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	03/04/2025

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 the investigation of complaints IN00454483 and IN00454320. Complaint IN00454483: Federal/state deficiencies related to the allegation(s) are cited at F9999. Complaint IN00454320: Federal/state deficiencies related to the allegation(s) are cited at F9999 and F755. Survey date: March 4, 2025 Facility number: 000555 Provider number: 155370 AIM number: 100267530 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 6 Medicaid: 37 Other: 6 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 6, 2025.	F 0000	Submission of this plan of correction by the facility is not a legal admission that a deficiency exists or that the statement of deficiencies was correctly cited. In addition, preparation and submission of this plan of correction 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. the facility respectfully requests a desk review to determine substantial compliance.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview, and record review, the facility failed to ensure a resident received only the medications ordered by a physician and that medications were properly	F 0755	**PLAN OF CORRECTION** **ID NUMBER:155370**	04/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
PEGGYE LOWERY	ADON	04/29/2025

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.

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	labeled for 1 of 3 residents reviewed for pharmacy services. A resident was self-administering an antacid medication without the medication being properly labeled or ordered by a physician. (Resident D) Finding includes: During an interview and observation on 3/4/25 at 10:30 A.M., Resident D was sitting in a reclining chair in her room. A clear plastic cup was approximately two-thirds full of multi-colored tablets. The cup contained no labels or information that indicated what the contents of the cup were. Resident D indicated that her stomach had been bothering her and that the "Tums" (motioned towards the cup of tablets) (calcium carbonate medications) had not helped. Resident D was holding a sheet of paper and indicated that a nurse had just brought her the results of a scan completed the previous day. During record review on 3/4/25 at 2:00 P.M., Resident D's diagnoses included but were not limited to dysphagia, gastro-esophageal reflux disease, congestive heart failure, and type II diabetes. Resident D's most recent quarterly minimum data set (MDS) assessment, dated 2/15/25, indicated the resident had no cognitive impairment. Resident D's physician orders did not contain an order for any calcium carbonate medications. Resident D did have an order to administer insulin per self and keep insulin and accu-check supplies at bedside (ordered 1/16/25). A self administration of medications assessment, dated 1/20/25, indicated Resident D was capable		**SURVEY DATE: March 4, 2025** **TAG NUMBER:** **F755** **SCOPE: D** **1 Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** a Resident D's medications were removed immediately from bedside. b Resident D's physician was notified and orders received and completed. **2 How will you identify other residents having the potential to be affected by the same deficient practice?** **a** All residents of the facility have the potential to be affected of the alleged deficient practice. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** **a** The director of nursing or designee, inserviced the nurses on the following topics but not limited to: self-administration of medication policy, proper storage and labeling of medication. **4 How will you monitor the corrective action(s) to ensure the deficient practice will not**	

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	of self-administering medications. Resident D's nurse's progress notes indicated the following: 3/4/25 at 8:00 A.M. - Yesterday's (3/3/25) Doppler results were negative. Resident aware of results. 3/4/25 at 9:00 A.M. - Resident D was in a pleasant mood with no complaints. Resident watching television in recliner. During an interview on 3/4/25 at 2:45 P.M., LPN 6 indicated Resident could keep insulin and accu-check supplies at bedside but did not have an order to self-administer any other medications and that the resident did not have a physician's order for "Tums." LPN 6 indicated Resident D's family had likely brought the medication in without informing nursing staff. On 3/4/25 at 3:10 P.M., the Assistant Director of Nursing (ADON) supplied a facility policy titled, "Resident Self-Administration of Medication, dated 5/30/23. The policy included, ...7. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party..." This citation relates to complaint IN00454320. 3.1-25(a) 3.1-25(b)(1) 3.1-25(j)		**recur, i.e., what quality assurance program will be put into place?** **a** The Director of Nursing or designee conducted a Quality Assurance (QA) review and monitoring for ongoing compliance by checking to ensure that there are no medications at bedside. **b** Using the audit tool, a minimum sample of 5 residents 2x a week will be reviewed. The review shall be completed twice (2x) a week for the first month, then weekly on the 2nd month until resolution is noted. Monitoring shall be ongoing for a minimum of ninety (90) days and may be extended if consistent compliance is not established. **c** Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported at the monthly Quality Assurance Committee meetings for further action(s). **COMPLETION DATE: April 18, 2025**	
F 9999 Bldg. 00	Administration and Management	F 9999	F999 1. Corrective Action for Residents	04/18/2025

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	3.1-13(g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents. Based on observation and interview the facility failed to report to the state agency an interruption of resident services and the closure of resident spaces. The state agency was not notified when the facility's water lines failed on 1/20/25 which caused the kitchen to be without water for approximately 48 hours and led to the closure of the facility's main dining room. Finding includes: During an observation on 3/4/25 at 9:15 A.M., the main dining room doors were closed with a printed sign that indicated the dining room was closed. The dining room doors were locked. During an interview on 3/4/35 at 9:25 A.M., the Assistant Director of Nursing (ADON) indicated that no state reported incidents had been submitted to the state agency since 11/2024. During an interview on 3/4/25 at 9:40 A.M., the Dietary Manager indicated water lines above the facility kitchen had froze and busted the water pipe on 1/20/25. The kitchen was without water and served cold lunch and supper meals for two days following the disruption. The kitchen was		Affected: On 1/20/25, a water utility interruption occurred in the kitchen due to a busted frozen water pipe above the kitchen ceiling. Although the facility continued to have water throughout the building, water was interrupted in the kitchen area until repairs could be made on 1/22/2025. Immediate steps were taken to ensure resident ensuring kitchen hygiene through alcohol-based hand rubs and using alternate food preparation protocols. No residents experienced adverse outcomes. As of 1/22/2025 residents have been able to access the dining room and there are no restrictions for the kitchen/dietary services. 2. Measures to Ensure All Other Residents Are Not Affected Facility leadership conducted a review of the utility disruption and emergency preparedness procedures. All residents received continued care without disruption. All systems have since returned to normal function. 3. Systemic Changes to Prevent Recurrence: The facility's Emergency Preparedness Plan has been updated to explicitly include water	

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	partially relocated to the main dining room and the main dining room had been closed to the residents since 1/20/25. During an interview on 3/4/25 at 10:50 A.M., Resident C indicated she used to eat in the main dining room but has not been able to do so since the water leak in the kitchen. Resident C indicated she had been eating meals in her room. During an interview on 3/4/25 at 3:10 P.M., the ADON indicated the facility follows state regulations in regard to reporting incidents or interruptions to resident services. This citation relates to complaints IN00454483 and IN00454320.		utility reporting procedures. Training was provided to the administrator and Director of Nursing on 4/17/2025 reinforcing the requirement to notify the State Agency of any utility interruption lasting more than 4 hours. 4. Monitoring to Ensure Sustained Compliance The Administrator or Designee will conduct monthly audits for six months to review: Utility logs Incident reports Reporting compliance documentation Audit outcomes will be reviewed monthly during the QA/QAPI meeting to ensure ongoing compliance. Date of Completion: 4/18/2025	