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

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY STREET ADDRESS, CITY, STATE, ZIP CODE S59 WLONGEST ST PAOLI, IN 47454	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES FAOLI, IN 47454 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (FO00) INITIAL COMMENTS Facility number: 000226 Provider number: 155333 AIM number: 100267730 Paoli Health and Living Center was found to be compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the paper compliance review for the Investigation of Compliance review for the Investigation Compliance review for the Investigation Compliance review for the Investigation C			155333					
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 000226