STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 00 B. WING	06/11/2024

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

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F 0000 Bldg. 00	This visit was for the investigation of complaints IN00435453, IN00435065, IN00433765, IN00432682, and IN00436416 IN00435453: No deficiencies related to the allegations are cited. IN00435065: No deficiencies related to the allegations are cited. IN00433765: No deficiencies related to the allegations are cited. IN00432682: Deficiencies related to the allegations are cited at F656 and F9999. IN00436416: No deficiencies related to the allegations are cited. Survey Dates: June 10 & 11, 2024 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Census bed type: SNF: 9 SNF/NF: 77 Total: 86 Census payor type: Medicare: 7 Medicaid: 63 Other: 16 Total: 86 These deficiencies reflect State findings cited in	F 0000	This plan of correction is to serve as Paoli Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Paoli Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for the following citations. ="" b="">="" b="">="" b="">="" b="">="" span="">="" span="">	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Smith	DON	06/27/2024

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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	accordance with 410 IAC 16.2-3.1. Quality review completed on June 12, 2024.			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for			

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	future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure the plan of care was implemented for 1 of 3 residents reviewed for resident abuse. A resident was not assisted by two staff members during a transfer according to the resident's plan of care. (Resident C) Finding includes: During a review of facility reported incidents on 6/10/24 at 12:30 P.M., a reported incident dated, 6/6/24 included that Resident C state that QMA was rough with her when positioning leg during a transfer. During record review on 6/11/24 at 10:30 A.M., Resident C's diagnoses included, but were not limited to, age-related physical debility, contracture of left knee, infection and inflammatory reaction due to internal left hip prosthesis, and unspecified displaced fracture of fourth cervical vertebra. Resident C's most recent Admission MDS (Minimal Data Set) assessment, dated 4/21/24, included that Resident C had no cognitive	F 0656	F 656 I The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident C was assessed at the time of the allegation, and given appropriate support and services. There were no injuries noted. C.N.A 6 was given re-education on following the plan of care for transfers. II. The facility will identify other residents that may potentially be affected by the practice. Current residents receiving care have the potential to be affected. Other interviewable residents were interviewed for any plan of care concerns, or staff not following plan of care/transfer concerns. No other residents have had any concerns with transfers or not following their plan of care. If any concerns would have been noted, they would have been addressed as necessary. All resident’s plan	06/28/2024

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	impairment, had one-sided impairment to upper and lower extremities, and was dependent for transfers. Resident C's physician orders included, but were not limited to, up as tolerated per plan of care (initiated 4/18/24). Resident C's care plan included, but was not limited to; Resident requires assistance with ADLs including bed mobility and transfers. Interventions included, follow physical therapy/occupational therapy recommendations, provide assistance for transfers as needed, and provide assistive device as needed (started 4/25/24). During a review of CNA POC (Point of Care) documentation from 6/1/24 to 6/10/24, Resident C required "total dependence" daily for transfers. The facility's investigation of the reported incident from 6/6/24 included an undated handwritten note signed by PT 4 and included, "...when I got to [Resident C's] room and observed [CNA 6] attempting to put [Resident C] in (wheelchair) with Hoyer lift alone. [CNA 6] had Hoyer lift control in her right hand and was pulling on [Resident C's] left leg, which made [Resident C] yell out in pain. I went into [Resident C's] room to assist and also noticed that the arm of the Hoyer (lift) was very close to [Resident C's] face..." During an observation on 6/11/24 at 11:15 A.M., Resident C was lying in bed. Her left knee was bent and she appeared to have difficulty rolling over in bed without assistance. During an interview on 6/11/24 at 1:45 P.M., PT 2		of care was reviewed. III. The facility procedures for transfers and care planning was reviewed with no changes made to the policy/procedures. The facility will put into place the following systematic changes to ensure that the practice does not recur. Nursing staff will receive re-education regarding transfers and the procedures for following the plan of care for residents' by 6/26/24. Transfer competencies with C.N.As will be completed by 6/28/24. IV. The facility will monitor the corrective action by implementing the following measures. DON/Designee will observe 2 random resident's care and transfers 5x a week for 8 weeks, then 2 random resident's care and transfers 2x a week for 8 weeks, and then 2 random resident's care and transfers weekly for 36 weeks to ensure the plan of care is being appropriately followed or as deemed by the Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 6/28/24	

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	indicated that Resident C was assessed to be dependent for transfers and required a mechanical lift such as a Hoyer lift for transfers and that two staff members are required to assist with a mechanical lift. During an interview on 6/11/24 at 2:00 P.M., PT 4 indicated that they had observed Resident C being transferred in a Hoyer lift by one staff member and that two staff should always be present during a Hoyer lift transfer to ensure resident and staff safety as well as proper positioning. On 6/11/24 at 3:40 P.M., the DON supplied a facility policy titled Safe Use of a Mechanical Lift, and dated 2/1/23. The policy included, "...At least 2 trained staff members are needed to safely move a resident using a mechanical lift." This citation relates to complaint IN00432682. 3.1-35(g)(2)			
F 9999 Bldg. 00	3.1-9 PERSONAL PROPERTY (g) The facility must inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident at the time of admission. It is the resident's responsibility to maintain and updated the inventory listing of the resident's personal property. This rule was not met as evidenced by: Based on interview and record review, the facility failed to inventory a residents personal property	F 9999	F 9999 I. The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident B's inventory sheet was completed and put into the resident's medical record. II. The facility will identify other residents that may potentially be affected by the practice. Current residents receiving care have the potential to be affected.	06/28/2024

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	upon admission and was unable to complete an inventory check off at discharge for 1 of 3 residents reviewed for misappropriation. No inventory was kept for a resident's clothing or personal belongings. (Resident B) Finding includes: During a review of resident council minutes on 6/10/24 at 12:15 P.M., the meeting minutes from a meeting on 5/23/24 included, but was not limited to, missing items from laundry. During record review on 6/11/24 at 10:00 A.M., Resident B's record indicated he had admitted to the facility on 3/28/24 and discharged from the facility on discharged with family on 4/9/24. No inventory sheet was found in Resident B's record. During an interview on 6/11/24 at 11:05 A.M., the Social Service Director (SSD) indicated that no inventory sheet was found for Resident B. SSD indicated that an inventory sheet should be filled out and added to the resident's record at the time of admission and is usually filled out by the admitting nurse. SSD was aware that Resident B had been missing a pair of pants, but indicated that family never gave the facility a description of the missing pants. During an interview on 6/11/24 at 11:55 A.M., LPN 4 indicated that when admitting a new resident, an inventory of the resident's belongings should be completed, and then at the time of discharge, the inventory should be checked off with family. On 6/11/24 at 3:40 P.M., the DON (Director of Nursing) supplied an undated admission		Current resident's records have been reviewed for completion of their personal inventory sheet. Any concerns noted, were addressed as necessary to ensure completion. III. The facility procedure on Personal Inventory Sheet completion was reviewed with no changes made. The facility will put into place the following systematic changes to ensure that the practice does not recur. Facility nursing staff will receive re-education regarding Personal Inventory Sheets by 6/26/24. The family members were contacted via a letter regarding Personal Inventory Sheet completion and the role the family plays in completion of the inventory sheets, and updating inventory sheets. IV. The facility will monitor the corrective action by implementing the following measures. DON/Designee will review All new admissions for completion of the Personal Inventory sheet weekly for 8 weeks, then up to 3 new admissions weekly for 8 weeks, and then 2 new admissions weekly for 36 weeks to ensure completion of Personal Inventory Sheets or as deemed by the Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing	

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	agreement that included, but was not limited to, "...Personal Property: ...Resident/Legal Representative will provide and mark any such personal possessions as needed and desired and will record all personal belongings (at admission and thereafter) on the resident's personal property inventory, signed by the resident or responsible party at admission." This citation relates to complaint IN00432682.		process, based upon the results of the audits. V. Plan of Correction completion date: 6/28/24	