STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155333	A. BUILDING -- B. WING	04/28/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/28/25 Facility Number: 000226 Provider Number: 155333 AIM Number: 100267730 At this Emergency Preparedness survey, Paoli Health and Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 109 certified beds, with a current census of 77. Quality Review completed on 05/02/25	E 0000	Please find enclosed the Plan of Correction for the State Licensure Survey conducted on April 28, 2025. This letter is to inform you that the plan of correction attached is to serve as Paoli Health & Living Community credible allegation of compliance. We allege substantial compliance on May 25th, 2025. We are requesting paper compliance for this plan of correction. Submission of this plan of correction in no way constitutes 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 or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Commitee Meeting.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000	Please find enclosed the Plan of	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 01 B. WING	04/28/2025

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
	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/28/25 Facility Number: 000226 Provider Number: 155333 AIM Number: 100267730 At this Life Safety Code survey, Paoli Health and Living Community Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 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 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (111) construction and was sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in resident sleeping rooms in the 400 and 500 halls, furthermore, battery operated smoke detectors were located in all other resident sleeping rooms. The facility has a capacity of 109 and had a census of 77 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached wood sheds and one metal shed used for facility storage. Quality Review completed on 05/02/25		Correction for the State Licensure Survey conducted on April 28, 2025. This letter is to inform you that the plan of correction attached is to serve as Paoli Health & Living Community credible allegation of compliance. We allege substantial compliance on May 25th, 2025. We are requesting paper compliance for this plan of correction. Submission of this plan of correction in no way constitutes 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 or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Commitee Meeting.	
K 0331 SS=E	NFPA 101 Interior Wall and Ceiling Finish			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 01 B. WING	04/28/2025

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
Bldg. 01	Based on observation and interview, the facility failed to ensure materials used as an interior finish in 1 of 7 smoke compartments had a flame spread rating of Class A or Class B. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect Physical Therapy staff and residents while in the Physical Therapy gym. Findings include: Based on observation on 04/28/25 at 2:15 p.m. during a tour of the facility with the Administrator and Maintenance Director, there was an approximately 15 foot wide by 7 foot tall wall within the lower level Physical Therapy storage area constructed of a thin layer of plywood and backed by exposed wood studs. This was	K 0331	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor has since painted that wall with a product called Fireguard XL95. The product is still onsite for review. Please see the attached picture showing the painted wall and attached data sheet showing the product used. II. The facility will identify other residents that may potentially be affected by the deficient practice: All residents and staff that use the basement could be affected by this deficient practice. III. The facility will put into place the following systematic changes to ensure that the deficiency practice does not recur: There is no follow up or observation for this violation as it is a permanent resolution. IV. The facility will monitor the corrective action by implementing the following measures: CarDon Corporate Facilities will audit all new walls and construction to ensure they are constructed with the proper fire	05/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 01 B. WING	04/28/2025

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
	acknowledged by the Administrator and Maintenance Director at 2:15 p.m., furthermore, when asked, the Administrator and Maintenance Director said the plywood and wood studs did not have a flame spread rating as far as they knew. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		rating. V. Plan of Correction Completion Date: 5/12/25	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to ensure documentation was available to show that 12 smoke detectors were sensitivity tested within one year after installation. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the	K 0345	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor has contacted Safecare to perform a new building wide sensitivity test. The sensitivity test is scheduled for May 18th. The documentation will be uploaded into the portal once received. II. The facility will identify other residents that may potentially be affected by the deficient practice: All residents and staff could be affected by this deficient practice. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur:	05/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 01 B. WING	04/28/2025

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
	purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 04/28/25 at 11:20 a.m. with the Administrator and Maintenance Director present, the facility was able to produce a smoke detector sensitivity report dated 03/18/24 for all smoke detectors. The report indicated 12 smoke detectors failed the sensitivity test. A subsequent report dated 04/01/24 indicated the 12 smoke detectors that failed the sensitivity test were replaced. There was also an annual fire alarm system report dated 03/06/25 which indicated all smoke detectors were inspected and tested visually and functionally and all passed, however, there was no documentation to indicate the 12 smoke detectors that were replaced have been tested for sensitivity within one year after installation. Based on interview at 11:20 a.m., the Maintenance Director confirmed there was no documentation to show the 12 smoke detector that were replaced on 04/01/24 have been tested for sensitivity within one year after installation. This finding was reviewed with the Administrator		CarDon Corporate Facilities will audit the sensitivity test after completion to ensure it includes all proper information. IV. The facility will monitor the corrective action by implementing the following measures: CarDon Corporate Facilities will audit the sensitivity test after completion to ensure it includes all the proper information. V. Plan of Correction Completion Date: 5/18/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 01 B. WING	04/28/2025

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
	and Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 7 smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 20 resident, as well as staff. Findings include: Based on observations on 04/28/25 during a tour of the facility with the Administrator and Maintenance Director, the following was noted: a. At 1:40 p.m. there was one pendent sprinkler head in the laundry room dryer enclosure partially covered with corrosion. This was confirmed by the Maintenance Director at 1:40 p.m. b. At 1:58 p.m. there were two pendent sprinkler heads in the 400 Hall shower room covered with corrosion. This was confirmed by the Maintenance Director at 1:58 p.m. This finding was reviewed with the Administrator	K 0353	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor has contracted with Safecare to have the 3 sprinkler heads replaced. See attached pictures showing those 3 sprinkler heads being replaced. The Maintenance Supervisor has contracted with Safecare to supply 2 new sidewall sprinkler heads. Safecare stated they will be bringing the 2 new sidewall sprinkler heads to the facility on 5/19/25. The picture showing the 2 new sidewall sprinkler heads in the spare head box will be uploaded into the portal once received. II. The facility will identify other residents that may potentially be affected by the deficient practice: All residents and staff could be affected by this deficient practice. III. The facility will put into place	05/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 01 B. WING	04/28/2025

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
	and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system was provided with the minimum number of spare sprinklers in a spare sprinkler cabinet on the premises for the types and temperature ratings of the sprinklers on the property. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation on 04/28/25 between 1:15 p.m. and 3:00 p.m. during a tour of the facility with the Administrator and Maintenance Director, Quick Response and Standard Response sidewall type sprinkler heads were installed in several areas of the facility. Based on observation of the spare sprinkler head cabinet in the Sprinkler Riser Room at 1:48 p.m., there were no Quick Response sidewall type sprinkler heads in the spare sprinkler cabinet or on the premises, furthermore, there was		the following systematic changes to ensure that the deficient practice does not recur: There is a quarterly TELS task to inspect the fire sprinkler system to ensure no sprinkler heads have corrosion and are debris free. See attached TELS task labeled "Paoli TELS Sprinkler Head Inspection Task." IV. The facility will monitor the correction action by implementing the following measures: CarDon Corporate Facilities will audit this TELS task during their annual site inspections. V. Plan of Correction Completion Date: 5/20/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 01 B. WING	04/28/2025

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
	only one Standard Response sidewall type sprinkler head in the spare sprinkler cabinet. Based on interview at 1:48 p.m., the Maintenance Director agreed the spare sprinkler cabinet did not contain enough Quick Response and Standard Response sidewall type spare sprinkler heads. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled	K 0711	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice: A new building layout was created showing the smoke and fire zones. All associates were trained on the smoke and fire zones what to do if evacuation was needed within a zone. See attached drawing showing these fire zones. Inservice paperwork will be available for review during revisit. All associates were trained on what to do if a battery powered or hard-wired smoke detector goes off in a skilled resident room. Inservice paperwork will be made available for review during revisit. II. The facility will identify other residents that may potentially be	05/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 01 B. WING	04/28/2025

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
	equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's "Fire Policies and Procedure" on 04/28/25 at 12:55 p.m. with the Administrator and Maintenance Director present, the plan did not address the following: a. The plan did not address evacuation of the smoke compartment, furthermore, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail. b. The plan did address staff response to the activation of battery powered smoke alarms in the resident rooms, however, the plan did not address the fact that not all resident rooms are equipped with battery powered smoke alarms, because resident rooms in the 400 and 500 halls are equipped with hard wired smoke detectors addressable to the fire alarm control panel. Based on interview at 12:55 p.m., the Maintenance Director acknowledged the Fire Policies and Procedures did not include the previously mentioned items, and further confirmed resident rooms in the 400 and 500 halls were equipped with smoke detectors addressable to the fire alarm control panel. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		affected by the deficient practice: All residents and staff could be affected by this deficient practice. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur: The Maintenance Supervisor will train all new associates during new employee orientation on how the smoke/fire zone evacuation process goes. The Maintenance Supervisor will train all new associates during new employee orientation on how to respond to a resident room smoke detector activation. IV. The facility will monitor the corrective action by implementing the following measures: Cardon Corporate Facilities will audit these processes during their annual site inspection. V. Plan of Correction Completion Date: 5/20/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 01 B. WING	04/28/2025

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
	3.1-19(b)			