	T OF HEALTH AND HI R MEDICARE & MEDI						ORM APPROVED MB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370		JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/27/2023	
	PROVIDER OR SUPPLIE	ER OF NEW HARMONY		251 HI	address, city, state, zip cod GHWAY 66 IARMONY, IN 47631		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3 IATE	(X5) COMPLETION DATE
Bldg	conducted by the I accordance with 4 Survey Date: 06/2 Facility Number: Provider Number: 10 At this Emergency Healthcare of New compliance with F Requirements for	27/23 000555 155370	E 0	000	Submission of this Plan of Correction by the facility is no legal admission that a deficie exists or that this Statement Deficiencies was correctly cir In addition, preparation and submission of this POC does constitute an admission or agreement of any kind by the facility of the truth of any fact forth in this allegation by the survey agency. Please acce following as the facility's creat allegation of compliance.	ency of ted. s not s sot ts set ept the	
E 0041 SS=F Bldg	the survey, the cer Quality Review co The requirement a MET as evidenced 482.15(e), 483.7 Hospital CAH an §482.15(e) Cond (e) Emergency a The hospital mus standby power s emergency plan this section and	ompleted on 07/06/23 at 42 CFR, Subpart 483.73 is NOT 1 by: 3(e), 485.625(e) d LTC Emergency Power lition for Participation: and standby power systems. st implement emergency and ystems based on the set forth in paragraph (a) of in the policies and set forth in paragraphs (b)(1) section.					
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATUR	E	TITLE		(X6) DATE
Janie Swe				Adminis			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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	OF CORRECTION	x1) provider/supplier/clia identification number 155370	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP C		06/	(X3) DATE SURVEY COMPLETED 06/27/2023		
	PROVIDER OR SUPPLI	ER OF NEW HARMONY	STREET ADDRESS, CITY, STATE, ZIP COD 251 HIGHWAY 66 NEW HARMONY, IN 47631					
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
	(e) Emergency a The [LTC facility implement emer systems based forth in paragrap §482.15(e)(1), § Emergency gen generator must the location requ Care Facilities C Interim Amendin 12-4, TIA 12-5, Code (NFPA 10 Amendments TI and TIA 12-4), a structure is built structure or built 482.15(e)(2), §4 Emergency gen The [hospital, C implement the e inspection, testii requirements fo Facilities Code, Code. 482.15(e)(3), §4 Emergency gen and LTC facilities source to power have a plan for l power systems emergency, under	and standby power systems. and the CAH] must gency and standby power on the emergency plan set oh (a) of this section. 483.73(e)(1), §485.625(e)(1) erator location. The be located in accordance with uirements found in the Health Code (NFPA 99 and Tentative nents TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety 1 and Tentative Interim A 12-1, TIA 12-2, TIA 12-3, and NFPA 110, when a new or when an existing ding is renovated. 83.73(e)(2), §485.625(e)(2) erator inspection and testing. AH and LTC facility] must mergency power system ng, and [maintenance] und in the Health Care NFPA 110, and Life Safety 83.73(e)(3), §485.625(e)(3) erator fuel. [Hospitals, CAHs s] that maintain an onsite fuel emergency generators must now it will keep emergency operational during the ess it evacuates. It §482.15(h), LTC at						
	§483.73(g), and The standards i	CAHs §485.625(g):] ncorporated by reference in approved for incorporation by						

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN OF	DF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	ì í	ILDING	NSTRUCTION	CO	ATE SURVEY MPLETED /27/2023		
	VIDER OR SUPPLIE	r DF NEW HARMONY		STREET ADDRESS, CITY, STATE, ZIP COD 251 HIGHWAY 66 NEW HARMONY, IN 47631					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
$ \begin{array}{c} F \\ 5 \\ 5 \\ t \\ Y \\ H \\ E \\ A \\ () \\ t \\ t \\ g \\ h \\ . \\ . \\ . \\ . \\ . \\ . \\ . \\ . \\ .$	ederal Register 52(a) and 1 CFI the material from ou may inspect formation Resc oulevard, Baltin rchives and Rev NARA). For info- nis material at N o to: ttp://www.archiv of_federal_regu any changes in corporated by r ocument in the nnounce the ch- l) National Fire atterymarch Pa ouncy, MA 0216 .617.770.3000. ) NFPA 99, Hea 012 edition, issued ii) TIA 12-3 to N 012. v) TIA 12-4 to N 013. <i>i</i> ) TIA 12-5 to N 013. <i>i</i> ) TIA 12-5 to N 013. <i>i</i> ) TIA 12-6 to N 014. <i>i</i> (ii) NFPA 101, L dition, issued Ar <i>i</i> (iii) TIA 12-1 to I 1, 2011. x) TIA 12-2 to N 0, 2012.	Protection Association, 1 rk, i9, www.nfpa.org, lth Care Facilities Code, ued August 11, 2011. rim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued March 3, ife Safety Code, 2012							

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD			(X3) DATE SURVEY COMPLETED 06/27/2023	
	PROVIDER OR SUPPLIE	BR OF NEW HARMONY		251 HI	address, city, state, zip cod GHWAY 66 IARMONY, IN 47631		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	1	(X5) COMPLETIO DATE
	<ul> <li>22, 2013.</li> <li>(xiii) NFPA 110, Standby Power S including TIAs to 2009</li> <li>Based on record ra failed to implement inspection, testing found in the Healt 110, and Life Safe CFR 483.73(e)(2)</li> <li>1. Based on record facility failed to end inspections for 1 of for 29 of 52 weeks NFPA 99 requires shall be maintaine 2010 Edition, Stard Standby Power Sy batteries, includin, voltage, used in condinate inspected weekly and compliance with m 8.3.7.2 states defered or replaced immed defects. Chapter 6 written record of if exercising period, maintained and avaintained visitors.</li> <li>Findings include:</li> </ul>	AFPA 101, issued October Standard for Emergency and Systems, 2010 edition, o chapter 7, issued August 6, eview and interview, the facility at the emergency power system is, and maintenance requirements h Care Facilities Code, NFPA ety Code in accordance with 42  d review and interview, the nsure a written record of weekly of 1 generator was maintained s. Chapter 6-4.4.1.3 of 2012 batteries for on-site generators d in accordance with NFPA 110, ndard for Emergency and estems. 8.3.7 requires storage g electrolyte levels or battery onnection with systems shall be and maintained in full manufacturer's specifications. ctive batteries shall be repaired diately upon discovery of 5.5.4.2 of NFPA 99 requires a nspection, performance, and repairs shall be regularly vailable for inspection by the urisdiction. This deficient ext all residents, staff and	EO	041	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 week inspection routinely each week. Written records of these inspections are being maintaine B. The facility has completed ar documented the four (4) hour te for the emergency generator. Th 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 generator for this facility. Therefore, no oth examples exist that may be potentially affected by this alleg deficient practice. 3. The following measures and systemic changes have been put in place to assure that this alleg deficient practice does not recur A. The following measure has	kly ed. nd est nis e n: "s ner ed ut led	08/30/202

TERS FO	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	r í	ILDING		COMPLE		
		155370	B. WI			06/27/2		
		_		STREET .	ADDRESS, CITY, STATE, ZIP COD			
	PROVIDER OR SUPPLIE				GHWAY 66			
PREMIE	R HEALTHCARE C	OF NEW HARMONY		NEW H	IARMONY, IN 47631			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	p.m. with the Main	tenance Director present, there			been taken: The Maintenance			
		tion available to show the			Director has been inserviced			
	emergency generat	for was inspected/tested weekly			regarding the requirement to:	(1).		
	during 29 of the m	ost recent 52 week period.			inspect the generator a minim	um		
	Based on interview	at the time of record review,			of weekly and to document thi	s		
	the Maintenance D	Pirector said the emergency			inspection and (2) complete a	four		
	generator does self	test every week but he only			(4) hour test for the emergenc	у		
	documents it when	instructed to by TELS.			generator a minimum of every	,		
					thirty-six (36) months and to			
	This finding was re	eviewed with the Administrator			document this test.			
	and Maintenance I	Director during the exit			B. The following systemic cha	nge		
	conference.				has been taken: The Maintena	ance		
					Director shall provide the			
	2. Based on record	l review and interview, the			Administrator a copy of the wr	itten		
	facility failed to pr	ovide complete documentation			weekly generator inspection re			
	for the testing of 1	of 1 Emergency Power Standby			each week. The Maintenance			
	-	nce with NFPA 110, Standard			Director shall also provide the			
		l Standby Power Systems,			Administrator with a written co			
		equired by NFPA 99 Health Care			of the four (4) hour emergency			
		ction 6.4.1.1.6.1. NFPA 110			generator test report every 36			
		s that all Level 1 Emergency			months. In addition, these rep			
		all be tested at least once within			shall be reviewed during the			
		Where the assigned class is			monthly Quality			
		s, it shall be permitted to			Assurance/Quality Improveme	ent		
	-	fter 4 hours. NFPA 99 Section			Meetings.			
	6.4.1.1.6.1 states th	nat Type 1 and Type 2 essential			4. The following Quality Monitor	orina		
		ower sources shall be classified			program has been implemente	•		
		X, Level 1 generator sets. This			monitor and assure that correct			
		could affect all residents, staff,			actions are achieved, effective			
	and visitors.	, ,			sustained:			
					A. The Administrator shall auc	lit I		
	Findings include:				the weekly emergency genera			
	6				inspection records each week			
	Based on record re	view on 06/27/23 between 9:30			ensure they are completed an			
		with the Maintenance Director			documented. The Administrate			
	present, the facility				shall also audit documentation			
		a four hour test of the			that the four (4) hour emergen			
		for within the past 36 months			generator testing has been	- y		
		generator. This was confirmed			completed within the last 36			
		e Director at the time of record			months This shall be ongoing	for a		
	by the Maintenanc	e Director at the tille of fecolu			I monune mile small be origoing	iura		

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE SUR COMPLETE	
		155370	B. WING			06/2	27/2023
NAME OF	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COD		
PREMIE	R HEALTHCARE (	DF NEW HARMONY			GHWAY 66 IARMONY, IN 47631		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	Ň	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E RIATE	COMPLETION DATE
IAG	review.	K LSC IDENTIFTING INFORMATION		IAU	minimum of three (3) month		DATE
	icview.				may continue longer until	5 8110	
	This finding was re	eviewed with the Administrator			compliance is achieved and		
	and Maintenance I	Director during the exit			ongoing. Noted problems w		
	conference.				immediately corrected and		
					identified patterns/trends of		
					non-compliance will be brou	ght to	
					the Quality Improvement		
					Committee for further correct	ctive	
					action(s).		
< 0000							
Bldg. 01							
Diag. 01	A Life Safety Cod	e Recertification and State	K 0	000	Submission of this Plan of		
		was conducted by the Indiana	K U	000	Correction by the facility is r	not a	
		alth in accordance with 42 CFR			legal admission that a defici		
	483.90(a).				exists or that this Statement Deficiencies was correctly c	of	
	Survey Date: 06/2				In addition, preparation and submission of this POC doe	s not	
	Facility Number:				constitute an admission or		
	Provider Number:				agreement of any kind by th		
	AIM Number: 100	0267530			facility of the truth of any fac forth in this allegation by the		
	At this Life Safety	Code survey, Premier			survey agency. Please acc		
		Harmony was found not in			following as the facility's cre	•	
	compliance with R	equirements for Participation in			allegation of compliance.		
		d, 42 CFR Subpart 483.90(a),					
	-	ire and the 2012 edition of the					
		ection Association (NFPA) 101,					
	•	LSC), Chapter 19, Existing					
	Health Care Occup	pancies and 410 IAC 16.2.					
		lity was determined to be of					
		struction and was fully					
		acility has a fire alarm system					
		noke detectors in the corridors, corridors, plus battery					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	A. BUIL B. WINC	Ĵ	<u>01</u>	(X3) DATE SURVEY COMPLETED 06/27/2023	
	PROVIDER OR SUPPLIEI	R NEW HARMONY		251 HIGH	dress, city, state, zip cod WAY 66 RMONY, IN 47631		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTI CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	i	(X5) COMPLETION DATE
	rooms. The facility	ectors in all resident sleeping has a capacity of 96 and had a time of this survey.					
	access were sprinkl facility services we detached garage us maintenance and fa detached wood fran softener salt and ac						
< 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm Syster Maintenance Fire Alarm Syster Maintenance A fire alarm syste in accordance wit	n - Testing and m is tested and maintained h an approved program					
	National Electric ( National Fire Alar Records of syster and testing are re 9.6.1.3, 9.6.1.5, N Based on record re failed to ensure doo testing of 4 of 4 du performed. NFPA 2010 Edition, Secti sensitivity shall be installation, and ev After the second re sensitivity tests ind remained within its range, the length of shall be permitted to	e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. IFPA 70, NFPA 72 view and interview, the facility cumentation for the sensitivity ct smoke detectors was 72, National Fire Alarm Code, on 14.4.5.3.1 states detector checked within 1 year of ery alternate year thereafter. quired calibration test, if icate that the detector has listed and marked sensitivity ct time between calibration tests o be extended to a maximum of uency is extended, records of	K 034	a tt tc A h s d 2 b re	. The following corrective ction(s) have been taken for nose residents and/or areas for b have been allegedly affected ne deficient practice: A. The facility has completed, a las documentation regarding, t ensitivity testing for identified fuct smoke detectors. The following action(s) have een taken to identify other esident(s) and/or areas with the otential to be affected by this	by nd he	08/30/202

	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NETRICTION	(X3) DATE SURV	0938-039
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	21
IND PLAN	OF CORRECTION	155370	B. WING	01	06/27/2023	
		155570	B. WING		00/21/2023	
JAME OF	PROVIDER OR SUPPLIE	B	STREET	ADDRESS, CITY, STATE, ZIP COD		
				GHWAY 66		
PREMIE	R HEALTHCARE C	OF NEW HARMONY	NEW H	ARMONY, IN 47631		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR		<b>IPLETION</b>
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	detector caused nu	isance alarms and subsequent		alleged deficient practice an	d	
	trends of these alar	ms shall be maintained. In		subsequent actions of correct	ction:	
	zones or areas whe	re nuisance alarms show an		A. There are no other duct s	moke	
	increase over the p	revious year, calibration tests		detectors aside from those s	ited in	
	shall be performed	. To ensure that each smoke		this deficiency. Therefore, no	o other	
	detector is within it	ts listed and marked sensitivity		examples exist that may be		
	range, it shall be te	sted using any of the methods:		potentially affected by this a	leged	
	(1) Calibrated test			deficient practice.		
	(2) Manufacturer's	calibrated sensitivity test		3. The following measures a	nd	
	instrument.			systemic changes have bee	n put	
	(3) Listed control e	equipment arranged for the		in place to assure that this a	lleged	
	purpose.			deficient practice does not re	ecur:	
		fire alarm control unit		A. The following measure ha	IS	
	-	by the detector causes a signal		been taken: The Maintenand	e	
		where its sensitivity is outside		Director has been in-service	d	
	its listed sensitivity	-		regarding the requirement to		
		d sensitivity method acceptable		perform smoke sensitivity te	-	
	to the authority hav			on duct smoke detectors wit		
		have sensitivity outside the		one year of installation and e	every	
		sensitivity range shall be		other year thereafter. The		
	cleaned and recalib	-		importance of maintaining		
		ivity cannot be tested or		documentation that this testi	•	
		y spray device that administers		has been completed was als	0	
		centration of aerosol into the		reviewed.		
		cient practice could affect all		B. The following systemic ch	-	
	residents, staff, and	i visitors.		has been taken: The Mainte	nance	
	Findings includes			Director shall create a	duat	
	Findings include:			calendar/log identifying each		
	Based on record to	view on 06/27/23 between 9:30		smoke detector; when it was installed; and when it is next		
		with the Maintenance Director		for testing. The maintenance		
		detector sensitivity test report		director shall be responsible		
	-	s not a complete report. The		keeping this log up-to-date.		
		smoke detectors were not		calendar/log shall be shared		
	-	y. The report indicated "NA"		the Administrator.	vviu i	
		"model", and was blank in the		4. The following Quality Mor	itoring	
		Based on interview at the time		program has been implement	-	
		he Maintenance Director		monitor and assure that corr		
		sensitivity testing information		actions are achieved, effecti		
		noke detectors during the		sustained:		
	101 the four duct sh	none accounts during the		Sustaineu.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/27/2023		
	PROVIDER OR SUPPLIE	R DF NEW HARMONY	251 HI	address, city, state, zip coe GHWAY 66 IARMONY, IN 47631	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION y test.	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) A. The Administrator sha	ILD BE ROPRIATE	(X5) COMPLETION DATE	
	This finding was r	eviewed with the Administrator Director during the exit		the calendar/log of the du detectors (discussed in 3 above) each month to en any changes (e.g. installa new or replacement duct detectors, etc.) are scheo be tested per requirement shall be ongoing for a mit three (3) months and ma continue longer until com achieved and ongoing. N problems will be immedia corrected and identified patterns/trends of non-co will be brought to the Qua Improvement Committee corrective action(s).	uct smoke . B. sure that ation of smoke duled to tt. This nimum of y upliance is oted ately mpliance ality		
SS=F	Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testii Water-based Fire Records of syste inspection and te secure location a a) Date sprinkle b) Who provide c) Water system Provide in REMA	RKS information on non-required or partial					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/27/2023 155370 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 251 HIGHWAY 66 PREMIER HEALTHCARE OF NEW HARMONY NEW HARMONY, IN 47631 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility K 0353 1. The following corrective 08/30/2023 failed to document sprinkler system inspections in action(s) have been taken for accordance with NFPA 25 for 1 of 1 sprinkler those residents and/or areas found system. NFPA 25, Standard for the Inspection, to have been allegedly affected by Testing, and Maintenance of Water-Based Fire the deficient practice: Protection Systems, 2011 Edition, Section 5.1.2 A. The facility has completed, and states valves and fire department connections has documentation of the monthly shall be inspected, tested, and maintained in sprinkler system control valve accordance with Chapter 13. Section 13.1.1.2 inspection. This shall be ongoing states Table 13.1.1.2 shall be utilized for thereafter. inspection, testing and maintenance of valves, 2. The following action(s) have valve components and trim. Section 4.3.1 states been taken to identify other records shall be made for all inspections, tests, resident(s) and/or areas with the and maintenance of the system and its potential to be affected by this components and shall be made available to the alleged deficient practice and authority having jurisdiction upon request. This subsequent actions of correction: deficient practice could affect all residents, staff, A. There are no other sprinkler and visitors in the facility. systems aside from the one sited in this deficiency. Therefore, no Findings include: other examples exist that may be potentially affected by this alleged Based on record review on 06/27/23 between 9:30 deficient practice. a.m. and 1:00 p.m. with the Maintenance Director 3. The following measures and present, there was no monthly sprinkler system systemic changes have been put control valves inspection documentation for the in place to assure that this alleged past 12 month period. Based on interview at the deficient practice does not recur: time of record review, the Maintenance Director A. The following measure has confirmed the lack of sprinkler system inspections been taken: The Maintenance on the control valves during the past 12 months. Director has been in-serviced regarding the requirement to This finding was reviewed with the Administrator perform monthly sprinkler system and Maintenance Director during the exit control valve inspections and to conference. maintain documentation of these inspections. 3.1-19(b) B. The following systemic change has been taken: The Maintenance Director shall provide the Administrator a copy of the written monthly sprinkler system control

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Event ID:

GKNS21 Facility

Facility ID: 000555

If continuation sheet

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07/25/2023

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 06/27/2023		
	PROVIDER OR SUPPLIE	R DF NEW HARMONY		251 HI	address, city, state, zip ( GHWAY 66 IARMONY, IN 47631	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION BHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
< 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting than required end exits, or hazardo of smoke and are solid-bonded cor capable of resisti minutes. Doors in compartments ar	corridor openings in other closures of vertical openings, us areas resist the passage a made of 1 3/4 inch e wood or other material ng fire for at least 20 n fully sprinklered smoke e only required to resist the e. Corridor doors and doors			valve inspections. In a these reports shall be during the monthly Qu Assurance/Quality Imp Meetings. 4. The following Quality program has been imp monitor and assure th actions are achieved, sustained: A. The Administrator se the monthly sprinkler se control valve inspection documentation each m ensure it has been con documented. This shall ongoing for a minimum months and may conti until compliance is act ongoing. Noted proble immediately corrected identified patterns/tren non-compliance will be the Quality Improveme Committee for further action(s).	addition, reviewed aality provement ty Monitoring plemented to at corrective effective and shall audit system on nonth to mpleted and all be n of three (3) inue longer nieved and ems will be and of e brought to ent		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/27/2023 155370 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 251 HIGHWAY 66 PREMIER HEALTHCARE OF NEW HARMONY NEW HARMONY, IN 47631 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 K 0363 . The following corrective action(s) 08/30/2023 failed to ensure 1 of over 75 corridor doors would have been taken for those resist the passage of smoke. This deficient residents and/or areas found to practice could affect at least 20 residents, as well have been allegedly affected by as staff and visitors. the deficient practice: A. The facility has repaired the Findings include: Cardinal Unit Shower room corridor door. 2. The following action(s) have Based on observations on 06/27/23 between 1:00 Event ID: GKNS21 Facility ID: 000555 Page 12 of 28 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

07/25/2023

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155370	B. WING		06/27/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
PREMIE	R HEALTHCARE (	OF NEW HARMONY		GHWAY 66 IARMONY, IN 47631		
(Y4) ID	CIDO(AD)	OTATEMENT OF DEFICIENCIE	m		(772)	
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE	
	p.m. and 3:00 p.m.	during a tour of the facility with		been taken to identify other		
	the Maintenance D	Director, the corridor door to the		resident(s) and/or areas with t	the	
	Cardinal Unit Sho	wer Room had six, one fourth		potential to be affected by this	;	
	inch holes through	the door just below the door		alleged deficient practice and		
	handle. Based on	interview at the time of		subsequent actions of correct	ion:	
	observation the Ma	aintenance Director agreed the		A. Facility corridor doors are		
	door was not smok	te resistant and the holes need		identified as having the potent	tial to	
	to be repaired.			be affected by this deficiency.		
				These doors have been inspe	cted	
	This finding was r	eviewed with the Administrator		to ensure there are no holes of	or	
	and Maintenance I	Director during the exit		other breaches that compromi	ise	
	conference.			their ability to act as a smoke		
				barrier per this requirement. D	Joors	
	3.1-19(b)			with such breaches have beer	n	
				repaired.		
				3. The following measures and	d	
				systemic changes have been	put	
				in place to assure that this alle	eged	
				deficient practice does not rec	our:	
				A. The following measure has	i	
				been taken: The Maintenance	;	
				Director has been in-serviced		
				regarding the importance of		
				ensuring that corridor doors a	re in	
				good repair without damage,		
				holes, or other breaches that		
				would impede the smoke		
				resistance.		
				B. The following systemic cha	nge	
				has been taken: The Maintena	ance	
				Director shall include weekly		
				visual inspections of corridor of	doors	
				during regular rounds to ensu	re	
				doors are damage-free and do	o not	
				allow the passage of smoke.		
				4. The following Quality Monit	oring	
				program has been implemente	ed to	
				monitor and assure that corre	ctive	
				actions are achieved, effective	e and	
				sustained:		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	COMF	e survey pleted 7/2023
	PROVIDER OR SUPPLIE	R DF NEW HARMONY	251 H	i address, city, state, zip cod NGHWAY 66 HARMONY, IN 47631		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY) A. The Administrator,	ION D BE DPRIATE	(X5) COMPLETION DATE
				Maintenance Director, and appointed designee(s) sha visually inspect five corride each week to ensure there holes or other breaches th allow the passage of smol shall be ongoing for a mini- three (3) months and may continue longer until comp achieved and ongoing. No problems will be immediat corrected and identified patterns/trends of non-con- will be brought to the Qual Improvement Committee f corrective action(s).	all or doors e are no lat would ke. This imum of bliance is oted ely npliance lity	
K 0500 SS=F Bldg. 01	Section 18.5 and requirements that provided K-tags, information, along Safety Code or N should be include Based on record re failed to ensure 4 of current inspection heaters were in saf 101, Section 19.1. to be designed, con operated to minim emergency requiring	A - Other RKS section any LSC 19.5 Building Services t are not addressed by the but are deficient. This g with the applicable Life FPA standard citation, ed on Form CMS-2567. view and interview, the facility of 4 fuel-fired water heaters had certificates to ensure the water to operating condition. NFPA 1.3.1 requires all health facilities nstructed, maintained, and ize the possibility of a fire ng the evacuation of occupants. tice could affect all residents,	K 0500	<ol> <li>The following correctiv action(s) have been taken those residents and/or are to have been allegedly affe the deficient practice:</li> <li>The facility has had th (4) identified fuel-fired wat heaters inspected and ma their certificates of inspect</li> </ol>	for bas found ected by ne four er intains	08/30/202:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/27/2023	
	PROVIDER OR SUPPLIE	R DF NEW HARMONY	STREET ADDRESS, CITY, STATE, ZIP CO 251 HIGHWAY 66 NEW HARMONY, IN 47631			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN BE PRIATE	(X5) COMPLETIC DATE
	Findings include: Based on record re a.m. and 1:00 p.m present, the four fu facility had certific 09/23/21. Based of review, the Mainte expiration dates of heaters. This finding was r	eview on 06/27/23 between 9:30 with the Maintenance Director hel-fired water heaters in the cates with expiration dates of on interview at the time of record enance Director confirmed the C the four fuel-fired water eviewed with the Administrator Director during the exit		<ol> <li>The following action(s) been taken to identify other resident(s) and/or areas wirpotential to be affected by the alleged deficient practice a subsequent actions of correct.</li> <li>A. There are no other fue water heaters aside from the sited in this deficiency. The no other examples exist that be potentially affected by the alleged deficient practice.</li> <li>The following measures systemic changes have been in place to assure that this deficient practice does not.</li> <li>A. The following measures been taken: The Maintenare Director has been in-servic regarding the requirement the fuel-fired waters are inspected per requirement. The important maintaining documentation/certification inspections have been correlated been taken: The Maintenare Director shall a calendar/log identifying e fuel-fired water heater; whe last inspected and when it is due for the next inspection. maintenance director shall responsible for keeping this</li> </ol>	th the this and ection: d-fired hose erefore, at may his s and en put alleged recur: e has hee ed to ater ace of s that hpleted c he create ach en it was is next The be	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	A. 3	MULTIPLE C BUILDING WING	DNSTRUCTION <u>01</u>	COM	(X3) DATE SURVEY COMPLETED 06/27/2023	
	PROVIDER OR SUPPLIE	r DF NEW HARMONY	-	251 HI	address, city, state, zip cod GHWAY 66 IARMONY, IN 47631	-		
(X4) ID PREFIX	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION	
TAG K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include alarm signal and conditions. Fire of and unexpected conditions, at lea The staff is famili aware that drills a	the transmission of a fire simulation of emergency fire Irills are held at expected times under varying st quarterly on each shift. ar with procedures and is are part of established trills are conducted between		TAG	to date. The calendar/log s shared with the Administrat 1.The following Quality Monitoring program has bee implemented to monitor and assure that corrective action achieved, effective and sus A. The Administrator shall the calendar/log of the fuel- water heater (discussed in 3 above) each month to ensu changes (e.g. installation of or replacement fuel-fired wa heaters, etc.). This shall be ongoing for a minimum of s months and may continue le until compliance is achieved ongoing. Noted problems w immediately corrected and identified patterns/trends of non-compliance will be brow the Quality Improvement Committee for further corre- action(s).	or. en d ns are tained: I audit fired 3.B. re any finew ater e ix (6) onger d and ill be	DATE	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155370 B. WING 06/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 251 HIGHWAY 66 PREMIER HEALTHCARE OF NEW HARMONY NEW HARMONY, IN 47631 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 K 0712 08/30/2023 1. Based on record review and interview, the 1.The following corrective facility failed to provide quarterly fire drill action(s) have been taken for those residents and/or areas found documentation for 2 of 3 shifts during 4 of 4 quarters. This deficient practice could affect all to have been allegedly affected by residents, as well as staff and visitors in the the deficient practice: facility. A. A second shift fire drill has Findings include: been performed. The monitoring company В. Based on review of the facility's fire drill reports was called to ensure the signal on 06/27/23 between 9:30 a.m. and 1:00 p.m. with was received. the Maintenance Director present, there were 13 fire drills performed during the past 12 month period, however, the facility lacked fire drill 1.The following action(s) have documentation for the following shifts and been taken to identify other quarters during the past 12 month period: resident(s) and/or areas with the a. Second shift (evening) of the second quarter potential to be affected by this (April, May, and June) of 2022 and so far in 2023. alleged deficient practice and b. Third shift (night) of the third quarter (July, subsequent actions of correction: August, and September), and fourth quarter (October, November, and December) of 2022, and, A. All residents have the first quarter (January, February, and March) of potential to be affected by the 2023. alleged deficient practice. There Based on interview at the time of record review. have been 3 fire drills completed the Maintenance Director confirmed the lack of on all three shifts. fire drill reports during the previously mentioned R The fire alarm company was shifts and quarters. called after each drill to ensure they received the signal. This was This finding was reviewed with the Administrator documented in the fire drill report. and Maintenance Director during the exit conference. 1.The following measures and systemic changes have been put 3.1-19(b) in place to assure that this alleged deficient practice does not recur: 2. Based on record review and interview, the facility failed to ensure 13 of 13 fire drill reports A. The following measure has Facility ID: 000555

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#### CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155370 B. WING 06/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 251 HIGHWAY 66 PREMIER HEALTHCARE OF NEW HARMONY NEW HARMONY, IN 47631 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE included complete documentation of the been taken: The Maintenance transmission of a fire alarm signal to the Director has been in-serviced monitoring company/fire department during the regarding the requirement to past twelve months. LSC 19.7.1.4 requires fire ensure that fire drills are not drills in health care occupancies shall include the routine and simulate emergency transmission of the fire alarm signal and fire conditions. simulation of emergency conditions. This В. The following systemic deficient practice could affect all residents. change has been taken: The Maintenance Director shall create Findings include: a calendar of fire drills for the next 12 months that include varving Based on review of the facility's fire drill reports times on all 3 shifts. This on 06/27/23 between 9:30 a.m. and 1:00 p.m. with calendar shall be shared with the the Maintenance Director present, all 13 fire drill Administrator. reports performed during the past 12 month period were not provided with documentation for the 1. The following Quality transmission of the alarm to the monitoring Monitoring program has been company. Based on interview at the time of implemented to monitor and assure that corrective actions are record review, the Maintenance Director acknowledged there was no information on any of achieved, effective and sustained: the fire drill reports to verify that transmission of the alarm was received by the monitoring A. The Administrator shall audit the calendar with the fire drill company. reports after each drill. This shall This finding was reviewed with the Administrator be ongoing for a minimum of three and Maintenance Director during the exit (3) months and may continue conference. longer until compliance is achieved and ongoing. Noted 3-1.19(b) 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 0761 SS=E Bldg. 01 GKNS21

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 000555

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	(X2) MULTIPLE CO A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 06/27/2023
	PROVIDER OR SUPPLIE	r DF NEW HARMONY	251 HI	address, city, state, zip cod GHWAY 66 IARMONY, IN 47631	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Based on observat interview; the faci inspection and test door assembly was LSC 19.1.1.4.1.1. dividing fire barrie permitted only in of by approved self-c (See also Section 8 required to have a 8.3.4.2 shall be pro- labeled fire door a assemblies and the including all frame and sills in accord. NFPA 80, Standar Opening Protectiv specified in this C door assemblies sh less than annually, inspection shall be by the AHJ. NFPA	ion, record review, and lity failed to ensure an annual ing of 1 of 1 oxygen room fire is completed in accordance with Communicating openings in ers required by 19.1.1.4.1 shall be corridors and shall be protected losing fire door assemblies. 3.3.) LSC 8.3.3.1 Openings fire protection rating by Table otected by approved, listed, ssemblies and fire window fir accompanying hardware, es, closing devices, anchorage, ance with the requirements of d for Fire Doors and Other es, except as otherwise ode. NFPA 80 5.2.1 states fire nall be inspected and tested not and a written record of the e signed and kept for inspection A 80, 5.2.4.1 states fire door e visually inspected from both overall condition of door	K 0761	<ul> <li>1. The following corrective action(s) have been taken for those residents and/or areas for to have been allegedly affected the deficient practice:</li> <li>A. The oxygen room fire door assembly was inspected and documented.</li> <li>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.</li> <li>A. An audit of all doors within the facility has been completed.</li> <li>B. Any fire door without an annual assembly inspection has now been inspected, and the inspection documented.</li> </ul>	08/30/202: ound d by vr /e he on: n d.
	<ul> <li>following items sh</li> <li>(1) No open holes</li> <li>either the door or the door of the door, item and in the door, fram noncombustible the and in working or damage.</li> <li>(4) No parts are method are method as a set of the door of t</li></ul>	or breaks exist in surfaces of frame. I light frames, and glazing beads rely fastened in place, if so e, hinges, hardware, and reshold are secured, aligned, ler with no visible signs of		<ol> <li>The following measures ar systemic changes have been p in place to assure that this alled deficient practice does not rec</li> <li>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.</li> <li>The following systemic change has been taken: The</li> </ol>	put eged ur: as

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GKNS21 Facility ID: 000555

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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155370	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/27/2023	
	PROVIDER OR SUPPLIE	R DF NEW HARMONY	STREET ADDRESS, CITY, STATE, ZIP COD 251 HIGHWAY 66 NEW HARMONY, IN 47631			
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY O (6) The self-closing the active door corr from the full open (7) If a coordinator closes before the au (8) Latching hardw door when it is in t (9) Auxiliary hardw prohibit operation a frame. (10) No field modil have been perform (11) Gasketing and inspected to verify This deficient prace residents, as well a Findings include: Based on record re a.m. and 1:00 p.m. present, the facility documentation for oxygen transfilling Based on interview the Maintenance D documentation of a oxygen transfilling Based on observati with the Maintenar and 3:00 p.m., ther room fire door asset	is installed, the inactive leaf ctive leaf. vare operates and secures the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY) each door into the TELS syst to ensure no annual inspect missed on any fire door with facility. 1.The following Quality Monitoring program has been implemented to monitor and assure that corrective action achieved, effective and sust A. The Administrator shall review every fire door inspect This shall be ongoing for a minimum of six (6) months a may continue longer until compliance is achieved and ongoing. Noted problems witi immediately corrected and identified patterns/trends of non-compliance will be brout the Quality Improvement Committee for further correct action(s).	stem ion is in the en in s are cained: ction. and ill be	(X5) COMPLETION DATE

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155370	(X2) MULTIPLE CO A. BUILDING B. WING	A. BUILDING <u>01</u> B. WING	
	PROVIDER OR SUPPLI	er OF NEW HARMONY	251 HI	address, city, state, zip cod GHWAY 66 IARMONY, IN 47631	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL 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 System System Mainten The generator of source and asso of supplying serv 10-second criter monthly test, a p annually confirm safety and critica and testing of the switches are per NFPA 110. Generator sets a exercised under year in 20-40 da once every 36 m Scheduled test u a complete simu automatic or mai loads, and are co personnel. Maint energy power so accordance with circuit breakers a program for perio components is e manufacturer rea of maintenance a and readily avail and circuits are n and separate fro Minimizing the p emergency power consideration for 6.4.4, 6.5.4, 6.6. NFPA 111, 700. 1. Based on recor	ns - Essential Electric Syste ns - Essential Electric ance and Testing or other alternate power ciated equipment is capable vice within 10 seconds. If the ion is not met during the rocess shall be provided to this capability for the life al branches. Maintenance e generator and transfer formed in accordance with are inspected weekly, load 30 minutes 12 times a y intervals, and exercised toonths for 4 continuous hours. under load conditions include lated cold start and nual transfer of all EES onducted by competent tenance and testing of stored purces (Type 3 EES) are in NFPA 111. Main and feeder are inspected annually, and a podically exercising the stablished according to quirements. Written records and testing are maintained able. EES electrical panels marked, readily identifiable, m normal power circuits. ossibility of damage of the er source is a design r new installations. 4 (NFPA 99), NFPA 110,	K 0918	The following corrective action(	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u>		(X3) DATE SURVEY COMPLETED	
		155370	B. WING	<u>.</u>		7/2023
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP C	COD	
PREMIE	R HEALTHCARE (	OF NEW HARMONY		IIGHWAY 66 HARMONY, IN 47631		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE APPROPRIATE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	inspections for 1 o	f 1 generator was maintained		residents and/or areas	found to	
	for 29 of 52 weeks	. Chapter 6-4.4.1.3 of 2012		have been allegedly a	ffected by	
	NFPA 99 requires	batteries for on-site generators		the deficient practice:		
	shall be maintained	d in accordance with NFPA 110,		A. The facility has com	npleted a	
	2010 Edition, Stan	dard for Emergency and		weekly inspection of th	neir	
	Standby Power Sy	stems. 8.3.7 requires storage		emergency generator		
		g electrolyte levels or battery		continues to complete		
	voltage, used in co	nnection with systems shall be		inspection routinely ea	•	
	-	and maintained in full		Written records of the		
		nanufacturer's specifications.		inspections are being	maintained.	
	*	tive batteries shall be repaired		B. The facility has com		
		iately upon discovery of		documented the four (		
	-	5.4.2 of NFPA 99 requires a		for the emergency ger	•	
	-			shall occur at least eve		
		and repairs shall be regularly		months.		
		ailable for inspection by the		2. The following action	(s) have	
		risdiction. This deficient		been taken to identify	. ,	
		ct all residents, staff and		resident(s) and/or area		
	visitors.	et all residents, starr and		. ,		
	VISILOIS.			potential to be affected	•	
	Tin dia an in dad			alleged deficient pract		
	Findings include:			subsequent actions of		
	D 1 .	64		A. There are no other	-	
		f the generator inspection		for this facility. Therefore		
	-	3 between 9:30 a.m. and 1:00		examples exist that ma	-	
	-	ntenance Director present, there		potentially affected by	this alleged	
		tion available to show the		deficient practice.		
		tor was inspected/tested weekly		3. The following meas		
	-	ost recent 52 week period.		systemic changes hav		
		v at the time of record review,		in place to assure that	-	
		Director said the emergency		deficient practice does	s not recur:	
		f test every week but he only		A. The following meas		
	documents it when	instructed to by TELS.		been taken: The Main	tenance	
				Director has been in-s	erviced	
	This finding was re	eviewed with the Administrator		regarding the requiren	nent to: (1).	
	and Maintenance I	Director during the exit		inspect the generator	a minimum	
	conference.			of weekly and to docu	ment this	
				inspection and (2) con		
	3.1-19(b)			(4) hour test for the en		
				generator a minimum		
	2. Based on record	d review and interview, the		thirty-six (36) months a	-	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	01	COMPLETED	
		155370	B. WI	1G		06/2	7/2023
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD	_	
					GHWAY 66		
PREMIE	R HEALTHCARE (	OF NEW HARMONY		NEW H	IARMONY, IN 47631		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	) BE DPRIATE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		rovide complete documentation			document this test.		
	-	of 1 Emergency Power Standby			B. The following systemic	-	
		nce with NFPA 110, Standard			has been taken: The Main	tenance	
		d Standby Power Systems,			Director shall provide the		
		equired by NFPA 99 Health Care			Administrator a copy of the		
		ection 6.4.1.1.6.1. NFPA 110			weekly generator inspection	-	
		s that all Level 1 Emergency			each week. The Maintena		
	-	all be tested at least once within			Director shall also provide		
		Where the assigned class is rs, it shall be permitted to			Administrator with a writte		
	U U	after 4 hours. NFPA 99 Section			of the four (4) hour emerge	-	
		hat Type 1 and Type 2 essential			generator test report every months. In addition, these		
		ower sources shall be classified			shall be reviewed during the		
		X, Level 1 generator sets. This			monthly Quality		
		could affect all residents, staff,			Assurance/Quality Improv	ament	
	and visitors.				Meetings.	Smont	
					4. The following Quality M	onitorina	
	Findings include:				program has been implem	-	
	8				monitor and assure that co		
	Based on record re	eview on 06/27/23 between 9:30			actions are achieved, effe	ctive and	
	a.m. and 1:00 p.m.	. with the Maintenance Director			sustained:		
	present, the facility	y could not provide			A. The Administrator shall	audit	
	documentation of	a four hour test of the			the weekly emergency ger	nerator	
	emergency genera	tor within the past 36 months			inspection records each w	eek to	
	for the emergency	generator. This was confirmed			ensure they are completed	l and	
	by the Maintenance	e Director at the time of record			documented. The Adminis	trator	
	review.				shall also audit documenta		
					that the four (4) hour emer		
		eviewed with the Administrator			generator testing has beer		
		Director during the exit			completed within the last 3		
	conference.				months This shall be ongo	-	
	2 1 10(1)				minimum of six (6) weeks	and	
	3.1-19(b)				may continue longer until	- I	
					compliance is achieved an	a	
					ongoing. Noted	olv	
					problems will be immediat	ыу	
					corrected and identified	nliance	
					patterns/trends of non-con	-	
					-	-	
					will be brought to the Qual Improvement Committee f	ity	

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLE		
		155370	B. WING		06/27/2	27/2023	
NAME OF	PROVIDER OR SUPPLIE	R	STREE	T ADDRESS, CITY, STATE, ZIP COD	I		
		DF NEW HARMONY		HGHWAY 66 HARMONY, IN 47631			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE PRIATE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	corrective action(s).		DATE	
0920 SS=E	NFPA 101 Electrical Equipm	ent - Power Cords and					
Bldg. 01	Extens Electrical Equipm Extension Cords Power strips in a used for compon patient-care-relat (PCREE) assemil assembled by qui the conditions of the patient care w non-PCREE (e.g except in long-ten do not use PCRE meet UL 1363A of for non-PCREE in (outside of vicinit non-patient care other UL standar used with general cords are not use wiring of a structu temporarily are re completion of the installed and mee 10.2.3.6 (NFPA 9) (NFPA 70), 590.3 Based on observat	ent - Power Cords and patient care vicinity are only	K 0920	1.The following corrective action(s) have been taken f		08/30/202	
	wiring in 2 of 2 ob requires utilities to 9.1.2 requires elect comply with NFP/ 2011 Edition. NFI	sed as a substitute for fixed served staff areas. LSC 19.5.1 comply with Section 9.1. LSC trical wiring and equipment to A 70, National Electrical Code, PA 70, Article 400.8 requires that, permitted, flexible cords and		<ul><li>those residents and/or area to have been allegedly affer the deficient practice:</li><li>A. The power strip in the employee breakroom was r as well as the multi-plugged</li></ul>	cted by emoved		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155370 B. WING 06/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 251 HIGHWAY 66 PREMIER HEALTHCARE OF NEW HARMONY NEW HARMONY, IN 47631 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE cables shall not be used as a substitute for fixed adapter in the Cardinal unit wiring of a structure. This deficient practice could pantry. affect staff only in two staff only areas. 1.The following action(s) have Findings include: been taken to identify other resident(s) and/or areas with the Based on observations on 06/27/23 between 1:00 potential to be affected by this p.m. and 3:00 p.m. during a tour of the facility with alleged deficient practice and the Maintenance Director, the following was subsequent actions of correction: noted: a. There was a microwave oven plugged into a A. An audit of all outlets in the power strip in the Employee Breakroom. facility has been completed to b. There was a microwave oven, coffee maker, ensure no other power strips or and refrigerator plugged into a multi-plugged multi-plugged adapters are being adapter in the Cardinal Unit Pantry. utilized. Based on interview at the time of each observation, the Maintenance Director 1.The following measures and acknowledged the use of the power strip and systemic changes have been put multi-plugged adapter in the two staff areas. in place to assure that this alleged deficient practice does not recur: This finding was reviewed with the Administrator and Maintenance Director during the exit A. The following measure has conference. been taken: The Maintenance Director and all staff have been 3.1-19(b) 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 GKNS21

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Facility ID: 000555

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	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	. ,	BUILDING	<u>01</u>	COMPLETED	
		155370		WING	<u></u>		7/2023
				STREET	ADDRESS, CITY, STATE, ZIP COE	)	
NAME OF 1	PROVIDER OR SUPPLIE	R			GHWAY 66		
PREMIE	R HEALTHCARE (	OF NEW HARMONY		NEW H	IARMONY, IN 47631		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					corrected and identified		
					patterns/trends of non-co	-	
					will be brought to the Qua	-	
					Improvement Committee	for further	
					corrective action(s).		
( 0000							
( 0923	NFPA 101						
SS=E		Cylinder and Container					
Bldg. 01	Storag						
		Cylinder and Container					
	Storage						
		equal to 3,000 cubic feet					
	-	s are designed, constructed,					
		accordance with 5.1.3.3.2					
	and 5.1.3.3.3.						
	>300 but <3,000						
	Storage locations	s are outdoors in an					
		in an enclosed interior					
	space of non- or	limited- combustible					
	construction, with	n door (or gates outdoors)					
	that can be secu	red. Oxidizing gases are not					
	stored with flamn	nables, and are separated					
	from combustible	es by 20 feet (5 feet if					
	sprinklered) or er	nclosed in a cabinet of					
	noncombustible	construction having a					
	minimum 1/2 hr.	fire protection rating.					
		al to 300 cubic feet					
	In a single smoke	e compartment, individual					
	cylinders availab	le for immediate use in					
	patient care area	s with an aggregate volume					
	of less than or ea	ual to 300 cubic feet are not					
	required to be sto	pred in an enclosure.					
	Cylinders must b	e handled with precautions					
	as specified in 1	1.6.2.					
		sign readable from 5 feet is					
		gate of a cylinder storage					
		sign includes the wording as					
		- 0	1		1		1

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	A. BUILDING <u>01</u> CC B. WING 06			completed 06/27/2023	
	PROVIDER OR SUPPLIE	<sup>R</sup> DF NEW HARMONY		251 HI	address, city, state, zip cod GHWAY 66 IARMONY, IN 47631		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſE	(X5) COMPLETIO DATE
	STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with inter threshold pressure established. Emp avoid confusion. are protected from 11.3.1, 11.3.2, 11 99) Based on observati failed to ensure cyl such as oxygen we in 1 of 4 smoke co Care Facilities Coo states storage for n volume equal to or meters (300 cubic and 11.3.3.2. NFP precautions in hand 11.3.3.1 shall be in 11.6.2.3(11) states properly chained o stand or cart. This at least 20 resident Findings include: Based on observati p.m. and 3:00 p.m. the Maintenance D sized oxygen cylin the oxygen transfil cylinder was not su stand or otherwise interview at the tim	TION: OXIDIZING GAS(ES) NO SMOKING." ed so cylinders are used in ey are received from the cylinders are segregated a. When facility employs egral pressure gauge, a re considered empty is oby cylinders are marked to Cylinders stored in the open n weather. .3.3, 11.3.4, 11.6.5 (NFPA on and interview, the facility inders of nonflammable gases re properly secured from falling mpartments. NFPA 99, Health le, 2012 Edition, Section 11.3.3 onflammable gases with a total less than greater than 8.5 cubic feet) shall comply with 11.3.3.1 A 99, Section 11.3.3.2 states fling cylinders specified in accordance with 11.6.2. Section freestanding cylinders shall be r supported in a proper cylinder deficient practice could affect s, staff, and visitors.	K 0!	923	<ol> <li>The following corrective action(s) have been taken for those residents and/or areas for to have been allegedly affected the deficient practice:</li> <li>The oxygen cylinders have been removed from the facility B. Hooks have been hung o the wall in the oxygen room for all other portable tanks.</li> <li>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 fac and not secured properly in the oxygen storage room.</li> <li>The following measures and</li> </ol>	d by e n r the re ne on: o ility	08/30/202

OT A TEN OF	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(V2) D + 7	TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	î /	PLETED
		155370	B. WING			27/2023
	PROVIDER OR SUPPLIE	R DF NEW HARMONY	251 H	t address, city, state, zip cod HGHWAY 66 HARMONY, IN 47631		
(X4) ID						(N5)
PREFIX		STATEMENT OF DEFICIENCIE	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
		ng on the floor and not		systemic changes have b	-	
		nder stand or otherwise		in place to assure that this	-	
	secured from fallin	ıg.		deficient practice does no	t recur:	
	This finding was re	eviewed with the Administrator		A. The following measu	re has	
		Director during the exit		been taken: The Maintena		
	conference.			Director and nursing staff		
	3.1-19(b)			been in-serviced regardin	-	
	5.1-19(0)			storage of all portable oxy tanks.	gen	
				1.The following Quality		
				Monitoring program has b		
				implemented to monitor a		
				assure that corrective act achieved, effective and su		
				A. The Maintenance Dir		
				shall audit the oxygen roo		
				random times 10 times a		
				This shall be ongoing for a minimum of three (3) mor		
				may continue longer until		
				compliance is achieved a	nd	
				ongoing. Noted problems	will be	
				immediately corrected and		
				identified patterns/trends		
				non-compliance will be br the Quality Improvement	ougnt to	
				Committee for further corr	ective	
				action(s).		
				、 <i>′</i>		

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