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

FORM APPROVED
OMB NO. 0938-039

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	05/28/2021

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: May 24, 25, 26, 27, & 28, 2021 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Census bed type: SNF: 4 SNF/NF: 80 Total: 84 Census payor type: Medicare: 13 Medicaid: 64 Other: 17 Total: 84 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 4, 2021.	F 0000	Submission of this plan of correction does not constitute an admission by Paoli Health and Living's Community 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. The plan of correction is to serve as Paoli Health and Living's Community's credible allegation of compliance. The facility respectfully requests desk review for the following citation.	
F 0583 SS=E Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 00 B. WING	05/28/2021

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
	facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, interview, and record review, the facility failed to ensure resident privacy was maintained during 3 random observations and 3 of 15 residents interviewed regarding privacy. Staff did not knock or announce themselves before entering resident rooms. (Resident 74, Resident 82, Resident 41, Resident 81, Resident 12) Finding includes: During an interview on 5/24/21 at 12:03 P.M., Resident 82 indicated that staff does not always knock or announce themselves before entering	F 0583	F 583 Personal Privacy / Confidentiality of Records I. The corrective actions to be accomplished for those residents found to have been affected by the practice. · There were no residents affected by the alleged practice. Residents 74, 82, 41, 81, and 12 were not affected by this alleged deficient practice.· Staff members immediately educated on knocking on residents doors and	06/19/2021

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	05/28/2021

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
	their room. During an interview on 5/25/21 at 12:37 P.M., Resident 74 indicated that staff does not always knock before entering their room. During an interview on 5/24/21 at 10:46 A.M., Resident 41 indicated staff came into the resident's room without knocking, and did not explain who they were or why they were in the room. During an interview with Resident 12 in the resident's room on 5/26/21 at 9:33 A.M., CNA 3 entered the room without knocking on the door, and did not indicate why there were in the room. CNA 3 then exited the room and indicated "I'll come back" During an observation on 5/25/21 at 12:36 P.M., CNA 7 entered resident 74's room without knocking or announcing themselves. On 5/27/21 at 10:10 A.M., CNA 4 was observed to enter Resident 81's room without knocking on the door, and did not explain to the resident why they were in the room. During an interview on 5/28/21 at 10:57 A.M., QMA 8 indicated when entering resident rooms, staff should knock, introduce themselves, and explain why they are in the room. On 5/28/21 at 11:04 A.M. RNC 3 (Regional Nurse Consultant) supplied a facility policy titled, "Welcome to Our Community!" The policy included, "Resident Privacy... Please be respectful of the privacy of other Residents and knock before entering another Resident's apartment. If a Resident is receiving care of any kind, privacy		announce themselves prior to entering their rooms. II. The facility will identify other residents that may potentially be affected by practice. · Facility rounds were made to ensure staff were knocking on resident rooms doors and introducing themselves prior to walking in room.· No residents were found to be affected during these rounds. III. The facility will put into place the following systemic changes to ensure that the practice does not recur. · Staff will be educated on our privacy policy which includes knocking on doors and announcing self before entering rooms. IV. The facility will monitor the corrective action by implementing the following measures. · The DON or designee will interview 5 random residents weekly for 6 weeks, then bi weekly for 6 weeks, then monthly for 2 months of monitoring using the Quality Improvement Tool F-583 7 day audit tool (See Attachment F) to ensure staff are knocking on doors and announcing themselves prior to entering their rooms. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once	

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	05/28/2021

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
	must be completed or you must have the Resident's consent to be in the room." 3.1-3(p)(1)		compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of correction completion date. Date of compliance: 6/19/2021 The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Paoli Health and Living's Community's credible allegation of compliance.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and			

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	05/28/2021

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
	controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording			

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	05/28/2021

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
	incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to maintain proper infection control techniques during 1 of 1 gastric tube medication administration observations, 1 of 2 Residents observed for catheter care, 1 of 4 observations of care, and a random observation of staff donning (putting on) PPE (Personal Protective Equipment) prior to entering an isolation room. Staff did not complete proper hand hygiene during care, a catheter tubing and bag were resting on the floor, and staff wore a surgical mask under an N95 respirator mask. (Resident 16, Resident 18, Resident 81, Resident 289) Findings include: 1. On 5/27/21 at 9:54 A.M., Resident 81's clinical record was reviewed. The most recent (quarterly) MDS (Minimal Data Set) Assessment, dated 5/8/21, indicated the resident had an indwelling catheter. Current orders included, but were not limited to, Foley catheter (dated 5/18/21). A current care plan (dated 2/8/21) for indwelling urinary catheter included, but was not limited to, the following intervention; Do not allow tubing or	F 0880	F880 Infection Prevention and ControlS/S E I. The corrective actions to be accomplished for those residents found to have been affected by the practice. · There were no residents affected by the alleged practice. Residents 16, 18, 81, and 289 were not affected by this alleged deficient practice.· Staff members immediately educated on proper hand hygiene during care, face masks usage, donning PPE when entering an isolation room, urinary catheter bag/tubing proper placement. II. The facility will identify other residents that may potentially be affected by practice. · Facility rounds were made to ensure staff were wearing face masks appropriately, washing hands appropriately during care, donning PPE when entering an isolation room, following infection	06/19/2021

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	05/28/2021

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
	any part of the drainage system to touch the floor. On 5/25/21 at 10:18 A.M., Resident 81 was observed lying in the bed, with the catheter bag and tubing resting on the floor. On 5/26/21 at 12:22 P.M., Resident 81 was observed sitting in a wheelchair in the resident's room with the catheter tubing under the wheelchair, resting on the floor. On 5/27/21 at 10:10 A.M., Resident 81 was observed lying in the bed, with the catheter bag and tubing resting on the floor. CNA 7 was in the room assisting Resident 81 out of the bed and into a wheelchair. During the transfer, CNA 7 clipped the catheter bag to their own pant leg, resting the catheter bag and tubing on their uniform pants. CNA 7 and CNA 4 were observed assisting Resident 81 to transfer from the bed to a wheelchair. After assisting, CNA 4 washed hands for 8 seconds. During an interview on 5/28/21 at 9:22 A.M., LPN 2 indicated resident catheter bags and tubing should not have been on the floor. During an interview on 5/28/21 at 10:57 A.M., QMA 8 indicated staff should wash hands for 60 seconds. On 5/28/21 at 11:04 A.M. RNC 3 (Regional Nurse Consultant) supplied an undated facility policy titled, Catheterizing the Urinary Bladder with an Indwelling Catheter Skills Validations." The policy included, "...no tubing must touch the floor." On 5/28/21 at 11:04 A.M. RNC 3 supplied a facility policy titled, Hand Washing/ Hand Hygiene Policy, dated 3/24/2016. The policy included,		control protocol with foley catheter bags/tubing placement.· No residents were found to be affected during these rounds. III. The facility will put into place the following systemic changes to ensure that the practice does not recur. · Staff will be educated on the CDC guidance of face masks usage, hand washing policy, PPE quick reference guide, urinary catheter tubing/bag placement, and donning PPE when entering an isolation room (See Attachment A).· Consultant Infection Preventionist educated IDT team/IP on face masks usage, hand washing policy, PPE quick reference guide, urinary catheter bag/tubing placement, and donning PPE when entering an isolation room (See Attachment B)· Root Cause Analysis (RCA) with facility consultant Infection Preventionist, including input from the facility Medical Director/DON/IP was completed. CMS/CDC Fundamentals of Covid-19 Prevention Training Self-assessment Questionnaire with facility Medical Director/DON/IP was completed. (See Attachment C) IV. The facility will monitor the corrective action by implementing the following measures.· The IP/DON or designee, will observe	

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	05/28/2021

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
	"Employees must wash their hands for at least twenty seconds..." 2. On 5/27/21 at 12:50 P.M., RN 10 (Registered Nurse) was observed to prepare medications for Resident 16. RN 10 entered Resident 16's room and donned gloves. RN 10 obtained a tissue, removed the left glove, and donned a clean glove to the left hand. No hand hygiene was observed between doffing (removing) and donning the left hand glove. RN 10 then looked through Resident 16's closet for supplies, removed both gloves, and donned a clean pair of gloves. No hand hygiene was observed between gloves. RN 10 was then observed to administer medications to Resident 16 via a gastric tube. 3. During an observation on 5/27/21 at 1:42 P.M. LPN 6 was entering Resident 289's isolation room. Resident 289's room door had signage indicated the resident was on contact and droplet precautions. LPN 6 was wearing a surgical mask under an N95 respirator mask. During an interview on 5/27/21 SDC 2 (Staffing Development Coordinator) indicated an N95 respirator mask should be worn directly against the face to provide a proper seal. On 5/28/21 at 11:04 A.M. RNC 3 supplied a facility policy titled, (Company Name) PPE COVID-19 Quick Reference Guide, dated 12/28/2020, and indicated the facility follows CDC (Centers for Disease Control and Prevention) guidance PPE use. The facility policy included, "Admissions/Re-admissions... Contact Precautions... Droplet Precautions... Wear Standard N95 or KN95 or surgical facemask when N95/KN95 not available." The CDC states (regarding the fit for an N95 respirator), "if the		the staff for proper facemask usage, donning PPE, and hand hygiene during care to ensure proper infection control policy is being followed daily for 6 weeks, then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 7 day audit tool (See attachment D). · The IP/DON or designee will observe residents foley catheter bags to ensure tubing and foley catheter bag are properly placed daily for 6 weeks, then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 7 day audit tool (See Attachment E). The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of correction completion date. Date of compliance: 6/19/2021 The Administrator will be responsible for ensuring the facility is complying by date of compliance listed.	

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	05/28/2021

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
	respirator does not form a seal with the face, it cannot provide the expected level of protection." 3.1-18(b) 3.1-18(l)			