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	10/16/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate supervision, monitor behaviors, update the plan of care, and document relevant information to prevent accidents and then following an accident for 2 of 3 residents reviewed for accidents and dementia care. A resident (Resident C) with a history of wandering behaviors was not observed to enter another resident's room (Resident D) which led to a resident-to-resident altercation and a bite wound. (Resident C, Resident D)Findings include:1. During record review on 10/15/25 at 9:30 A.M., Resident C's diagnoses included but were not limited to dementia with behavioral disturbance.Resident C's most recent admission MDS (Minimum Data Set) assessment, dated 10/8/25 indicated the resident had severe cognitive impairment, a behavior of wandered daily during a 7-day review period, and that the wandering did not significantly intrude on the privacy or activities of others. Resident C's physician orders included, but were not limited to, Monitor behavior every shift and document A) No behavior, B) Combative/hitting/kicking, C) Crying/restlessness/agitation, D) Insomnia, E) Hallucinations/Delusions/Psychosis, and/or F) Biting/Spitting - Include 0) No intervention needed, 1) Resident easily redirected, 2) Keep redirecting, 4) Close monitoring, 5) 1-to-1 monitoring (started 9/26/25). Resident C's care plan included but was not limited to; Resident is a wanderer due to disoriented to place, impaired safety awareness, and wanders aimlessly (created and last revised 9/30/25). Resident wanders aimlessly throughout the facility unaware of whereabouts or safety (created and last revised 9/30/25). A goal included, Resident will not injure self or cause injury to othersResident C's progress notes included, but were not limited to:10/6/25 at 12:23 P.M. - Resident brought male resident to nurse and stated that he was going into all the female rooms stealing from them.10/6/25 at 3:33 P.M. - Resident frequently pushing male residents into her room and closing the door. Very difficult to redirect at times.10/7/25 at 1:42 P.M. - Resident was trying to make another resident get out of her bed. Resident became very angry and went into her room and slammed the door.10/13/25 at 2:30 A.M. - Staff intervened in altercation between Resident D and Resident C. Resident C had Resident D by the right arm and was biting her forearm. Residents were separated and Resident D assessed for injury. Resident D had pale blue bruising and some edema to right forearm but no open wound.Resident C's treatment administration record (TAR) for the month of October 2025 included no documented behaviors from 10/1/25 to 10/12/25. No documentation that indicated behavioral monitoring was completed was available on night shift 10/10/25. A response to a behavior on night shift 10/12/25 included 4) close monitoring.Resident C's Psychiatry Progress Note, dated 10/13/25 included, This is a psychiatric follow-up for (Resident C). The primary reason for the encounter is to address an incident involving aggression. Staff. reported that the patient was involved in an altercation with another resident overnight, where she bit the other person and removed a small chunk of flesh. During an interview on 10/15/25 at 1:35 P.M., LPN 4 indicated Resident C often wandered during the day and night shift and was usually easily redirected. During an interview on 10/16/25 at 10:15 A.M., the Social Service Director (SSD) indicated it would have been appropriate to update Resident D' plan of care following an increase in Resident D's behavior of wandering following incidents on 10/6/25 and 10/7/25 that involved other residents and an increase in Resident D's agitation and difficulty with redirection. On 10/16/25 at 10:30 A.M., the Assistant Director of Nursing (ADON) indicated the facility did not have a policy regarding resident behavior and wandering prevention. 2. During record review on 10/15/25 at 9:45 A.M., Resident D's diagnoses included but was not limited to Alzheimer's disease and vascular dementia. Resident D's most recent quarterly MDS assessment dated [DATE] indicated the resident had severe cognitive impairment. Resident D' physician orders included but were not limited to; triple antibiotic external ointment - apply to wound on left forearm topically in the morning for wound care until 10/28/25, cleanse with wound cleanser and cover with dry dressing daily (received 10/13/25 and started 10/14/25 at 9:00 A.M.) Resident D's nurse's progress notes included, but were not limited to:10/13/25 at 2:30 A.M. - Staff intervened in altercation between Resident D and Resident C. Resident C had Resident D by the right arm and was biting her forearm. Residents were separated and Resident D assessed for injury. Resident D had pale blue bruising and some edema to right forearm but no open wound. Resident D complained of pain to wrist and pain on moving her fingers. Physician notified and gave order for Xray of right wrist/forearm.10/13/25 at 10:41 A.M. - Resident complained of pain to left forearm.10/14/25 at 10:50 A.M. - Resident's left arm cleaned. Triple Antibiotic Ointment (TAO) and bandage applied.A Physical Aggression Received report for Resident D, dated 10/13/25