

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: 12/18/2017	
NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 599 W LONGEST ST PAOLI, IN 47454			
X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 CORRESPONDING TO THE APPROPRIATE DEFICIENCY)		X5) COMPLETION DATE	
E 0000 Bldg. -	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 12/18/17</p> <p>Facility Number: 000226 Provider Number: 155333 AIM Number: 200267730</p> <p>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</p> <p>The facility has 109 certified beds, with a current census of 88.</p> <p>Quality Review completed on 12/19/17 - DA</p>		E 0000				
K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in</p>		K 0000				

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that adequate provision is made to the patients. (see instructions.) Except for nursing homes, the findings stated above are finalizable 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 final 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required for continued program participation.

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