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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paoli Health and Living Community	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 3 residents reviewed for pharmaceutical services. A resident received an incorrect dose of an ordered medication for three days for a total of four doses due to incorrectly transcribed physician's order. (Resident B)Finding includes:During review on 1/14/26 at 11:00 A.M., a facility reported incident, dated 1/2/26, indicated Resident B had admitted to the facility following a hospitalization and with an order for the medication metoprolol 25 milligrams (mg), give 1/2 tablet twice a day. During transcription from the hospital discharge orders to the facility medication administration record, the order was entered as metoprolol 25 mg one tablet twice a day. As a result, the resident received three doses of the metoprolol 25 mg tablet. During therapy, the resident became weak and short of breath. The hospital did keep the resident for observation. Record review on 1/14/26 at 2:00 P.M., Resident B's diagnoses included but were not limited to heart disease, obesity, heart failure, and atrial fibrillation.Resident B's hospital discharge orders, dated 12/31/25, included but were not limited to metoprolol tartrate 25 mg oral tablet, 0.5 tablet twice a day. Resident B's facility physician orders included, metoprolol tartrate 25 mg tablet, 1 tablet twice a day, (started 12/31/25 and discontinued 1/6/26).Resident B's medication administration record (MAR) indicated the resident received metoprolol tartrate 25 mg tablet, 1 tablet the evening of 12/31/25, the morning of 1/1/26, the evening of 1/1/26, and the morning of 1/2/26. Resident B's nurse's progress notes included but were not limited to:1/2/26 at 4:55 P.M. - Resident was receiving therapy and became short of breath. Vital signs were obtained with a blood pressure of 86/48 millimeters of mercury (mm Hg), and a pulse of 42 beats per minute (BPM). Resident bradycardic and hypotensive. Emergency Medical Services (EMS) called, and resident was transported to the hospital emergency department. During an interview on 1/14/26 at 11:45 A.M., RN 7 indicated Resident B's hospital discharge order for metoprolol tartrate was entered incorrectly into the facility's MAR and resulted in the resident receiving twice the ordered dose. During an interview on 1/15/26 at 11:00 A.M., LPN 4 indicated the admitting nurse used an admission checklist when admitting a new resident to the facility. On 1/15/26 at 1:40 P.M., RN 7 supplied an undated Nurse admission Checklist and indicated the checklist was a tool to be used by the admitting nurse but was not required to be filled out and was not part of the resident's record. The checklist included, Physician Orders Prescription Physician Orders from Transfer Papers, make sure medications have appropriate (diagnosis) [space to Initial] . Orders verified by two nurses [Initial Nurse One, Initial Nurse Two] .On 1/15/26 at 1:54 P.M., RN 7 supplied an undated Transcribing Orders policy. The policy included, Physician orders will be transcribed to dedicated medical records timely, completely and accurately using acceptable standards of practice . Copying Physician Orders 1. Occasionally physician orders may need to be transcribed from one physician order form to another . 2. Great care must be taken to ensure accuracy and completeness when transcribing orders .This citation relates to intakes 2700726 and 2713037.3.1-48(a)(1)3.1-48(c)(2)

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

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 01/15/2026
NAME OF PROVIDER OR SUPPLIER Paoli Health and Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 559 W Longest St Paoli, IN 47454	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during 3 of 4 observations of resident care. Staff failed to change gloves when completing a dirty task and prior to starting a clean task, failed to perform hand hygiene between glove uses, and failed to implement enhanced barrier precautions for a resident per the physician's order. (Resident C, Resident D, Resident F)Findings include:1. During an observation on 1/15/26 at 1:23 A.M., CNA 2 and CNA 4 provided incontinence care for Resident C. CNA 2 and CNA 4 removed a wet brief and provided perineal care while wearing gloves. CNA 4 then applied a new brief wearing the same gloves, then opened the top drawer of a bedside table and retrieved a tube of cream and applied the resident's peri-area. CNA 4 placed the tube back in the drawer, removed gloves, pulled new gloves from a pants pocket and put on new gloves without performing hand hygiene. CNA 2 and CNA 4 then pulled the resident up in bed and adjusted the resident's pillow before removing gloves and washing their hands.2. During an observation on 1/15/26 at 2:10 A.M., CNA 6 and CNA 4 provided incontinence care for Resident D. CNA 6 removed a soiled brief, provided peri-care, and removed a soiled draw sheet from under the resident. CNA 6 then removed gloves and donned new gloves without performing hand hygiene. CNA 6 held a clean sheet against his scrub top as he rolled the sheet and placed it under the resident. A new brief was applied, and CNA 6 and CNA 4 adjusted the resident and the resident's pillow prior to removing their gloves and performing hand hygiene.During an interview on 1/15/26 at 10:30 A.M., RN 7 indicated staff should perform hand hygiene when removing gloves when changing from a dirty to clean task. On 1/15/26 at 1:15 P.M., RN 7 provided a facility policy titled Infection Control, dated 6/6/19. The policy included, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment to help prevent and manage transmission of diseases and infections . The hand hygiene procedures to be followed by staff involved in direct contact .3. During an observation on 1/15/26 at 1:40 A.M., CNA 6 and LPN 9 assisted Resident F up from her bed to the restroom. CNA 6 and LPN 9 then assisted the resident back from the commode and back to her bed. Neither CNA 6 nor LPN 9 wore a gown or implemented enhanced barrier precautions while providing assistance. During a record review on 1/5/26 at 11:00A.M , Resident F's physician orders included but were not limited to, enhanced barrier precautions (started 1/14/26). Resident F's nurse's progress notes included but were not limited to; 1/14/26 at 5:09 P.M. - Physician contacted. Resident had positive methicillin-resistant Staphylococcus aureus (MRSA) from nare swab at hospital on 1/11/26. Physician replied that the resident is colonized and to place resident in enhanced barrier precautions (EBP). During an observation on 1/15/26 at 11:30 A.M., Resident F's restroom did contain a container with personal protective equipment (PPE) supplies, however no signage that indicated either resident in the room required EBP.During an interview on 1/5/26 at 12:10 P.M., LPN 15 indicated Resident F had recently received an order for EBP and still needs a sign in the room to indicate to staff that PPE should be used for all personal care since no specific care is not specified in the physician's order. On 1/15/26 at 1:40 P.M., RN 7 supplied a facility policy titled Enhanced Barrier Precautions Policy and Procedure, dated 1/15/25. The policy included, Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of Multidrug-resistant Organisms (MDROs). EBP employs targeted gown and glove use during high contact resident care activities .This citation relates to intake 2700726. 3.1-18(b)(2)3.1-18(l)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment in 3 of 4 resident halls observed. Resident rooms contained used towels/washcloths on the floors, resident bed pans were stored uncovered in shared restrooms, resident toothbrushes were stored uncovered and unlabeled in shared restrooms, and odors were present 2 of 2 days during the survey. (100 hall, 200 hall, 300 hall, room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER])Findings include:1. During a review of the facility grievance log on 1/14/26 at 11:00 A.M., a grievance was filed on 12/18/25 that dirty laundry was left in a resident's room. 2. On 1/14/26 at 11:15, Hall 300 contained a urine odor. On 1/15/26 at 2:16 P.M., Hall 300 contained a urine odor. 3. During an observation on 1/14/26 at 2:30 P.M., the shared restroom in room [ROOM NUMBER] contained two resident toothbrushes, uncovered and unlabeled. On 1/14/26 at 2:40 P.M., room [ROOM NUMBER] contained a towel on the floor near the restroom door. The shared restroom contained two toothbrushes, unlabeled and uncovered on the back of the sink, and one automatic toothbrush unlabeled and uncovered on the back of the commode. On 1/15/26 at 12:24 A.M., room [ROOM NUMBER] contained a washcloth on the floor next to the nearest bed to the door. On 1/15/26 at 12:45 A.M, room [ROOM NUMBER] contained a washcloth on the floor under the foot of the bed nearest the door. On 1/15/26 at 1:30 A.M., the shared restroom in room [ROOM NUMBER] contained a bed pan resting between a handrail and the bathroom wall, uncovered. On 1/15/26 at 10:15 A.M., room [ROOM NUMBER] contained a washcloth on the floor under the foot to bed nearest the door.On 1/15/26 at 11:30 A.M., the shared restroom in room [ROOM NUMBER] contained a bed pain resting between a handrail and the bathroom wall, uncovered. During an interview on 1/15/26 at 11:00 A.M., LPN 4 indicated resident bed pans should be covered if being stored in a shared restroom and that resident toothbrushes should be stored away and covered when in a shared restroom. During interview on 1/15/26 at 2:05 P.M., QMA 12 indicated staff should not leave linens or washcloths lying on the floor after providing care and should clean up after themselves following care. On 1/25/26 at 1:55 P.M., RN 7 supplied a facility policy titled [Company Name] Infection Control Precautions, dated 10/28/14. The policy included, Linens Handle, Transport and process used linens in a manner in which it prevents skin and mucous membrane exposure and contamination of clothing. Avoids (sic) transfer of pathogens to other patients and or the environment . Patient care equipment Handle equipment soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of pathogens to other patients or the environment .This citation relates to intake 2700726. 3.1-19(f)(5)3.1-19(g)(1)