STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING -- B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/27/23 Facility Number: 000555 Provider Number: 155370 AIM Number: 100267530 At this Emergency Preparedness survey, Premier Healthcare of New Harmony was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 96 certified beds. At the time of the survey, the census was 62. Quality Review completed on 07/06/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Submission of this Plan of Correction by the facility is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. Please accept the following as the facility's credible allegation of compliance.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

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

Janie Swedenburg | Administrator | 07/24/2023

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
	155370	A. BUILDING -- B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING -- B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING -- B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 29 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection reports on 06/27/23 between 9:30 a.m. and 1:00	E 0041	The following corrective action(s) have been taken for those residents and/or areas found to have been allegedly affected by the deficient practice: A. The facility has completed a weekly inspection of their emergency generator and continues to complete this weekly inspection routinely each week. Written records of these inspections are being maintained. B. The facility has completed and documented the four (4) hour test for the emergency generator. This shall occur at least every 36 months. 2. The following action(s) have been taken to identify other resident(s) and/or areas with the potential to be affected by this alleged deficient practice and subsequent actions of correction: A. There are no other generators for this facility. Therefore, no other examples exist that may be potentially affected by this alleged deficient practice. 3. The following measures and systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING -- B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 29 of the most recent 52 week period. Based on interview at the time of record review, the Maintenance Director said the emergency generator does self test every week but he only documents it when instructed to by TELS. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 2. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 06/27/23 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the facility could not provide documentation of a four hour test of the emergency generator within the past 36 months for the emergency generator. This was confirmed by the Maintenance Director at the time of record		been taken: The Maintenance Director has been inserviced regarding the requirement to: (1). inspect the generator a minimum of weekly and to document this inspection and (2) complete a four (4) hour test for the emergency generator a minimum of every thirty-six (36) months and to document this test. B. The following systemic change has been taken: The Maintenance Director shall provide the Administrator a copy of the written weekly generator inspection report each week. The Maintenance Director shall also provide the Administrator with a written copy of the four (4) hour emergency generator test report every 36 months. In addition, these reports shall be reviewed during the monthly Quality Assurance/Quality Improvement Meetings. 4. The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained: A. The Administrator shall audit the weekly emergency generator inspection records each week to ensure they are completed and documented. The Administrator shall also audit documentation that the four (4) hour emergency generator testing has been completed within the last 36 months This shall be ongoing for a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING -- B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		minimum of three (3) months and may continue longer until compliance is achieved and ongoing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
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: 06/27/23 Facility Number: 000555 Provider Number: 155370 AIM Number: 100267530 At this Life Safety Code survey, Premier Healthcare of New Harmony 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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, plus battery	K 0000	Submission of this Plan of Correction by the facility is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. Please accept the following as the facility's credible allegation of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 96 and had a census of 62 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except a detached garage used for a maintenance shop and maintenance and facility storage, plus two detached wood framed sheds used for the water softener salt and activities supplies. Quality Review completed on 07/06/23			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure documentation for the sensitivity testing of 4 of 4 duct smoke detectors was performed. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of	K 0345	1. The following corrective action(s) have been taken for those residents and/or areas found to have been allegedly affected by the deficient practice: A. The facility has completed, and has documentation regarding, the sensitivity testing for identified duct smoke detectors. 2. The following action(s) have been taken to identify other resident(s) and/or areas with the potential to be affected by this	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 06/27/23 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the smoke detector sensitivity test report dated 06/24/22 was not a complete report. The facility's four duct smoke detectors were not tested for sensitivity. The report indicated "NA" under "make" and "model", and was blank in the sensitivity column. Based on interview at the time of record review, the Maintenance Director confirmed the lack sensitivity testing information for the four duct smoke detectors during the		alleged deficient practice and subsequent actions of correction: A. There are no other duct smoke detectors aside from those sited in this deficiency. Therefore, no other examples exist that may be potentially affected by this alleged deficient practice. 3. The following measures and systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has been taken: The Maintenance Director has been in-serviced regarding the requirement to perform smoke sensitivity testing on duct smoke detectors within one year of installation and every other year thereafter. The importance of maintaining documentation that this testing has been completed was also reviewed. B. The following systemic change has been taken: The Maintenance Director shall create a calendar/log identifying each duct smoke detector; when it was installed; and when it is next due for testing. The maintenance director shall be responsible for keeping this log up-to-date. This calendar/log shall be shared with the Administrator. 4. The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	06/24/22 sensitivity test. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		A. The Administrator shall audit the calendar/log of the duct smoke detectors (discussed in 3. B. above) each month to ensure that any changes (e.g. installation of new or replacement duct smoke detectors, etc.) are scheduled to be tested per requirement. This shall be ongoing for a minimum of three (3) months and may continue longer until compliance is achieved and ongoing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler system. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 06/27/23 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for the past 12 month period. Based on interview at the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0353	1. The following corrective action(s) have been taken for those residents and/or areas found to have been allegedly affected by the deficient practice: A. The facility has completed, and has documentation of the monthly sprinkler system control valve inspection. This shall be ongoing thereafter. 2. The following action(s) have been taken to identify other resident(s) and/or areas with the potential to be affected by this alleged deficient practice and subsequent actions of correction: A. There are no other sprinkler systems aside from the one sited in this deficiency. Therefore, no other examples exist that may be potentially affected by this alleged deficient practice. 3. The following measures and systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has been taken: The Maintenance Director has been in-serviced regarding the requirement to perform monthly sprinkler system control valve inspections and to maintain documentation of these inspections. B. The following systemic change has been taken: The Maintenance Director shall provide the Administrator a copy of the written monthly sprinkler system control	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
			valve inspections. In addition, these reports shall be reviewed during the monthly Quality Assurance/Quality Improvement Meetings. 4. The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained: A. The Administrator shall audit the monthly sprinkler system control valve inspection documentation each month to ensure it has been completed and documented. This shall be ongoing for a minimum of three (3) months and may continue longer until compliance is achieved and ongoing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 75 corridor doors would resist the passage of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 06/27/23 between 1:00	K 0363	. The following corrective action(s) have been taken for those residents and/or areas found to have been allegedly affected by the deficient practice: A. The facility has repaired the Cardinal Unit Shower room corridor door. 2. The following action(s) have	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the corridor door to the Cardinal Unit Shower Room had six, one fourth inch holes through the door just below the door handle. Based on interview at the time of observation the Maintenance Director agreed the door was not smoke resistant and the holes need to be repaired. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		been taken to identify other resident(s) and/or areas with the potential to be affected by this alleged deficient practice and subsequent actions of correction: A. Facility corridor doors are identified as having the potential to be affected by this deficiency. These doors have been inspected to ensure there are no holes or other breaches that compromise their ability to act as a smoke barrier per this requirement. Doors with such breaches have been repaired. 3. The following measures and systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has been taken: The Maintenance Director has been in-serviced regarding the importance of ensuring that corridor doors are in good repair without damage, holes, or other breaches that would impede the smoke resistance. B. The following systemic change has been taken: The Maintenance Director shall include weekly visual inspections of corridor doors during regular rounds to ensure doors are damage-free and do not allow the passage of smoke. 4. The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
			A. The Administrator, Maintenance Director, and/or appointed designee(s) shall visually inspect five corridor doors each week to ensure there are no holes or other breaches that would allow the passage of smoke. This shall be ongoing for a minimum of three (3) months and may continue longer until compliance is achieved and ongoing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview, the facility failed to ensure 4 of 4 fuel-fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff and visitors in the facility.	K 0500	1.The following corrective action(s) have been taken for those residents and/or areas found to have been allegedly affected by the deficient practice: A. The facility has had the four (4) identified fuel-fired water heaters inspected and maintains their certificates of inspection.	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	Findings include: Based on record review on 06/27/23 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the four fuel-fired water heaters in the facility had certificates with expiration dates of 09/23/21. Based on interview at the time of record review, the Maintenance Director confirmed the expiration dates of the four fuel-fired water heaters. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		1.The following action(s) have been taken to identify other resident(s) and/or areas with the potential to be affected by this alleged deficient practice and subsequent actions of correction: A. There are no other fuel-fired water heaters aside from those sited in this deficiency. Therefore, no other examples exist that may be potentially affected by this alleged deficient practice. 1.The following measures and systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has been taken: The Maintenance Director has been in-serviced regarding the requirement to ensure that the fuel-fired water heaters are inspected per requirement. The importance of maintaining documentation/certifications that inspections have been completed has also been reviewed. B. The following systemic change has been taken: The Maintenance Director shall create a calendar/log identifying each fuel-fired water heater; when it was last inspected and when it is next due for the next inspection. The maintenance director shall be responsible for keeping this log up	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
			to date. The calendar/log shall be shared with the Administrator. 1.The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained: A. The Administrator shall audit the calendar/log of the fuel-fired water heater (discussed in 3.B. above) each month to ensure any changes (e.g. installation of new or replacement fuel-fired water heaters, etc.). This shall be ongoing for a minimum of six (6) months and may continue longer until compliance is achieved and ongoing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 4 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 06/27/23 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there were 13 fire drills performed during the past 12 month period, however, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period: a. Second shift (evening) of the second quarter (April, May, and June) of 2022 and so far in 2023. b. Third shift (night) of the third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2022, and, first quarter (January, February, and March) of 2023. Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 13 of 13 fire drill reports	K 0712	1.The following corrective action(s) have been taken for those residents and/or areas found to have been allegedly affected by the deficient practice: A. A second shift fire drill has been performed. B. The monitoring company was called to ensure the signal was received. 1.The following action(s) have been taken to identify other resident(s) and/or areas with the potential to be affected by this alleged deficient practice and subsequent actions of correction: A. All residents have the potential to be affected by the alleged deficient practice. There have been 3 fire drills completed on all three shifts. B. The fire alarm company was called after each drill to ensure they received the signal. This was documented in the fire drill report. 1.The following measures and systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
K 0761 SS=E Bldg. 01	included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 06/27/23 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, all 13 fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on any of the fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3-1.19(b)		been taken: The Maintenance Director has been in-serviced regarding the requirement to ensure that fire drills are not routine and simulate emergency fire conditions. B. The following systemic change has been taken: The Maintenance Director shall create a calendar of fire drills for the next 12 months that include varying times on all 3 shifts. This calendar shall be shared with the Administrator. 1.The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained: A. The Administrator shall audit the calendar with the fire drill reports after each drill. This shall be ongoing for a minimum of three (3) months and may continue longer until compliance is achieved and ongoing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.	K 0761	1.The following corrective action(s) have been taken for those residents and/or areas found to have been allegedly affected by the deficient practice: A. The oxygen room fire door assembly was inspected and documented. 1.The following action(s) have been taken to identify other resident(s) and/or areas with the potential to be affected by this alleged deficient practice and subsequent actions of correction: A. An audit of all doors within the facility has been completed. B. Any fire door without an annual assembly inspection has now been inspected, and the inspection documented. 1.The following measures and systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has been taken: The Maintenance Director has been in-serviced regarding the requirement for annual inspection and testing of fire door assemblies. B. The following systemic change has been taken: The Maintenance Director has entered	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 20 residents, as well as staff, and visitors. Findings include: Based on record review on 06/27/23 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly. Based on observations during a tour of the facility with the Maintenance Director between 1:00 p.m. and 3:00 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		each door into the TELS system to ensure no annual inspection is missed on any fire door within the facility. 1.The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained: A. The Administrator shall review every fire door inspection. This shall be ongoing for a minimum of six (6) months and may continue longer until compliance is achieved and ongoing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly	K 0918	The following corrective action(s) have been taken for those	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	inspections for 1 of 1 generator was maintained for 29 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection reports on 06/27/23 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 29 of the most recent 52 week period. Based on interview at the time of record review, the Maintenance Director said the emergency generator does self test every week but he only documents it when instructed to by TELS. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the		residents and/or areas found to have been allegedly affected by the deficient practice: A. The facility has completed a weekly inspection of their emergency generator and continues to complete this weekly inspection routinely each week. Written records of these inspections are being maintained. B. The facility has completed and documented the four (4) hour test for the emergency generator. This shall occur at least every 36 months. 2. The following action(s) have been taken to identify other resident(s) and/or areas with the potential to be affected by this alleged deficient practice and subsequent actions of correction: A. There are no other generators for this facility. Therefore, no other examples exist that may be potentially affected by this alleged deficient practice. 3. The following measures and systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has been taken: The Maintenance Director has been in-serviced regarding the requirement to: (1). inspect the generator a minimum of weekly and to document this inspection and (2) complete a four (4) hour test for the emergency generator a minimum of every thirty-six (36) months and to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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 failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 06/27/23 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the facility could not provide documentation of a four hour test of the emergency generator within the past 36 months for the emergency generator. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		document this test. B. The following systemic change has been taken: The Maintenance Director shall provide the Administrator a copy of the written weekly generator inspection report each week. The Maintenance Director shall also provide the Administrator with a written copy of the four (4) hour emergency generator test report every 36 months. In addition, these reports shall be reviewed during the monthly Quality Assurance/Quality Improvement Meetings. 4. The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained: A. The Administrator shall audit the weekly emergency generator inspection records each week to ensure they are completed and documented. The Administrator shall also audit documentation that the four (4) hour emergency generator testing has been completed within the last 36 months This shall be ongoing for a minimum of six (6) weeks and may continue longer until compliance is achieved and ongoing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
			corrective action(s).	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure a power strip and a multi-plug adapter were not used as a substitute for fixed wiring in 2 of 2 observed staff areas. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and	K 0920	1.The following corrective action(s) have been taken for those residents and/or areas found to have been allegedly affected by the deficient practice: A. The power strip in the employee breakroom was removed as well as the multi-plugged	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff only in two staff only areas. Findings include: Based on observations on 06/27/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was a microwave oven plugged into a power strip in the Employee Breakroom. b. There was a microwave oven, coffee maker, and refrigerator plugged into a multi-plugged adapter in the Cardinal Unit Pantry. Based on interview at the time of each observation, the Maintenance Director acknowledged the use of the power strip and multi-plugged adapter in the two staff areas. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		adapter in the Cardinal unit pantry. 1.The following action(s) have been taken to identify other resident(s) and/or areas with the potential to be affected by this alleged deficient practice and subsequent actions of correction: A. An audit of all outlets in the facility has been completed to ensure no other power strips or multi-plugged adapters are being utilized. 1.The following measures and systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has been taken: The Maintenance Director and all staff have been in-serviced regarding power cords and extension cords. 1.The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained: A. The Maintenance Director shall randomly audit 20 rooms a week. This shall be ongoing for a minimum of three (3) months and may continue longer until compliance is achieved. Noted problems will be immediately	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
			corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	
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 room, where the sign includes the wording as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	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 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 4 smoke compartments. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 06/27/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, there was one medium sized oxygen cylinder freestanding on the floor in the oxygen transfilling/storage room. The oxygen cylinder was not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observation, the Maintenance Director acknowledged the oxygen	K 0923	1.The following corrective action(s) have been taken for those residents and/or areas found to have been allegedly affected by the deficient practice: A. The oxygen cylinders have been removed from the facility. B. Hooks have been hung on the wall in the oxygen room for the all other portable tanks. 1.The following action(s) have been taken to identify other resident(s) and/or areas with the potential to be affected by this alleged deficient practice and subsequent actions of correction: A. An audit was conducted to determine if any other oxygen units are located within the facility and not secured properly in the oxygen storage room. 1.The following measures and	08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 01 B. WING	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

(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
	cylinder freestanding on the floor and not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		systemic changes have been put in place to assure that this alleged deficient practice does not recur: A. The following measure has been taken: The Maintenance Director and nursing staff have been in-serviced regarding the storage of all portable oxygen tanks. 1.The following Quality Monitoring program has been implemented to monitor and assure that corrective actions are achieved, effective and sustained: A. The Maintenance Director shall audit the oxygen room at random times 10 times a week. This shall be ongoing for a minimum of three (3) months and may continue longer until compliance is achieved and ongoing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).	