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	09/06/2023

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 Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/06/23 Facility Number: 000553 Provider Number: 155660 AIM Number: 100267430 At this Emergency Preparedness survey, Pulaski Health Care Center was found in 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 50. Quality Review completed on 09/08/23	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 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
Jean Fort	Administrator	09/22/2023

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.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/06/23 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, 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. Due to rule out of the COVID-19 virus, resident rooms East #5 and West #4 were not surveyed. The facility has the capacity for 58 and had a census of 50 at the time of this survey.	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. 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	

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	All areas residents have customary access to were sprinklered. The facility also has one detached equipment shed that was unsprinklered. Quality Review completed on 09/08/23		are respectfully requesting a desk review to clear any and all proposed or implemented remedies that have been presented to date.	
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 detection system (or is constantly monitored at an attended location within the locked			

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	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 and interview, the facility failed to ensure the means of egress through 4 of 6 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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 unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be	K 0222	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: On 9/6/2023, The exit codes were posted by The following doors-NE, East, South and West (by laundry room).	09/22/2023

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	permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 36 residents, 8 staff and 4 visitors if needing to exit the facility. Findings include: Based on observations with the facility Administrator during a tour of the facility between 1:40 p.m. and 2:40 p.m. on 09/06/23, the following exit doors were marked as a facility exit, were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit: a. The exit door by resident rooms NE #5 and #6 b. The exit door by resident rooms E #7 and #8 c. The exit door by resident rooms S #9 and S #10 d. The exit door by the laundry area Based on an interview at the time of the observations, the facility Administrator stated the aforementioned facility exits were indeed marked as exits and could be opened by entering a four-digit code, but the code was not posted adding that they may have been removed by residents after they were posted. This finding was reviewed with the Administrator at the exit conference on 09/06/23 at 3:15 p.m. 3.1-19(b)		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 have the potential to be affected. All doors were checked and codes were immediately placed on exit doors that were missing the codes. 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: Maintenance will check the exit doors weekly x 4 weeks then monthly x 5 months to ensure the codes remain posted at the keypads of each exit door utilizing the audit tool labeled “Door Code Audit Tool.” Maintenance will replace the posted door codes when they are worn or unable to read. 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.	

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			5.) By what date the systemic changes will be completed? A: September 22, 2023	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 3 doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 10 residents, 2 staff and 2 visitors. Findings include: Based on observations with the facility Administrator during a tour of the facility at 1:56 p.m. on 09/06/23, the Northeast wing door to a secured courtyard was not posted with any type of signage to determine whether the door was an exit or not an exit. Based on interview at the time of the observations, the Administrator stated that	K 0293	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: On 9/6/2023, a temporary sign was posted at the Northeast wing door that stated “This is not an Exit.” 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 have the potential to be affected. All exit doors were checked and only the Northeast door was mislabeled. Permanent “Not an Exit” sign was ordered on 9/8/23 from Amazon. The sign was delivered and placed on the Northeast wing door. 3.) What measures will be put	09/22/2023

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	they were considering making the Northeast unit a dementia unit and agreed that the door to the courtyard is not an exit to the public way, and acknowledged the aforementioned door to the courtyard did not have an EXIT or NO EXIT sign posted. 3.1-19(b)		into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? A: Maintenance will check the exit doors weekly x 4 weeks then monthly x 5 months to ensure the correct exit/not an exit signage is posted, utilizing the audit tool labeled “Exit Door Signs 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 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: September 22, 2023	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance			

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	and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 heat detector was accessible for testing and was maintained in accordance with the applicable requirements of NFPA 72, 2010 Edition, National Fire Alarm Code Section 14.4.5 requires testing shall be performed in accordance with the schedules in Table 14.4.5 or more often if required by the authority having jurisdiction. Table 14.4.5 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. NFPA 72 Section 17.4.5, states initiating devices shall be installed in a manner that provides accessibility for periodic maintenance. This deficient practice could affect all occupants. Findings include: Based on record review with the facility Administrator on 09/06/23 at 11:30 a.m., the fire alarm annual testing paperwork entitled "Annual Fire Alarm and Signaling Inspection" completed on 05/17/23 conducted by the facility's vendor in the Heat and Other Detectors section states a "Heat Detector - Fixed Temp. located in the Attic above the Nurse's Station was not inspected or listed on the inspection form as N/I. This same device on the inspection document in 2022 had the same inspection status as N/I or not inspected. Based on an interview at the time of record review when the Administrator was asked why this particular device is not getting inspected, she stated that had no idea but would contact the vendor and ask for an explanation. This finding was reviewed with the Administrator at the exit conference on 09/06/23 at 3:15 p.m.	K 0345	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: On 9/6/2023, Administrator called Brenneco Fire Protection Company to inquire why the inspection report listed N/I on the heat detector above the nurses station. The representative was unsure and stated that she would have a technician out the next day (9/7/23) to inspect it. 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 have the potential to be affected. The Brenneco technician inspected the heat detector above the nurses station on 9/7/23 and it passed. An email confirmation was sent to Administrator of Pulaski Health Care Center along with the corrected inspection report. 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: Maintenance was educated on thoroughly reviewing the inspection reports from Brenneco to ensure there are no items failed	09/22/2023

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	3.1-19(b)		or not inspected and that the reports must be provided to Administrator upon receipt. 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: Administrator will review each report upon receipt and ensure that any failed or not inspected items are addressed immediately. The reports will be reviewed in the monthly Quality Assurance Meeting. 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: September 22, 2023	
K 0712 SS=F 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	K 0712	1.) What corrective action(s) will	09/22/2023

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	failed to document quarterly fire drills for 3 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review with the facility Administrator on 09/06/23 at 11:30 a.m., the following was noted: a) The fire drill conducted in the first quarter on 01/20/23 did not have a time that the drill was conducted listed on the "Fire Drill Report" document. b) The fire drill conducted in the second quarter on 04/30/23 did not have a time that the drill was conducted listed on the "Fire Drill Report" document. c) The fire drill conducted in the fourth quarter on 10/25/22 did not have a time that the drill was conducted listed on the "Fire Drill Report" document. Based on interview at the time of record review, the Administrator acknowledged that there were no times listed on any of the aforementioned fire drills and that she would speak to her Maintenance Director about it. This finding was reviewed with the Administrator at the exit conference on 09/06/23 at 3:15 p.m. 3.1-19(b) 3.1-51(c)		be accomplished for those residents found to have been affected by the deficient practice? A: The times were listed on the attendance signature section on the back side of the fire drill forms and Administrator pointed that out to the surveyor. On 9/6/2023, Administrator spoke to maintenance assistant to verify that the times listed on the back side of the forms were the correct times that needed to be recorded onto the front side of the form. Maintenance assistant verified and Administrator recorded the times that were listed on the back side of forms onto the front side of the forms. The times were available to the surveyor on the back side of the forms during the survey, just not on the front. 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: The fire drill forms were corrected immediately and an education was conducted with maintenance on completing both sides of the form completely after each fire drill. Administrator signature line has been added the fire drill forms. Administrator will review the form after each fire drill to ensure that the forms are completed and sign off.	

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			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: Maintenance was educated on completing both sides of the form after each fire drill. Administrator signature line has been added to the fire drill forms. Administrator will review/audit the form after each fire drill to ensure that the forms are completed before signing off. 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: Administrator will review/audit the form after each fire drill to ensure that the forms are completed. The completed fire drill forms will be reviewed in the monthly Quality Assurance Meeting **x 6months**. 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: September 22, 2023	