STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00370436. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00370436 - Substantiated. Federal/State deficiencies related to the allegations are cited at F812 and F880. Survey dates: January 20 and 21, 2022. Facility number: 000555 Provider number: 155370 AIM number: 100267530 Census Bed Type: SNF/NF: 53 Total: 53 Census Payor Type: Medicare: 11 Medicaid: 37 Other: 5 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 24, 2022.	F 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. This facility respectfully requests a desk review to determine substantial compliance.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served in a sanitary manner during 2 of 2 kitchen observations, and 1 of 1 dining room observations. Drinks was unlabeled and undated, floors and equipment were soiled, hand hygiene was not performed, food temperatures were not done, and facial hair was not covered. (Kitchen) During an observation of the kitchen on 1/20/22 between 9:02 a.m. and 9:23 a.m., the following was observed: 1. The walk-in refrigerator had 4 pitchers of tea and 2 pitchers of lemonade, unlabeled and undated. 2. The floor had dirt and debris on them. 3. The back of the stove had a brownish-black	F 0812	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: 1. The facility has taken the following corrective action(s) to address those areas specifically identified as affected: A. The pitchers of tea and lemonade noted to be un-labeled	02/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	build-up on it and the top of the stove had debris on it. 4. The stove hood was soiled with dirt and debris. 5. Three male employees had facial hair that was uncovered. 6. A box cutter was observed lying on a shelf in the dry storage area with the blade exposed. 7. The oven mitts were soiled. 8. The handwashing sink had a black film in it. 9. The walk-in refrigerator's handle was broken and a metal rolling cart had a broken handle on it. 10. The dishwasher was observed to have brown and white substances on it and the dishwasher had steam covering the temperature dials. The dishwasher temperatures were only partially documented from January 1, 2022, through January 21, 2022. 11. The dishwasher, 3-compartment sinks, and several pans had a white substance on them. 12. The Dietary Supervisor was wearing a soiled shirt. During an observation of the kitchen on 1/21/22 from 11:09 a.m. through 12:10 p.m., the following were observed: 13. The back of the stove had a brownish-black build-up on it. 14. The handwashing sink had a black film on it and a soiled washcloth was observed in it.		and un-dated were discarded. B. The floor noted with dirt and debris has been thoroughly cleaned C. The back of the stove with brownish-black build-up on it and the top of the stove noted with debris have been thoroughly cleaned. D. The stove hood was thoroughly cleaned of dirt and debris. E. Employees with facial hair were immediately instructed to don appropriate hair coverings. F. The box cutter lying on a shelf in the dry storage area was immediately removed and stored properly. G. Soiled oven mitts were replaced. H. The handwashing sink was thoroughly cleaned. I. The walk-in refrigerator's handle and the metal rolling cart broken handle were repaired. J. The dishwasher was cleaned and the service provider was contacted to address the issue of steam build-up over temperature dials. K. Dietary staff was immediately instructed to document dishwasher temperatures per facility policy. L. The dishwasher, 3-compartment sinks, and pans noted with a white substance on them have been thoroughly cleaned.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	15. The oven mitts remained soiled. 16. The Dietary Supervisor was observed to be wearing a soiled shirt. 17. A soiled, dry cloth and a soiled, dry towel were observed laying on the prep table next to a tray of cornbread. 18. Cook 1 was observed to don a pair of gloves with no hand hygiene observed. She obtained a dry, soiled cloth and wiped the steam table and stove with it. She moved a pan of peas from the prep table to the steam table and wiped the steam table with the same cloth. She obtained a clean knife and placed the knife on the prep table. Cook 1 removed her gloves and performed hand hygiene. 19. The Dietary Supervisor donned a pair of gloves and was observed to place 4 spoodles (6 ounces) of ham and beans into the food processor for the mechanical soft diets. He placed his right hand into the food processor to "seat" the processor blade. He obtained a clean pan, placed his hand into the processor again, and added 3 more spoodles of ham and beans into the processor. He place the lid on and processed the food. He poured the food into a pan and placed the pan onto the steam table. He changed his gloves and performed hand hygiene. He obtained a set of keys from his pocket and gave the keys to the activity person. He obtained 5 spoodles of the ham and beans for the puree diets, removed some of the ham and beans from the processor, and placed them back into the pan on the steam table, placed his hand into the processor to "seat the blade, and pureed the food. He removed his gloves. He obtained 4 clean bowls, and poured		M. The Dietary Supervisor has been instructed regarding wearing clean and appropriate work attire. N. Soiled dry cloths and towel noted on the prep table were removed. O. Cook 1 and the Dietary Supervisor have been provided training and education regarding proper hand hygiene. P. Cook 1 and the Dietary Supervisor was provided training and education regarding proper cleaning procedures and to not use soiled items to clean prep tables, etc. This also included education regarding cross contamination issues. Q. The Dietary Supervisor has been provided education and training regarding: · proper use of the food processor. · infection control procedures. Specific discussion was given to the observation of taking keys from his pocket and laying keys on prep table and placing other items (plastic wrap) in food prep areas. Discussion was also given to infection prevention and when to perform hand hygiene (e.g., pulling pants up and scratching head) · the appropriate procedure to ensure residents are provided the correct portion sizes (e.g., 6 ounces). · Using recipes to properly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	the pureed ham and beans into the bowls. The recipe indicated the resident should receive 6 ounces of the ham and beans. He changed his gloves, placed plastic wrap over the bowls, and placed the bowls onto the steam table. He placed the soiled food processor into the dishwasher. After cleaning the food processor, he wiped the bowl and lid dry with a paper towel. 20. The Dietary Supervisor was observed to place 4 spoodles (4 ounces) of peas into the food processor and placed his hand into the processor to "seat" the blade. He obtained an undetermined amount of hot water into a cup and poured the water into the processor with the peas. He started and stopped the processor, placing his hand into the food to "seat" the blade again. He obtained a wet, soiled cloth and wiped the processor and processor table. He removed his gloves, removed the processor lid and replaced it onto the processor, and wiped the processor table again. The activity person returned with the set of keys which the Dietary Supervisor laid on the table next to the processor. He performed hand hygiene and obtained 4 clean bowls. He poured the peas into the bowls, covered them with plastic wrap, and placed them onto the steam table. The recipe indicated the resident was to receive 6 ounces of the peas. He placed the processor in the dishwasher. 21. The Dietary Manager was observed to don a pair of gloves and place 4 slices of cornbread into the processor. He wiped the processor table with the wet, soiled cloth and placed the soiled cloth into the soiled linen container. He added an undetermined amount of water to the processor during the pureeing process. He obtained another slice of cornbread and added it to the processor. He removed his gloves and performed hand		prepare and determine correct portion sizes for pureed foods · Proper cleaning procedures. Specific discussion was given to not using soiled cloths for cleaning · The facility procedure for taking food temperatures and use/cleaning of thermometers R. The Dietary Aide 2 was provided education and training regarding: · The facility's policy regarding proper attire when entering the kitchen · Infection control procedures and prevention of infections. Specific discussion was given to wearing of his coat and performing duties when not in proper attire and required hand hygiene S. The dietary aide 1 was provided education and training regarding: · The facility's policy and procedure for covering transport carts T. All undated foods were either dated or discarded U. The food processor vendor has been contacted to get the proper fitting blade. V. The kitchen has been thoroughly cleaned and the staff is following the established cleaning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	hygiene. He obtained 4 clean bowls and poured the cornbread into the bowls, covering them with plastic wrap, and placing them on the steam table. 22. The Dietary Supervisor was observed to pull his pants up prior to obtaining 2 trays of clean bowls. 23. When plating the food, the Dietary Supervisor did not obtain a temperature of the foods. When questioned regarding the temperature of the food, the Dietary Supervisor indicated he had not obtained the food temperatures and obtained a thermometer. When obtaining the ham and bean temperature, the thermometer dropped into the food. The Dietary Supervisor removed the thermometer after obtaining the temperature. He wiped the thermometer off with a napkin and obtained the temperature of the peas. The Dietary Supervisor did not obtain the temperatures of the mechanical soft ham and beans or the pureed foods. 24. Dietary Aide 2 was observed to enter the kitchen wearing a coat. Dietary Aide 2 was observed to enter the walk-in refrigerator and obtain a carton of a drink supplement which he poured into 2 cups. He obtained another clean cup which he placed juice into. He placed plastic wrap over the cups and placed the drinks in the walk-in refrigerator. He ambulated through the kitchen and obtained a condiment. Dietary Aide 2 never removed his coat or perform hand hygiene. 25. During the lunch meal service, the Dietary Supervisor was observed to serve the food, obtain a box of plastic wrap, place the box on the prep table, scratch his head and pull up his pants. No hand hygiene was performed.		schedule. 2. The facility has identified all residents as being at risk to be affected by these deficient practices. 3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include: A. Dietary personnel shall be educated and trained regarding the following policies and procedures: · Proper storage of food items including, but not limited to, labeling and dating · Dietary cleaning schedule including floors, appliances, and equipment · Cleaning procedures for all kitchen items including, but not limited to, ovens, stoves, dish machine, floors, sinks, carts, and other equipment/areas · Infection prevention, including but not limited to, cleaning techniques, proper cleaning tools, prevention of cross contamination, proper hand hygiene, and maintaining a clean food prep area. Additionally, specific discussion was given to when to wash hands (e.g., after pulling up pants, after touching hair or other contaminated items such as keys)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	26. After completion of the meal trays for the hall, Dietary Aide 1 was observed to push the tray cart to the exit door of the kitchen to take to the unit. Dishwasher 1 indicated to Dietary Aide 1 that he needed to cover the hall cart "since State is in the building." Dietary Aide 1 and Dishwasher 1 proceeded to obtain a plastic cover for the cart. 27. On 1/21/22 at 1:24 p.m., the food temperature logs were reviewed for November, 2021, December, 2021, and from January 1 through January 21, 2022. No food temperatures had been logged. On 1/20/22 at 10:40 a.m., the Dietary Supervisor indicated facial hair should be covered and he had left the exposed box cutter on the shelf. He indicated all foods should be labeled and dated. The kitchen needed a "good" cleaning but the kitchen had been short of staff until recently. He indicated the kitchen had a cleaning schedule but the staff had not had time to do it. He indicated the food processor was new but the blade would not fit correctly in it. On 1/20/22 at 2:07 p.m., the Administrator indicated she had worked with the kitchen staff frequently since beginning employment at the facility. She indicated all facial hair should be covered and hand hygiene performed when entering the kitchen. On 1/21/22 at 3:45 p.m., the Administrator indicated the food processor was new and hands should not be placed into the processor with food in it, the food carts should be covered prior to exiting the kitchen, and coats should be removed prior to entering the kitchen. She indicated the kitchen need a thorough cleaning and she would be getting new oven mitts, pans, bowls, and		· Proper dietary staff uniforms and attire. Specific discussion was given to clean clothing and effective covering of facial hair. Specific discussion was also given to not wearing street cloths in the Kitchen areas (e.g., coats) · Proper storage of items such as box cutters · Proper usage of the food processor · When to clean or replace equipment. Specific discussion was given to soiled oven mitts. · Ensuring that needed repairs, such as cart handles and refrigerator handles, are completed in a timely manner · The facility's policy and procedure for food temperatures including documentation and maintenance of food temperature logs · The facility's policy and procedure for dish machine temperatures including documentation and maintenance of dish machine temperature logs · The appropriate procedure to ensure residents are provided the correct portion sizes. · Using recipes to properly prepare and determine correct portion sizes for pureed foods · Ensuring food is not contaminated during transport by covering carts appropriately prior to leaving kitchen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	utensils. She indicated the kitchen had not logged any food temperatures and did not have any documentation of the kitchen being cleaned. On 1/21/22 at 4:03 p.m., the Administrator indicated the facility followed the "Retail Food Establishment Sanitation Requirements." This Federal tag relates to Complaint IN00370436. 3.1-21(i)(2) 3.1-21(i)(3)		4. The facility has implemented the following Quality Assurance Plan to monitor on-going facility performance and compliance with this requirement: A. The Administrator and/or appointed designee(s) shall monitor that corrective actions are effective and ongoing via random observations of the dietary department physical environment and the performance of dietary personnel a minimum of three times weekly for a minimum of ninety (90) days or longer if warranted. Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s) as necessary. 5.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 and to ensure infection control practices were followed during 2 of 2 days of survey and during resident care for 1 of 3 observations. Protective eye wear was not worn by the staff and hand hygiene was not performed. (Resident D) 1. On 1/20/22 from 8:10 a.m.-2:30 p.m., no protective eyewear was worn by any of the facility staff. On 1/20/22 at 8:25 a.m., the Administrator indicated the facility had a positive staff member. 2. On 1/21/22 at 9:46 a.m., the Maintenance personal and Assistant Director of Nursing (ADON) was observed ambulating on the resident unit with no protective eyewear on.	F 0880	**F880** 1. The facility has implemented per the DPOC instructions for immediate corrective action to address those areas specifically identified as affected: a. All staff were educated based on CDC guidance on how and when to don and doff PPE with return demonstration including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. b. All staff was in-serviced by DON/designee on hand hygiene (handwashing and ABHS) and understand when to perform hand hygiene. This also included return demonstration on both hand	02/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	3. On 1/21/22 at 9:49 a.m., the DON was observed to perform a dressing change to Resident D. The DON obtained the supplies, entered the resident's room, and pull the resident's curtain. She performed hand hygiene and donned gloves. She removed the resident's leg pillow and assisted the resident to turn to her left side. The DON opened the dressings on the top of the overbed table. She obtained the trash can on the opposite side of the bed and removed her right glove, She applied wound cleanser to the wound and changed both gloves. She obtained a marker from her pocket and dated the new dressing. She applied a collagen dressing to the wound and changed her gloves. She exited and re-entered the resident's room, donning a new pair of gloves. The DON assisted the resident to her left side, applied skin prep to the periwound, and applied a foam dressing. The resident was then repositioned and her sheet reapplied. The DON collected the trash, removed her gloves, and performed hand hygiene. On 1/21/22 at 8:45 a.m., the Director of Nursing (DON) indicated all staff should be either wearing a face shield or goggles at all times. On 1/21/22 at 10:32 a.m., CNA 1 and Agency CNA 1 indicated hands should be washed upon entering exiting a resident's room, if visibly soiled, when going from clean to dirty, if you handle an inanimate object, and with gloves changes. On 1/21/22 at 3:45 p.m., the Administrator indicated the facility followed CMS and CDC guidance regarding the use of personal protective equipment. The current facility policy, "Handwashing/Hand Hygiene," undated, provided by the Administrator on 1/21/22 at 4:06 p.m., included,		washing and use of ABHS. c. All nursing staff in-serviced by Clinical Nurse Consultant on infection control practices regarding wound care including and focusing on dressing changes. d. All staff in-serviced on proper eye protection and the current guidance on when to wear it according to the CDC and ISDH. 2. Systemic a. It is believed that an increase in-servicing and rounding is needed by nurse managers to keep everyone up to date on guidance changes as well as monitoring of agency and new staff. We have had nurse managers working regular shifts to keep up with patient care which has contributed to the systemic issue with infection control. b. Administrator has assigned ADON the specific task of spending at least 10 documented hours a week on infection control education with staff. Also 1 hour of documented in person training on infection control by DON/designee will be performed for all new hires. c. The LTC infection control assessment has been completed and appropriate changes implemented. 3. Training a. All staff in-serviced by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
	but was not limited to, "Employees must wash their hands for at least 30-60 seconds using antimicrobial or non-antimicrobial soap and water under the following condition: Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice), Before and after assisting a resident with personal care, Before and after changing a dressing..." This Federal tag relates to Complaint IN00370436. 3.1-18(b) 3.1-18(l)		DON/designee on hand-washing including use of soap and ABHS. b. All staff in-serviced by DON/designee on wearing proper eye protection and when to wear it. c. Licensed nurses in-serviced by Regional Nurse Consultant on infection control with specific focus on dressing changes. d. All training included return demonstration. 4. Monitoring a. The Administrator will monitor the actual documented time spent weekly on infection control education including in person training during orientation for all new employees. This will be monitored for at least 6 weeks and until compliance is maintained. b. The IP nurse/DON/designee will monitor hand-washing, use of proper eye protection and general infection control procedures including dressing changes. This monitoring will be daily for 6 weeks. c. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate infection control practices and complying with solutions identified in the most recent infection control self-assessment. This will occur for 6 weeks and until compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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
			is maintained. 5. Quality Assurance and Performance Improvement a. The DPOC will be brought to QAPI monthly and updated as needed to sustain substantial compliance. This will occur for at least 6 months and until substantial compliance. b. The administrator/designee shall monitor all staff for compliance with donning and doffing PPE 3 to 5x a week for not less than 6 months to ensure compliance. c. The administrator/designee shall monitor all staff for proper hand-hygiene 3 to 5x week for not less than 6 months to ensure compliance. d. The Administrator, DON/designee shall monitor nursing staff for compliance with infection control during wound care 3 to 5x weekly for not less than 6 months to ensure compliance. e. The administrator/designee will monitor all staff for compliance with wearing protective eyewear 3 to 5x week for not less than 6 months to ensure compliance. f. All monitoring will be brought to QAPI monthly where reviews will be made and patterns of non-compliance identified and reported to QAPI Committee for further action and/or recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	01/21/2022

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