STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155495	A. BUILDING -- B. WING	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PADDOCK SPRINGS	2695 SHELDON STREET WARSAW, IN 46582

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/14/24 Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230 At this Emergency Preparedness survey, Paddock Springs was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 57. Quality Review completed on 11/15/24	E 0000		
K 0000 Bldg. 02	A Life Safety Code Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/14/24 Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230 At this Life Safety Code survey, Paddock Springs was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Humberto Nunez	Executive Director	12/04/2024

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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	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 18, New Health Care Occupancies and 410 IAC 16.2. This one-story facility constructed in 2018 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wire smoke detection in the corridors, areas open to the corridors and in all resident rooms. The facility is fully protected by a Type II ESS 150 kW Natural Gas generator. The Healthcare Facility is connected to an Assisted Living Facility (Residential Board and Care Occupancy) from which it is separated by a Fire Wall with a 2-hour Fire Resistance Rating. All areas where the residents will have customary access were sprinklered. The facility has 60 certified beds. At the time of the survey, the census was 57. Quality Review completed on 11/15/24			
K 0345 SS=C Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation and interview with the	K 0345	K – 345 – Fire Alarm System – Testing and Maintenance 1 The facility's fire control panel time was incorrect during observation. The fire control panel time was updated and verified for accuracy. There were no residents affected by the deficient practice. The deficient practice has the potential to affect all residents in the facility.	11/29/2024

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	Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) at 1:45 p.m. on 11/14/24, the fire control panel time indicated 3:21 p.m. Based on interview at time of observation the DPO acknowledged the time on the fire control panel was incorrect. This finding was reviewed with the Executive Director, Director of Nursing, and Director of Plant Operations at the exit conference. 3.1-19(b)		2 The time on the fire control panel was updated and is correct. The DPO has been educated by the Executive Director regarding facility, state, and federal regulations regarding the inspection and documentation of the Fire Alarm System. The Director of Plant Operations has been educated on proper inspection and documentation of the Fire Alarm System per the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. 3 The DPO or designee will audit the Fire Alarm System for correct date and time weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months for continued compliance. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance Date: 11/29/2024	

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K 0712 SS=C Bldg. 02	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills under varying conditions according to LSC 101 19.7.1.6 and LSC 4.7.4 which require drills be conducted at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Director of Plant Operations (DPO) from 8:45 a.m. to 11:46 a.m. on 11/14/24, the "Perform a fire Drill" form indicated fire drills conducted during the first shift were all held within 1 hour and 5 minutes or less than the fire drill previously held, second shift fire drills were held within 40 minutes of each other, and during third shift three of the four fire drills were all held at the same time. During the first shift, fire drills were conducted in: first quarter at 9:30 a.m. on 02/11/24, second quarter at 10:00 a.m. on 05/27/24, third quarter at 8:55 a.m. on 08/11/24, and fourth quarter at 10:30 a.m. on 10/27/23. During the second shift, fire drills were conducted in: first quarter at 9:35 p.m. on 03/07/24, second quarter at 9:15 p.m. on 6/24/24, third quarter at 9:55 p.m. on 09/04/24, and fourth quarter at 9:20 p.m. on 12/26/23. During the third shift, fire drills were conducted in: first quarter at 4:45 a.m. on 01/07/24, second quarter at 4:45 a.m. on 4/29/24, third quarter at 4:45 a.m. on 07/24/24, and fourth quarter at 11:05 p.m. on 10/15/24.	K 0712	K – 712 – Fire Drills 1 The facility failed to ensure fire drills were completed at varying times throughout each shift. The DPO has completed fire drills at varying times on different shifts. There were no residents affected by the deficient practice. The deficient practice has the potential to affect all residents in the facility. 2 The fire drills have been updated at varying times on different shifts to meet the requirement. The DPO has been educated by the Executive Director regarding facility, state, and federal regulations regarding the appropriate expected and unexpected fire drills within the facility. 3 The ED or designee will audit all Fire Drills monthly for 6 months for continued compliance. 4 As a quality measure, the ED or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance	11/29/2024

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	Based on interview at the time of record review, the DPO acknowledged the dates and times of the fire drills. This finding was reviewed with the Executive Director, Director of Nursing, and Director of Plant Operations at the exit conference. 3.1-19(b) 3.1-51(c)		met. Compliance Date: 11/29/2024	
K 0761 SS=E Bldg. 02	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, observation and interview, the facility failed to ensure annual inspection and testing of 1 of 1 oxygen storage room fire door assemblies was completed. LSC 19.3.2.4 states medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing. 8.7.1.1 states protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclosing the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.3 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this	K 0761	K – 761 – Maintenance, Inspection and Testing - Doors 1 The facility failed to inspect the oxygen storage room door was inspected annually. The oxygen storage room door was inspected immediately and added to the monthly report. No residents were affected by the deficient practice. The deficient practice has the potential to affect all residents in the facility. 2 The oxygen storage room door was inspected and added to the routine fire door inspection report and audit to be completed monthly. The DPO has been educated by the Executive Director regarding facility, state, and federal regulations in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. 3 The DPO or designee will	11/29/2024

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	Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are		audit the Fire Doors weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months for continued compliance. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance Date: 11/29/2024	

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	inspected to verify their presence and integrity. This deficient practice affects residents, staff and visitors in the 400 Hall smoke compartment. Findings include: Based on record review and interview with the Director of Plant Operations (DPO) from 8:45 a.m. to 11:46 a.m. on 11/14/24, no documentation of an annual inspection of the oxygen storage room fire door assembly was available for review. Based on observation during tour of the facility with the Director of Plant Operations (DPO) from 11:48 a.m. to 1:48 p.m. on 11/14/24, one oxygen storage room was observed which contained "E" type medical oxygen cylinders. Based on interview at the time of record review, the DPO stated an annual inspection was not conducted for the oxygen storage room fire door assembly in the last year. This finding was reviewed with the Executive Director, Director of Nursing, and Director of Plant Operations at the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens 1. Based on observation and interview, the facility failed to ensure a multi-plug adaptor was not used as a substitute for fixed wiring in 1 of 16 resident rooms in the 300 hall. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects residents, staff and visitors in the 300 hall.	K 0920	K – 920 – Electrical Equipment – Power Cords and Extension Cords 1 The facility failed to ensure there were no multi-plug adapters being used in resident rooms. The multi-use adapters were removed from rooms 202 and 304 immediately and verified. No residents were affected by the deficient practice. The deficient	11/29/2024

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	Findings include: Based on observation during tour of the facility with the Director of Plant Operations (DPO) from 11:48 a.m. to 1:48 p.m. on 11/14/24, resident room 202 had a multi-plug adapter in use to power an electric recliner, a lamp and a clock. Based on interview at the time of observation with the Director of Plant Operations (DPO), he was not aware of the muti-plug adapter prior to observation during tour. 2 Based on observation and interview, the facility failed to ensure a power strip in 1 of 12 resident rooms met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 1 resident, staff and visitors. Findings include: Based on observation during tour of the facility with the Director of Plant Operations (DPO) from 11:48 a.m. to 1:48 p.m. on 11/14/24, resident room 304 had a table-top artificial Christmas tree plugged into and supplied power by a power strip that did not have a label indicating it meets the UL rating of 1363A or 60601-1. Based on interview at the time of observation, the DPO observed the power strip and stated the power strip was not of an approved type. This finding was reviewed with the Executive		practice has the potential to affect all residents in the facility. 2 A 100% audit was completed of the facility for any multi-plug adapters and the deficiency was corrected. The staff has been educated by the Executive Director regarding facility, state, and federal regulations regarding use of extension cords and multiplug adapters. 3 The DPO or designee will audit 5 resident rooms for use of extension cords or multi-plug adaptors weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months for continued compliance. 4 As a quality measure, the DPO or designee will review any findings and corrective action monthly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance Date: 11/29/2024	

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	Director, Director of Nursing, and Director of Plant Operations at the exit conference. 3.1-19(b)			