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	04/25/2022

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/25/22 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 91. Quality Review completed on 04/27/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/25/22 Facility Number: 000226 Provider Number: 155333 AIM Number: 100267730 At this Life Safety Code survey, Paoli Health and	K 0000	May 9, 2022 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance	

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.

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	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 91 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 04/27/22		Event ID: HTJT21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on April 25, 2022. 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 9th, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 812-723-2595 Sincerely, Marquetta Motsinger, HFA Administrator Paoli Health and Living Submission of this plan of correction in no way constitutes an admission by Paoli Health and Living or its management company that the allegations	

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			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 Committee meeting.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain the walking surface for 1 of 11 exit discharge areas. This deficient practice could affect up to 25 residents, as well as staff and visitors. Findings include: Based on observations on 04/25/22 between 1:00 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the east exit to the lower level Physical Therapy area discharged to a concrete patio which transitioned to a set of steps to a parking lot (public way). There were three	K 0271	**K 271** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The concrete path of egress leaving the walk out basement therapy gym had multiple cracks causing an unsafe path of egress. CarDon Corporate Facilities has sent JVS	06/01/2022

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	separate areas along the path to the public way that had cracks at least four feet wide and 1 to 2 inches deep. The cracks in the concrete on the path to the public way could be a tripping hazard while exiting from this area in the event of an emergency. Based on interview at the time of observation, the Maintenance Supervisor said he was aware of the cracks in the concrete and was checking into getting them fixed. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		Construction there to develop a scope of work for repair. Once Purchase order has been given, we will forward to Life Safety. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff in the Therapy Gym 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.** Observation A- There is a new TELS task for the Maintenance Supervisor to walk the community and inspect the sidewalks for a safe path of egress. See attached every 6 month task Labeled “Paoli TELS Task Sidewalk Inspection” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the path of egress around the community during the annual site visit inspections.	

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			V. Plan of Correction completion date. Plan of Completion date is June 1st, 2022.	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 2 of 65 hard wired smoke detectors was not installed where air flow would adversely affect its operation. NFPA 72, 2010 edition, 17.7.6.3.2 requires that smoke detectors shall not be located directly in the airstream of supply registers. Section 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. This deficient practice could affect at least 40 residents, as well as staff and visitors in the 100 and 200 halls.	K 0341	**K 341** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- There is a smoke detector located in the hallway near the end of the 200 hall that is too close to a supply air vent. The Maintenance Supervisor has had Integrated Electronics come and relocate the smoke detector. See	05/05/2022

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	Findings include: Based on observations on 04/25/22 between 1:00 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. There was a ceiling mounted smoke detector at the south end of the 200 hall outside the MDS Office within one foot of an air supply vent register. b. There was a ceiling mounted smoke detector in the 100 hall corridor near the smoke barrier doors within six inches of an air supply vent. Based on interview at the time of each observation, the Maintenance Supervisor agreed the two smoke detectors were within one foot of the air supply vents. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		attached picture labeled “Paoli smoke detector 1” showing the new location. Observation B- There is a smoke detector located in the hallway near the end of the 100 hall that is too close to a supply air vent. The Maintenance Supervisor has had Integrated Electronics come and relocate the smoke detector. See attached picture labeled “Paoli smoke detector 2” showing the new location. **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.** CarDon Corporate Facilities has reeducated the Maintenance Supervisor on the proper location of smoke detectors. **IV The facility will monitor the corrective action by implementing the following**	

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			measures. CarDon Corporate Facilities will inspect the path of egress around the community during the annual site visit inspections **V. Plan of Correction completion date.** Plan of Completion date is May 5th, 2022.	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to provide an automatic sprinkler system	K 0351	**K 351**	06/01/2022

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	that provided complete coverage in 1 of 7 smoke compartments. This deficient practice could affect all residents, as well as staff and visitors while in the main dining room. Findings include: Based on observations on 04/25/22 between 1:00 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, there was a 4 foot by 10 foot section at the north side of the main dining room that was not protected by sprinkler coverage. There was a wall between this section of the dining room that would not allow the nearest sprinkler head to provide sprinkler coverage to this area. Based on interview at the time of observation, the Maintenance Supervisor agreed there was no sprinkler coverage to this area of the main dining room. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- There is a section in the north dining room that does not have proper fire protection. This is a little cart storage area that has been there for some time. The Maintenance Supervisor has contacted Advantage Fire to come investigate and add a sprinkler head in this area. Once more information is available to the correct fix it will be sent to life safety. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff in the Dining Room 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.** CarDon Corporate Facilities has reeducated the Maintenance Supervisor on the proper location of sprinkler heads.	

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			IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities will inspect the sprinkler head locations within the community during the annual site visit inspections **V. Plan of Correction completion date.** Plan of Completion date is June 1st, 2022.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection	K 0353	**K 353**	05/15/2022

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	was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants. Findings include: Based on observations on 04/25/22 between 1:00 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the facility's fire department connection (FDC) was located towards the rear west side of the facility on the walls outside the sprinkler riser room. There was FDC signage provided near the fire department connection, however, there was no FDC signage at the front of the facility for the responding fire department to lead them to the FDC for easy identification. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor who agreed there should be FDC signage at the front of the facility. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The communities FDC is located towards the rear of the community and there is no visible signage at the road to indicate where the FDC is located. CarDon Corporate Facilities has ordered the proper signage directing the Fire Department to the rear of the community. Once install we will send documentation and pictures to life safety. **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.** Observation A- There is a TELS task to inspect the FDC signage annually to ensure the proper location and in good condition. See attached TELS task labeled	

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	3.1-19(b)		"Paoli FDC Signage TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the FDC signage to ensure it is in the proper location and in good condition during their annual site visit inspection. **V. Plan of Correction completion date.** Plan of Completion date is May 15th, 2022.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 7 of 8 electrical panels observed in the facility corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B).	K 0511	**K 511** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The community failed to ensure that all the	05/15/2022

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	(B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on an observations on 04/25/22 between 1:00 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, 7 of 8 electrical panels observed in the facility corridors were unlocked when tested. The panels included breakers to a variety of items in the facility. Based on interview at the time of each observation, the Maintenance Supervisor agreed all electrical panels in the facility corridors need to be locked. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		electrical panels that were accessible to residents had a locking mechanism. The Maintenance Supervisor is in the process of purchasing locks for the electrical panels. Once the material is received and installed updated pictures will be sent to life safety. **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.** Observation A- There is a TELS task to inspect the Electrical Panels annually to ensure that they are locked. See attached TELS task labeled “Paoli Electrical Panel TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will	

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			inspect the electrical panels to ensure they are locked during their annual site visit inspection. **V. Plan of Correction completion date.** Plan of Completion date is May 15th, 2022.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage			

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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
	room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfilling room door to the egress corridor would close completely and latch into the door frame. This deficient practice could affect residents, staff and visitors while in the front entrance corridor which included staff offices, the front lounge area, and a portion of the 200 hall. Findings include: Based on observations on 04/25/22 between 1:00 p.m. to 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the oxygen storage/transfilling room contained six liquid oxygen containers. The corridor door to this room did not close completely and latch when tested several times. Based on interview at the time of observation, the Maintenance Supervisor agreed the oxygen room door did not close completely and latch. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.	K 0923	**K 923** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Building failed to ensure that the oxygen transfer room door latched. The Maintenance Supervisor has corrected the locking mechanism, so it latches every time. **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.	05/05/2022

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	04/25/2022

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	3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation A- There is a current monthly TELS task to inspect the Oxygen Room door to ensure that it latches. See attached task labeled “Paoli Oxygen Room Door Inspection Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the oxygen room to ensure it latches and locks during their annual site visit inspection. **V. Plan of Correction completion date.** Plan of Completion date is May 5th, 2022.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling			

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	155333	A. BUILDING 01 B. WING	04/25/2022

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	to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. This deficient practice could affect residents, staff and visitors while in the front entrance corridor which included staff offices, the front lounge area, and a portion of the 200 hall. Findings include: Based on observations on 04/25/22 between 1:00 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the oxygen storage/transfer room was equipped with a mechanically vented exhaust fan, however, it was not working at the time of observation. Based on interview at the time of observation, the Maintenance Supervisor agreed the mechanically vented exhaust fan was not working. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0927	**K 927** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The community failed to ensure that the oxygen transfer room exhaust fan was in good working condition. The Maintenance Supervisor has replaced the motor in the fan to make it operational. **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.**	05/05/2022

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	04/25/2022

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			Observation A- There is a current monthly TELS task to inspect the Oxygen Room door to ensure that it latches. See attached task labeled “Paoli Oxygen Room Fan Inspection Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the oxygen room fan to ensure its operation latches during their annual site visit inspection. **V. Plan of Correction completion date.** Plan of Completion date is May 5th, 2022.	