

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Paoli Health and Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 559 W Longest St Paoli, IN 47454	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>39130</p> <p>Based on observation, interview, and record review, the facility failed to ensure the plan of care was implemented for 1 of 3 residents reviewed for resident abuse. A resident was not assisted by two staff members during a transfer according to the resident's plan of care. (Resident C)</p> <p>Finding includes:</p> <p>During a review of facility reported incidents on 6/10/24 at 12:30 P.M., a reported incident dated, 6/6/24 included that Resident C state that QMA was rough with her when positioning leg during a transfer.</p> <p>During record review on 6/11/24 at 10:30 A.M., Resident C's diagnoses included, but were not limited to, age-related physical debility, contracture of left knee, infection and inflammatory reaction due to internal left hip prosthesis, and unspecified displaced fracture of fourth cervical vertebra.</p> <p>Resident C's most recent Admission MDS (Minimal Data Set) assessment, dated 4/21/24, included that Resident C had no cognitive impairment, had one-sided impairment to upper and lower extremities, and was dependent for transfers.</p> <p>Resident C's physician orders included, but were not limited to, up as tolerated per plan of care (initiated 4/18/24).</p> <p>Resident C's care plan included, but was not limited to; Resident requires assistance with ADLs including bed mobility and transfers. Interventions included, follow physical therapy/occupational therapy recommendations, provide assistance for transfers as needed, and provide assistive device as needed (started 4/25/24).</p> <p>During a review of CNA POC (Point of Care) documentation from 6/1/24 to 6/10/24, Resident C required total dependence daily for transfers.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 155333	If continuation sheet Page 1 of 2

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's investigation of the reported incident from 6/6/24 included an undated handwritten note signed by PT 4 and included, .when I got to [Resident C's] room and observed [CNA 6] attempting to put [Resident C] in (wheelchair) with Hoyer lift alone. [CNA 6] had Hoyer lift control in her right hand and was pulling on [Resident C's] left leg, which made [Resident C] yell out in pain. I went into [Resident C's] room to assist and also noticed that the arm of the Hoyer (lift) was very close to [Resident C's] face .</p> <p>During an observation on 6/11/24 at 11:15 A.M., Resident C was lying in bed. Her left knee was bent and she appeared to have difficulty rolling over in bed without assistance.</p> <p>During an interview on 6/11/24 at 1:45 P.M., PT 2 indicated that Resident C was assessed to be dependent for transfers and required a mechanical lift such as a Hoyer lift for transfers and that two staff members are required to assist with a mechanical lift.</p> <p>During an interview on 6/11/24 at 2:00 P.M., PT 4 indicated that they had observed Resident C being transferred in a Hoyer lift by one staff member and that two staff should always be present during a Hoyer lift transfer to ensure resident and staff safety as well as proper positioning.</p> <p>On 6/11/24 at 3:40 P.M., the DON supplied a facility policy titled Safe Use of a Mechanical Lift, and dated 2/1/23. The policy included, .At least 2 trained staff members are needed to safely move a resident using a mechanical lift.</p> <p>This citation relates to complaint IN00432682.</p> <p>3.1-35(g)(2)</p>		