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	04/11/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 6, 7, 8, 9, 10, 11, 2025 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Census Bed Type: SNF/NF: 72 SNF: 4 Total: 76 Census Payor Type: Medicare: 6 Medicaid: 58 Other: 12 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 21, 2025.	F 0000	=”” spansubmission=”” does=”” not=”” constitute=”” an=”” admission=”” by=”” or=”” its=”” management=”” company=”” that=”” the=”” allegations=”” contained=”” in=”” survey=”” report=”” a=”” true=”” accurate=”” portrayal=”” provision=”” nursing=”” care=”” other=”” services=”” facility.=”” nor=”” agreement=”” allegations.=”” facility=”” respectfully=”” requests=”” desk=”” review=”” for=”” following=”” citations.<=”” p=””> =”” p=””> =”” p=””> This plan of correction is to serve as Paoli Health and Living 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. =”” p=””> =”” bthe=””> =”” b=””> =”” bthe=”>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lyndie McGraw	Administrator	05/16/2025

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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			=”” span=””> =”” span <=”” spansubmission=”” does=”” not=”” constitute=”” an=”” admission=”” by=”” or=”” its=”” management=”” company=”” that=”” the=”” allegations=”” contained=”” in=”” survey=”” report=”” a=”” true=”” accurate=”” portrayal=”” provision=”” nursing=”” care=”” other=”” services=”” facility.=”” nor=”” agreement=”” allegations. <=”” span=””>=”” span=”>	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect and dignity for 2 of 3 residents reviewed for dignity concerns and one random observation. Staff leaned over a resident to provide care and remove a fitted sheet, a resident's hair was disheveled, food was observed on a resident's face, blood ran down a resident's neck and staff failed to wipe it off, a resident had a gauze dressing on her forehead that was not covered, water was observed on the bedside table of a (nothing by mouth) NPO resident, and staff indicated they would provide water with a mouth sponge to a resident and failed to provide it. (Resident 57, Resident 44, Resident 64) Findings include: 1. On 4/7/25 at 1:10 P.M., Resident 57's clinical record was reviewed. Diagnoses included, but was not limited to, anemia, hypertension, and anxiety disorder.	F 0550	I. The corrective actions to be accomplished for those residents found to have been affected by the practice: Resident 64's face was cleaned and oral care was provided at the time of the concern. Proper hygiene was provided and bed linens were changed at the time of the concern. Resident 64 was provided water with a mouth sponge at the time of the concern. The cup of water was removed from the room at the time of the concern. Resident 57's forehead gauze dressing was covered at the time of the concern. However, at the time of the concern, the physician order did not state that the	05/07/2025

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	The most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/6/25, indicated Resident 57 was cognitively intact and had a skin tear. During an observation on 4/6/25 at 10:44 A.M., Resident 57 was observed in bed with an undated, uncovered yellow gauze dressing. During an observation of care on 4/10/25 at 11:01 A.M., Licensed Practical Nurse (LPN) 36 placed a yellow gauze dressing on Resident 57's forehead and failed to secure or cover the dressing. During an interview on 4/10/25 at 11:22 A.M., LPN 36 indicated sometimes a border dressing is placed over the gauze dressing for dignity reasons. During an interview on 4/10/25 at 1:12 P.M., Resident 57 indicated she liked for the bandage on her head to be covered up. During an interview on 4/10/25 at 1:17 P.M., the Assistant Director of Nursing (ADON) indicated Resident 57 would sometimes have the gauze covered because the gauze would fall down and Resident 57 felt like people were starring at her if it was not covered. 2. On 4/7/25 at 3:00 P.M., Resident 64's clinical record was reviewed. Diagnoses included, but were not limited to, traumatic brain injury, post traumatic stress disorder, schizophrenia, and dysphagia. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/9/25, indicated Resident 64's cognition was not able to be assessed, he had no behaviors, and was totally		forehead dressing had to be covered. Resident 57's order and care plan was updated to reflect her preference to have her forehead dressing be covered. Resident 44 received oral care and nail care at the time of the concern. Resident 44's shirt was changed, and hair was brushed at the time of the concern. 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. Current residents have been observed for any dignity/resident rights concerns. No other residents were affected. III. The facility policy on Resident Rights was reviewed with no changes made to the policy The facility will put into place the following systematic changes to ensure that the practice does not recur: Facility staff re-educated regarding resident rights and dignity and the facility procedures for hygiene, changing bed linens, oral care, wound card, and fluids at bedside. Nurses aides re-educated and completing a peri-care skills validation.	

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	dependent on staff. On 4/8/25 at 1:44 P.M., a Styrofoam cup of water with a lid and a straw were observed on the nightstand of Resident 64. While performing incontinence care, Certified Nurse Aide (CNA) 34 leaned over the resident and yanked on the upper corner of the fitted sheet to remove it from the mattress. The residents back was laying on the urine soaked sheet. CNA 34 leaned over the resident's legs and roughly wiped the buttocks of the resident. The resident's back was not wiped after laying on the soiled sheet. CNA 16 returned to the bedside and indicated the resident's sore on his chin was bleeding and the blood was going down his neck. CNA 34 went to the bathroom to remove gloves and wash their hands and all staff left the room. Resident 64 was left with blood running down his neck from his chin not wiped off and staff did not notify the nurse that the sore needed attention. On 4/8/25 at 4:07 P.M., Resident 64 was observed having medication administered through his g-tube (a tube inserted directly into the stomach through the abdominal wall) by Registered Nurse (RN) 66. Upon entrance into the room, blood was observed on the bed sheet, the resident's chin had dried blood on it, and there was dried blood observed down the resident's neck. During the medication administration, the resident repeatedly indicated "I need water" three times. RN 66 indicated she would use the oral sponges on him after she was finished with the medication administration. At that time, the resident's breath was observed to have a very strong odor and the skin inside his mouth was peeling and sticking on his teeth. The resident's bed sheet was not changed after the medication administration was over, the sore on his chin was not cleaned, the		IV. The facility will monitor the corrective action by implementing the following measures: DON/Designee will observe 2 random residents' oral care/hygiene/bed linens/appropriate wound coverings/fluids at bedside 5x a week for 8 weeks, and then 2 random residents' oral care/hygiene/bed linens/appropriate wound coverings/fluids at bedside 2x a week for 8 weeks, and then 2 random residents' oral care/hygiene/bed linens/appropriate wound coverings/fluids at bedside weekly for 36 weeks 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 these audits. V. Plan of Correction completion date: 5/7/25	

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	blood was not wiped off his neck, and the nurse did not return with the oral sponges to care for Resident 64. On 4/9/25 at 11:55 A.M., Resident 64 was laying in his bed and a Styrofoam cup of water with a lid and straw was sitting on his bedside table beside his bed. During an interview on 4/9/25 at 12:40 P.M., CNA 26 indicated if the sore on his chin was actively bleeding and it was going down his chin and neck, she would use an incontinence care wipe or wash cloth to clean it off and tell the nurse to look at it. At that time, she indicated Resident 64 was not to have anything by mouth (NPO) and they put the Styrofoam cup of water in his room for the nurse's to use when they flush his g-tube but it shouldn't have a straw in it because the resident can't have water. She indicated Resident 64 would ask for water and food especially if he saw his roommate getting it. She indicated they should use oral sponges to moisten his mouth. 3. On 4/7/25 at 10:13 A.M., Resident 44 was observed sitting in his room with dried food visible on his mouth and shirt, long fingernails with brown substance under them, and a thick white film covering his teeth. He indicated he had a shower earlier that morning. On 4/7/25 at 2:09 P.M., Resident 44's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, dementia without behaviors, schizophrenia, and anxiety. The most recent Annual MDS assessment, dated 3/8/25, indicated Resident 44's cognition was not able to be assessed, he had no behaviors, was partial to moderate assistance of staff (resident			

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	performed over half the effort) for oral hygiene, substantial to maximum assistance of staff (staff performed over half the effort) for personal hygiene, and dependent on staff for showering. On 4/8/25 at 2:17 P.M., Resident 44 was observed sitting in the bed in his room with dried food on his mouth and shirt, long fingernails with brown substance under them, and a thick white film covering his teeth. At that time, family indicated that they had brought concerns up with the staff about his cleanliness in the past and nothing had been done about it. They indicated when they visited, they took care of it or it wouldn't get done. On 4/9/25 at 11:55 A.M., Resident 44 was observed sitting in his wheelchair in the main lobby with his hair disheveled. During an interview on 4/09/25 12:34 PM CNA 26 indicated after resident's were done eating, the staff should make sure the resident doesn't have food on their face or clothing. She indicated Resident 44 was dependent on staff to do that for him, along with showering, combing his hair, and trimming his fingernails although his family sometimes did it for him too when they visit. During an interview on 4/10/25 at 1:42 P.M., the Assistant Director of Nursing (ADON) indicated staff should always treat the residents with dignity and respect when they were providing care to the residents. On 4/10/25 at 3:00 P.M., a current Resident Rights Policy, dated 6/6/19, was provided by Regional Clinical Support 2 and indicated " [company name] and it's member communities are committed to protecting and promoting the rights of the residents who reside in out communities. It is our			

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	policy that residents shall be treated with kindness, respect and dignity by associates, volunteers, contractors, and visitors" 3.1-3(a) 3.1-3(t)			
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure a notice of transfer or discharge was given to residents or resident representatives for 3 of 5 residents reviewed for hospitalizations, and the ombudsman was not notified for 5 of 5 residents reviewed for hospitalizations. The transfer discharge form was not completed. There was no documentation of a resident, representative, and the ombudsman receiving a notice of transfer or discharge at the time of hospitalization. (Resident 15, Resident 56, Resident 48, Resident 41, Resident 231) Findings include: 1. On 4/9/25 at 9:03 A.M., Resident 15's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 8/9/24 and returned back to the facility from the hospital on 8/13/24. Resident 15's clinical record lacked documentation of ombudsman notification for Resident 15's transfer. 2. On 4/8/25 at 1:29 P.M., Resident 231's clinical record was reviewed. Diagnoses included, but were not limited to, stroke (cerebral infarction), hypertension (HTN), and congestive heart failure (CHF).	F 0623	I. The corrective actions to be accomplished for those residents found to have been affected by the practice: Ombudsman was notified of Resident 15, Resident 56, Resident 48, Resident 41m and Resident 231 hospitalizations at the time of the concern. Ombudsman was notified of all hospitalizations from January 2025 - March 2025 at the time of the concern. Resident 41's notice of transfer or discharge completed form was uploaded into the resident's clinical record at the time of the concern. II. The facility will identify other residents that may potentially be affected by the practice: Residents residing at Paoli Health and Living have the potential to be affected by the deficient practice. All discharges within the last 30 days were reviewed for notice of	05/07/2025

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	The most recent Annual MDS assessment, dated 3/27/25, indicated Resident 231 was cognitively intact. The clinical record indicated Resident 231 was hospitalized on the following dates: 1/15/25-1/17/25 1/24/25-2/7/25 2/17/25-2/20/25 2/28/25-3/21/25 The Ombudsman was not notified of the transfers. 3. On 4/8/25 at 10:03 A.M., Resident 41's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of external lower lip and dysphasia. A progress note, dated 11/6/25 at 3:48 P.M., indicated Resident 41 was scheduled to leave the facility the following day for a surgery. Resident was discharged on 11/7/24 at 6:23 A.M. and returned 11/14/24. A Discharge Minimum Data Set (MDS) assessment was completed and signed on 11/7/24. Resident 41's clinical record lacked documentation that a Notice of Transfer or Discharge form was completed and/or sent with the resident and representative at the time of discharge on 11/7/24. 4. On 4/8/25 at 9:47 A.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to, right hip fracture and dementia. Resident 48 was transferred to the hospital on 3/10/25 following a fall.		transfer/discharge and ombudsman notification if applicable. III. The facility Bed Hold policy was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur: Facility staff re-educated regarding the facility's transfer/discharge procedure for residents. SS re-educated on monthly reporting process for notifications of transfers/discharges to the LTC Ombudsman. IV. The facility will monitor the corrective action by implementing the following measures: DON/Designee will review all resident transfers/discharges 5x a week for 8 weeks to ensure proper procedures for notice of transfers/discharges and ombudsman notification were followed, then will review all resident transfers/discharges 2x a week for 8 weeks to ensure proper procedures for notice of transfers/discharges and ombudsman notification were followed, then will review all resident transfers/discharges weekly for 36 weeks or as deemed by the Quality Assurance Committee to ensure proper	

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	Notification to the Ombudsman was lacking. 5. On 4/8/25 at 9:33 A.M., Resident 56's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and anxiety. Resident 56 was transferred to the hospital on 1/9/25 following a fall. Notification to the Ombudsman was lacking. On 4/8/25 at 10:20 A.M., the Assistant Director of Nursing (ADON) indicated when a resident was transferred, staff should sent a Continuity of Care Document (CCD), a transfer observation form, face sheet, and bed hold policy. She indicated the documents sent with a resident should have been scanned into the resident's clinical record. On 4/9/25 at 2:29 P.M., the Social Services Director (SSD) indicated she was unaware that the ombudsman should have been notified of Resident 41, Resident 48, or Resident 56's transfer or discharge, and did not know how the previous SSD did the notifications as she had taken over the position in February of this year. On 4/11/25 at 10:04 A.M., the Administrator indicated the previous SSD had been responsible for the notification to the ombudsman, but was only able to go back 90 days in the old email and unable to see if notification had been sent. The facility did not have record of the notifications. On 4/11/25 at 11:50 A.M., the Administrator provided a current Bed Hold policy, dated 12/15/22, and indicated at that time the policy would have been the same for the transfer or discharge forms. The policy indicated "[Company name] and its member communities will provide the resident and resident representative written		procedures for notice of transfers/discharges and ombudsman notification were followed. The results of the audits will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based on the results of the audits. V. Plan of Correction completion date: 5/7/25	

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	notice which specifies the duration of the bed-hold policy when a resident is admitted and again if the resident is hospitalized or on a therapeutic leave" 3.1-12(a)(6)(A)(iv)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure a bed hold policy was given to residents or resident representatives for 2 of 5 residents reviewed for hospitalizations. The bed hold form was not completed. There was no documentation of a resident or representative receiving a bed hold at the time of hospitalization. (Resident 15, Resident 41) Findings include: 1. On 4/9/25 at 9:03 A.M., Resident 15's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 8/9/24 and returned back to the facility from the hospital on 8/13/24. Resident 15's clinical record lacked documentation of a bed hold policy given to the resident or a representative at the time of the transfer. 2. On 4/8/25 at 10:03 A.M., Resident 41's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of external lower lip and dysphasia. A progress note, dated 11/6/25 at 3:48 P.M., indicated Resident 41 was scheduled to leave the facility the following day for a surgery. Resident was discharged on 11/7/24 at 6:23 A.M.	F 0625	I. The corrective actions to be accomplished for those residents found to have been affected by the practice: Resident 15 was provided with the bed hold policy retrospectively and uploaded to clinical record. Resident 41's completed transfer/discharge paperwork with bed hold policy was uploaded into Resident 41's clinical record at the time of the concern. II. The facility will identify other residents that may potentially be affected by the practice: Residents residing at Paoli Health & Living have the potential to be affected by the deficient practice. All discharges within the last 30 days were reviewed to ensure resident or resident representative received bed hold policy. III. The facility Bed Hold policy was reviewed with no changes made to the policy. The facility will put into place the following	05/07/2025

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	and returned 11/14/24. A Discharge Minimum Data Set (MDS) assessment was completed and signed on 11/7/24. Resident 41's clinical record lacked documentation that a Bed Hold policy was provided to the resident and representative at the time of discharge on 11/7/24. On 4/8/25 at 10:20 A.M., the Assistant Director of Nursing (ADON) indicated when a resident was transferred, staff should sent a Continuity of Care Document (CCD), a transfer observation form, face sheet, and bed hold policy. She indicated the documents sent with a resident should have been scanned into the resident's clinical record. On 4/11/25 at 11:50 A.M., the Administrator provided a current Bed Hold policy, dated 12/15/22, that indicated "[company name] and its member communities will provide the resident and resident representative written notice which specifies the duration of the bed-hold policy when a resident is admitted and again if the resident is hospitalized or on a therapeutic leave" 3.1-12(a)(25) 3.1-12(a)(26)		systematic changes to ensure that the practice does not recur: Facility staff re-educated regarding providing bed hold policy to resident or resident representative when resident transfers or discharges from facility. IV. The facility will monitor the corrective action by implementing the following measures: DON/Designee will review all resident transfers/discharges 5x a week for 8 weeks to ensure bed hold policy was provided to resident or resident representative at time of transfer/discharge, then will review all resident transfers/discharges 2x a week for 8 weeks to ensure bed hold policy was provided to resident or resident representative at time of transfer/discharge, then will review all resident transfers/discharges weekly for 36 weeks or as deemed by Quality Assurance Committee to ensure bed hold policy was provided to resident or resident representative at time of transfer/discharge. 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	

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PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

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F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurate for 2 of 5 residents reviewed for unnecessary medications, 1 of 2 residents reviewed for skin conditions, and 1 of 4 residents reviewed for accidents. Residents were taking an anticoagulant, antiplatelet, and anticonvulsant medications and a resident had falls that were not listed on the MDS assessments. (Resident 231, Resident 57, Resident 15, Resident 56) Findings include: 1. On 4/8/25 at 1:29 P.M., Resident 231's clinical record was reviewed. Diagnoses included, but were not limited to, stroke (cerebral infarction), hypertension (HTN), and congestive heart failure (CHF). The most recent Annual MDS assessment, dated 3/27/25, indicated Resident 231 was cognitively intact and did not take an antiplatelet or anticoagulant medication. Current Physician's Orders included, but were not limited to, the following medications: Aspirin (antiplatelet) 81 milligram (mg) tablet, give one tablet orally once a day upon Rising, ordered 3/21/25 Eliquis (anticoagulant) 5 mg tablet, give one orally twice a day upon Rising and before bedtime, ordered 3/21/25 A current Antiplatelet Care Plan, dated 2/20/25	F 0641	date: 5/7/25 I. The corrective actions to be accomplished for those residents found to have been affected by the practice: Resident 231's Minimum Data Set (MDS) assessment was updated to reflect antiplatelet and anticoagulant medications. Resident 56's Minimum Data Set (MDS) assessment was updated to reflect the falls on 11/19/24, 1/9/25, and 1/30/25. Resident 15's Minimum Data Set (MDS) assessment was updated to reflect the anticonvulsant and days for insulins and injections. Resident 57's Minimum Data Set (MDS) assessment was updated to reflect cancer diagnosis. II. The facility will identify other residents that may potentially be affected by the practice: Residents residing at Paoli Health and Living have the potential to be affected by the deficient practice. An audit was done on the most recent MDS assessments completed within the last 30 days for accuracy of assessment and	05/07/2025

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	and last reviewed 2/20/25, included an intervention to administer medications as ordered, initiated 2/20/25. The Medication Administration Record (MAR) for March of 2025 indicated resident received both aspirin and Eliquis daily starting on 3/21/25. During an interview on 4/10/25 at 10:15 A.M., the MDS Coordinator indicated the MDS Assessment erroneously lacked the correct information and should have listed an anticoagulant and antiplatelet on the resident's current medication list. 2. On 4/8/25 at 10:28 A.M., Resident 56's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and anxiety. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/16/25, indicated cognition could not be assessed, and no falls since the last assessment (11/18/24) or re-entry (1/9/25 Emergency Room visit). From 11/18/24 through 2/16/25, Resident 56 experienced falls on 11/19/24, 1/9/25, and 1/30/25. On 4/11/25 at 10:28 A.M., the MDS Coordinator indicated Resident 56's falls should have been marked on the 2/16/25 Quarterly MDS assessment. 3. On 4/9/25 at 9:03 A.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, depression, and hypertension. The most recent Annual Minimum Data Set (MDS) assessment, dated 1/27/25, indicated Resident 15 received injections and insulin on 2 of the 7 days during the 7 day look back period. The MDS lacked documentation that Resident 15		coding of falls, medications, and diagnoses. Any findings will be corrected. III. The facility utilizes Resident Assessment Instrument (RAI) Manual. RAI manual was reviewed with no changes made. The facility will put into place the following systematic changes to ensure that the practice does not recur: MDS staff re-educated on completing Minimum Data set (MDS) assessments completely and accurately. IV. The facility will monitor the corrective action by implementing the following measures: MDS/Designee will audit 5 MDS assessments for accuracy of assessment and coding of falls, medications, and diagnoses weekly for 8 weeks, then 3 MDS assessments for accuracy of assessment and coding of falls, medications, and diagnoses weekly for 8 weeks, and then 2 MDS assessments for accuracy of assessment and coding of falls, medications, and diagnoses weekly for 36 weeks 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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	received an anticonvulsant. Current Physician Orders included, but were not limited to, Mounjaro (insulin) pen injector 7.5 milligrams (mg) per 0.5 milliliters (ml) subcutaneous once a day, dated 4/1/25. Gabapentin (anticonvulsant) 600mg tablet once a day before bedtime, dated 7/5/22. Novolog flexpen U-100 insulin 100 unit/ml sliding scale three times a day, dated 9/18/24 Resident 15's Medication Administration Record (MAR) indicated he received the following medications on the following dates from 1/21/25 through 1/27/25: Mounjaro (insulin injection) on 1/22/25 Novolog (insulin injection) on 1/23/25 and 1/24/25 Gabapentin (anticonvulsant) 1/21/25, 1/22/25, 1/23/25, 1/24/25, 1/25/25, 1/26/25, 1/27/25 During an interview on 4/10/25 at 9:27 A.M., MDS Staff 38 indicated both the insulin and injections should have been marked for 3 days and the anticonvulsant should have been marked on the MDS. 4. During an interview on 4/6/25 at 10:44 A.M., Resident 57 indicated she had cancer on her forehead. On 4/7/25 at 1:10 P.M., Resident 57's clinical record was reviewed. Current diagnoses included, but was not limited to, malignant melanoma of scalp and neck (cancer), anemia, and anxiety disorder. The most recent Quarterly MDS, dated 2/6/25 indicated Resident 57 was cognitively intact. The		process, based upon results of the audits. V. Plan of Correction completion date: 5/7/25	

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	MDS failed to indicate Resident 57 had cancer. During an interview on 4/10/25 at 9:24 A.M., MDS Staff 38 indicated cancer should have been marked on the MDS. During an interview on 4/10/25 at 9:30 A.M., MDS Staff 38 indicated the facility utilized the Resident Assessment Instrument (RAI) manual as their policy.			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to ensure residents requiring assistance with Activities of Daily Living (ADLs) received adequate assistance with bathing, nail care and oral care for 3 of 3 residents reviewed for ADL care. (Resident 44, Resident 64, Resident 14) Findings include: 1. During an interview on Monday 4/7/25 at 10:44 A.M., Resident 14 indicated she was supposed to get a bath on Monday and Thursday but didn't always get them. She indicated she couldn't remember the last bath she got but knew she didn't get one last Thursday. She indicated the aides would tell her they were too busy. On 4/8/25 at 10:32 A.M., Resident 14 was observed lying in bed. She indicated she did not get a bath the previous day (Monday). She indicated an aide had asked her if she would like a washcloth to wash her face and hands, but no one else had asked her that. On Thursday 4/10/25 at 11:00 A.M., Resident 14	F 0677	I. The corrective actions to be accomplished for those residents found to have been affected by the practice: Resident 14 was given a bath per preference at the time of the concern. Resident 14's clothes were changed at the time of the concern. Resident 14's care plan preferences were reviewed and updated. Facility did have documentation of complete bed baths being given for Resident 14 per the resident's preferred schedule. The facility documentation was not a part of the resident's clinical record. Resident 44 was provided with oral care at the time of the concern. Resident 44's clothing was changed at the time of the concern. Resident 44's hair was brushed at the time of the concern. Resident 44 had been	05/07/2025

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	was observed lying in bed. She indicated she had the same dress on since she had went to her doctor's appointment a week ago yesterday. She indicated she had not had a bath yet today. The aide had offered her a shower, but she prefers a bed bath and couldn't do it by herself. On 4/7/25 at 2:21 P.M., Resident 14's clinical records were reviewed. Diagnoses included, but were not limited to, infection and inflammatory reaction due to internal right knee prosthesis, thrombocytopenia, pain in right knee, and unsteadiness on feet. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/26/25, indicated Resident 14 was cognitively intact, required substantial/maximal assistance, helper does more than half the effort, for toilet use, bed mobility, shower/bath and hygiene. Resident 14's preference to choose between a tub bath, shower, bed bath or sponge bath was very important. A current Resident has specific personal preferences care plan, start date 10/12/20, included, but was not limited to, an intervention to honor resident's bathing preference if applicable-resident's preference is: (per facility schedule), start date 10/12/20. March-April ADLs-Type of Bath 3/7/25 Complete Bath 3/10/25 Complete Bath 3/13/25 Complete Bath 3/20/25 Complete Bath 3/24/25 Complete Bath No other complete baths recorded thru 4/7/25, no refusals documented. During an interview on 4/9/25 at 11:42 A.M.,		referred to podiatry and had refused podiatry care visits. Resident 44's podiatry visit documentation was uploaded to Resident 44's clinical record at the time of the concern. Resident 44 was provided with fingernail and toenail care by the facility as resident allowed. Facility did have documentation of showers being given for Resident 44 per the resident's preferred schedule. The facility documentation was not a part of the resident's clinical record. Facility grievance forms were reviewed, and there is no record of Resident 44's spouse voicing care concerns. Resident 64 was provided with oral care and water on oral sponges at the time of the concern. Fluids were removed from Resident 64's room at the time of the concern. Resident 64's bed linens were changed at the time of the concern. Facility did have documentation of showers being given for Resident 64 per the resident's preferred schedule. The facility documentation was not a part of the resident's clinical record. Resident 64's family was contacted again on 4/10/25 with a request to consent or decline to ancillary services. Facility is awaiting response from family and will follow up accordingly. Resident 64 was provided with toenail care and fingernail care by	

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	Certified Nurse Aide (CNA) trainee 28 indicated Resident 14 was a bath. Residents got 2-3 baths per week depending on their choice. She indicated she was able to get her work done during her shift, and if a bath wasn't able to be done she would tell the next shift. 2. On 4/7/25 at 10:13 A.M., Resident 44 was observed sitting in his room with dried food visible on his mouth and shirt, long fingernails with brown substance under them, and a thick white film covering his teeth. He indicated he had a shower earlier that morning. On 4/8/25 at 2:17 P.M., Resident 44 was observed sitting in the bed in his room with dried food on his mouth and shirt, long fingernails with brown substance under them, and a thick white film covering his teeth. At that time, family indicated that they had brought concerns up with the staff about his cleanliness in the past and nothing had been done about it. They indicated when they visited, they sometimes took care of it or it wouldn't get done. On 4/9/25 at 11:55 A.M., Resident 44 was observed sitting in his wheelchair in the main lobby with his hair disheveled. On 4/7/25 at 2:09 P.M., Resident 44's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, dementia without behaviors, schizophrenia, and anxiety. The most recent Annual MDS assessment, dated 3/8/25, indicated Resident 44's cognition was not able to be assessed, he had no behaviors, was partial to moderate assistance of staff (resident performed over half the effort) for oral hygiene, substantial to maximum assistance of staff (staff performed over half the effort) for personal		the facility as resident allowed. II. The facility will identify other residents that may potentially be affected by the practice: Residents residing at Paoli Health and Living have the potential to be affected by the deficient practice. All notes for ancillary services were reviewed for the past 60 days and uploaded into resident clinical records as needed. All shower and ADL documentation were reviewed for the past 30 days. An observation was done for all residents for any hygiene concerns. Any concerns identified were addressed accordingly. III. The facility procedures for ADLs were reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur: Facility staff re-educated on activities of daily living and documentation of activities of daily living in the resident's clinical record. The facility SS re-educated on ancillary services and documentation in resident clinical records. IV. The facility will monitor the corrective action by implementing the following measures:	

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	hygiene, and dependent on staff for showering. The most recent Care Plan Conference for Resident 44, dated 4/3/25, indicated ancillary service preferences were reviewed and updated. "Wife had raised concerns of recent issues with personal care of resident in recent visit [nails had some dirt under, some food fallen on shirt and wheelchair]" The clinical record indicated Resident 44 missed showers on the following dates from February 1, 2025 through April 9, 2025 without documentation of refusals: 2/3/25 3/10/25 3/20/25 3/27/25 4/3/25 3. On 4/8/35 at 1:44 P.M., Resident 64 was observed to have long toenails and dark substance underneath his long fingernails during incontinence care. On 4/8/25 at 4:07 P.M., Resident 64 was observed during a medication administration. He repeatedly indicated "I need water" three times. Registered Nurse (RN) 66 indicated she would use the oral sponges on him after she was finished with the medication administration. At that time, the resident's breath was observed to have a very strong odor and the skin inside his mouth was peeling and sticking on his teeth. The nurse did not return with the oral sponges to provide oral care for Resident 64. On 4/7/25 at 3:00 P.M., Resident 64's clinical record was reviewed. Diagnoses included, but were not limited to, traumatic brain injury, post		DON/Designee will review all residents' scheduled showers to include nail care, bed linens, oral care, and all hygiene tasks to ensure completion and documentation into the residents' clinical record 5x a week for 8 weeks, all residents' scheduled showers to include nail care, bed linens, oral care, and all hygiene tasks to ensure completion and documentation into the residents' clinical record 2x a week for 8 weeks, and then all residents' scheduled showers to include nail care, bed linens, oral care, and all hygiene tasks to ensure completion and documentation into the residents' clinical record weekly for 36 weeks or as deemed by the Quality Assurance Committee. The results of the audits will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. The Administrator/Designee will review all residents scheduled for ancillary services and ensure all documentation is uploaded into the residents' clinical record monthly x 8 weeks, then will review 5 residents who are scheduled for ancillary services and ensure all documentation is uploaded into the residents'	

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	traumatic stress disorder, schizophrenia, and dysphagia. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/9/25, indicated Resident 64's cognition was not able to be assessed, he had no behaviors, and was totally dependent on staff. The clinical record indicated Resident 64 missed the following showers February 1, 2025 through April 9, 2025 without documentation of a refusal: 2/12/25 2/15/25 2/22/25 3/1/25 3/15/25 3/29/25 During an interview on 4/9/25 at 12:39 P.M., the Administrator indicated the ancillary podiatrist came to the facility every other month, the ancillary dental hygienist came every other month, and the ancillary dentist came as needed to the facility to see residents. She provided notes on Resident 44 from the ancillary providers that his last completed dental exam, dated 5/15/24, indicated resident has "poor oh [oral health], heavy plaque" and podiatry last saw him on 2/26/25 for trimming dystrophic (misshapen or unhealthy) nails and debrided (damaged or infected parts of the nail are removed) 5 nails or less but indicated these notes were not part of the clinical record. At that time, she indicated Resident 64 was admitted in September of 2024 and there was not a signed refusal or consent to ancillary services in his clinical record at that time and they would be following up with family about that.		clinical record monthly x 8 weeks, then will review 2 residents who are scheduled for ancillary services and ensure all documentation is uploaded into the residents' clinical record monthly x 36 weeks or as deemed by the Quality Assurance Committee. The results of the audits 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: 5/7/25	

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	During an interview on 4/9/25 at 12:34 P.M., CNA 26 indicated each hall had a shower schedule and provided the 300 Hall schedule at that time. At the bottom of the shower schedules, it indicated on shower days, bed linens were to be changed, nails were to be cleaned and trimmed, and resident may be shaven with showers on shower days and shaven daily. If resident refuses a shower, staff must notify assigned nurse and the nurse must make a progress note and notify the unit manager. Resident 64 should have a shower on Wednesday evenings and Saturday evenings according to the shower schedule and she would let the nurse know if his fingernails or toenails were long and needed attention because she wouldn't feel comfortable trimming his. She indicated oral care was part of the resident's morning care and she would use oral sponges on Resident 64 twice a shift when she worked and it was documented as "A.M. care" and not listed separately. CNA 26 indicated Resident 44 should have showers on Monday and Thursday during day shift, was dependent on staff to comb his hair, and trim his fingernails, although his family would sometimes did it for him when they visit. She indicated they would refuse care at times and the nurse was notified. During an interview on 4/10/25 at 10:32 A.M., the Director of Nursing (DON) indicated oral care should be performed at least once a day and as needed. During an interview on 4/10/25 at 1:42 P.M. the Assistant Director of Nursing (ADON) indicated CNAs should be looking at and cleaning the resident's nails every shower and letting the nurses know if the toenails or fingernails need clipped. Nurses should be clipping them or sending outside of the facility if they are not able			

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	to do it safely. Showers were done according to the shower schedule and documented on paper shower sheets and in the "Point of Care" section of the Electronic Medical Record. At that time, she indicated the shower sheets were not scanned into the resident's clinical record. On 4/10/25 at 3:00 P.M., a current Activities of Daily Living Policy was requested. At that time, Regional Clinical Support 2 indicated they did not have a policy for that but would use the Resident Rights Policy provided, dated 6/6/19, which indicated " [company name] and it's member communities are committed to protecting and promoting the rights of the residents who reside in out communities. It is our policy that residents shall be treated with kindness, respect and dignity by associates, volunteers, contractors, and visitors ... " 3.1-38(a)(2)(A) 3.1-38(a)(3)(C) 3.1-38(b)(1)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure care and services were provided to a resident with an open skin area for 1 of 3 residents reviewed with skin conditions. Assessments including measurements and description of the area were not completed for an open skin area. (Resident 60) Finding includes: On 4/7/25 at 2:05 P.M., Resident 60's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and	F 0684	I. The corrective actions to be accomplished for those residents found to have been affected by the practice: Resident 60's skin area is healed. State surveyors were unable to view Resident 60's skin condition due to resident refusal. Order for weekly head-to-toe skin assessment in place for resident. Resident 60's care plan was reviewed and updated.	05/07/2025

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	depression. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/9/25, indicated cognition status could not be assessed, the resident required partial to moderate assistance (helper does less than half the effort) with toileting, bathing, and transfers, and no skin concerns were identified. Physician orders included, but were not limited to: Observe (to right hip/buttock) dressing to open area every shift for soil or dislodgement. Observe for signs and symptoms of pain or infection, dated 4/4/25. Observe (right upper thigh/buttock) every shift. Observe for signs and symptoms of pain or infection, dated 3/4/25. mupirocin ointment; 2 %; apply a small amount to right upper thigh/buttock area twice a day, dated 3/4/25 through 3/6/25. mupirocin ointment; 2 %; apply a small amount to right upper thigh/buttock area twice a day, dated 3/6/25 through 3/18/25. A current care plan, revised 4/6/25, indicated resident had a boil to the buttocks. Interventions included, but were not limited to, record the location, size (length, width, and depth), color, distribution, contour, consistency of boil, dated 3/3/25. A Skin Integrity Event, dated 3/4/25, indicated a right upper thigh and buttock area was identified 3/3/25. The area was 1.5cm (centimeters) x 1cm, round, red, and an open boil like area that had popped. The area had scant, clear drainage.		II. The facility will identify other residents that may potentially be affected by the practice: Residents residing at Paoli Health and Living have the potential to be affected by the deficient practice. All residents with open skin wounds in the past 30 days were reviewed to ensure that care and services were being provided as ordered. III. The facility policy on wound management was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur: Facility nursing staff re-educated on wound management policy and procedures. Facility nurse management re-educated on care planning of wounds. IV. The facility will monitor the corrective action by implementing the following measures: DON/Designee will review all residents with open wounds weekly for 8 weeks to ensure proper assessment of wounds are being documented, then 3 random residents with open wounds weekly for 8 weeks to ensure proper assessment of wounds are	

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	Progress notes included, but were not limited to, the following: 3/4/25 at 3:43 P.M. Area to right upper thigh/buttock. A new order was placed for mupirocin twice a day. 3/4/25 at 5:42 P.M. Area to buttocks measured today. (The clinical record lacked the measurement that was completed) 3/4/25 at 11:42 P.M. Area to right buttock, treatment completed per order. 3/5/25 at 10:09 A.M. Area to buttock, treatment in place. 3/6/25 at 1:48 A.M. Area to buttock, treatment completed per order. 3/6/25 at 11:35 P.M. Area to buttock, treatment in place. 3/29/25 at 11:46 A.M. A Physician note indicated resident getting wound care to area on buttock. 4/6/25 at 2:16 P.M. A Social Services note indicated family was updated that a couple of the nursing staff resident was familiar and comfortable with were able to observe and treat the area/boil on the resident's buttock. A Quarterly/Annual nursing assessment, dated 3/28/25, indicated no skin conditions. Resident 60's clinical record lacked any assessments of the open area to the buttock after the Skin Integrity Event, dated 3/4/25. Resident 60's clinical record lacked a reason for		being documented, and then 2 random residents with open wounds weekly for 36 weeks to ensure proper assessment of wounds are being documented or as deemed by the Quality Assurance Committee. The results of the audits 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: 5/7/25	

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	discontinuing the mupirocin ointment used for the buttock on 3/18/25. On 4/8/25 at 10:08 A.M., the Assistant Director of Nursing (ADON) indicated the resident had refused observation of the area on her buttock. However, she indicated at that time the resident did allow her to observe the area. She indicated there was not a dressing and the area was closed. She indicated that the area was one that had opened and closed many times. On 4/9/25 at 9:45 A.M., the ADON indicated the wound physician did rounds weekly, and the floor nurses did assessments of wounds on Fridays. At that time, she indicated she was not sure when Resident 60's buttock wound was healed, and would look for additional assessments on the wound (information was not provided). On 4/9/25 at 10:04 A.M., the ADON indicated after an initial assessment that included measurements, only pressure ulcers, vascular wounds, incisions, and diabetic wounds would continue to get measured routinely. She indicated a boil was not considered a wound and would be treated the same as a skin tear, observing daily visually but no documentation. She indicated the order for the open boil was to observe and not to monitor, therefore no measurements or other assessments were completed. On 4/9/25 at 11:23 A.M., the Director of Nursing (DON) provided a current Wound Management policy, dated 2/1/19, that indicated "The Wound Team meets each week, preferably the same day and time to benefit the resident(s) being assessed. Each wound will be observed by the wound team to provide oversight of the care plan interventions and ensure that each resident's condition is			

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	accurately assessed in a timely manner. The skin conditions that the Wound Team should evaluate include, but are not limited to, the following: New wounds or open areas ... Existing pressure and non-pressure open areas ... Any other skin condition that has the potential to worsen without adequate management ... Healed area for four (4) weeks after healing" 3.1-37(a)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services Based on observation, interview, and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 of 1 residents reviewed for behavioral health. A resident's clinical record lacked documentation of behavior monitoring. (Resident 64) Finding includes: On 4/8/25 at 1:44 P.M., Certified Nurse Aide (CNA) 34 and CNA 16 were observed performing incontinence care on Resident 64. During the care, the resident indicated "Let her do it". At the conclusion of care, when CNA 34 was leaving the room, the resident yelled "A--hole". On 4/7/25 at 3:00 P.M., Resident 64's clinical record was reviewed. Diagnoses included, but were not limited to, traumatic brain injury (TBI), post traumatic stress disorder, schizophrenia, and dysphagia. The most recent Quarterly Minimum Data Set	F 0740	I. The corrective actions to be accomplished for those residents found to have been affected by the practice: Resident 64's care plan was updated to reflect behaviors at the time of the concern. Behavior monitoring was initiated at the time of the concern for Resident 64. II. The facility will identify other residents that may potentially be affected by the practice: Residents residing at Paoli Health and Living have the potential to be affected by the deficient practice. All residents' documentation for the past 30 days were reviewed for any behaviors. If behaviors identified, plan of care would be developed as appropriate. III. The facility policy on Behavioral	05/07/2025

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	(MDS) assessment, dated 1/9/25, indicated Resident 64's cognition was not able to be assessed, he had no behaviors, and was totally dependent on staff. A current Antipsychotic Medication Care Plan, dated 10/15/24, included, but was not limited to, the following intervention: Monitor resident's behavior and response to medication, created 11/15/24 A current Antidepressant Medication Care Plan, dated 12/31/24, included, but was not limited to, the following intervention: monitor resident's mood and response to medication, created 12/31/24 The clinical record lacked documentation of behaviors exhibited by Resident 64. During an interview on 4/8/25 at 3:15 P.M., the Director of Nursing (DON) indicated Resident 64 sometimes called staff names, covered up in his blanket in a cocoon, and would roll away from staff. During an interview on 4/8/25 at 4:03 P.M., the Administrator and Regional Clinical Support 1 indicated Resident 64 did not have a care plan that he had behaviors of refusing care or yelling out, because with a TBI, they weren't sure what behaviors he might have. During an interview on 4/9/25 at 12:40 P.M., Certified Nurse Aide (CNA) 26 indicated Resident 64 really doesn't complain or refuse much. He will sometimes if he was sleeping and wrapped up with his blanket over his head, but otherwise he was pretty easy going.		Health Management program was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur: Facility staff re-educated on behavioral health management program, procedures, and monitoring. Facility SS re-educated on behavioral health management program, procedures, and monitoring. IV. The facility will monitor the corrective action by implementing the following measures: Admin/Designee will review all residents' documentation for behaviors 5x week for 8 weeks to ensure behavioral health management and monitoring is being followed, then 10 random residents' documentation for behaviors 2x week for 8 weeks to ensure behavioral health management and monitoring is being followed, and then 10 random residents' documentation for behaviors weekly for 36 weeks or as deemed by the Quality Assurance Committee to ensure behavioral health management and monitoring is being followed. The results of the audits will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing	

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	During an interview on 4/10/25 at 10:13 A.M., the Administrator indicated all behavior documentation had been provided for Resident 44. On 4/10/25 at 3:00 P.M., A current Behavioral Health Management Program Policy, dated January 2024, was provided by Regional Clinical Support 2 and indicated "[company name] communities provide services to our residents with specific diseases and disorders. Some of our residents have medical disabilities that can lead to disruptive behaviors and these behaviors have the potential to create a negative effect on the resident, other residents, visitors, and staff. It is [company name]'s policy that each community will have a behavior program that: identifies, monitors, manages, and disseminates (whenever possible) all behavior events ... each individual resident will receive services according to their needs ... Residents who demonstrate any of the following characteristics should be involved in the behavior program ... any resident demonstrating new or worsening behaviors ... unresolved repetitive behaviors ... currently has a doctor's order to use antipsychotic, antidepressant ... Each [company name] facility will use the following documents to track behaviors and document ongoing services/interventions ... The nurse or social services will complete a behavioral event in the electronic medical record for each new or worsening behavior the resident demonstrates ...CNAs are able to document ... during the clinical meeting, when the IDT [Interdisciplinary team] is present, each behavior will be discussed ... IDT will write a note ... It is [company name] policy to ensure etiology of a resident's behavior is thoroughly investigated, documented, and care planned ... "		process, based upon the results of the audits. V. Plan of Correction completion date: 5/7/25	

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	3.1-37(a) 3.1-43(a)(1)			
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on observation, interview, and record review, the facility failed to maintain medical records on residents that are complete and accurate for 2 of 2 residents reviewed for self administration of medications, and 2 of 4 residents reviewed for activities of daily living. Two residents who self-administered medication did not have assessments documented. Ancillary services were not documented accurately for two residents. (Resident 10, Resident 66, Resident 44, Resident 64) Findings include: 1. On 4/8/25 at 10:54 A.M., Resident 10's clinical records were reviewed. Diagnosis included, but was not limited to, Type 2 diabetes mellitus without complications. The most recent Quarterly Minimum Data Set, dated 1/9/25, indicated Resident 10 was cognitively intact, was independent with eating and bed mobility, needed set up or clean up assistance with toilet use, and needed supervision with transfers. Physician's Orders included, but were not limited to, the following: Humalog KwikPen Insulin (insulin lispro) insulin pen; 100 unit/mL (milliliter); amt: Per Sliding Scale; If Blood Sugar is less than 60, call MD (Medical Doctor). If Blood Sugar is 151 to 200, give 14 Units. If Blood Sugar is 201 to 250, give 16 Units.	F 0842	I. The corrective actions to be accomplished for those residents found to have been affected by the practice: Resident 10's clinical record was updated to reflect that Resident 10 was assessed and could safely administer insulin themself. Resident 10's insulin order was updated to include an assessment of resident's ability to inject insulin with each administration. Resident 10's care plan was reviewed and updated as needed. Resident 66's clinical record was updated to reflect that Resident 66 was assessed and could safely administer nose spray themself. Resident 66's nose spray order was updated to include an assessment of resident's ability to administer nose spray with each administration. Resident 66's care plan was reviewed and updated. Ancillary services documentation was uploaded into Resident 44's clinical record. Resident 44's family made aware of recent ancillary services visit dates and the schedule for ancillary services.	05/07/2025

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	If Blood Sugar is 251 to 300, give 18 Units. If Blood Sugar is 301 to 350, give 20 Units. If Blood Sugar is 351 to 400, give 22 Units. If Blood Sugar is greater than 400, give 22 Units. If Blood Sugar is greater than 400, call MD. subcutaneous Special Instructions: Resident may administer insulin per self after nurse has drawn it up. IF over 400 give SSI (Sliding Scale Insulin) and call MD With Meals, dated 8/10/2023 1/30/2025 (DC Date) Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); amt: 55 units; subcutaneous Special Instructions: Resident may administer insulin per self after nurse has drawn it up. Once A Day, Before Bedtime, dated 8/10/2023 1/29/2025 (DC Date) A current Diabetic Care Plan indicated resident has potential for hypo/hyperglycemia and diabetic complications related to diabetes mellitus. resident prefers to inject own insulin after nurse doses, initiated on 10/8/20 and last revised on 4/06/25, included, but was not limited to, an intervention to administer medications per MD order, initiated on 10/8/20. The clinical records lacked documentation that Resident 10 was assessed and could safely administer insulin herself. On 4/9/25 at 10:30 A.M., the Director of Nursing was asked for document that some type of assessment was done to show that Resident 10 could safely administer her own insulin, and not provided. During an interview on 4/10/25 at 11:35 A.M., Regional Clinical Specialist 1 indicated they didn't		Ancillary services documentation was uploaded into Resident 64's clinical record. Toenail care, fingernail care, and oral care were provided as resident allowed. A new consent/refusal form for ancillary services was mailed to Resident 64's resident representative on 4/10/25. II. The facility will identify other residents that may potentially be affected by the practice: Residents residing at Paoli Health and Living have the potential to be affected by the deficient practice. SS conducted an audit of all residents to ensure ancillary services consent/declination forms are uploaded into residents' clinical record. SS conducted an audit to ensure all residents ancillary services visits in the last 60 days were uploaded into the residents' clinical record. All residents will be reviewed to determine if they may potentially be self-administering medications without prior assessment documented. III. The facility policy on Dental Services and the Nurse job description were reviewed with no changes made to the policy or job description. The facility procedure on ancillary services was reviewed	

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	fill out a self administration assessment on Resident 10 for the insulin because none of the questions apply to her. During an interview on 4/10/25 at 11:43 A.M., Regional Clinical Specialist 1 indicated she did not have any documentation in medical record that Resident 10 was observed injecting insulin safely. She indicated they charted by exception. 2. On 4/10/25 at 2:29 P.M., Resident 66's clinical records were reviewed. Diagnoses included, but were not limited to, cerebral infarction, need for assistance with personal care, and abnormalities of gait and mobility. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/5/25, indicated Resident 66 had moderate cognitive impairment, required set up for eating, supervision for toilet use, was independent for bed mobility and required partial/moderate assistance, helper does less than half the effort for transfers. Current Physician Orders included, but were not limited to, the following: Flonase Allergy Relief (fluticasone propionate) OTC (over the counter) spray,suspension; 50 mcg/actuation (microgram/actuation); amount: 1 spray both nostrils; Once A Day Upon Rising, dated 4/1/25. The clinical record lacked an order for Resident 66 to administer Flonase to herself, and a care plan that it was her preference to administer Flonase herself. There was no documentation that Resident 66 was observed being able to give Flonase correctly. 3. During an interview on 4/8/25 at 2:17 P.M., Resident 44's family indicated she was not made		with no changes made to the procedure. The facility will put into place the following systematic changes to ensure that the practice does not recur: Appropriate facility staff re-educated on documentation and maintaining complete and accurate medical records on residents. Facility nurses and QMAs re-educated on self-administration policies and procedures. Facility SS re-educated on the procedure for ancillary services. IV. The facility will monitor the corrective action by implementing the following measures: Admin/Designee will review 2 random residents 5x a week for 8 weeks to ensure ancillary services consents, declinations, and visits are uploaded into residents' clinical record, then 2 random residents 2x a week for 8 weeks to ensure ancillary services consents, declinations, and visits are uploaded into residents' clinical record, and then 2 random residents for 36 weeks or as deemed by the Quality Assurance Committee to ensure ancillary services consents, declinations, and visit are uploaded into residents' clinical record. The results of the audits will be reviewed at the monthly quality	

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	aware of when dental services was coming to the facility and she did not know when the last time was that Resident 44 was seen but she paid for the services. At that time, she indicated his teeth were not cleaned and his nails were dirty underneath and long. The most recent Care Plan Conference for Resident 44, dated 4/3/25, indicated ancillary service preferences were reviewed and updated. The clinical record lacked dental and podiatry notes indicating the resident had been seen by ancillary services while he was in the facility. 4. On 4/8/35 at 1:44 P.M., Resident 64 was observed to have long toenails and dark substance underneath his long fingernails during incontinence care. On 4/8/25 at 4:07 P.M., Resident 64 was observed to have a very strong odor from his mouth and the skin inside his mouth was peeling and sticking on his teeth. The most recent Care Plan Conference for Resident 64, dated 3/27/25, indicated ancillary service preferences were reviewed and updated. The clinical record lacked dental and podiatry notes indicating the resident had been seen by ancillary services while he was in the facility. The clinical record lacked a signed ancillary services consent that information for ancillary services was provided. During an interview on 4/9/25 at 12:39 P.M., the Administrator indicated the ancillary podiatrist came to the facility every other month, the		assurance meetings. Changes may be established to the auditing process, based on the results of the audits. DON/Designee will review 2 random residents who self-administer medications 5x a week for 8 weeks to ensure proper documentation is in clinical record, then 2 random residents who self-administer medications 2x week for 8 weeks to ensure proper documentation is in clinical record, and then 2 random residents who self-administer medications weekly for 36 weeks or as deemed by the Quality Assurance Committee to ensure proper documentation is in clinical record. The results of the audits will be reviewed at the monthly quality assurance meetings. Changes may be established to the auditing process, based on the results of the audits. V. Plan of Correction completion date: 5/7/25	

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	ancillary dental hygienist came every other month, and the ancillary dentist came as needed to the facility to see residents. She provided notes on Resident 44 from the ancillary providers that his last completed dental exam, dated 5/15/24, indicated resident has "poor oh [oral health], heavy plaque". The resident had appointments scheduled with the hygienist since then, but the resident refused care on those dates. Podiatry last saw him on 2/26/25 for trimming dystrophic (misshapen or unhealthy) nails and debrided (damaged or infected parts of the nail are removed) 5 nails or less. At that time, she indicated these notes were not scanned into the resident's clinical record and were not part of the clinical record. She indicated Resident 64 was admitted in September of 2024 and there was not a signed refusal or consent to ancillary services in his clinical record at that time and they would be following up with family about that. During an interview on 4/11/25 at 10:03 A.M., the Assistant Director of Nursing (ADON) indicated there should be documentation that the resident and/or representative were notified what ancillary services were available. There was a refuse and consent box for ancillary services that they should mark and sign at admission and/or during their first care conference. At that time, she indicated there should be documentation of dental and podiatry visits, refusal of care, and notification of all to family in the resident's clinical record. On 4/11/25 at 10:00 A.M., a current Accurate Documentation Policy was requested. At that time, the Administrator indicated there was not a policy for that but they would use the Nurse Job Description provided, last revised April 2012, that indicated " ... The employee must be able to			

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	perform each essential function effectively to be successful in this position ... 2. Completes assigned and required daily and weekly documentation including any ancillary assessment ... " On 4/11/25 at 10:20 A.M., a current Dental Services Policy, dated 6/1/18, was provided by the Administrator and indicated "[company name] and its member Communities are committed to ensuring all residents have access to routine and emergency dental care ... " 3.1-50(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on interview, observation, and record review, the facility failed to maintain proper infection control practices and provide a safe and sanitary environment for 1 of 2 residents observed for incontinence care and 1 of 1 residents reviewed for feeding tube care. Staff did not sanitize their hands between glove changes, wash cloths were laid on the side of the bathroom sink and then used for wiping the resident during incontinence care, clean linens and a resident's bare skin were touched with soiled gloves, and a bed sheet with blood on it was not changed. (Resident 64, Resident 281) Findings include: 1. On 4/8/25 at 1:44 P.M., Certified Nurse Aide (CNA) 34 and CNA 16 were observed performing incontinence care on Resident 64. CNA 34 rolled resident from left to right while pulling down the resident's pants and pulling out the lift pad that was underneath him. CNA 34 grabbed two wash	F 0880	I. The corrective actions to be accomplished for those residents found to have been affected by the practice: Staff involved in the observed care procedures for Resident 64 and Resident 281 were re-educated on proper infection control practices, glove use, handwashing, handling linens, and how to provide a safe and sanitary environment. Staff involved in the observed care procedures for Resident 64 were re-educated on perineal care procedures. Resident 64's face was cleaned and bed linens were changed. Resident 64 did not have any negative outcomes from the care procedures. Resident 281 did not have any negative outcomes from the care procedures.	05/07/2025

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PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

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	cloths and went into the bathroom. CNA 34 laid the washcloths on the side of the sink while he washed his hands. After getting the wash cloths wet, CNA 34 took the wash cloths back to the bedside. CNA 34 unfastened Resident 64's incontinence pad. While CNA 16 was washing her hands, the resident was laying on his left side and urinated on the bed sheets. CNA 16 went out of the room to get clean linens while CNA 34 removed the residents wet pants and socks and laid them at the foot of the bed. CNA 34 laid the resident on his back, wiped the head of the penis with a wash cloth, and then quickly wiped the rest of the groin area with the same cloth. CNA 34 proceeded to touch the residents knee with the soiled gloves. CNA 16 returned with clean linens and laid them at the foot of the bed near the soiled clothing and went to the bathroom to wash her hands. CNA 34 reached across Resident 64 and yanked on the upper corner of the fitted sheet to remove it from the mattress. When the sheet was pulled down, the mattress was wet where Resident 64 had urinated through the sheet. CNA 34 touched the clean linens at the bottom of the bed with soiled gloves, grabbed the other wet wash cloth, and wiped the wet area on the mattress. When CNA 16 returned to the bedside, CNA 34 went into the bathroom and laid two wash cloths on the side of the sink while they washed their hands with a five second lather. CNA 16 proceeded to roll the soiled linens under the resident, put the clean fitted sheet over the wet area on the left side of the mattress, put the clean incontinence pad under the resident, , and then went to the bathroom to remove her gloves and wash her hands in the bathroom. Resident 64 was quickly rolled from his back to his right side in the fetal position by CNA 34. The residents back was laying on the urine soaked sheet while he was laying on his back. CNA 34 leaned over the		II. The facility will identify other residents that may potentially be affected by the practice: Residents residing at Paoli Health & Living have the potential to be affected by the deficient practice. Hygiene observations were completed on all residents for any infection control concerns. III. The facility Incontinence Care Skills Validation form was reviewed with no changes made to the form. The facility will put into place the following systematic changes to ensure that the practice does not recur: Facility staff re-educated on proper infection control practices, glove use, handwashing, handling linens, incontinence care, peri care, and how to provide a safe and sanitary environment. IV. The facility will monitor the corrective action by implementing the following measures: DON/Designee will observe 2 random resident care procedures 5x a week for 8 weeks to ensure proper infection control practices are being followed, then 2 random resident care procedures 2x a week for 8 weeks to ensure proper infection control practices are being followed, and then 2 random	

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	resident's legs and roughly wiped the buttocks of the resident with a wet wash cloth wearing the same gloves. The resident had moisture associated skin damage to his sacrum. CNA 34 quickly rolled Resident 64 to his left side, touching the resident with the same gloves, pulled out the dirty linen from under the resident, and put them at the bottom of the bed on the clean fitted sheet. Then proceeded to pull the clean fitted sheet and incontinence pad from under the resident, put the sheet on the mattress, and fasten the incontinence pad. The resident's back was not wiped after laying on the soiled sheet. CNA 16 returned to the bedside and indicated the resident's sore on his chin was bleeding and the blood was going down his neck. CNA 34 went to the bathroom to remove gloves and wash their hands. They put gloves back on and proceeded to put the soiled linens that were laying on the clean fitted sheet at the bottom of bed into a trash bag. The bag tore and the soiled linens fell on the clean sheet again. CNA 34 double bagged the soiled linens and took them out of the room. Resident 64 was left with blood running down his neck from his chin. On 4/8/25 at 4:07 P.M., Resident 64 was observed having medication administered through his g-tube (a tube inserted directly into the stomach through the abdominal wall) by Registered Nurse (RN) 66. Upon entrance into the room, blood was observed on the bed sheet, the resident's chin had dried blood on it, and there was dried blood observed down the resident's neck. The resident's bed sheet was not changed after the medication administration was over, the sore on his chin was not cleaned, and the blood was not wiped off his neck. During an interview on 4/10/25 at 1:15 P.M., the		resident care procedures weekly for 36 weeks or as deemed by the Quality Assurance Committee to ensure proper infection control practices are being followed. The results of the audits 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: 5/7/25	

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	Infection Preventionist (IP) indicated when staff performed incontinence care, they should sanitize hands and change gloves between dirty and clean tasks. Staff should not touch the resident with soiled gloves and the soiled linens should be placed into a bag, not on the clean bed linens. If dirty linen was laid on a clean sheet, the whole bed should be changed. Staff should not lay wash cloths on the side of the sink because it contaminates them and staff should not lean over the resident to do care. If a resident urinated in the bed, it soaked through the sheets, and the mattress was wet, she would expect staff to get the resident back out of bed and clean the mattress with purple top container cleaning wipes and let the mattress dry before putting the clean sheets on the mattress. If the resident was actively bleeding and there was blood on the bed sheets, she would expect staff to address the site of bleeding immediately and put a clean sheet on the bed. 2. On 4/7/25 at 1:16 P.M., Resident 281's clinical records were reviewed. Resident 281 was admitted on 3/25/25. Diagnoses included, but were not limited to, dysphagia following unspecified cerebrovascular disease, traumatic subdural hemorrhage with loss of consciousness, and chronic pain syndrome. The current Admission Minimum Data Set (MDS) assessment was in process. Current Physician's Orders included, but were not limited to, the following: Raise head of bed at least 30 degrees at all times while in bed. Every Shift, dated 3/25/2025 Enhanced barrier precautions, dated 3/26/2025			

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	NPO (nothing by mouth), dated 3/31/2025 Feeding type: Nova Source Renal. Bolus at 240 mls (milliliters) QID (four times a day). Check placement prior to hooking up feeding, dated 4/2/2025 Flush G-tube (gastrostomy tube) with 90 mL of water prior to feeding and after feeding. Before flush,verify placement, check GI (gastrointestinal) contents for residual, hold flush and feeding if residual is greater than 100 mL. Notify MD (Medical Doctor) if GI content residual is greater than 100 mL. Four Times A Day, dated 4/2/2025 On 4/10/25 at 11:09 A.M., Licensed Practical Nurse (LPN) 32 was observed doing G-tube feeding for Resident 281. LPN 32 put gloves on, did not observe LPN 32 clean hands before or after entering room, and took a washcloth with a dried black substance on it from Resident 281, who indicated it was stool, took glove off but did not wash hands, put gloves on, then mask and gown, asked resident to lie down to do feeding, used remote to raise bed with gloves on, took one glove off and put clean glove on, did not clean hands, listened to stomach, opened G-tube, put syringe on G-tube, added 90 ml of water, poured in Novasource Renal 237 ml gravity infusion, 90 ml water added after infusion, G-tube clamped shut and placed under abdominal binder, rinsed syringe and placed in plastic bag, cleaned up bedside table, removed gloves, gown and mask, washed hands with 23 second lather, lowered bed, took trash bag out of trash can and tied, put clean trash bag in trash can, carried tied trash bag with soiled linen out to dirty linen closet. During an interview on 4/10/25 at 1:42 P.M., the Infection Preventionist (IP) indicated if staff took			

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	a soiled washcloth from resident with gloves on and removes gloves, hands should be sanitized or washed any times gloves were removed and before putting clean gloves on. On 4/11/25 at 10:00 A.M., the Administrator provided an undated Incontinence Care Skills Validation form which indicated "...5. Wash hands and apply gloves..." 3.1-18(b) 3.1-18(l) 3.1-19(g)(1) 3.1-19(g)(2)			
F 0949 SS=D Bldg. 00	483.95(i) Behavioral Health Training Based on interview and record review, the facility failed to ensure a sufficient and competent behavioral and mental health training program for all staff was implemented, as determined by staff needs and the facility assessment. Resident clinical records lacked documentation of behavior monitoring and staff were unaware of a resident's diagnosis. (Resident 64) Finding includes: 1. The current facility assessment, last reviewed 3/21/25, indicated the facility cared for an average of 80 long term care residents daily. Current diseases/conditions, physical, and cognitive disabilities of those residents included, but were not limited to, psychosis (hallucinations, delusions, etc), impaired cognition, mental disorder, depression, Bipolar disorder, Schizophrenia, PTSD, anxiety, TBI, Down Syndrome, autism, Alzheimer's disease, non-Alzheimer's dementia, and behaviors that	F 0949	I. The corrective actions to be accomplished for those residents found to have been affected by the practice: A plan of care for a history of trauma was in place for the resident involved. The plan of care was reviewed and updated for the involved resident. CNA 26 was re-educated on where to access this information in the resident's clinical record. II. The facility will identify other residents that may potentially be affected by the practice: Resident residing at Paoli Health & Living have the potential to be affected by the deficient practice. All other residents were reviewed	05/07/2025

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	need intervention. Eleven of those residents were indicated to have had behavioral health needs. It indicated the following mental health and behavior services were offered based on the resident's needs: manage the medical conditions and medication-related issues causing psychiatric symptoms and behaviors, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, and other psychiatric diagnoses, intellectual and/or developmental disabilities. 2. On 4/10/25 at 11:33 A.M., the Assistant Director of Nursing (ADON) provided in services conducted in the last year. The in services lacked documentation of education given on individualized care needed, monitoring behaviors, non pharmacological interventions, and interacting with residents diagnosed with Schizophrenia, PTSD, and TBI. 3. Insufficient behavioral health in services and training resulted in behavior monitoring not being implemented. Cross reference F740. During an interview on 4/9/25 at 12:34 P.M., CNA 26 indicated staff did do in services but she did not remember talking about Schizophrenia, TBIs, or PTSD specifically. The in services talked about dementia, what to do when a resident refused care, and how to redirect residents. She was unaware of a resident having behaviors and PTSD, what his triggers were, and what to do about them. During an interview on 4/10/25 at 11:13 A.M., Regional Clinical Support 2 indicated the corporation had in services the employees have to		to ensure they had a proper plan of care in place. III. The facility policy on Behavioral Health Management and the Inservice Education Meeting excerpt from the Employee Handbook were reviewed with no changes made to either. The facility will put into place the following systematic changes to ensure that the practice does not recur: Nurse aides re-educated on where to access trauma care plans in order to best handle resident-related behaviors. The facility implemented education for all staff regarding mental health disorders that will be completed now, annually, and upon hire. IV. The facility will monitor the corrective action by implementing the following measures: Administrator/Designee will audit 5 employee files to ensure appropriate behavioral/mental health training and education is being completed upon hire and annually. Audits will occur weekly x 12 weeks and then monthly x 6 months. V. Plan of Correction completion date: 5/7/25	

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	do on their electronic training program, but in person in services were decided by the facility depending on what their resident's needs were and depending on what it dealt with, it usually wasn't for all employees. During an interview on 4/10/25 at 11:33 A.M., the ADON indicated they don't give in services based on specific mental health diagnoses, such as schizophrenia, PTSD, or TBI, but they will in the future. On 4/10/25 at 3:00 P.M., a current Behavioral Health Management Program Policy, dated January 2024, was provided by Regional Clinical Support 2 and indicated "[company name] communities provide services to our residents with specific diseases and disorders. Some of our residents have medical disabilities that can lead to disruptive behaviors and these behaviors have the potential to create a negative effect on the resident, other residents, visitors, and staff. It is [company name]'s policy that each community will have a behavior program that: identifies, monitors, manages, and disseminates (whenever possible) all behavior events ... each individual resident will receive services according to their needs ... Residents who demonstrate any of the following characteristics should be involved in the behavior program ... any resident demonstrating new or worsening behaviors ... unresolved repetitive behaviors ... currently has a doctor's order to use antipsychotic, antidepressant ... Each [company name] facility will use the following documents to track behaviors and document ongoing services/interventions ... The nurse or social services will complete a behavioral event in the electronic medical record for each new or worsening behavior the resident demonstrates ...CNAs are able to document ... during the clinical			

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	meeting, when the IDT [Interdisciplinary team] is present, each behavior will be discussed ... IDT will write a note ... It is [company name] policy to ensure etiology of a resident's behavior is thoroughly investigated, documented, and care planned ... " On 4/11/25 at 9:00 A.M., a current In service Education Meeting excerpt from the Employee Handbook was provided by the administrator and indicated "Regular training and education for associates is provided to promote an informed and competent staff and to maintain a high quality of resident service and care ... This training is provided in compliance with all relevant State and Federal regulations ... " 3.1-37(a) 3.1-43(a)(1)			