STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	08/24/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 21, 22, 23 and 24, 2023. Facility number: 000553 Provider number: 155669 AIM number: 100267430 Census Bed Type: SNF: 5 SNF/NF: 45 Total: 50 Census Payor Type: Medicare: 3 Medicaid: 35 Other: 12 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/31/23.	F 0000	The preparation and execution of this Plan of Correction does not constitute admission or agreement, by the provider, of the alleged deficiencies, or the conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensure of the long-term care facility and this Plan of Correction in its entirety, constitutes this 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 is was in compliance with the requirements of participation. We are respectfully requesting a desk review to clear any and all proposed or implemented	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thelma Jean Fort	Administrator	09/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			remedies that have been presented to date.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure a resident's protective arm sleeves were applied as ordered by the physician, and discolorations were assessed and monitored for 2 of 3 residents reviewed for non-pressure skin condition. The facility also failed to ensure neurological checks were initiated following a fall for 1 of 2 residents reviewed for falls. (Residents 24, 42, and 7) Findings include: 1. On 8/21/23 at 2:40 p.m., Resident 24 was observed lying in bed in a hospital gown. The resident did not have any protective sleeves on either arm. There were multiple dark purple discolorations observed to both arms. On 8/22/23 at 10:12 a.m., Resident 24 was observed lying in bed in a hospital gown. The resident did not have any protective sleeves on either arm. The dark purple discolorations were still observed. On 8/23/23 at 2:18 p.m., Resident 24 was sitting up	F 0684	**Finding #1** **1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **A: An audit of the residents with tubigrip orders was completed. There are 4 residents with orders for tubigrips and only Resident #24 was not complete with the on/off tab in MatrixCare. This was corrected. Nursing department staff educated and the education has been added to the new hire orientation packet.** **2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?**	09/15/2023

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	in a recliner in her room. The resident was wearing a short sleeve shirt. There were no protective sleeves observed on either arm and the discolorations were still observed. Record review for Resident 24 was completed on 8/23/23 at 2:21 p.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, and dementia. The Admission Minimum Data Set (MDS) assessment, dated 8/19/23, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist with dressing. The resident had received an anticoagulant (blood thinning) medication. A Care Plan, dated 5/2/23 and revised 7/14/23, indicated the resident required assistance with ADLs (activities of daily living) due to a decline. An intervention included to observe skin condition with daily care. The August 2023 Physician's Order Summary (POS) indicated the following: - Eliquis (blood thinning medication) 2.5 mg (milligrams) twice a day - Tubi grips (protective sleeves) to both arms as tolerated every shift The August 2023 Treatment Administration Record (TAR) indicated, for the above dates of observation, the Tubi grips were checked off that they were applied. The record lacked any documentation the resident had refused or would not tolerate to wear them on the above dates of observation. Interview with CNA 2 on 8/23/23 at 2:53 p.m., indicated she had never applied Tubi grips on the		**A: The 4 residents that have orders for tubigrips have the potential to be affected. An audit of the residents with tubigrip orders was completed and only Resident #24 was not complete with the on/off tab in MatrixCare. This was corrected.** **3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?** **A: Tubigrip audit in place utilizing the "TUBIGRIP AUDIT" tool. Checking to ensure TAR documentation is correct with whether the residents have tubigrips on or off. Audit checks will be conducted by the DON or designee, 3 times per week x 12 weeks then 1 x per week for 12 weeks.** **Tubigrip education has been added to the new hire orientation packet.** **4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place?** **A: Audit results and any corrective action taken will be reported to the Quality Assurance Committee monthly.**	

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	resident and she was unaware the resident was supposed to wear them. Interview with LPN 1 on 8/23/23 at 2:55 p.m., indicated the resident had recently re-admitted to the facility from a hospital stay. The resident had received multiple discolorations to both her arms and hands while in the hospital due to needle sticks from blood draws and IV's. The resident was supposed to wear the Tubi grips on both her arms. The CNAs were responsible for putting the resident's Tubi grips on. If the resident refused them then they should let the nurse know. She indicated she should not have documented they were on when the resident was not wearing them. Interview with the Director of Nursing (DON) on 8/23/23 at 2:58 p.m., indicated nursing should be documenting if the resident was refusing or not able to tolerate the Tubi grips.2. Resident 42's record was reviewed on 8/23/23 at 3:56 p.m. Diagnoses included, but were not limited to, vascular dementia with anxiety, adult failure to thrive, and cervical disc degeneration. The Significant Change MDS assessment, dated 8/17/23, indicated the resident was moderately cognitively impaired for daily decision making. The resident required extensive assistance for bed mobility, transfer, toilet use, personal hygiene, and dressing. She had a history of falls without injury since admission or prior assessment. A Care Plan, dated 4/13/23, indicated the resident was at risk for falls. Interventions included, but were not limited to, remind and encourage call light use, proper footwear as indicated, observe for safety, and remind to call for assistance with mobility/transfers as needed.		**The QA Committee will review and make revisions as warranted on the basis of compliance.** **5.) By what date the systemic changes will be completed?** **A: 9-15-2023** **Finding #2** **1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **A: Resident 24 without noted harm. Interviewed the nurses that was working on the date of the missing neuro check form and was assured that the neuro checks were completed and the form must have been misplaced. Educated nurses on neuro checks and where the forms are to be placed upon completion.** **2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?** **A: Residents that have a fall have the potential to be affected. Educated nurses on neuro checks and where the forms are to be placed upon completion.**	

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	A Fall Event, dated 8/4/23 at 11:48 a.m., indicated the resident had an unwitnessed fall. The Physician and the resident representative were notified of the fall. A set of vital signs, including temperature, respirations, heart rate, blood pressure, and oxygen saturation, were obtained at the time of the fall. A Progress Note, dated 8/5/23 at 12:02 a.m., indicated the resident was observed laying on the floor beside her bed with blankets and pillows underneath her. A head to toe assessment was completed with no redness or injuries observed. The resident indicated she was sleeping and rolled out of the bed. The Physician and resident representative were updated and neurochecks were initiated. The record lacked documentation of completed neurochecks following the fall on 8/4/23. Interview with the Director of Nursing on 8/24/23 at 3:30 p.m., indicated the neurochecks should have been completed after an unwitnessed fall, but the staff were unable to locate the documentation. 3. Resident 7 was observed in her room on 8/21/23 at 10:18 a.m., there was bruising noted to the right forearm. The resident was unable to indicate how or when she acquired the bruise. On 8/23/23 at 10:18 a.m., the resident was observed sleeping in her recliner. The right forearm bruise remained and was darker in coloration. The resident's record was reviewed on 8/21/23 at 10:11 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), non-Alzheimer's dementia, heart failure, atrial		**3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?** **A: For all residents that require neuro checks after a fall, daily Audits will be conducted by the DON or designee x 6 months, utilizing the "NEURO CHECK" audit tool, to ensure neuro checks completed and form filed in proper location.** **4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place?** **A: Audit results and any corrective action taken will be reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the basis of compliance.** **5.) By what date the systemic changes will be completed?** **A: 9-15-2023** **Finding #3** **1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	

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	fibrillation (abnormal heart rhythm), arthritis, diabetes mellitus, muscle weakness, chronic obstructive pulmonary disease (COPD), and anemia (low iron). The Annual MDS (Minimum Data Set) assessment, dated 8/2/23, indicated the resident was impaired with decision making, received oxygen therapy, and was at risk for pressure ulcers and injuries. The resident required extensive assistance with one physical assist with bed mobility, transfers, dressing, toileting and personal hygiene. A Care Plan, with a revised date of 8/4/23, indicated the resident was at risk for bleeding and/or bruising related to taking an anticoagulant for atrial fibrillation. Interventions included, but were not limited to, administer medication as ordered, assess environment for needed changes, and provide gentle handling during care to avoid bruises/bleeding. A Physician's Order, dated 7/10/23, indicated to check for unusual bleeding and/or bruising. A Physician's Order, dated 7/26/23, indicated eliquis (blood thinner) 2.5 mg to be administered twice a day. Skin Assessments, completed weekly for July and August 2023, did not notate any right forearm bruise. Interview with the Director of Nursing (DON) on 8/24/23 at 1:48 p.m., indicated there was no documentation on the right forearm bruising. She measured the bruise and started an event note. 3.1-37(a)		**A: DON completed a skin assessment on Resident #7. An event completed in MatrixCare for Right forearm. investigation complete. POA, MD notified and care plan completed. Monitoring initiated. Dx: of purpura senilis received. Education was provided on the monitoring of skin discoloration.** **2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?** **A: An audit/skin sweep of all residents was conducted on 8-24-23 by the DON and Unit Manager to determine any noted skin concerns with no further concerns noted.** **3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?** **A: The DON or designee will conduct a skin sweep of 10 residents per week then every forth week a full building skin sweep will be conducted, utilizing the "SKIN SWEEP" audit tool, x 6 months.** **4.) How the corrective action(s)**	

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			will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place? **A: Audit results and any corrective action taken will be reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the basis of compliance.** **5.) By what date the systemic changes will be completed?** **A: 9-15-23**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was being administered at the correct flow rate for 1 of 1 residents reviewed for oxygen. (Resident 7) Finding includes: On 8/21/23 at 10:17 a.m., Resident 7 was observed.	F 0695	**1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **A: DON immediately adjusted O2 for resident #7. A Respiratory Care education**	09/15/2023

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	The resident was wearing oxygen via a nasal cannula with a flow rate set at 2.5 liters. On 8/23/23 at 10:18 a.m., Resident 7 was observed sleeping in her recliner. The resident was wearing oxygen via a nasal cannula with a flow rate set at 2.5 liters. On 8/23/23 at 11:25 a.m., Resident 7 was observed in her room wearing oxygen via nasal cannula with a flow rate set at 2.5 liters. On 8/23/23 at 3:10 p.m., Resident 7 was observed sitting in her recliner wearing oxygen via nasal cannula with a flow rate set at 2.5 liters. Resident 7's record was reviewed on 8/21/23 at 10:11 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), non-Alzheimer's dementia, heart failure, atrial fibrillation (abnormal heart rhythm), arthritis, diabetes mellitus, muscle weakness, chronic obstructive pulmonary disease (COPD), and anemia (low iron). The Annual Minimum Data Set (MDS) assessment, dated 8/2/23, indicated the resident was impaired with decision making, and received oxygen therapy. The resident required extensive assistance with one physical assist with bed mobility, transfers, dressing, toileting and personal hygiene. A Care Plan, with revised date 8/4/23, indicated the resident had COPD. Interventions included, but were not limited to, administer oxygen per the physician's order. A Physician's Order, dated 7/14/23, indicated oxygen at 2 liters per nasal cannula continuous		**was conducted with nursing staff.** **2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?** **A: All residents with O2 orders have the potential to be affected. DON conducted an audit of all residents with O2 orders to determine correct liters/minute with no further concerns. A Respiratory Care education was conducted with nursing staff.** **3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?** **A: DON or designee will conduct random audits across all shifts to ensure the O2 settings are correct 3x's per week x12 weeks the 1 x per week x 12 weeks utilizing the "OXYGEN LITER AUDIT" tool.**	

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	every shift as needed to maintain oxygenation greater than 90%. Interview with LPN 1 on 8/23/23 at 3:12 p.m., indicated the resident should be on 2 liters of oxygen and would go change the oxygen setting now. The Director of Nursing (DON) reviewed and changed the oxygen setting to 2 liters. 3.1-47(a)(6)		**4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place?** **A: Audit results and any corrective action taken will be reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the basis of compliance.** **5.) By what date the systemic changes will be completed?** **A: 9-15-23**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring;			

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	or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, related to not monitoring blood pressure and pulse before a blood pressure medication was administered for 1 of 5 residents reviewed for unnecessary medications. (Resident 32) Finding includes: Record review for Resident 32 was completed on 8/22/23 at 3:45 p.m. Diagnoses included, but were not limited to, hypertension, anxiety, depression, edema, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/11/23, indicated the resident was cognitively intact. A Care Plan, dated 9/21/22, indicated the resident had hypertension and was at risk for cardiac complications. Interventions included to administer medications as ordered and the vital signs were to be checked and monitored. The August 2023 Physician's Order Summary	F 0757	**1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **A: The DON immediately corrected by going into the Matrixcare system and turning on the Blood Pressure and Pulse tab for Resident #32. This ensures the nurse or QMA is alerted to check B/P and pulse and record it in the chart, prior to administering the medication. Education was provided to nursing staff.** **2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?** **A: DON performed an audit of all anti-hypertensive**	09/15/2023

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	(POS) indicated an order for metoprolol (treats high blood pressure) 50 mg (milligrams) twice a day. Hold the medication if the blood pressure was less than 100 or pulse was less than 55. The August 2023 Medication Administration Record (MAR) indicated the metoprolol was given on the following dates without checking the blood pressure and pulse before administration. Days: 8/1, 8/2, 8/3, and 8/12-8/22/2023 Evenings: 8/1, 8/2, 8/3, 8/4, and 8/11-8/22/2023 Interview with the Director of Nursing on 8/23/23 at 12:14 p.m., indicated the nurses had documented the blood pressure and pulse on some days in the vitals section in the computer. She would fix the order so the vitals section appeared with the medication order on the MAR. 3.1-48(a)(3)		**medications to determine if orders indicated B/P or pulse prior to administration. Resident #32 is the only resident with such order.** **3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?** **A: DON or designee will review all new anti-hypertensive orders when entered to determine if orders require vital signs prior to administration and turn on the appropriate tabs in the MatrixCare system. The new orders will be reviewed x 6 months and recorded on the "UNNECESSARY MEDICATION ANTI-HYPERTENSIVE" audit tool.** **4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place?** **A: Audit results and any corrective action taken will be**	

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			reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the basis of compliance. **5.) By what date the systemic changes will be completed?** **A: 9-15-2023**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment			

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	155660	A. BUILDING 00 B. WING	08/24/2023

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

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	conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			

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	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to staff not using personal protective equipment (PPE) while in a transmission based precautions (TBP) room during a random observation for infection control. (CNA 1) Finding includes: On 8/23/23 at 12:45 p.m., CNA 1 was observed entering a TBP room. There were signs on the door that indicated the resident was on contact and droplet isolation. PPE required was a gown, gloves, N-95 mask and face shield. The CNA entered the room and approached the resident without donning any PPE. The Unit Manager was in the hall and summoned the CNA from the doorway back into the hall. She indicated she needed to have worn PPE in the room. Interview with the CNA at that time, indicated she was aware she should have worn PPE. She began to don PPE at that time. The current document, "COVID-19 Emergency Plan, Policies and Procedures", indicated, "...Transmission Based Precautions:...2. Use personal protective equipment (PPE) appropriately, including gloves, face shield/	F 0880	**1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **A: DON and IP/Unit manager provided education and a disciplinary action to CNA 31, who has since terminated employment. CNA stated that the resident had tested negative the day before and she thought that the signage had not been taken down yet. DON and IP explained, although she did test negative for Covid-19 it is recommended that she remain in isolation for 2 more days. All Staff Education was conducted on wearing proper PPE and donning and doffing in rooms with Contact and Droplet precautions.** **2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will**	09/15/2023

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	goggles, and a gown...for all interactions that may involve contact with the resident or the resident's environment...." 3.1-18(b)		**be taken?** **A: All residents have a potential to be affected, if there are residents in facility who require Contact or Droplet precautions. All staff education was conducted. Continuous education and weekly spot checks when there are residents who require contact or droplet precautions.** **3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?** **A: All staff education was conducted. IP will conduct all staff education on wearing proper PPE and donning and doffing in rooms with Contact and Droplet precautions quarterly x 1 year and conduct weekly spot checks 5x per week if/when there are residents in the facility who require contact or droplet precautions within 1 year, utilizing the "Personal Protective Equipment (PPE Competency Validation" Audit Tool. This tool is included in the orientation process of all new hires with return**	

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			demonstration. **4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place?** **A: Audit results and any corrective action taken will be reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the basis of compliance.** **5.) By what date the systemic changes will be completed?** **A: 9-15-2023**	