

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155370	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER  PREMIER HEALTHCARE OF NEW HARMONY		STREET ADDRESS, CITY, STATE, ZIP COD 251 HIGHWAY 66 NEW HARMONY, IN 47631		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000  Bldg. --	<p>A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 09/23/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 11/21/24</p> <p>Facility Number: 000555 Provider Number: 155370 AIM Number: 100267530</p> <p>At this PSR to the Emergency Preparedness survey, Premier Healthcare of New Harmony was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 96 certified beds. At the time of the survey, the census was 44.</p> <p>Quality Review completed on 11/25/24</p>	E 0000	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation):	
K 0000  Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/23/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 11/21/24</p> <p>Facility Number: 000555 Provider Number: 155370 AIM Number: 100267530</p>	K 0000	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation):	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Stacy Blue

Administrator

12/04/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

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K 0345 SS=F Bldg. 01	<p>At this PSR to the Life Safety Code survey, Premier Healthcare of New Harmony was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 96 and had a census of 44 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except a detached garage used for a maintenance shop and maintenance and facility storage, plus two detached wood framed sheds used for the water softener salt and activities supplies.</p> <p>Quality Review completed on 11/25/24</p> <p><b>NFPA 101</b> Fire Alarm System - Testing and Maintenance</p> <p>Based on record review and interview, the facility failed to ensure documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every</p>	K 0345	<p>K 345 Plan of Correction</p> <p>1. The following corrective action(s) have been taken as follows: A The facility had the 2-year smoke detector sensitivity test conducted on</p>	11/26/2024

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	<p>alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:</p> <ul style="list-style-type: none"> <li>(1) Calibrated test method.</li> <li>(2) Manufacturer's calibrated sensitivity test instrument.</li> <li>(3) Listed control equipment arranged for the purpose.</li> <li>(4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range.</li> <li>(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction.</li> </ul> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 11/21/24 between 10:45 a.m. and 12:30 p.m. with the Administrator and Maintenance Director present, the facility was unable to produce a smoke detector sensitivity</p>		<p>11/25/24 by our contracted vendor. All detectors that failed were repaired on 11/26. (See Exhibit K345 A and Sensitivity Test 206P).</p> <p>1. The facility recognizes that all residents have the potential to be affected by this alleged deficient practice.</p> <p>1. The following measures have been taken to assure that this alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>A. Maintenance staff has been in serviced ( Exhibit C) regarding the importance of testing and maintaining the fire alarm system in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The requirement to maintain records of system acceptance, maintenance and testing must be readily available for review was reviewed by the Maintenance Director. (Exhibit C).</li> <li>The following Quality Monitoring program has been implemented to assure that corrective actions are achieved, effective and sustained:</li> </ul> <p>1. the Administrator and/or appointed designee(s) shall review during scheduled QAPI meetings the status of the 2-year smoke detector sensitivity testing. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further</p>	

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	<p>report for all smoke detectors for the past 24-month period.</p> <p>The most recent smoke detector sensitivity test report for the facility's 30 hard wired smoke detectors was dated 06/24/22. Based on interview at the time of record review, the Administrator and Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months.</p> <p>This finding was reviewed with the Administrator during the exit conference.</p> <p>3.1-19(b)</p> <p>This deficiency was cited on 09/23/24. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		<p>corrective action(s).</p> <p>Date of Completion 11/26/2024</p>	