STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 11, 12, 13, 14, 17, & 18, 2016 Facility number: 000553 Provider number: 155660 AIM number: 100267430 Census bed type: SNF: 7 SNF/NF: 47 Total: 54 Census payor type: Medicare: 3 Medicaid: 34 Other: 17 Total: 54 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 10/20/16.	F 0000	The preparation and execution of this Plan of Correction does not constitute admission or agreement, by the provider, of the alleged deficiencies, or the conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensure of the long term care facility and this Plan of Correction in its entirety, constitutes this providers credible allegation of compliance. Completion dates are provided for procedural purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is of the opinion that it was in compliance with the requirements of participation. We are respectfully requesting a desk review to clear any and all proposed or	

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
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
			implemented remedies that have been presented to date	
F 0221 SS=D Bldg. 00	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review, and interview, the facility failed to ensure a resident was free from physical restraints related to an activity lap tray not being assessed for 1 of 2 residents reviewed for physical restraints. (Resident #17) Finding includes: On 10/13/16 at 11:19 a.m., Resident #17 was observed sitting in her wheelchair in the area near the Nurse's Station. An activity lap tray was observed in place to her wheelchair. The resident was coloring in a coloring book on the activity lap tray. On 10/14/16 at 12:29 p.m., Resident #17 was observed sitting in her wheelchair in the Main Dining Room. The activity lap tray was observed in place to her wheelchair. Her lunch food items were observed on the activity lap tray and a staff member was assisting her with eating.	F 0221	F 221 Right to be free from Physical Restraint OT was ordered prior to survey completion for review of the Activity Tray to wheel chair and wheel chair positioning. See Sample #1 for F 221 Pre-Restraint Assessment Completed See Sample #2 for F 221 IDT review with OT/POA/ Physician See Nursing Note Sample #3a &3b for F 221 Activity Tray Log See Sample #4 for F 221 which will be reviewed weekly by DON or her designee to ensure time of Activity Tray use does not exceed more than one hour at a time for the specific individual or 1:1 activities of coloring/looking at books/ playing with age appropriate toy's / or identifying stickers on tray. Not to exceed two separate hours/Activities (1:1/individual) a day with use of Activity Tray to wheel chair. After on month will review to possibly reduce Activity Tray for 1:1/individual activities and set resident at a table this will be monitored/assessed with out	11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	Resident #17's record was reviewed on 10/1716 at 1:20 PM. Diagnoses included, but were not limited to, intellectual disability, seizures, and cerebrovascular accident (CVA, stroke). A Quarterly Minimum Data Set (MDS) assessment dated 7/29/16 indicated no restraints were used for Resident #17, she had no impairment to her upper extremities, and had impairment to both lower extremities. The 10/2016 Physician's Order Summary indicated an order for "lap tray in wc (wheelchair)." The Occupational Therapy Evaluation and notes, dated 3/5/15, indicated the resident was fitted with a new wheelchair system that included the adaptive equipment of a full lap tray. The evaluation indicated no restraint was used. The resident had a care plan for Activities of Daily Living. The interventions included, "...reclining high back wheelchair with head support, foam back cushion with lateral supports, wedge cushion, elevating leg rest with foot/leg board, activity tray (not a restraint) and anti-tippers..."		comes documented assessing for possible Psychosocial harm d/t reduction of Activity Tray use. Care Plans - Nursing/Social Services/ Activities adjusted as necessary and adjustments on-going. Staff will continue to praise and encourage resident R/T Activity Tray reduction. All Nursing and Activity staff will be in-serviced on this plan. Marshal Starke Developmental Services education provided for out of building activities. See Sample #5 for F221 Physician Order changed to indicate Activity Tray to Wheel Chair for coloring, playing with toys, looking at Books and sticker identification during individual and 1:1 activities. Not to exceed one hour at a time and not to exceed two hours daily. See Sample #6 for F221. Physical Restraint elimination assessment completed See Sample #7a&b for F 221 This process will be reported and discussed in QA monthly x's one year. See Sample A for F221	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	Interview with Unit Manager #1 on 10/18/16 at 11:30 a.m. indicated the resident had the activity lap tray so she could do activities more easily on it such as coloring. She indicated the activity lap tray was not considered a restraint because the resident was unable to transfer on her own. She indicated the resident was able to move her upper extremities but was unable to remove the activity tray herself. Interview with the Director of Nursing (DON) on 10/18/16 at 12:12 p.m. indicated the resident was admitted to the facility in 2008 with the activity tray and it had not been assessed as a restraint. She indicated therapy evaluated the resident when she got a new wheelchair in March 2015 and did not consider the activity tray a restraint because the resident was unable to transfer herself. She indicated the resident was able to move her upper extremities but was unable to remove the activity tray herself. A policy titled "Restraints", received from Unit Manager #1 as current indicated, "...1. An interdisciplinary team shall assess each restrained resident for least restrictive restraint possible. Restraints are applied only upon proper physician's order stating type of restraint,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	time restraint is to be applied, reason for restraint, and release of restraint...4. Restraints shall be reassessed at least quarterly by reviewing the care plan entry for the restraint." 3.1-3(w) 3.1-26(r) 3.1-26(s)			
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report an allegation of abuse timely to the Administrator of the facility for 1 of 3 abuse allegations reviewed. (Resident #41) Finding includes: Record review for Resident #41 was completed on 10/13/16 at 2:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, psychosis, and paranoid delusions. The Quarterly Minimum Data Set (MDS) assessment completed on 8/22/16 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 0, which indicated the resident was severely cognitively impaired. An Indiana State Department of Health reportable Incident, dated 9/24/16,	F 0225	F 225 Investigate/Report Allegations/Individuals The 2 staff; Activity Director and Social Service designee were disciplined thru counseling for failing to report an allegation of abuse timely to the Administrator of the facility. See Sample # 1a &1b F 225 Further education and discipline will occur immediately for staff not reporting allegations of abuse in a timely manner. All facility staff were in-serviced on the types of abuse and the timely reporting to the Administrator any allegation (s) of abuse regardless of cognitive abilities of the resident reporting the allegation. See Sample #2 & #3 for F 225 During an allegation of abuse investigation interviews will be initiated with alert residents to determine if the potential allegation has affected other residents. See Sample # 4 & #5 for F225	11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	indicated Resident #10 had reportedly confronted Activity Aide #1 about an incident that had occurred earlier in the week where the Activity Aide #1 had kissed another resident. The reportable incident indicated Activity Aide #1 was sent home from the facility and suspended pending an investigation. The investigation included statements from staff members. A statement from Social Service #1 dated 9/24/16, indicated that prior to 9/24/16, Resident #10 had made a statement that Activity Aide #1 had been observed kissing another resident on the cheek and saying "I Love You". She indicated Resident #10 was concerned since the resident involved was a priest. Social Service #1 indicated that she advised Resident #10 she would report the incident to the Activity Director. A statement from the Activity Director which did not include a date, indicated Social Service #1 had told her that Resident #10 had reported to her that she witnessed Activity Aide #1 kissing Resident #41 on the lips. Social Service #1 had asked the Activity Director if she thought that it could be true and the Activity Director said no, she did not think so, and Resident #10 was upset		During morning meeting the 24 hour report will be reviewed by the Unit Managers for potential incidents of abuse and reported to the Administrator or her/his designee immediately. Daily rounding 4-5 days a week by the Administrator or his/her designee to be accomplished for one month then weekly rounding will occur to remind staff in learning circles concerning the immediate reporting to the Administrator or designee any allegation of abuse. See Sample #6 for F 225. Results of the daily and weekly rounding with staff will be reported monthly in QA along with any Allegations of abuse that were reported to ISDH. See Sample A for F 225	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	with Activity Aide #1 the evening prior. The Activity Director indicated approximately an hour later she approached Activity Aide #1 and started to talk about the situation and the Aide quickly stated that Social Service #1 had already spoken to her about it. The Aide said she believed Resident #10 had it out for her. The Activity Director told the Aide to avoid conflict with Resident #10 and to make sure no kisses were given to Resident #41. A statement from Activity Aide #1, dated 9/24/16, indicated while she was painting Resident #10's fingernails, the resident had asked her if she knew what a priest swears to when they become one. The Aide asked the resident what that was and the resident had said getting involved with a woman is not allowed with a priest and she saw what the Aide did kissing Resident #41 on the mouth in the hallway. The Aide told the resident she was not thinking those kinds of things. A statement from CNA #1, dated 9/24/16 indicated Activity Aide #1 had told her that Resident #10 said Resident #41 was a man of God and that she had seen Activity Aide #1 kissing him. She indicated Activity Aide #1 said that she had tried explaining to Resident #10 that she was not making out with him and had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	only kissed him on his cheek. She had told the Aide that when reporting something that had happened she should let a nurse know what had happened. A statement from RN #1, dated 9/24/16, indicated Resident #10 stated at the last music activity, Activity Aide #1 was telling Resident #41 that she loved him very much. The RN asked the resident if anything else happened and she indicated yes that the Aide was "making out" with Resident #41. She indicated she had asked what the resident meant by "making out" and the resident indicated the Aide was kissing on him. The RN asked if her if the Aide had kissed Resident #41 on the lips and the resident indicated she did not recall. A discussion with the Administrator, Director of Nursing (DON) and the Activity Director with Activity Aide #1 completed on 9/27/16 indicated they had asked the Aide what had prompted her to kiss Resident #41 and tell him that she loved him. The Aide indicated she gave him a kiss on his cheek by his ear like she would a grandfather, but did not tell him she loved him. She further indicated when her supervisor the Activity Director told her to stop kissing Resident #41 that she had stopped and didn't do it again. The DON had explained to the Aide that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	another resident had witnessed the incident and thought it was inappropriate for her to give a priest a kiss on the cheek. She explained to the Aide the need to protect the residents that have poor cognitive abilities. She explained the residents are protected classes just as children and as employees they cannot have personal contact with them, even though innocent, because it could be mistaken for something else by someone else and or the resident themselves. A discussion with the Administrator and Resident #41's Co-Guardian (also a priest) indicated he had been in the facility to give Resident #41 Communion and Activity Aide #1 had brought Resident #41 to him. She had given him a slight kiss on the cheek and said "I love you" and Resident #41 replied, "I love you too". The reportable incident follow up added on 9/29/16, indicated Resident #41's Co-Guardian stated the kiss was not done maliciously and just thought the Aide needed to be educated on the priesthood. Education for all staff would be performed for appropriate physical and personal boundaries while working with residents and how to respond to affection by a resident. The Abuse prohibition and reporting procedures would also be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	included in the in-service. The incident did not rise to the level of abuse but did require education and discipline. Interview with the Administrator on 10/13/16 at 3:06 p.m., indicated Resident #10 had reported to the Social Service #1 that Activity Aide #1 had kissed Resident #41 on the lips and Resident #10 believed it was inappropriate because Resident #41 was a priest. She stated Social Service #1 then reported this to the Activity Director. A couple days later, the Aide had a discussion with Resident #10 about the incident and the Aide had reported the discussion to RN #1. At this time RN #1 felt this was something she needed to report to the DON. She reported it to the DON and then the DON called the Administrator and an incident was reported. The Administrator stated that looking back, Social Service #1 and the Activity Director should have reported the allegation to her immediately but they did not because they did not believe it to be an allegation of abuse. They had educated the staff member and all staff about personal boundaries with residents. 3.1-28(c) 3.1-28(e)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow the facility's abuse policy, related to reporting an allegation of abuse to the Administrator immediately for 1 of 3 abuse allegations reviewed. (Resident #41) Finding includes: Record review for Resident #41 was completed on 10/13/16 at 2:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, psychosis, and paranoid delusions. The Quarterly Minimum Data Set (MDS) assessment completed on 8/22/16 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 0, which indicated the resident was severely cognitively impaired. An Indiana State Department of Health reportable Incident, dated 9/24/16, indicated Resident #10 had reportedly	F 0226	F 225 Investigate/Report Allegations/Individuals The 2 staff; Activity Director and Social Service designee were disciplined thru counseling for failing to report an allegation of abuse timely to the Administrator of the facility. See Sample # 1a &1b F 225 Further education and discipline will occur immediately for staff not reporting allegations of abuse in a timely manner. All facility staff were in-serviced on the types of abuse and the timely reporting to the Administrator any allegation (s) of abuse regardless of cognitive abilities of the resident reporting the allegation. See Sample #2 & #3 for F 225 During an allegation of abuse investigation interviews will be initiated with alert residents to determine if the potential allegation has affected other residents. See Sample # 4 & #5 for F225 During morning meeting the 24 hour report will be reviewed by the Unit Managers for potential	11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	confronted Activity Aide #1 about an incident that had occurred earlier in the week where Activity Aide #1 had kissed another resident. The reportable incident indicated Activity Aide #1 was sent home from the facility and suspended pending an investigation. The investigation included statements from staff members. A statement from Social Service #1 dated 9/24/16, indicated that prior to 9/24/16, Resident #10 had made a statement that Activity Aide #1 had been observed kissing another resident on the cheek and saying "I Love You". Resident #10 was concerned since the resident involved was a priest. Social Service #1 advised Resident #10 she would report the incident to the Activity Director. A statement from the Activity Director which did not include a date, indicated Social Service #1 told her Resident #10 had reported that she witnessed Activity Aide #1 kissing Resident #41 on the lips. Social Service #1 had asked the Activity Director if she thought that it could be true and the Activity Director said no, she did not think so, and Resident #10 was upset with Activity Aide #1 the evening prior. The Activity Director approached Activity Aide #1 approximately an hour		incidents of abuse and reported to the Administrator or her/his designee immediately. Daily rounding 4-5 days a week by the Administrator or his/her designee to be accomplished for one month then weekly rounding will occur to remind staff in learning circles concerning the immediate reporting to the Administrator or designee any allegation of abuse. See Sample #6 for F 225. Results of the daily and weekly rounding with staff will be reported monthly in QA along with any Allegations of abuse that were reported to ISDH. See Sample A for F 225	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	later and started to talk about the situation and the Aide quickly stated that Social Service #1 had already spoken to her about it. The Aide said she believed Resident #10 had it out for her. The Activity Director had told the Aide to avoid conflict with Resident #10 and to make sure no kisses were given to Resident #41. A statement from Activity Aide #1, dated 9/24/16, indicated while she was painting Resident #10's fingernails, the resident had asked her if she knew what a priest swears to when they become one. The Aide indicated she asked the resident what that was and the resident said that getting involved with woman is not allowed for a priest and she saw what the Aide did kissing Resident #41 on the mouth in the hallway. The Aide told the resident she was not thinking those kinds of things. A statement from CNA #1, dated 9/24/16 indicated Activity Aide #1 had told her Resident #10 said Resident #41 was a man of God and she had seen Activity Aide #1 kissing him. Activity Aide #1 said she had tried explaining to Resident #10 that she was not making out with him and had only kissed him on his cheek. CNA #1 had told the Aide that when reporting something that had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	happened she should let a nurse know. A statement from RN #1, dated 9/24/16, indicated Resident #10 stated that at the last music activity, Activity Aide #1 was telling Resident #41 that she loved him very much. The RN asked the resident if anything else happened and she said yes, the Aide was "making out" with Resident #41. She had asked what the resident meant by "making out" and the resident indicated the Aide was kissing on him. The RN asked if her if the Aide had kissed Resident #41 on the lips and the resident said she did not recall. A discussion with the Administrator, Director of Nursing (DON) and the Activity Director with Activity Aide #1 completed on 9/27/16 indicated they had asked the Aide what had prompted her to kiss Resident #41 and tell him that she loved him. The Aide gave him a kiss on his cheek by his ear like she would a grandfather, but did not tell him she loved him. When her supervisor, the Activity Director, told her to stop kissing Resident #41, she had stopped and didn't do it again. The DON had explained to the Aide that another resident had witnessed the incident and thought it was inappropriate for her to give a priest a kiss on the cheek. She explained to the Aide the need to protect the residents that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	have poor cognitive abilities. She explained the residents are protected classes just as children and as employees they cannot have personal contact with them, even though innocent, because it could be mistaken for something else by someone else and or the resident themselves. A discussion with the Administrator and Resident #41's Co-Guardian (also a priest) indicated he was there to give Resident #41 Communion and Activity Aide #1 had brought Resident #41 to him. She had given him a slight kiss on the cheek and said "I love you" and Resident #41 replied, "I love you too". The reportable incident follow up added on 9/29/16, indicated Resident #41's Co-Guardian said the kiss was not done maliciously and just thought the Aide needed to be educated on the priesthood. The reportable indicated education for all staff would be performed for appropriate physical and personal boundaries while working with residents and how to respond to affection by a resident. The Abuse prohibition and reporting procedures would also be included in the in-service. The incident did not rise to the level of abuse but did require education and discipline.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	Interview with the Administrator on 10/13/16 at 3:06 p.m., indicated Resident #10 had reported to Social Service #1 that Activity Aide #1 had kissed Resident #41 on the lips and Resident #10 believed it was inappropriate because Resident #41 was a priest. Social Service #1 then reported this to the Activity Director. A couple days later, the Aide had a discussion with Resident #10 about the incident and the Aide had reported the discussion to RN #1. At this time RN #1 felt this was something she needed to report to the DON. She reported it to the DON and the DON called the Administrator and an incident was reported. She further indicated that looking back, Social Service #1 and the Activity Director should have reported the allegation to her immediately but did not because they did not believe it to be an allegation of abuse. The facility had educated the staff member and all staff about personal boundaries with residents. A facility policy titled, "Abuse Prohibition And Incident Reporting Policy", and received as current from the Administrator indicated, "...Standards: 1. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	of the facility..." "...Types of incidents to report: ... iii. Any sexual contact involving a resident who lacks the ability to give consent because of cognitive impairment. 1. Examples:...kissing...." 3.1-28(a)			
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on observation, record review, and interview, the facility failed to ensure a resident was assessed correctly for physical restraints related to a activity lap tray for 1 of 15 residents whose records were reviewed. (Resident #17) Finding includes: On 10/13/16 at 11:19 a.m., Resident #17 was observed sitting in her wheelchair in the area near the Nurse's Station. An activity lap tray was observed in place to her wheelchair. The resident was coloring in a coloring book on the activity lap tray. On 10/14/16 at 12:29 p.m., Resident #17 was observed sitting in her wheelchair in the Main Dining Room. The activity lap tray was observed in place to her wheelchair. Her lunch food items were observed on the activity lap tray and a staff member was assisting her with eating. Resident #17's record was reviewed on	F 0272	F 272 Comprehensive Assessment OT was ordered prior to survey completion for review of the Activity Tray to wheel chair and wheel chair positioning. See Sample #1 for F 272 Pre-Restraint Assessment Completed See Sample #2 for F 272 IDT review with OT/POA/ Physician See Nursing Note Sample #3 for F 272 All residents assessed for possible restraint and this was done and completed 11-10-2016 with no further conerns. The DON and MDS Coordinator will audit and monitor resident assessments for all applicable care areas for all residents to ensure residents needs are met using (RAI) resident assessment instrument. Each assessment will be reviewed before locking and transmittal for accuracy . MDS Review Log - Sample #3a for F272 will be utilized with results reported in QA monthly x 6 months and then will be audited Quarterly with @ least 10 samples in the Quarter x's one	11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	10/1716 at 1:20 PM. Diagnoses included, but were not limited to, intellectual disability, seizures, and cerebrovascular accident (CVA, stroke). A Quarterly Minimum Data Set (MDS) assessment dated 7/29/16 indicated no restraints were used for Resident #17, she had no impairment to her upper extremities, and had impairment to both lower extremities. Review of the 10/2016 Physician's Order Summary indicated an order for "lap tray in wc (wheelchair)." Interview with Unit Manager #1 on 10/18/16 at 11:30 a.m. indicated the resident had the activity lap tray so she could do activities more easily on it such as coloring. The activity lap tray was not considered a restraint because the resident was unable to transfer on her own. The resident was able to move her upper extremities but was unable to remove the activity tray herself. Interview with the Director of Nursing (DON) on 10/18/16 at 12:12 p.m., indicated the resident was admitted to the facility in 2008 with the activity tray and it had not been assessed as a restraint. Therapy evaluated the resident when she got a new wheelchair in March 2015 and		year. Activity Tray Log See Sample #4 for F 272 which will be reviewed weekly by KON or her designee to ensure time of Activity Tray use does not exceed more than one hour at a time for the specific individual or 1:1 activities of coloring/looking at books/ playing with age appropriate toy's / or identifying stickers on tray. Not to exceed two separate hours/Activities (1:1/individual) a day with use of Activity Tray to wheel chair. After on month will review to possibly reduce Activity Tray for 1:1/individual activities and set resident at a table this will be monitored/assessed with out comes documented assessing for possible Psychosocial harm d/t reduction of Activity Tray use. Care Plans - Nursing/Social Services/ Activities adjusted as necessary and adjustments on-going. Staff will continue to praise and encourage resident R/T Activity Tray reduction. All Nursing and Activity staff will be in-serviced on this plan. Marshal Starke Developmental Services education provided for out of building activities. Physician Order changed to indicate Activity Tray to Wheel Chair for coloring, playing with toys, looking at Books and sticker identification during individual and 1:1 activities. Not to exceed one hour at a time and not to exceed two hours daily. See Sample #5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	did not consider the activity tray a restraint because the resident was unable to transfer herself. The resident was able to move her upper extremities, but was unable to remove the activity tray herself. 3.1-31(a)		for F272. Physical Restraint elimination assessment completed See Sample #6 for F 272 This process will be reported and discussed in QA monthly x's one year. See Sample A for F 272	
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview the facility failed to post the required daily staffing information correctly. This had the potential to affect all 54 residents in the facility. Finding includes: On 10/13/2016 at 9:03 a.m. the facility staffing sign was posted on the wall near the nurses station. The staffing sign was dated October 13, 2016. The staffing sign did not list the specific hours of each of the three shifts. On 10/14/16 at 9:10 a.m., the facility staffing sign was posted on the wall near the nurses station. The staffing sign was dated October 14, 2016. The staffing sign did not list the hours of each of the three shifts. On 10/17/16 at 10:02 a.m., the facility staffing sign was posted on the wall near the nurses station. The staffing sign was dated October 17, 2016. The staffing sign did not list the hours of each of the three shifts. On 10/18/16 at 8:12 a.m., the facility	F 0356	F 356 Nurse Staffing Information See Sample #1 for F 356 which was used prior to survey. See Sample #2 for F 356 Revised from(s) being used. See Sample #3,#4 for F356 separating each shift - indicating shift times instead of Days, Evenings and Nights. The DON or her designee will receive the new Nurse Staff information sheet weekly x's 3 months to ensure the revised form is being used. This will be reported in QA monthly x's 3 months. The DON or her designee will initial (right upper corner) of the form indicating form was checked The DON or her designee will randomly spot check the form quarterly and will initial (right upper corner) of the form indicating form was checked. This will be done x's one year with report in QA. See Sample A for F 356	11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	staffing sign was posted on the wall near the nurses station. The staffing sign was dated October 18, 2016. The staffing sign did not list the hours of each of the three shifts. When interviewed on 10/18/16 at 8:20:09 AM a.m., the facility Director of Nursing indicated the staffing sign should have been correctly posted each day. 3.1-17(a)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to distribute food under sanitary conditions related to a beverage uncovered during serving of the South Hall room trays. This had the potential to affect 1 of 16 residents who received room trays. The facility also failed to ensure kitchen sanitation was completed related to	F 0371	F 371 Food Procure: Store/Prepare/Serve/ Sanitary The opened boxes of food in the freezer were discarded the day it was found. The Ice Dispenser was cleaned by staff to eliminate the lime build up. All staff were educated on the policy and Procedure of covered foods during transport to the residents. The entire resident population has the potential to be affected by	11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	opened boxes of food in the freezer and a build up of lime on the ice dispenser in the kitchen. This had the potential to affect 53 of 54 residents who received food from the kitchen. (South Hall and Kitchen) Findings include: 1. During an observation of lunch service on 10/11/16 at 12:00 p.m., CNA #2 was observed removing a food tray from a cart on the South Hall. The tray contained a covered dish. The CNA proceeded to pour coffee into a cup and place it onto the tray and carry it down to the end of the hall to a resident's room. The CNA did not cover the coffee before carrying it down the hall. Interview with the CNA during the time of the observation indicated she should have covered the coffee with a lid before taking it down the hall and there were lids on the cart, but she had just forgotten to put one on the coffee cup. Interview with the Food Service Director on 10/12/16 at 1:30 p.m., indicated the CNA should have covered the coffee before carrying it down the hall and the carts have lids on them for beverages to be covered. 2. During the Kitchen Sanitation tour on 10/11/16 at 9:20 a.m. with the Food		the deficient practice of uncovered foods during transport, opened boxes of food in the freezer and build up of lime/contaminants on the ice dispenser. A Transporting Food and Beverages in-service was given to all staff. See sample #1 for F 371. A Kitchen Ice Dispenser Policy and Procedure in-service was given to all Dietary staff. See sample #2 for F371. The Food Storage Policy and Procedure was reviewed and an in-service was given to all Dietary staff concerning same. See sample #3 for F 371. Measures put into place to ensure the deficient practice does not recur. Audits were developed by the Dietary Manager for the ; Transporting of Food, Ice machine Cleaning and Proper Food Storage. See Samples #4,#5, #6 for F371. The Dietary Manager (DM) or designee will audit the room carts to make sure all food items and beverages are covered during transport 4-5 days week for 1 month, then reduce to 1-2 times a week and be on-going. An Ice Machine cleaning audit will be completed by the Dietary Staff 2x's daily and checked randomly by the DM for completion and will be on-going. A Proper Food Storage Audit will be performed 2x's daily by the Head Cooks for each food storage area with any deficient practice corrected and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	Service Director, the following was observed: a. There were boxes of hamburger patties and fish fillets in the freezer open to air. b. The water/ice machine's plastic dispenser was covered with lime build up. At that time the Food Service Director indicated it just gets wiped off. Interview with the Food Service Director on 10/12/16 at 12:38 p.m., indicated the boxes of food should have been covered, and that the water/ice machine was not on the cleaning schedule. The facility "General Food Preparation and Handling" policy was reviewed on 10/12/16 at 1:38 p.m. The policy was provided by the Food Service Director and identified as current. The policy indicated prepared food will be transported to other areas in covered containers and the kitchen equipment should be clean. The facility "Food Storage" policy was reviewed on 10/17/16 at 2:00 p.m., the policy was provided by the Food Service Director and identified as current. The policy indicated that all frozen foods should be covered.		recorded. The DM or her designee will do random checks 4-5 days a week for one month the 2x's a week on-going. The results of the DM audits will be reported to the QA Committee monthly for 6 months and if found to have no deficient practices in 6 months will discontinue reporting to QA. If deficient practices continue the reporting to QA will continue for 1 year until substantial compliance is met. See Sample A for F 371	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	3.1-21(i)(3)			
F 0465 SS=B Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional environment related to gouged, marred bathroom walls, and door frames on 4 of 4 units throughout the facility. (East, West, North, South) Findings include: During the Environmental tour on 10/17/16 at 2:10 p.m., with the Environmental Special Director, the following was observed: 1. East Unit: a. The door frame entering the bathroom was marred in room 5A. Two residents resided in this room. 2. West Unit: a. The bathroom wall was marred in room 3A. Two residents resided in this room.	F 0465	F 465 Safe/Functional/Sanitary Environment The door frames and marred walls and doors were repaired in room 5A of the East unity, room 3A in the West Unit, room 8B in the North unit, rooms 3B and 8A in the South unit by November 1, 2016. The entire building will be put on a monthly rotating schedule preformed by the Maintenance Assistant for maintaining a functional, sanitary and comfortable environment for residents, staff and the public. See Sample #1 a-e for F 465. Areas of the building will be identified and prioritized for repair from the Monthly room checks and the daily Work Orders (Maintenance Log) generated by the Housekeeping staff. See Sample #2 for F 465. The monthly rotating room checks and intermittent daily work orders generated by the Housekeeping staff through daily checks will be analyzed by the Maintenance Supervisor and the Administrator to determine if the repairs would best be done by In House staff or outside Contracted	11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

(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
	3. North Unit: a. The bathroom wall was gouged and marred in room 8B. Two residents resided in this room. 4. South Unit: a. The bathroom wall was gouged in room 3B. Two residents resided in this room. b. The bathroom wall was gouged and marred in room 8A. Two residents resided in this room. Interview with the Environmental Special Director at the time, indicated all of the above areas were in need of cleaning and/or repair. 3.1-19(f)		companies/individuals. Approximate time lines will be established for said repairs. The Maintenance Assistant will preform the monthly checks and report to the Maintenance Supervisor who will develop a maintenance repair schedule. Progress on the repairs will be reported at the daily morning meetings by the Maintenance Supervisor or his or her designee. The Administrator and the Maintenance Supervisor will meet weekly, to review the progress of current and future repairs and preform a walk through for visual confirmation to ensure all building areas are identified and maintained. See Sample #3 for F465 The results of the weekly meeting and walk through of the facility will be reported monthly at the QA meeting. See Sample A for F 465.	