of force relocking shall be body This deficient pract residents, staff, and	hich states an irreversible ethe lock in the direction of conds, or 30 seconds where chority having jurisdiction, a force to the release device 10 under all of the following not be required to exceed 15 lbf and be required to be d for more than 3 seconds. The release process shall signal in the vicinity of the to the releasing device, y manual means only. ice could affect at least 13 visitors in the 500 hall.		TAG	accomplished for those residents found to have been affected by the deficient practice.  Observation A- The marked endoor 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.	nxit he ole.	DATE	
		during a tour of the facility with			III. The facility will put into place the following systemat	ic		
		pervisor and Regional			changes to ensure that the	.iC		
		e exit door leading into the 500			deficient practice does not			
	hall was equipped v	vith delayed egress. When the			recur.			
	several times the do magnetic hold locat However, the magn when the code was next to the door. Be observation, the Ma Regional Director a	or was pushed for 15 seconds for did not release from the feed at the top of the door, etic hold did release the door pushed on the keypad located fased on interview at the time of functionance Supervisor and cknowledged and agreed this lease when the panic bar was add several times.			Observation A- There is a new TELS task for the Maintenanc Supervisor to inspect all exterdoors to ensure the functional and delayed egress works. So attached weekly task Labeled "Paoli Delayed Egress Door Inspection."	e ior ity ee		
	P 35110	and development			IV The facility will monitor			
	This finding were re	eviewed with the			the corrective action by			

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Administrator, Regional Director, and

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implementing the following

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155333		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/12/2024		
	ROVIDER OR SUPPLIER		559 W	STREET ADDRESS, CITY, STATE, ZIP COD 559 W LONGEST ST PAOLI, IN 47454		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Maintenance Super conference. 3.1-19(b)	visor during the exit		measures.  CarDon Corporate Facilities winspect all exit doors during the annual site visit inspections to ensure the delayed egress	ne	
				function on all doors work.  V. Plan of Correction completion date.		
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lightir Emergency Lightir Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2-hour d automatically in		Plan of Completion date is Ma 29th, 2024.	arch	
	Based on record revinterview; the facili documentation for the backup lights that we seconds during 12 cannually for 90 min to ensure the light we periods of power out emergency lighting accordance with Serequires functional monthly, with a min maximum of 5 weel than 30 seconds, (3) conducted annually if the emergency lighting powered and (5) With the facility of the second of the facility of the faci	tiew, observation, and ty failed to ensure there was the testing of 1 of 1 battery were tested monthly for 30 of the past 12 months, and tutes during the past 12 months would provide lighting during ttages. LSC 19.2.9.1 requires shall be provided in ection 7.9. Section 7.9.3.1.1 (1) testing shall be conducted timum of 3 weeks and a tas between tests, for not less of Functional testing shall be for a minimum of 1 1/2 hours thing system is battery witten records of visual as shall be kept by the owner	K 0291	I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice.  Observation A- The communifialed to ensure that the batter powered emergency light that located at the generator had be tested for 30 seconds monthly 90 minutes annually. The Maintenance Supervisor has re educated that this needs to completed. He has created a clipboard that will hang in the sprinkler riser room to docume	ty ry t was been y and been b be	

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CENTERS FOR	MEDICAKE & MEDIC				OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01                                    </u>	COMPLETED	
		155333	B. WING		03/12/2024	
			<u> </u>			
NAME OF P	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
			559 W LONGEST ST			
PAOLI HI	EALTH AND LIVING	G COMMUNITY	PAOLI,	IN 47454		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINEDIS BLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG	·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIAT	DATE	
	jurisdiction. This d	leficient practice could affect all		this.		
	-	s staff and visitors in the				
	facility.					
				II. The facility will identify		
	Findings include:			other residents that may		
	- mamas merade.			potentially be affected by the		
	Based on record rev	view on 03/12/24 between 9:30		deficient practice.		
				denoient practice.		
	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			All Residents and staff could be	_	
				affected by this deficient practi-	ue.	
		past 12 month period.		III. The facility will put into		
	· ·	was no documentation		place the following systemati	С	
		ne battery powered emergency		changes to ensure that the		
	-	nually for 90 minutes during		deficient practice does not		
		period. Based on an interview		recur.		
		d review, this was confirmed by				
		pervisor and Regional		Observation A- There is a new		
	Director. During a	tour of the facility with the		TELS task for the Maintenance	;	
	Maintenance Super	visor and Regional Director		Supervisor to test the generate	or	
	between 12:45 p.m.	and 2:45 p.m., the facility was		emergency light every month a		
	equipped with one	emergency battery powered		annually for 90 minutes. See		
		mergency generator.		attached every month task		
	-			Labeled "Paoli TELS Generato	r	
	This finding was re	viewed with the Administrator,		Emergency Light TELS Task"		
	_	and Maintenance Supervisor				
	during the exit conf	-				
				IV The facility will monitor		
	3.1-19(b)			the corrective action by		
	(-)			implementing the following		
				measures.		
				incasures.		
				CarDon Corporate Facilities wi	ıı	
				audit the task and clipboard du		
				the annual site visit inspections	_	
				une annual site visit inspections	o.	
				V. Plan of Correction		
				completion date.	1	

	D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLET		(X3) DATE SURVEY  COMPLETED  03/12/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 559 W LONGEST ST PAOLI, IN 47454		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on record reversible for the ser wired smoke detections trument was used for sensitivity. NFF Code, 2010 Edition detector sensitivity of installation, and After the second recomply sensitivity tests individually tests individually tests individually tests individually the permitted to 5 years. If the frequence of these alarr zones or areas when increase over the probable performed, detector is within its	in - Testing and  in is tested and maintained in an approved program is requirements of NFPA 70, code, and NFPA 72, in and Signaling Code. in acceptance, maintenance adily available. in acceptance and interview, the facility applete documentation was astitivity testing of all hard bors, and to show what testing at to test all smoke detectors and a subsequent acceptance, maintenance alarma and subsequent acceptance, maintenance alarma and to show what testing at to test all smoke detectors and to show what testing at to test all smoke detectors and to show what testing at the testing and the states and to show what testing at the testing and the states and and anaked sensitivity at time between calibration tests and anaked sensitivity and acceptance and acceptance and NFPA 70, and NFPA 72, and NFPA 70, and NFPA 72,	K 0345	Plan of Completion date is Ma 21st, 2024.  K 345  I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation A- The Communificated to ensure that the every 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 sensitivity test.  II. The facility will identify other residents that may potentially be affected by the deficient practice.	03/21/2024  De n

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155333	B. W	ING		03/12/2024	
N. 100 000	NOVEMBER OF STATE		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	· ·			LONGEST ST		
	EALTH AND LIVING	G COMMUNITY		PAOLI, IN 47454		,	
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION  (FACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		calibrated sensitivity test					
	instrument.	. 10 4			All Residents and staff could be		
		quipment arranged for the			affected by this deficient pract	ice.	
	purpose.	fire alarm control unit					
	1 ' '				III. The feedlift, will not into		
	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				III. The facility will put into place the following systematics:	tic	
					changes to ensure that the	lic	
					deficient practice does not		
	to the authority hav	-			recur.		
		have sensitivity outside the					
		ensitivity range shall be			CarDon Corporate Facilities w	<sub>rill</sub>	
	cleaned and recalibrated, or replaced.				audit the sensitivity test after		
	The detector sensitivity cannot be tested or				completion to ensure it include	es	
	measured using any spray device that administers				all the proper information.		
	an unmeasured con	centration of aerosol into the					
	detector. This defic	cient practice could affect all			IV The facility will monitor		
	residents, staff, and	visitors in the facility.			the corrective action by		
					implementing the following		
	Findings include:				measures.		
	Dogod or managed	view on 03/12/24 between 9:30			CorDon Cornerate Facilities	au .	
		with the Maintenance			CarDon Corporate Facilities w audit the sensitivity test after	/111	
		gional Director present, there			completion to ensure it include	26	
		available to show a smoke					
		test of all smoke detectors			all the proper information.		
		06/28/22 by the facility's fire			V. Plan of Correction		
	_	ction vendor, however, the			completion date.		
		de the Alarm Point at which					
	1 -	etector was tested at.			Plan of Completion date is Ma	arch	
	Furthermore, the 06	5/28/22 report did not include			21st, 2024		
		nufacturer's calibrated					
	sensitivity test instr	rument. This was confirmed					
	by the Maintenance	Supervisor and Regional					
	Director at the time	of record review.					
	Tl.:- £ 1'	and a control and a first and					
	_	viewed with the Administrator,					
	_	and Maintenance Supervisor					
	during the exit conf	erence.					
	I		1		I	ı	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDIN 155333 B. WING		ILDING	<u>01</u>		te survey ipleted 12/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 559 W LONGEST ST PAOLI, IN 47454				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Spinkler System - 2012 EXISTING Nursing homes, a by construction ty throughout by an a sprinkler system in 13, Standard for th Systems. In Type I and II co protection measur substituted for spr areas where state sprinklers. In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2 19.3.5.5, 19.4.2, 1 Based on observation failed to ensure only i.e. quick response of installed in 1 of 8 st 2010 Edition, Instal Section 8.3.3.2 state sprinklers are instal compartment shall to otherwise permitted 8.3.3.4 states when are converted to use sprinklers, all sprint shall be changed. To	Installation  Ind hospitals where required pe, are protected approved automatic accordance with NFPA ne Installation of Sprinkler instruction, alternative res are permitted to be inkler protection in specific or local regulations prohibit sklers are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers tas required by NFPA 13,	K 03	551	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 sprinkly compartments had the same tyof sprinkler heads. The front leads 2 quick response heads we the others around had standard.	y er ype obby hile	04/01/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDERA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED	
	155333		B. WING 03			03/12	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 559 W LONGEST ST PAOLI, IN 47454				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
	Findings include:  Based on observation p.m. and 2:45 p.m. of the Maintenance Sur Director, the front leads of the sprinkler heads and heads in the front leads in the front leads in the front leads in the front leads. Based on interview was acknowledged Supervisor and Regargeed there were a sprinkler heads with	ons on 03/12/24 between 12:45 during a tour of the facility with apervisor and Regional ounge near the entrance to the of the front lobby. The front odd with two quick response the remainder of the sprinkler obby were standard response at the time observation, this by the Maintenance gional Director, and they both mixture of different type hin this compartmented space.			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	the the en	
					Plan of Completion data is As	ril	
					Plan of Completion date is Ap	III	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155333		(X2) MULTIP A. BUILDIN	LE CONSTRUCTION IG <u>01</u>	· ′	(X3) DATE SURVEY COMPLETED	
		B. WING 03/12/2024				
NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP COD 559 W LONGEST ST PAOLI, IN 47454				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN O	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TON SHOULD BE THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAC	DEFICIENC	CY)	DATE
				1st, 2024.		
K 0353 SS=C Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system  Provide in REMAF coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record rev interview; the facili system inspections for 1 of 1 sprinkler for the Inspection, 7 Water-Based Fire P Edition, Section 5.1 department connect tested, and maintain 13. Section 13.1.1.1 utilized for inspectiv valves, valve compostates records shall tests, and maintenar components and shall	supply source  RKS information on non-required or partial or system.  and NFPA 25 riew, observation, and ty failed to document sprinkler in accordance with NFPA 25 systems. NFPA 25, Standard resting, and Maintenance of rotection Systems, 2011  2 states valves and fire ions shall be inspected, and in accordance with Chapter 2 states Table 13.1.1.2 shall be on, testing and maintenance of onents and trim. Section 4.3.1 be made for all inspections, ance of the system and its all be made available to the	K 0353	K 353  I. The corrective a accomplished for residents found to affected by the depractice.  Observation A- The failed to ensure an a sprinkler control was done weekly we gauge testing. The Supervisor has additional supervisor has additing the supervisor has additional supervisor has additional supervisor has additional superviso	those c have been efficient  e community d document that valve inspection while doing the e Maintenance ded the valve	03/15/2024
		isdiction upon request. This ould affect all residents, staff,		inspection to his cu testing tracking she		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		f '			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	COMPLETED		
	155333		B. WING 03/12/2024				
	ROVIDER OR SUPPLIER			559 W I	ADDRESS, CITY, STATE, ZIP COD LONGEST ST		
PAULITI	EALTH AND LIVING	3 COMMONT F		PAOLI,	IN 47454		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	DATE	
	and visitors in the fa	acility.			tracking sheet is on a clip boa	rd in	
	Findings includes				the sprinkler riser room.		
	Findings include:				II The feeility will identify		
	Raced on review of	the sprinkler system			II. The facility will identify other residents that may		
		on 03/12/24 between 9:30 a.m.			potentially be affected by the	_	
	_	the Maintenance Supervisor			deficient practice.		
	*	tor present, there was no			asiloidii piadilooi		
	•	lve inspection documentation			All Residents and staff could be	pe	
	_	st 12 month period. Based on			affected by this deficient pract		
	interview at the tim	e of record review, the					
	_	visor said the sprinkler system					
		isually inspected at least once					
	a week, but not doc	umented.			III. The facility will put into		
					place the following systemat	tic	
	_	viewed with the Administrator,			changes to ensure that the		
	_	and Maintenance Supervisor			deficient practice does not		
	during the exit conf	erence.			recur.		
	3.1-19(b)				Observation A- There is a TEI	S	
	3.1 17(0)				task to inspect the fire sprinkle		
					system weekly. We have add		
					control valve inspection to this		
					current task. See attached TE		
					task labeled "Paoli TELS Gau	ge	
					and valve inspection Task"		
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
					CarDon Corporate Facilities w	<sub>vill</sub>	
					audit this task and clipboard		
					during their annual site		
					inspections.		
					V. Plan of Correction		
					completion date.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155333		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 03/12/2024	
PAOLI H	PROVIDER OR SUPPLIEI	G COMMUNITY	559 W PAOLI	ADDRESS, CITY, STATE, ZIP COD LONGEST ST , IN 47454	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using complies with NFI Code, electrical w complies with NFI Code. Existing ins service provided it 18.5.1.1, 19.5.1.1 1. Based on observ facility failed to ens was provided with (GFCI) protection a 70, NEC 2011 Edit Circuit-Interrupter states, ground-fault personnel shall be in 210.8(A) through (in circuit-interrupter is accessible location. Informational Note circuit interrupter in accessible location. Informational Note circuit interrupter in feeders. (B) Other Than Dw single-phase, 15- an installed in the locat through (8) shall ha circuit-interrupter in (1) Bathrooms (2) Kitchens	I Electric I Electric I Electric I Electric I gas or related gas piping PA 54, National Fuel Gas Viring and equipment PA 70, National Electric I Estallations can continue in Ino hazard to life. I gainst electric stallations, ground fault circuit interrupter I against electric shock. NFPA I ion at 210.8 Ground-Fault I Protection for Personnel, I circuit-interruption for I provided as required in I continued in a readily I is See 215.9 for ground-fault I protection for personnel on I welling Units. All 125-volt, I ind 20-ampere receptacles I ations specified in 210.8(B)(1)	K 0511	Plan of Completion date is Man 15th, 2024.  I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation A- The communit failed to ensure that all the our on the dining room counter to prear the sink were GFCI protected. The Maintenance Supervisor has rewired recept to existing receptacle with a Creceptacle.  II. The facility will identify other residents that may potentially be affected by the deficient practice.	o3/15/2024  be n  ty tlets p tacle GFCI
	_	(3) and (4): Receptacles that are ble and are supplied by a		All Residents and staff in the dining room could be affected this deficient practice.	by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/12/2024 155333 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 559 W LONGEST ST PAOLI HEALTH AND LIVING COMMUNITY **PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance III. The facility will put into with 426.28 or 427.22, as applicable. place the following systematic Exception No. 2 to (4): In industrial establishments changes to ensure that the only, where the conditions of maintenance and deficient practice does not supervision ensure that only qualified personnel recur. are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) Observation A- The rewiring of the shall be permitted for only those receptacle outlet to GFCI is a permanent fix outlets used to supply equipment that would to this violation so no further follow create a greater hazard if power is interrupted or up is needed. having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within IV The facility will monitor 1.8 m (6 ft.) of the outside edge of the sink. the corrective action by Exception No. 1 to (5): In industrial laboratories, implementing the following receptacles used to supply equipment where measures. removal of power would introduce a greater hazard shall be permitted to be installed without CarDon Corporate Facilities will GFCI protection. inspect all electrical outlets that Exception No. 2 to (5): For receptacles located in should be GFCI protected during patient bed locations of general care or critical their annual inspection. care areas of health care facilities other than those covered under V. Plan of Correction 210.8(B)(1), GFCI protection shall not be required. completion date. (6) Indoor wet locations (7) Locker rooms with associated showering Plan of Completion date is March 15th, 2024. (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.

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staff.

This deficient practice could affect mostly kitchen

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155333			A. BUILDING B. WING	01	COMPLETED 03/12/2024
NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY			559 W	ADDRESS, CITY, STATE, ZIP COD LONGEST ST I, IN 47454	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Findings include:				
	p.m. and 2:45 p.m. the Maintenance St Director, the right helectric receptacle fibehind the dining reprovided with GFC was within five feet a GFCI testing devithe electrical circuit time of observation and Regional Directics.	ons on 03/12/24 between 12:45 during a tour of the facility with apervisor and Regional half of the wall mounted quad furthest to the right of the sink boom steam table was not I protection. This receptacle to of the sink. When tested with the tested with the tested on interview at the the Maintenance Supervisor tor agreed the previously le was not properly GFCI			
	_	viewed with the Administrator, and Maintenance Supervisor Perence.			
	3.1-19(b)				
	facility failed to ensure protected in 1 of 8 station. Article 406 (Cover Plates), require installed so as to and seat against the 2011 Edition. Article Receptacles shall be terminals are not expenses.	ration and interview, the sure electrical wiring was smoke barriers. NFPA 70, 2011 6.6, Receptacle Faceplates aires receptacle faceplates shall completely cover the opening mounting surface. NFPA 70, le 406.5 (F) Exposed Terminals, e enclosed so that live wiring aposed to contact. This build affect mostly kitchen staff.			
	Findings include:				
		on on 03/12/24 between 12:45 during a tour of the facility with			

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155333		r í	JILDING	01	COMPL 03/12/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 559 W LONGEST ST PAOLI, IN 47454				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0531 SS=D Bldg. 01	Director, the wall migust above the sink by table had a loose recout from the wall abinterview at the time. Maintenance Supervacknowledged the letthe wall behind the said it would be fixed.  This finding was reversely to the wall behind the said it would be fixed. This finding was reversely to the wall behind the said it would be fixed. This finding was reversely believed to the wall behind the said it would be fixed. This finding was reversely believed to the wall behind the said it would be fixed. This finding was reversely believed to the wall behind the said it would be fixed. This finding was reversely believed to said the wall behind the said it would be fixed. This finding was reversely believed to said the wall behind the wall behind the said it would be fixed. This finding was reversely believed to said the wall behind the said it wall behind the wall behin	with the provision of 9.4. ected and tested as A17.1, Safety Code for alators. Firefighter's d monthly with a written  conform to ASME/ANSI e for Existing Elevators I existing elevators, having f 25 feet or more above or at best serves the needs of anel for firefighting with Firefighter's Service asME/ANSI A17.3. r's service Phase I key detector automatic recall, e Phase II emergency in-car chine room smoke					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM			COMPLI	ETED
		155333	B. W	B. WING 03/12/2024			2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LONGEST ST		
DVULH	EALTH AND LIVING	COMMUNITY		l	IN 47454		
I AOLITI	LALIII AND LIVIN	S COMMONT I		I AOLI,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	detectors.)						
	19.5.3, 9.4.2, 9.4.						
		view, observation, and	K 0	531			03/15/2024
	interview; the facili	-					
		provided for the testing of 1			K 531		
	_	hter recall in accordance with					
	· ·	ting. LSC 9.4.6.2 states that all			I. The corrective actions to b	oe	
		fighters' emergency operations			accomplished for those		
		9.4.3 shall be subject to a			residents found to have beer	ו	
		with a written record of the			affected by the deficient		
		kept on the premises as			practice.		
		A17.1/CSA B44, Safety Code			Ob		
	for Elevators and Escalators. This deficient practice could affect up to two residents and staff				Observation A- The community		
	1 ~	vator to the Physical Therapy			failed to document that the		
	_	vator to the Physical Therapy		monthly fire fighter recall was being tested on the elevator. The		rho I	
	gym.				_	ne	
	Findings include:				Maintenance Supervisor has		
	rindings include.				contacted Murphy Elevator to show and educate him on how	, to	
	Rased on record rev	view on 03/12/24 between 9:30			safely do this.	10	
		with the Maintenance			Salely do tills.		
	_	gional Director present, there					
		ion available for the monthly			II. The facility will identify		
		st for the elevator for the past			other residents that may		
	_	r. Based on interview at the			potentially be affected by the	,	
	_	ew, the Maintenance Supervisor			deficient practice.		
	and Regional Direc	tor said they were not sure if			·		
	the elevator was eq	uipped with a firefighter recall,			All Residents and staff could b	oe	
	and said there was i	no documentation available for			affected by this deficient pract	ice.	
	the testing of a firef	fighter recall for the elevator.					
	Based on observation	on on 03/12/24 between 12:45					
	p.m. and 2:45 p.m.	during a tour of the facility with					
	the Maintenance Su	pervisor and Regional			III. The facility will put into		
	Director the elevator	or was equipped with a			place the following systemat	ic	
		y operation. This was			changes to ensure that the		
		laintenance Supervisor and			deficient practice does not		
	Regional Director a	at the time of observation.			recur.		
		viewed with the Administrator,			Observation A- There is a curi	rent	
	Regional Director,	and Maintenance Supervisor			monthly TELS task to test the	l	

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Event ID:

C77X21 Facility ID: 000226

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2024 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  155333	A. BUILDING  B. WING	01	COMPLETED 03/12/2024			
NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 559 W LONGEST ST PAOLI, IN 47454					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	during the exit confo	erence.		firefighter recall on the elevator See attached task labeled "Pa Fire Fighter Recall TELS Task	oli			
				IV The facility will monitor the corrective action by implementing the following measures.				
				CarDon Corporate Facilities we inspect the firefighter recall paperwork to ensure that it is being completed and documented.	ill			
				V. Plan of Correction completion date.				
				Plan of Completion date is Ma 15th, 2024.	rcn			
K 0712 SS=C Bldg. 01	alarm signal and s conditions. Fire dri and unexpected til conditions, at leas The staff is familia aware that drills ar routine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1	t quarterly on each shift.  r with procedures and is the part of established tills are conducted between AM, a coded ty be used instead of						
		iew and interview, the facility drills were held at varied times	K 0712	K 712	03/15/2024			

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Event ID:

C77X21

Facility ID: 000226

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155333		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 03/12/2024		
		PROVIDER OR SUPPLIEF		559 W	r address, city, state, zip cod / LONGEST ST I, IN 47454	
(X4) PREI			STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TA	.G	and varied dates for deficient practice of facility.  Findings include:  Based on review of	e all shifts and quarters. This build affect all residents in the call the facility's fire drill reports on 9:30 a.m. and 12:45 p.m. with	TAG	I. The corrective actions to accomplished for those residents found to have be affected by the deficient practice.  Observation A- The communication of the	<b>en</b> nity
		the Maintenance Su Director present, th a. 11 of 12 fire dril month period were of each month. b. 3 of 4 third shift month period were a.m. Based on interview	appervisor and Regional e following was noted: ls conducted during the past 12 held during the last three days fire drills during the past 12 held between 4:48 a.m. and 5:15 at the time of record review, appervisor and Regional		fire drills did not vary enough between time and date. The Maintenance Supervisor has re educated that fire drills ca occur at the end of every mc CarDon Corporate Facilities laid out a time and date map help ensure this does not ha again.	n s been annot onth. has
		fire drills conducted period and agreed to by time or date.  This finding was re Regional Director, during the exit confidence of the conf	lged the times and dates of all during the past 12 month hey were not varied enough viewed with the Administrator, and Maintenance Supervisor Ference.		II. The facility will identify other residents that may potentially be affected by the deficient practice.  All Residents and staff could affected by this deficient practice.	<b>he</b> I be
		3.1-19(b) 3.1-51(c)			III. The facility will put into place the following system changes to ensure that the deficient practice does not recur.  The Maintenance Superviso been re educated that fire dr cannot occur at the end of er month. CarDon Corporate Facilities has laid out a time	r has rills very

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/03/2024 FORM APPROVED OMB NO. 0938-039

CENTERSTOR	WIEDICARE & WIEDI	CAID SERVICES				OW	ID NO. 0936-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	01	COMPI	LETED	
		155333	B. W	ING		03/12	/2024
		100000		_		00/12	72021
NAME OF E	ROVIDER OR SUPPLIE	7 <b>D</b>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	KOVIDEK OK SUFFEII			559 W	LONGEST ST		
PAOLI H	EALTH AND LIVIN	IG COMMUNITY		PAOLI,	IN 47454		
	arn 0 ( ) n	V. C. D. L. D. L. D.	1		T		1 775
(X4) ID		Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					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		
					inspect the fire drill documen		
					and logs to ensure they vary each		
					month.	nonth.	
					V. Plan of Correction		
					completion date.		
					Completion date.		
					Plan of Completion date is M	arch	
					-	alcii	
					15th, 2024.		
					1		1

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