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	07/26/2024

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. This visit included the Investigation of Complaint IN00435619. Complaint IN00435619 - No deficiencies related to the allegations are cited. Survey dates: July 22, 23, 24, 25 and 26, 2024 Facility number: 000553 Provider number: 155660 AIM number: 100267430 Census Bed Type: SNF: 6 SNF/NF: 51 Total: 57 Census Payor Type: Medicare: 5 Medicaid: 39 Other: 13 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/31/24.	F 0000	=”” span=””> =”” span=””> =”” span=””> 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean Fort	Administrator	08/12/2024

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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			are respectfully requesting a desk review to clear any and all proposed or implemented remedies that have been presented to date.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessments were accurately completed related to antiplatelet medication use for 2 of 18 MDS assessments reviewed. (Residents 22 and 7) Findings include: 1. The record for Resident 22 was reviewed on 7/24/24 at 10:06 a.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease. The Quarterly MDS assessment, dated 6/4/24, indicated the resident had not received any antiplatelet medications in the past seven days. A Physician's Order, dated 7/6/23, indicated to give aspirin delayed release 81 mg (milligrams) daily. The Medication Administration Record (MAR), dated 6/2024, indicated the resident had received the aspirin medication daily. During an interview on 7/25/24 at 2:45 p.m., the MDS Coordinator indicated she had not coded aspirin as an antiplatelet medication. She coded	F 0641	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: R22 and R7 Minimum Data Set (MDS) comprehensive assessments were accurately completed related to the antiplatelet medication ordered. 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 who have orders for an antiplatelet medication have been identified. The MDS has been modified and completed with an accurate assessment for residents who receive antiplatelet medications. 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: Provided the MDS Coordinator	08/12/2024

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	the medications by the class and not by what they were used for, but she would look in to it. 2. The record for Resident 7 was reviewed on 7/24/24 at 10:54 a.m. Diagnoses included, but were not limited to, hypertension, congestive heart failure, and venous insufficiency. The Admission Minimum Data Set (MDS) assessment, dated 5/13/24, indicated the resident had not received any antiplatelet medications in the past seven days. A Physician's Order, dated 5/7/24, indicated to give aspirin (an antiplatelet medication) 81 milligram tablet daily. The Medication Administration Record (MAR), dated 7/2024, indicated the resident had received the aspirin tablet daily. During an interview on 7/25/24 at 4:15 p.m., the Director of Nursing indicated the aspirin should have been coded correctly on the MDS and provided no further information. 3.1-31(i)		with education on proper MDS coding of antiplatelet and anticoagulant medication. The care plan coordinator will review the daily order report to identify any new orders for antiplatelet medications and an MDS comprehensive assessment will be accurately completed related to the antiplatelet medications. 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: The Director of Nursing or designee will conduct an audit weekly of all MDS submissions to ensure compliance. These audits will be conducted weekly x 8weeks, then monthly x 4 months. Audit results will be reviewed and discussed in QA monthly during the 6 month duration. 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: 8/12/2024	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

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	and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the			

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	comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed and in place for anticoagulant and antiplatelet medication use for 1 of 18 resident care plans reviewed. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 7/24/24 at 10:54 a.m. Diagnoses included, but were not limited to, hypertension, congestive heart failure, and venous insufficiency. The Admission Minimum Data Set (MDS) assessment, dated 5/13/24, indicated the resident had received an anticoagulant medication in the past seven days. The resident had not received any antiplatelet medications in the past seven days. A Physician's Order, dated 5/7/24, indicated to give aspirin (an antiplatelet medication) 81 milligram tablet daily. A Physician's Order, dated 5/7/24, indicated to give apixaban (an anticoagulant medication) 5 milligrams twice daily. The Medication Administration Record (MAR), dated 7/2024, indicated the resident had received the aspirin and apixaban as ordered. During an interview on 7/25/24 at 4:15 p.m., the Director of Nursing indicated there should have been a care plan in place for anticoagulant and antiplatelet medications, including monitoring for side effects of the medications.	F 0656	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: R7 comprehensive care plan has been developed and in place to include aspirin as an anticoagulant and antiplatelet medication. 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 who have orders for aspirin have been identified. The care plans of residents who receive aspirin therapy have been developed and are in place to indicate aspirin as an anticoagulant and antiplatelet medication. 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 care plan coordinator and MDS coordinator has been educated on ensuring care plans are developed and in place for aspirin therapy as an anticoagulant and antiplatelet medication. The care plan coordinator will review the daily	08/12/2024

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	3.1-35(a)		order report and identify any new orders for aspirin therapy. A care plan will be developed and put in place to indicate the usage as an anticoagulant and antiplatelet medication. 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: The Director of Nursing or designee will conduct an audit weekly to ensure compliance. These audits will be conducted weekly x 8 weeks, then monthly for 4 months. Audit results will be reviewed and discussed in QA monthly during the 6 month duration. 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: 8/12/2024	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and			

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	§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment to prevent contractures (a fixed shortening or hardening of muscles or tendons) or decreased range of motion, related to passive range of motion not completed as recommended and a splinting device not in place as ordered for 2 of 2 residents reviewed for range of motion (ROM). (Residents 14 and 12) Findings include: 1. On 7/22/24 at 1:59 p.m., Resident 14 was observed in her bed. She indicated she was paralyzed from the waist down. She was afraid of her legs becoming contracted because she was not getting any type of range of motion (ROM) exercises. The resident's record was reviewed on 7/23/24 at 2:42 p.m. Diagnoses included, but were not limited to, acute transverse myelitis disease of the central nervous system, Diabetes Mellitus and chronic pain. The Quarterly Minimum Data Set assessment, dated 6/22/24, indicated the resident was cognitively intact and dependent on staff for	F 0688	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: R14 -Order received to reassess resident for therapy services post hospitalization, R14 refused. R14 has orders for passive range of motion to upper and lower extremity. Resident to receive passive range of motion (PROM) daily as ordered. R12 carrot splinting device or a securely fitted wash cloth has been worn as ordered. R12 care plan dated 7/11/23 did indicate “Allow to refuse and vent feelings.” The care plan has been updated to include that he will remove the carrot splinting device and securely fitted wash cloth at will and encourage to wear when removed. 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?	08/12/2024

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	toileting and transfers, and required substantial/ maximum assist for bed mobility. The resident received Physical Therapy (PT) services from 3/14/24-5/29/24. The PT Discharge Summary indicated skilled interventions provided were addressing core strength and seated balance, bed mobility, trunk ROM and LE (lower extremities) ROM and training of caregivers with LE ROM program. Discharge recommendations were 24-hour care and home exercise program with upper extremities and lower extremities ROM with assist of CNAs. During an interview on 7/24/24 at 2:20 p.m., QMA 1 indicated some residents received ROM, but Resident 14 did not, she was only on the turning and repositioning program. During an interview on 7/26/24 at 9:00 a.m., PT Aide 1 indicated recommendations for Resident 14 made at discharge were to do ROM to the lower extremities and splinting was not recommended at that time. Recommendations were either made verbally or by communication sheets to nursing staff. During an interview on 7/26/24 at 9:10 a.m., the Director of Nursing indicated ROM should be documented in the Point of Care tasks in the computer and there was nothing documented for Resident 14. During an interview on 7/25/24 at 1:30 p.m., the Administrator indicated the resident would be re-evaluated by PT. 2. During an interview on 7/22/24 at 1:15 p.m., Resident 12 indicated he usually had a carrot (splinting device for contractures) in his left hand, however he was unable to find it so he was not		A: All residents who have orders and recommendations via therapy services have been identified and orders are in place and treatment provided as ordered. 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: Nursing department staff educated on performing range of motion (ROM) as ordered and prevention of contractures and decreased range of motion. Therapy services will provide the nursing department all discharge recommendations via a communication tool. The licensed nursing staff will ensure all orders are in place. CNA's are provided a list of all residents who are to receive ROM and/or splinting. The CNA's will document the services provided daily. 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: The Director of Nursing or designee will review/audit the CNA ROM/splinting documentation weekly to ensure compliance. These audits will be conducted weekly x 8 weeks, then monthly x 4 months. Audit results will be reviewed and discussed in QA	

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	holding the carrot at the time. His left hand was noted to be contracted. On 7/23/24 at 11:27 a.m., Resident 12 was observed in a wheelchair at a table in the dining room. His left hand was contracted and there was no carrot or washcloth observed in his hand. On 7/24/24 at 10:57 a.m., Resident 12 was observed in a wheelchair self-propelling in the hallway. His left hand was contracted and there was no carrot or washcloth observed in his hand. On 7/26/24 at 10:17 a.m., Resident 12 was observed in a wheelchair self-propelling in the hallway. His left hand was contracted and there was no carrot or washcloth observed in his hand. He indicated at the time, if a washcloth was used instead of the carrot, the washcloth would occasionally fall out of his hand. Resident 12's record was reviewed on 7/24/24 at 2:40 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness or paralysis of one side of the body) of the left nondominant side and contracture of the left hand, wrist, and elbow. The Annual MDS assessment, dated 7/2/24, indicated the resident was cognitively intact for daily decision making and had impairment and limited range of motion to one side on both the upper and lower extremities. A Physician's Order, dated 10/12/23, indicated the resident wore a carrot, palm protector, or rolled washcloth to the left hand every shift. A Care Plan, dated 7/11/23, indicated the resident had a contracture to the left hand, arm, and foot. Interventions included, but were not limited to,		monthly during the 6 month duration. 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: 8/12/2024	

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	apply carrot to the left hand or rolled wash cloth removing for meals, range of motion, or washing, and allow to refuse and vent feelings. During an interview on 7/24/24 at 2:52 p.m., CNA 1 indicated the resident had a contracture to the left hand and wore some type of splinting device to that hand at all times. During an interview on 7/26/24 at 10:10 a.m., the Director of Nursing indicated sometimes the resident did remove the splinting devices on his own, however that was not care planned at the time and would be added to his care plan. 3.1-42(a)(2)			
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; 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			

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	§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 adequate monitoring was in place for a resident receiving scheduled opioid medication (pain medication) for 1 of 5 residents reviewed for unnecessary medications. (Resident 24) Finding includes: Resident 24's record was reviewed on 7/23/24 at 12:21 p.m. Diagnoses included, but were not limited to, fracture of the left femur, dementia, and osteoarthritis. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 6/10/24, indicated the resident was severely cognitively impaired for daily decision making. The resident received scheduled pain medication in the last 5 days and received an opioid medication. A Physician's Order, dated 5/30/24, indicated to give hydrocodone-acetaminophen (an opioid pain medication) 5-325 milligram tablet twice a day. The June 2024 Medication Administration Record indicated the resident received the hydrocodone-acetaminophen tablet as ordered. A Care Plan, dated 5/1/24, indicated the resident was at risk for pain related to osteoarthritis, decreased mobility, and recent left hip fracture with surgical repair. Interventions included, but were not limited to analgesics as ordered and attempt non-pharmacological interventions as needed.	F 0757	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: R24 scheduled opioid pain medication order was changed to PRN due to non-use. R24 has an order for a non-opioid medication that has been effective with relief indicated. 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 who have orders for scheduled opioid pain medication have been identified. Monitoring for side effects of the opioid pain medication has been added to orders and care plans. 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 licensed nursing staff educated on monitoring for side effects of opioid pain medications and provided a chart of opioid medications and side effects. These charts will remain on medication carts for review as needed. Licensed nursing staff will include the monitoring of side	08/12/2024

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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
	There were no orders or a care plan related to opioid side effect monitoring. During an interview on 7/26/24 at 10:10 a.m., the Director of Nursing indicated there should be a care plan or order for side effect monitoring for an opioid medication. She was unable to provide any further information. A Policy titled, "Pain - Clinical Protocol," indicated "...Monitoring...4. The staff and physician will monitor for adverse effects of pain medications such as gastrointestinal bleeding from nonsteroidal anti-inflammatory drugs (NSAIDs), and anorexia, confusion, lethargy, severe constipation related to opioids. a. The physician will adjust or discontinue medications accordingly, based on effectiveness and side effects..." 3.1-48(a)(3)		effects on any new order received by physician for opioid pain medication. The care plan coordinator will review new orders daily and for new opioid pain medication orders, will careplan the medication to include monitoring of side effects. 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: The Director of Nursing or designee will complete a medication review/audit weekly to ensure compliance. These audits will be conducted weekly x 8 weeks, then monthly x 4 months. Audit results will be reviewed and discussed in QA monthly during the 6 month duration. 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: 8/12/2024	