STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155495	A. BUILDING **02** B. WING _____	R **12/14/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	Initial Comments A Posit Revisit Survey (PSR) to the Emergency Preparedness Survey on 10/26/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/14/23 Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230 At this PSR 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 54. Quality Review completed on 12/19/23	{E 000}		
{K 000}	INITIAL COMMENTS A Post Revisit Survey (PSR) to the Life Safety Code Survey on 10/26/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/14/23 Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230 At this PSR survey, Paddock Springs was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a),	{K 000}		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155495	A. BUILDING **02** B. WING _____	R **12/14/2023**

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{K 000}	Continued From page 1 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 a capacity of 60 and had a census of 54 at the time of this survey. Quality Review completed on 12/19/23	{K 000}		