STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/24/18 Facility Number: 000553 Provider Number: 155660 AIM Number: 100267430 At this Emergency Preparedness survey, Pulaski Health Care Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 58 certified beds. At the time of the survey, the census was 53. Quality Review completed on 01/26/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 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 provider's 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 implemented remedies	

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 -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0024 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Supervisor on 01/24/18 at 11:55 a.m., no policies and procedures that included the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on interview at the time of record review, the Maintenance Supervisor confirmed no documentation was available for review.	E 0024	that have been presented to date. **ISSUE: E024 Policies & Procedures – Volunteers and Staffing** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A policy and procedure has been developed to address the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. **2.HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. A policy and procedure has been developed to address the use of volunteers in an emergency or other	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. **1.WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Emergency Preparedness policies and procedures will be reviewed annually and updated as needed in accordance with 42 CFR 483.73. **1.HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Emergency Preparedness policies and procedures will be reviewed annually and updated as needed in accordance with 42 CFR 483.73. Results will be reported to the QAPI committee which will make any needed recommendations. The Administrator or her designee will be responsible for follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0026 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include: Based on record review on Maintenance Supervisor on 01/24/18 at 11:58 a.m., the emergency preparedness plan failed to include a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview at the time of record review, the Maintenance Supervisor confirmed no documentation was available for review.	E 0026	**1.BY WHAT DATE the systemic changes will be completed?** February 23, 2018 **ISSUE: E026 Roles under a Waiver declared by Secretary** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A policy and procedure addressing the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. **2.HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice.	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			A policy and procedure addressing the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. **1.WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Emergency Preparedness policies and procedures will be reviewed annually and updated as needed in accordance with 42 CFR 483.73. **1.HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Emergency Preparedness policies and procedures will be reviewed annually and updated as needed in accordance with 42 CFR 483.73. Results will be reported to the QAPI committee which will make any needed recommendations. The Administrator or her designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			will be responsible for follow up. **1.BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
E 0034 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Supervisor on 01/24/18 at 12:04 p.m., the emergency preparedness communication plan failed to include a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). Based on interview at the time of record review, the Maintenance Supervisor confirmed no other documentation was available for review.	E 0034	**ISSUE: E034 Information on Occupancy/Needs** **1.WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility maintains a Facility Assessment that contains information about the facility's occupancy, needs, and our ability to provide assistance, which can be given to the authority having jurisdiction of the Incident Command Center, or designee during an emergency. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			practice. The facility maintains a Facility Assessment that contains information about the facility's occupancy, needs, and our ability to provide assistance, which can be given to the authority having jurisdiction of the Incident Command Center, or designee during an emergency. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Facility Assessment will be reviewed annually and updated as needed. The Emergency Preparedness policies and procedures will be reviewed annually and updated as needed in accordance with 42 CFR 483.73. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** **Results will be reported monthly to the QAPI committee which will make any needed recommendations.** The Facility Assessment will be reviewed annually and updated as needed. The Emergency Preparedness policies and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			procedures will be reviewed annually and updated as needed in accordance with 42 CFR 483.73. Results will be reported to the QAPI committee which will make any needed recommendations. The Administrator or her designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
E 0035 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Supervisor on 01/24/18 at 11:35 a.m., the emergency preparedness communication plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). Based on interview at the time of record review, the Maintenance Supervisor confirmed no other documentation was available	E 0035	**ISSUE: E035 Sharing Plan with Patients** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives.	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for review.		**1.HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. The facility emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Emergency Preparedness policies and procedures will be reviewed annually and updated as needed in accordance with 42 CFR 483.73. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** **Results will be reported monthly to the QAPI committee**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING -- B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			which will make any needed recommendations. The Emergency Preparedness policies and procedures will be reviewed annually and updated as needed in accordance with 42 CFR 483.73. Results will be reported to the QAPI committee which will make any needed recommendations. The Administrator or her designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/24/18 Facility Number: 000553 Provider Number: 155660 AIM Number: 100267430 At this Life Safety Code survey, Pulaski Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101,	K 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility, consisting of the original building and a later addition was surveyed as one building since both were determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and resident rooms in the northeast wing. All other resident rooms are equipped with battery powered single station smoke detectors. The facility has the capacity for 58 and had a census of 53 at the time of this survey. All areas residents have customary access to were sprinklered. One detached equipment shed was unsprinklered. Quality Review completed on 01/26/18 - DA		Furthermore, the operation and licensure of the long term care facility and this Plan of Correction in its entirety, constitutes this provider's 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 implemented remedies that have been presented to date.	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 1 fire barrier walls was protected. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies. Table 8.3.4.2 requires 2 hour fire rated walls and partitions to have fire door assemblies with a rating of at least 1 1/2 hours fire rating. This deficient practice could affect staff and at least 9 residents. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 at 12:59 p.m., the Maintenance Supervisor identified the occupancy separation wall from the hospital. The cross corridor door did not have a resistive rating tag. Both sides of the door contained large windows without a fire resistive rating. The hospital side the of the wall did not contain drywall. Based on interview at the time of observation, the Maintenance Supervisor confirmed that cite plans were not available for review. 3.1-19(b)	K 0131	**ISSUE: K131 Multiple Occupancies – Section of Health Care Facilities** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The fire barrier wall separating the health care facility from the hospital has been repaired. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. All fire barrier walls have been examined to ensure they are intact. **3. WHAT measures will be put**	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			into place or what systemic changes will be made to ensure that the deficient practice does not recur? Fire barrier walls will be examined on a monthly basis by the Maintenance Supervisor or his designee to ensure they are intact. The Maintenance Supervisor will be re-educated on the importance of maintaining the fire barrier walls by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the examinations of the fire barrier walls weekly times four weeks and monthly thereafter by the Maintenance Supervisor or his designee. Results will be reported monthly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 1 of 3 corridors from obstructions per 19.2.1 LSC 19.2.1 states that every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and up to 10 residents. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 at 12:37 p.m., a large walled off sitting area was in the path of egress requiring occupants to walk around it near the Front Entrance. The pathway on one side contained a table. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged that impediments such as the table was a potential impediments to full use of the	K 0211	**ISSUE: K211 Means of Egress - General** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The table near the front entrance has been moved. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. All paths of egress have been examined to ensure full instant use in the case of fire or other emergency.	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	means of egress access corridors. 3.1-19(b)		**3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Paths of egress will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure full instant use in the case of fire or other emergency. The Maintenance Supervisor will be re-educated on the importance of maintaining the paths of egress by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the examinations of the paths of egress monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			5. BY WHAT DATE the systemic changes will be completed? February 23, 2018	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation, record review, and interview, the facility failed to ensure 8 of 8 exits had a code posted. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. LSC 19.2.2.2.5.2 requires door-locking arrangements	K 0222	**ISSUE: K222 Egress Doors** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 between 12:19 p.m. and 2:46 p.m., all exit doors were held in the locked position with a magnetic hold down device. Furthermore, the exit doors were equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. Each exit door contained two keypads. Each exit door contained a sign stating "Thank you for visiting Pulaski Health Care Center this year" and "2015" was posted in the corner. Based on an interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition and confirmed there was not a clinical need to lock any door. 3.1-19(b)		Eight of eight exit doors have codes posted. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. Exit doors have been examined to ensure that there are codes posted. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Exit doors will be examined on a regular basis to ensure that there are codes posted. The Maintenance Supervisor will be re-educated on the importance of maintaining codes for the exit doors by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			A preventative maintenance form will be used to document the examinations of the exit doors monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to maintain protection of 1 of 1 popcorn popper in the Main Dining room. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 at 2:07 p.m., the Main Dining room contained a popcorn popper. The single corridor door did not have a self-closing device installed. The double corridor doors failed to coordinate the doors. Based on interview at the time of observation, the Maintenance Supervisor confirmed the popcorn was popped in the Main Dining room and acknowledged the corridor doors. 3.1-19(b) 2. Based on observation and interview, the facility	K 0321	**ISSUE: K321 Hazardous Areas - Enclosure** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The popcorn popper is only used in the kitchen area. The double corridor doors for the main dining room has a door coordinator installed. An automatic closing device has been placed on the North East furnace room door. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to maintain protection of 1 of 1 North East Furnace room in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing. This deficient practice could affect staff and up to 4 residents. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 at 1:34 a.m., the North East Furnace room contained fuel-fire equipment. The corridor door did not have a self-closing device installed. Based on interview at the time of observation, the Maintenance Supervisor confirmed the corridor door did not self-close. 3.1-19(b)		All residents have the potential to be affected by the alleged deficient practice. The popcorn popper is only used in the kitchen area. All doors for hazardous areas have been examined to ensure they have an automatic closing device. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Activity Staff will be re-educated to ensure that the popcorn popper is only used behind the appropriate fire barriers by February 23, 2018. Doors for hazardous areas will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure they have automatic closing devices. The Maintenance Supervisor will be re-educated on the importance of having automatic closing devices on doors for hazardous areas by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			examinations of the doors for hazardous areas monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 at 1:05 p.m., the Kitchen contained a UL 300 hood system. Based on interview, the Dietary Manager was asked what she would do if there was a grease fire underneath the hood. She replied she grab the K class fire extinguisher then pull the fire alarm pull station. She failed to indicate pulling the Ansul hood pull station. Based on interview, the Maintenance Supervisor acknowledged her response and confirmed that he will instruct all kitchen staff on proper response. 3.1-19(b)	K 0324	**ISSUE: K324 Cooking Facilities** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Dietary staff will be re-educated in the use of the UL 300 hood system in the kitchen by February 23, 2018. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. Dietary staff will be re-educated in the use of the UL 300 hood system in the kitchen by February 23, 2018. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Dietary staff will be re-educated semi-annually on the use of the UL 300 hood system in the kitchen. An	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			annual fire drill specific to the use of the UL 300 hood system will be conducted by the Maintenance Supervisor or his designee. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** In-services will be monitored quarterly by the QAPI committee which will make any needed recommendations. Fire Drill Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure materials used as an interior finish on the walls at 1 of 1 Main Nurse's station had a flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method For Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect staff and up to 22 residents. Findings include: Based on observation with the Maintenance	K 0331	**ISSUE: K331 Interior Wall and Ceiling Finish** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Fire protectant will be applied to the wainscoting wood simulated panels at the nurses' station to ensure it has a flame spread classification of Class B by February 23, 2018. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. The facility has been inspected to ensure that other interior walls or ceilings have finishes in accordance with 19.3.3.1 LSC 101 10.2.3.4. **3. WHAT measures will be put**	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Supervisor on 01/24/18, the Main Nurse's station area contained wainscoting wood simulated panels. Based on interview at 2:46 p.m., the Maintenance Supervisor was unable to provide documentation for a flame spread classification of Class A or B. 3.1-19(b)		**into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Interior walls and ceilings will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure they have finishes in accordance with 19.3.3.1 LSC 101 10.2.3.4. The Maintenance Supervisor will be re-educated on the importance of interior walls or ceilings having finishes in accordance with 19.3.3.1 LSC 101 10.2.3.4. by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the examinations of the interior walls and ceilings monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			February 23, 2018	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with 19.3.5.1. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance	K 0351	**ISSUE: K351 Sprinkler System - Installation** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The zip ties have been removed from the sprinkler pipe in the attic above the Main Nurse's station.	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Supervisor on 01/24/18 at 2:35 p.m., two cables were zip tied around the sprinkler pipe in the attic above the Main Nurse's station. Based on interview at the time of observation, the Maintenance Supervisor confirmed the wire and zip tie on the sprinkler pipe. 3.1-19(b)		**2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. The sprinkler pipe in the attic has been inspected to ensure that it is not used to support non-system components. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Sprinkler pipe will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure that it is not used to support non-system components. The Maintenance Supervisor will be re-educated on the importance of not using sprinkler pipe to support non-system components by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			will be used to document the examinations of the sprinkler pipe monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the 1 of 1 ceiling construction. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff and up to 8 residents. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 at 12:49 a.m. then again at 1:35 p.m., two ceiling tiles were designed as a grate and allowed the passage of air in the North Hall. Then again, a ceiling tile was designed as a grate and allowed the passage of air in the North Hall. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the drop ceiling was not smoke resistive. 3.1-19(b)	K 0353	**ISSUE: K353 Sprinkler System – Maintenance and Testing** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The ceiling tile grates were replaced with solid smoke resistive ceiling tiles. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. The ceiling tiles in the facility were inspected to ensure that no other grates were in use. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Ceiling tiles will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure they are not designed as a grate. The	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Maintenance Supervisor will be re-educated on the importance of having solid smoke resistive ceiling tiles by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the examinations of the ceiling tiles monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
K 0372 SS=D Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff only. Findings include: Based on observations with the Maintenance Supervisor on 01/24/18 at 1:43 p.m., a three inch by three inch penetration in the North East attic smoke barrier was discovered. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)	K 0372	**ISSUE: K372 Subdivision of Building Spaces – Smoke Barrier Construction** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The smoke barrier wall at the North East attic smoke barrier has been repaired. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. The smoke barrier walls in the facility attic have been examined to ensure that they are intact.	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Smoke barrier walls will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure they are intact. The Maintenance Supervisor will be re-educated on the importance of having smoke barrier walls intact by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the examinations of the smoke barrier walls monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			5. BY WHAT DATE the systemic changes will be completed? February 23, 2018	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 3 sets of corridor doors would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect staff and up to 12 residents. Findings include: Based on observation with the Maintenance Supervisor on 12/21/16 at 6:01 p.m., the North East set of corridor smoke doors swing in the same direction with the one door equipped with an	K 0374	**ISSUE: K374 Subdivision of Building Spaces – Smoke Barrier Doors** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The North East set of corridor smoke doors has been equipped with a door coordinating device to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier.	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	astragal. The door set was not equipped with a door coordinating device to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor door set was not equipped with a coordinating device to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. 3.1-19(b)		**2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. Corridor smoke doors have been examined to ensure that all doors equipped with an astragal close last and form a smoke resistant barrier. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Corridor smoke doors will be examined on a monthly basis by the Maintenance Supervisor or his designee to ensure that all corridor smoke doors equipped with an astragal close last and form a smoke resistant barrier. The Maintenance Supervisor will be re-educated on the importance of having corridor smoke doors equipped with an astragal close last and form a smoke resistant barrier by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			be put into place? A preventative maintenance form will be used to document the examinations of the corridor smoke doors monthly by the Maintenance Supervisor or his designee. Results will be reported monthly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice	K 0712	**ISSUE: K712 Fire Drills**	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	affects all occupants. Findings include: Based on record review of the "Fire/ Safety Drill" form with the Maintenance Supervisor on 01/24/18 at 10:20 a.m., three sequential second shift fire drills took place between 5:08 a.m. and 6:33 p.m. for three of the last four quarters. Then again, four sequential third shift fire drills took place between 5:00 a.m. and 5:30 a.m. for four of the last four quarters. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the drills were not varied. 3.1-19(b) 3.1-51(c)		**1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A schedule has been developed for 2018 fire drills to ensure they are conducted at varied times. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. A schedule has been developed for 2018 fire drills to ensure they are conducted at varied times. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Fire Drills will be reviewed quarterly in the Safety Committee meeting to ensure they are conducted at varied times. The Maintenance Supervisor will be re-educated to the regulation related to conducting fire drills at expected and unexpected times under varying conditions, at least quarterly on each shift. **4. HOW the corrective action(s) will be monitored to ensure the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			deficient practice will not recur, i.e. what quality assurance program will be put into place? Fire Drills will be reviewed quarterly in the Safety Committee meeting to ensure they are conducted at varied times. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 candle was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 at 12:30 p.m. then again at 1:04 p.m., a candle with three wicks was discovered in the Administrator's office. Then again, a candle with a wick was discovered in the Medical Records office. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the wicks in each candle. 3.1-19(b)	K 0753	**ISSUE: K753 Combustible Decorations** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The candle was removed from the Administrator's office. The candle was removed from the Medical Records Office. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. Offices have been inspected to ensure that there are no candles with wicks in the facility. Staff will be re-educated on the requirement to not allow candles with wicks in the facility by February 23, 2018. **3. WHAT measures will be put into place or what systemic changes**	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			will be made to ensure that the deficient practice does not recur? Offices will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure that there are no candles with wicks in the facility. Staff will be re-educated on the requirement to not allow candles with wicks in the facility by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the examinations of the offices monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0781 SS=F Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation, interview, and record review, the facility failed to enforce 1 of 1 policy for the use of portable space heaters in accordance with 19.7.8. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Supervisor on 10/13/17 at 1:53 p.m., a space heater was discovered in the Assistant Director of Nursing office. Based on interview and record review at the time of observation, the Maintenance Supervisor acknowledged the space heater and confirmed that the facility's space heater policy does not allow space heaters in the facility. 3.1-19(b)	K 0781	**ISSUE: K781 Portable Space Heaters** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The portable space heater has been removed from the Nursing Office. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. Offices have been inspected to ensure that there are no portable space heaters in them. Staff will be re-educated on the requirement to not allow portable space heaters in the facility by February 23, 2018.	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Offices will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure that there are no portable space heaters in them. Staff will be re-educated on the requirement to not allow portable space heaters in the facility by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the examinations of the offices monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			February 23, 2018	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 multiplug adapter and 8 of 8 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute	K 0920	**ISSUE: K920 Electrical Equipment – Power Cords and Extension Cords** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** a) The surge protector in the front office has been removed.	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for fixed wiring of a structure. This deficient practice affects staff and up to 10 residents. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 between 12:30 p.m. and 2:37 p.m., the following was discovered: a) a surge protector was powering another surge protector powering computer equipment in the Front Office. The next desk over contained a a surge protector was powering another surge protector powering computer equipment. b) a surge protector was powering another surge protector powering Internet equipment in the Server room c) a surge protector was powering another surge protector powering computer equipment in the Activity Director's office d) a multiplug adapter powering electrical equipment in the attic above the Main Nurse's station. Additionally, an extension cord powering a shop light was discovered. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged and confirmed each aforementioned electrical code issue. 3.1-19(b)		b) The surge protector in the server room has been removed. c) The surge protector in the Activity Director's office has been removed. d) The multiplug adapter in the attic has been removed. The extension cord has been removed. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. The facility has been examined to ensure there are no other surge protectors, multiplug adapters or extension cords being used incorrectly. Facility staff will be re-educated on the proper use of surge protectors, multiplug adapters and extension cords by February 23, 2018. **3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Areas in the facility will be examined on a regular basis by the Maintenance Supervisor or his designee to ensure that surge protectors, multiplug adapters or extension cords are not being used	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			incorrectly. Facility staff will be re-educated on the proper use of surge protectors, multiplug adapters and extension cords by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the facility examination for surge protectors, multiplug adapters or extension cords monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported quarterly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic changes will be completed?** February 23, 2018	
K 0927 SS=D Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to protect 4 of 4 oxygen cylinders in the oxygen storage room. 2012 NFPA 99, Health Care Facilities Code, 11.6.2.3(11) requires freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor on 01/24/18 at 1:20 p.m., oxygen storage room had four oxygen cylinders that was freestanding on the floor. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the unprotected cylinders. 3.1-19(b)	K 0927	**ISSUE: K927 Gas Equipment – Transfilling Cylinders** **1. WHAT corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The oxygen cylinders have been properly chained or supported in a cylinder stand or cart. **2. HOW other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice. The oxygen room has been examined to ensure that oxygen cylinders are properly chained or supported in a cylinder stand or cart.	02/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			3. WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The oxygen room will be checked regularly to ensure that oxygen cylinders are properly chained or supported in a cylinder stand or cart. Staff will be re-educated on the proper storage of oxygen cylinders by February 23, 2018. **4. HOW the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** A preventative maintenance form will be used to document the oxygen room check weekly times four, monthly times three and quarterly thereafter by the Maintenance Supervisor or his designee. Results will be reported monthly to the QAPI committee which will make any needed recommendations. The Maintenance Supervisor or his designee will be responsible for follow up. **5. BY WHAT DATE the systemic**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 01 B. WING	01/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			changes will be completed? February 23, 2018	