STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Healthcare of New Harmony	251 Highway 66 New Harmony, IN 47631

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plan conferences were completed quarterly for 1 of 1 residents reviewed for care plan conferences. (Resident 34)Finding includes: During an interview on 12/1/25 at 12:15 P.M., a family member indicated that she had not had any care plan conferences with the facility since Resident 34 was admitted to the facility. On 12/3/25 at 11:18 A.M., Resident 34's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease. Resident 34 was admitted to the facility on [DATE]. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/12/25, indicated Resident 34 had severe cognitive impairment and was dependent on staff for transfers, toileting, and bathing. The most recent care plan conference was completed on 7/9/25 with Resident 34's family member in attendance.The clinical record lacked documentation to indicate that a care plan conference had been completed since 7/9/25.During an interview on 12/3/25 at 2:06 P.M., the Assistant Director of Nursing (ADON) indicated that Resident 34 had not had a care plan conference completed since July. At that time, she indicated care plan conferences were to be completed quarterly.On 12/4/25 at 1:11 P.M., the Administrator provided a current undated Care Conference Policy and Procedures policy that indicated Quarterly Care Conference held every 90 days.3.1-35(d)(2)(B)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure as needed (PRN) orders for psychotropic drugs, that were ordered beyond 14 days, indicated a specific duration of use for 4 of 5 residents reviewed for hospice services. (Resident 1, Resident 4, Resident 35, and Resident 40) Findings include:1. On 12/2/25 at 1:18 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Alzheimer's disease. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 10/17/25, indicated Resident 35's cognition level was unable to be assessed because the resident was rarely understood, was dependent on staff (staff does all the work) for showering, toileting, and transfers, and was taking an antianxiety medication. Physician orders included, but were not limited to: lorazepam intensol oral concentrate (an antianxiety medication) 2 milligrams per milliliter (mg/mL) - Give 0.25 mL by mouth every four hours as needed (PRN) for anxiety, restlessness, shortness of breath, pain; Start date 10/9/25. The order did not contain a stop date. The care plan included, but was not limited to: Resident has a diagnosis of anxiety and takes antianxiety medication Lorazepam; Date Initiated: 8/27/24 2. On 12/1/25 at 10:30 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with other behavioral disturbance and Chronic Obstructive Pulmonary Disease. The current Quarterly Minimum Data Assessment (MDS) Assessment, dated 10/14/25, indicated Resident 4 was severely cognitively impaired. Resident 4 was dependent on staff for transferring, toileting, and hygiene, and did not receive an antianxiety medication during the 7-day lookback period. Current physician orders included, but were not limited to:lorazepam oral tablet 0.5 milligrams (mg) (an antianxiety medication) - Give 0.5 mg by mouth every 30 minutes as needed for anxiety/restlessness for mild/moderate/severe anxiety, shortness of breath, restlessness. Resident is on hospice services with less than six months life expectancy, start date 10/18/24 with no end date. The care plan included, but was not limited to:Resident takes anti-anxiety medication lorazepam due to end of life care (hospice) Initiated: 10/16/24 3. On 12/1/25 at 11:00 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic respiratory failure and Chronic Obstructive Pulmonary Disease (COPD). The current Quarterly Minimum Data Set (MDS) Assessment, dated 11/25/25, indicated Resident 1 was cognitively intact. Resident 1 required supervision for eating, hygiene, dressing, and transferring, and received an antianxiety medication during the 7-day lookback period. Current physician orders included, but were not limited to:lorazepam oral tablet 0.5 milligrams (mg) - Give 0.5 mg by mouth every two hours as needed for terminal restlessness, moderate to severe restlessness, anxiety, shortness of breath, and pain. Resident is on hospice services with less than six months life expectancy, dated 8/8/25 with no end date. The care plan included, but was not limited to:Resident is taking anti-anxiety Lorazepam. Date Initiated: 10/16/2024 4. On 12/4/25 at 11:07 A.M., Resident 40's clinical record was reviewed. Diagnoses included, but were not limited to, senile degeneration of the brain. Resident 40 was admitted to hospice services on 4/30/25. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/15/25, indicated Resident 40 was not assessed for cognitive impairment because she was rarely or never understood. Resident 40 was dependent on staff (staff does all the work) for all Activities of Daily Living (ADLs) and did not (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receive any antianxiety medications during the 7-day lookback period. Physician orders included, but were not limited to:lorazepam (an antianxiety medication) 0.5 milligrams (mg) - Give one tablet by mouth every two hours as needed (PRN) for anxiety, mild to severe restlessness, shortness of breath, and pain. Resident is on hospice services with less than six months life expectancy, dated 5/6/25 with no stop date The care plan included, but was not limited to:Resident takes lorazepam due to her being on hospice end of life care, initiated 6/18/25 A pharmacy review, dated 9/9/25, indicated Please evaluate the continued need for PRN lorazepam. Please consider: Discontinuing lorazepam PRN. (or) Add stop date to lorazepam PRN for short-term use (max 14 days) and evaluate use. If current order is necessary, then please reevaluate resident and document risk/benefit to continue up to an additional 14 days to assist facility with regulatory compliance. The attending physician or prescribing practitioner must first evaluate the resident to determine if the new order for the PRN anxiolytic is appropriate . Unfortunately, this regulation does not differentiate for hospice patients and does not allow for exceptions to the rule. The physician signed the pharmacy review but did not indicate a response to the request for evaluation. The clinical record lacked documentation to indicate the PRN antianxiety medication had a stop date or that the resident was re-evaluated to determine if the order for the PRN antianxiety medication was appropriate. During an interview on 12/4/25 at 10:05 A.M., the Assistant Director of Nursing (ADON) indicated that PRN antianxiety medications required a stop date of 14 days. Hospice residents had a statement in their order that indicated they had a life expectancy of six months or less; however, if the resident lived longer than six months, the order was left in without a physician re-evaluation, date change, or new order. At that time, the ADON indicated she was unaware that the regulation did not make an exception for residents receiving hospice services. On 12/4/25 at 1:42 P.M., the Administrator provided a current undated PRN Antianxiety Medication Policy and Procedure policy that indicated All PRN antianxiety medication use must follow CMS regulations and facility medication administration standards. On 12/4/25 at 1:58 P.M., the Administrator provided a current Use of Psychotropic Medication(s) policy, dated 10/1/25, that indicated PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. 3.1-48(a)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to revise a resident's care plan with a new intervention following a fall for 2 of 4 residents reviewed for falls. (Resident 23 and Resident 1)Findings include: 1. On 12/3/25 at 9:36 A.M., Resident 23's clinical record was reviewed. Diagnoses included, but were not limited to, alcohol dependence with alcohol-induced persistent dementia. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 10/17/25, indicated Resident 23 had severe cognitive impairment, was dependent on staff for all Activities of Daily Living (ADLs), and had two or more falls with injury and two or more falls without injury since the prior assessment on 7/17/25. A current fall risk assessment, dated 9/11/25, indicated that Resident 23 was at risk for falls. A care plan conference was completed on 10/23/25 with Resident 23's Power of Attorney (POA) in attendance. The care plan was reviewed. A current risk for falls care plan, initiated 7/21/25, included the following interventions:Assist the resident with transfers. Date Initiated: 7/21/25Environment free of clutter. Date Initiated: 7/21/25Resident will be assisted daily with ADL care needs. Date Initiated: 7/21/25Resident will be provided with non skid footwear. Date Initiated: 7/21/25Resident will have therapy as ordered. Date Initiated: 7/21/25 A current actual falls care plan, initiated 7/21/25, indicated Resident 23 had an actual fall on 7/19/25, 9/11/25, 9/17/25, and 11/2/25, and included the following interventions:9/11/2025: Intervention: bed bolsters to aid the resident with bed positioning. Date Initiated: 7/21/259/17/2025 Intervention: When Resident 23 is in a wheelchair, staff to ensure the resident is within the line of vision of staff. Date Initiated: 9/22/25Change of plain mat to the open side of the bed. Date Initiated: 11/13/25 When the resident is experiencing terminal restlessness, the resident is to be in bed with a change of plane to the floor to open the side of the bed. Date Initiated: 11/5/25 Physician orders included the following fall interventions:fall mat to open side of bed, dated 9/16/25Bed in lowest position with bed bolsters to bed, dated 9/16/25Low Air Loss (LAL) mattress with bolster to bed for parameter awareness and prevention of wounds, dated 5/12/25 A Health Status progress note, dated 8/11/25 at 11:00 P.M., indicated that Resident 23 had a witnessed fall while sitting on the side of her bed. The clinical record lacked documentation to indicate that a new intervention was added to the care plan after that fall. During an interview on 12/3/25 at 2:52 P.M., the Assistant Director of Nursing (ADON) indicated that she was unable to find a documented intervention put in place after Resident 23's fall on 8/11/25. 2. On 12/1/25 at 11:00 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic respiratory failure and Chronic Obstructive Pulmonary Disease (COPD). The (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	current Quarterly Minimum Data Set (MDS) Assessment, dated 11/25/25, indicated Resident 1 was cognitively intact. Resident 1 required supervision for eating, hygiene, dressing, and transferring, and had a history of falls. Current Physician orders included, but were not limited to, the following:Nonskid strips in front of the recliner, dated 8/11/25.Commode riser for safety with toileting transfers, dated 2/12/25. A Nurse's Note, dated 11/15 at 1:15 A.M., indicated that Resident 1 had an unwitnessed fall after sliding out of bed. A Post Fall Evaluation Nurse's Note, dated 11/18/25 at 5:36 A.M., indicated that Resident 1 was a High Fall Risk and had an unwitnessed fall at that time. The current Fall Risk Care Plan lacked documentation of new interventions for the unwitnessed falls that occurred on 11/14/25 and 11/17/25. During an interview on 12/2/25 at 3:44 P.M., the Assistant Director or Nursing (ADON) indicated there should be a new intervention after each fall. On 12/4/25 at 2:15 P.M., the Administrator provided a current Comprehensive Care Plan policy dated January 2025. The policy indicated .assessment of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. 3.1-35(e)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure practitioner's diagnostic practices met professional standards of care for 2 of 6 residents reviewed for medication review. Residents had new diagnoses of schizophrenia over [AGE] years of age after admission to the facility. (Resident 4 and Resident 35) Findings include:1. On 12/1/25 at 10:30 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance and schizoaffective disorder. The current Quarterly Minimum Data Assessment (MDS) Assessment, dated 10/14/25, indicated Resident 4 was severely cognitively impaired. Resident 4 was dependent on staff for transferring, toileting, and hygiene, received an antipsychotic medication during the 7-day lookback period, and had a diagnosis of schizophrenia. Current physician orders included, but were not limited to:risperidone (an antipsychotic medication) oral tablet 0.5 milligrams (mg) - Give 0.5 mg by mouth two times a day related to schizoaffective disorder, bipolar, dated 11/18/25. The clinical record lacked documentation to indicate that Resident 4 had a diagnosis of schizoaffective disorder before admission to the facility. The clinical record, including progress notes, documents, and assessments, lacked documentation that indicated when and how the diagnosis was determined. On 12/2/25 at 3:15 P.M., the Assistant Director of Nursing (ADON) was asked to provide documentation to support the mental health diagnosis of schizoaffective disorder, bipolar type, but was unable to provide it. 2. On 12/2/25 at 1:18 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, schizoaffective disorder, bipolar type and Alzheimer's disease. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 10/17/25, indicated Resident 35's cognition level was unable to be assessed because the resident was rarely understood and was dependent on staff (staff does all the work) for showering, toileting, and transfers. Resident 35 received an antipsychotic during the 7-day lookback period and had a diagnosis of schizophrenia. Physician orders included, but were not limited to:Seroquel Tablet (an antipsychotic medication) 25 milligrams (mg) - Give 12.5 mg by mouth one time a day related to schizoaffective disorder, bipolar type; Start date: 10/18/22, Discontinued: 5/21/25. The clinical record indicated that the schizoaffective disorder, bipolar type diagnosis was not present on admission and was added to the resident's record on 6/29/23. A pharmacy recommendation, signed by the physician on 6/26/23, indicated the physician did not indicate a new diagnosis for schizoaffective disorder, bipolar type. The clinical record, including progress notes, documents, and assessments, lacked documentation that indicated where the diagnoses came from. On 12/3/25, documentation to support the mental health diagnosis of schizoaffective disorder, bipolar type, was requested. On 12/3/25 9:38 A.M., the Assistant Director of Nursing (ADON) indicated she was unsure where the diagnosis came from and was unable to locate a physician assessment or documentation that the physician gave the diagnosis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/25 at 1:11 P.M., the Administrator provided a policy titled Nursing Home Documentation Policy that indicated ensure that all documentation in the medical record is accurate, timely, complete, objective, and compliant with federal and state regulations. 3.1-35(g)(1)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. Based on interview and record review, the facility failed to ensure Qualified Medication Aides (QMAs) were providing services within their scope of practice for 1 of 5 residents reviewed for medication use. A QMA administered as needed (PRN) medication without prior authorization from a licensed nurse. (Resident 7)Finding includes: On 12/2/25 at 10:28 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, pain, and migraine headaches.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 10/29/25, indicated Resident 7 was cognitively intact, was independent in all Activities of Daily Living (ADLs), and received an opioid medication during the 7-day lookback period.Physician orders included, but were not limited to:tramadol (an opioid pain medication) 50 milligrams (mg) - Give 50 mg by mouth every eight hours as needed (PRN) for pain, dated 7/2/25sumatriptan succinate (a medication used to treat migraine headaches) 25 mg tablet - Give one tablet by mouth every 24 hours PRN for migraine headaches, dated 11/16/23Resident 7's electronic Medication Administration Record (eMAR) from 10/1/25 to 12/2/25 included, but was not limited to, the following dates that tramadol 50 mg PRN was administered by a Qualified Medication Aide (QMA) without authorization from a licensed nurse:10/5/25 at 8:13 P.M. (given by QMA 12)10/14/25 at 7:22 P.M. (given by QMA 12)10/17/25 at 7:44 P.M. (given by QMA 12)10/18/25 at 7:46 P.M. (given by QMA 12)10/21/25 at 7:14 P.M. (given by QMA 12)10/28/25 at 7:09 P.M. (given by QMA 12)Resident 7's electronic Medication Administration Record (eMAR) from 10/1/25 to 12/2/25 included, but was not limited to, the following dates that sumatriptan 25 mg PRN was administered by a QMA without authorization from a licensed nurse:11/4/25 at 8:04 P.M. (given by QMA 12)During an interview on 12/4/25 at 10:15 A.M., QMA 15 indicated that before a QMA gave a PRN medication, authorization from a nurse was acquired and documented in the medication administration notes.On 12/4/25 at 1:11 P.M., the Administrator provided an undated QMA Scope of Practice that indicated Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: . (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. 3.1-35(g)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents were provided adequate supervision on the dementia unit during 1 of 1 random observations. (Cardinal hall dining room) Finding includes:During a random observation on 12/1/25 at 11:45 A.M. in the Cardinal unit (dementia unit), residents seated in the dining room participated in activities.At 11:59 A.M, the activities staff left the unit.At 12:29 P.M., two residents seated across the table from each other appeared to have a verbal altercation about one resident who knocked on the table. No staff members were observed on the dementia unit or at the nurses' station of the unit.At 12:33 P.M., the dining cart was delivered near the nurses' station by dietary. Licensed Practical Nurse (LPN) 7 was observed exiting a resident's room on the East hall adjacent to the dementia unit. Seven residents were currently residing in Cardinal Hall at the time of meal service. On 12/4/25 at 10:29 A.M., the facility's Alzheimer's/Dementia Special Care Unit form was reviewed. The form indicated the unit should be staffed with one full-time nurse and two full-time certified nurse aides (CNA) during day shift on the unit. On 12/4/25 at 1:11 P.M., the Administrator provided a policy titled Dementia Care Unit Staffing Policy and Procedure that indicated ensures that the dementia care unit is staffed with sufficient, qualified, and dementia trained personnel at all times. Staff must maintain continuous supervision. 3.1-45(a)(2)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure the kitchen manager met required qualifications for 1 of 1 dietary manager qualifications reviewed. (Dietary Manager)Finding include:During an interview on 12/1/25 at 9:15 A.M., the Dietary Manager indicated she did not have a Certified Dietary Manager Certification. She indicated that she had the course books for two years but had not had the time to complete the certification. During an interview on 12/3/25 at 8:06 A.M., the Assistant Director of Nursing (ADON) indicated the Dietary Manager was required to take the certification test within six months to a year of being hired. On 12/3/25 at 2:03 P.M., employee files were reviewed. The Dietary Manager was hired on 3/5/24. On 12/4/25 at 1:00 P.M., the Administrator provided a current undated Director of Dietary Services job description. The job description indicated Required Education and Experience.Certified Dietary Manager (CDM) Credential. 3.1-20(e)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure complete and accurate documentation was available in resident clinical records for 2 of 4 residents reviewed for falls. (Resident 17 and Resident 35)Findings include:1. On 12/2/25 at 9:14 A.M., Resident 17's clinical record was reviewed. Resident 17 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, vascular dementia. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 10/30/25, indicated Resident 17 was severely cognitively impaired, was dependent on staff (staff does all the work) for bathing and was independent for transfers, and had two or more falls since the previous MDS assessment with one fall injury. The current care plan included, but was not limited to: Had an actual fall incident: Fall on 5/7/24, actual fall 9/4/24, actual fall 8/25/25, actual fall 10/16/25, actual fall 10/27/25; Date Initiated: 11/27/2023 A health status progress note, dated 10/28/25 at 8:01 A.M., indicated Resident 17 had swelling present to left knee, Resident complained of moderate pain; Requested x-ray order. A practitioner progress note, dated 10/28/25 at 11:59 P.M., indicated Staff reported resident had a fall yesterday while out of facility at an appointment. The clinical record lacked documentation of the fall that occurred on 10/27/25, or notification to family regarding the fall or x-ray order in clinical progress notes, forms, documents, or assessments. During an interview on 12/3/25 at 9:54 A.M., the Director of Nursing (DON) indicated she would expect staff to document a fall that occurred outside the facility once the resident returned to the facility. 2. On 12/2/25 at 1:18 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Alzheimer's disease.The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 10/17/25, indicated Resident 35's cognition level was unable to be assessed because the resident was rarely understood, was dependent on staff (staff does all the work) for showering, toileting, and transfers, and had two or more falls without injury since the prior MDS Assessment.The care plan included, but was not limited to: Had an actual fall on: 9/12/2025, 10/11/2025; Date Initiated: 3/19/24Intervention: when up out of bed, place in wheelchair and have in line of sight. Date Initiated: 10/14/25 A nurse's note, dated 10/11/25 at 4:30 P.M., indicated [resident family] and physician aware of fall. The clinical record lacked documentation of the fall that occurred on 10/11/25 in clinical progress notes, forms, documents, or assessments. On 12/4/25 at 1:11 P.M., the Administrator provided a policy titled Falls Clinical Protocol that indicated The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. Falls should be identified as witnessed or unwitnessed events. 3.1-50(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Healthcare of New Harmony	251 Highway 66 New Harmony, IN 47631

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to implement infection prevention measures for 2 of 2 residents reviewed for catheters and 1 random dining observation. Catheter bags were observed on the floor and hand hygiene was not offered to residents prior to eating. (Resident 3, Resident 39, and Cardinal Unit)Findings include: 1. On 12/1/25 at 10:20 A.M., Resident 3's catheter bag was observed laying on the floor while the resident was lying in bed. On 12/1/25 at 1:15 P.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, multiple sclerosis, disorganized schizophrenia, and neuromuscular dysfunction of bladder. The current Quarterly Minimum Data Set (MDS) Assessment, dated 11/6/25, indicated Resident 3 was moderately cognitively impaired. Resident 3 was dependent on staff for transferring, hygiene, and dressing. Resident 3 had a suprapubic catheter. Current physician orders included, but were not limited to:Insert Suprapubic Catheter French (FR) size 20FR, balloon size 3 milliliter (mL). Change Suprapubic catheter and urinary bag monthly and PRN (as needed) for system failure in the morning every 30 days and every 24 hours as needed for PRN and system failure, dated 11/20/25 2. On 12/1/25 at 10:15 A.M., Resident 39 was observed in bed. A catheter bag hanging from the bed was resting on the floor. On 12/2/25 at 11:45 A.M., Resident 39's clinical record was reviewed. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and chronic kidney disease. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 10/27/25, indicated that Resident 39 had moderate cognitive impairment, was dependent on staff for toileting, and had an indwelling catheter. Physician orders included, but were not limited to:Insert coude catheter size 16F balloon size 10. Change foley catheter and urinary bag every 14 days for system failure and if urinary bag gets cloudy with sediment, dated 8/22/25 A care plan conference was completed on 10/28/25. The resident declined to attend. Care plans were reviewed. A current risk for infection care plan, initiated 8/20/25, included an intervention to manage indwelling catheters to minimize risk of infection. On 12/2/25 at 2:41 P.M., Resident 39 was observed in bed. A catheter bag hanging from the bed was resting on the floor. On 12/4/25 at 10:13 A.M., the Infection Preventionist indicated that catheter bags should not touch the floor. On 12/4/25 at 11:11 A.M., the Administrator provided a current Catheter Care, Urinary policy, revised March 2020, that indicated Be sure the catheter tubing and drainage bag are below the resident's bladder and kept off the floor. On 12/4/25 at 11:11 A.M., the Administrator provided a current Urinary Drainage Bags policy, (continued on next page)

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	155370	A. Building B. Wing	12/04/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed January 2025, that indicated Urinary drainage bags should be maintained below the residents' bladder, off the floor, and in a urinary bag cover. 3. During a random dining observation on the Cardinal Unit, on 12/1/25 at 11:45 A.M., residents were seated in the dining room participating in activities.At 11:59 A.M, the activities staff left the unit.At 12:33 P.M., the dining cart was delivered to unit.At 12:42 P.M., Staff began serving lunch trays to residents. Hand hygiene or clothing protectors were not offered to residents in the dining room. During an interview on 12/4/25 at 10:13 A.M., the Director of Nursing indicated staff serving in the dining room should offer hand hygiene and clothing protectors to residents who may need one. On 12/4/25 at 1:42 P.M., the Administrator provided a policy titled Resident Hand Hygiene Policy and Procedure that indicated ensures that all residents are offered, cued, or assisted with hand hygiene as part of the facility's Infection Prevention & Control Program. Staff will support residents in performing hand hygiene at clinically indicated times to prevent infection and maintain resident dignity . Indicated times when hand hygiene is required to reduce infection risk before: meals, snacks, and drinks. after: group activities. or touching shared surfaces. 3.1-18(b)(1)3.1-18(l)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) dedicated part time hours to the role of IP for 1 of 1 staff members reviewed for IP. The full time Director of Nursing (DON) also served as the Infection Preventionist. Finding includes:On 12/4/25 at 10:13 A.M., the Director of Nursing (DON) indicated she was also serving as the facility's Infection Preventionist, and indicated she dedicated around two hours each work day to infection control tasks. During an interview on 12/4/25 at 11:50 A.M., the Director of Nursing indicated she had been serving as the Director of Nursing and the Infection Preventionist since September 2025. On 12/4/25 at 1:11 P.M., the Administrator provided an Infection Preventionist job description that indicated The Infection Preventionist is responsible for developing, implementing, and monitoring the facility's Infection Prevention and Control in alignment with federal, state, and local regulations. Position type and hours: full time. On 12/4/25 at 1:11 P.M., the Administrator provided a Director of Nursing job description that indicated The Director of Nursing is responsible for planning, development and overall operation of the Director of Nursing which ensures guests receive quality care 24 hours a day.