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	02/04/2025

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00449796 and IN00451233. Complaint IN00449796 - Federal/State deficiencies related to the allegations are cited at F686. Complaint IN00451233 - Federal/State deficiencies related to the allegations are cited at F686. Unrelated deficiency is cited. Survey dates: February 3 & 4, 2025 Facility number: 000553 Provider number: 155660 AIM number: 100267430 Census Bed Type: SNF/NF: 45 SNF: 5 Total: 50 Census Payor Type: Medicare: 5 Medicaid: 34 Other: 11 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/7/25.	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	02/21/2025

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 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services to promote healing, related to treatments not completed as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident D) Finding includes: During an observation and interview on 2/3/25 at 1:55 p.m., CNA 1 and CNA 2 entered Resident D's room to provide incontinence care. The CNA's assisted the resident to turn onto her left side. Resident D had a urinary catheter and the pad underneath the resident was soiled with urine. The resident indicated her urine would sometimes leak around the catheter. CNA 2 indicated the resident had pressure ulcers on the right and left upper back thigh. The areas on the posterior thighs were observed to be open and not covered with dressings. CNA 2 observed the soiled pad that was being removed and indicated the dressings were not found on the soiled pad. During an observation and interview on 2/3/25 at 2:05 p.m., the Director of Nursing (DON) indicated there were no dressings covering the pressure areas on the bilateral posterior thighs. CNA 2 indicated when she had provided care earlier, she had not "paid attention" and was unsure if the dressings were on the pressure areas at the time of the earlier care. CNA 2 indicated she was unsure how long the dressings had not been on	F 0686	**I How corrective action will be accomplished for those residents found to have been affected by the deficient practice;** R. G was immediately cleansed and pericare was rendered. R.G foley cathater was repositioned, orders were reviewed, dressing was applied per the physicians order with the plan of care in place. E 1 was reeducated on proper notification and wound prevention. **II How the facility will identify other residents having the potential to be affected by the same deficient practice;** Residents with wounds have been identified. The licensed staff will continue to ensure dressings are in place as ordered by the physician. The nursing assistant will continue to be responsible for immediately notifying the nurse of a dressing that has come off or an open area identified as care is being rendered. The licensed staff will continue to conduct skin assessments weekly, upon admission and as needed. Orders will be put in place and the plan of care updated if an area is	02/21/2025

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	the open areas. Resident D's record was reviewed on 2/4/25 at 1:30 p.m. The diagnoses included, but were not limited to, transverse myelitis and diabetes mellitus. A Care Plan, dated 10/23/24, indicated a pressure ulcer to the right posterior thigh. The interventions included the treatment and dressing would be completed to the wound as ordered. An Annual Minimum Data Set assessment, dated 11/7/24, indicated an intact cognitive status, was dependent for bed mobility and toileting, had a urinary catheter, was always incontinent of bowel, had one stage two (partial thickness of skin/shallow open ulcer) and one stage three (full thickness tissue loss) pressure ulcer. A Care Plan, dated 11/20/24, indicated a pressure ulcer was present on the the left posterior thigh. The interventions included the treatment and dressing would be completed to the wound as ordered. The Physician's Orders, dated 1/22/25, indicated the right and left posterior thighs were to be cleansed with normal saline, collagen (wound dressing) was to be applied to the wound beds and a bordered gauze was to be applied to cover the wound. The treatments were scheduled every evening at bedtime. This citation relates to Complaints IN00449796 and IN00451233. 3.1-40(a)		identified upon assessment. **III What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not occur;** Nursing staff will be re-inserviced on wound prevention to prevent worsening wounds and ensure the necessary treatment and services are rendered to promote healing. **IV How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected and will not recur;** The Don/Designee will conduct observational wound rounds to ensure dressings are in place 3x weekly x4 weeks, then twice weekly x 4 weekly, then weekly, on-going and as needed to ensure compliance. All noncompliant issues will be reviewed and discussed in QA monthly x 3 or until compliance is met. **Compliance Date; 2/21/25**	
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (CNA 1 and CNA 2) when providing care to residents (Resident G and Resident D) who were in Enhanced Barrier Precautions (EBP), for two random observation for infection control. Finding includes: 1. During an observation and interview on 2/23/25 at 1:45 p.m., CNA 1 and CNA 2 had transferred Resident G from the chair to the bed. A mechanical lift had been utilized. The resident had a urinary catheter. There was a sign on the room door that indicated EBP was to be used. CNA 1 and CNA 2 were observed with gloves on. Gowns were not being worn. CNA 2 indicated gowns were only needed if they were providing urinary catheter care. Resident G's record was reviewed on 2/4/25 at 3:42 p.m. The diagnoses included, but were not limited to, obstructive reflux uropathy. A Physician's Order, dated 8/10/24, indicated EBP was to be implemented for all high contact resident care activities due to the indwelling urinary catheter. A Minimum Data Set assessment, dated 12/10/24, indicated an intact cognitive status, a urinary catheter was present, and there was one stage two (partial thickness) pressure area present. A Care Plan, dated 1/22/25, indicated a pressure area was present on the left ischium and EBP was to be utilized during care.	F 0880	**I How corrective action will be accomplished for those residents found to have been affected by the deficient practice;** E 1 and E 2 were immediately reeducated on Enhance Barrier Precaution and the importance of wearing Personal Protective Equipment (PPE) while rendering care to those who requires it. R. D and R.G have had proper donning and doffing of PPE as needed during care. **II How the facility will identify other residents having the potential to be affected by the same deficient practice;** All residents have the potential to be affected. **III What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not occur;** Nursing staff will be re-inservied on Enhance Barrier Precaution to ensure the correct Personal Protective Equipment is used when providing care to residents who requires it. **IV How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected and will not recur;**	02/21/2025

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	2. During an observation and interview on 2/3/25 at 1:55 p.m., CNA 1 and CNA 2 entered Resident D's room to provide incontinent care. The CNAs washed their hands and applied gloves. They started to provide care and were stopped. CNA 2 indicated a gown only had to be used if they were providing catheter care or wound care. The CNAs then utilized the PPE indicated for EBP. Resident D's record was reviewed on 2/4/25 at 1:30 p.m. The diagnoses included, but were not limited to, transverse myelitis and diabetes mellitus. A Physician's Order, dated 6/27/24, indicated EBP was to be implemented for all high contact resident care activities due to the indwelling urinary catheter. A Care Plan, dated 10/23/24, indicated a pressure ulcer to the right posterior thigh. The interventions included Enhanced Barrier Precautions were to be used with care. An Annual Minimum Data Set assessment, dated 11/7/24, indicated an intact cognitive status, was dependent for bed mobility and toileting, had a urinary catheter, was always incontinent of bowels, had one stage two (partial thickness of skin/shallow open ulcer) and one stage three (full thickness tissue loss) pressure ulcer present. A Care Plan, dated 11/20/24, indicated a pressure ulcer was present on the the left posterior thigh. The interventions included EBP was to be used with care. During an interview on 2/3/25 at 2:10 p.m. the Director of Nursing (DON) indicated the staff		The Don/Designee will conduct observational rounds to ensure proper PPE is worn for residents who requires advance barrier precautions 3x weekly x4 weeks, then on-going twice weekly and as needed to ensure compliance. All noncompliant issues will be reviewed and discussed in QA monthly x 3 or until compliance is met. **Completion Date;** 2/21/25	

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	have been educated on the use of EBP. A facility policy, dated 2024, and received from the DON as current, indicated EBP (gowns and gloves) were to be used during high-contact resident care activities, which included dressing, bathing/showering, transferring, hygiene, linen changes, brief changes, bathroom assistance, device care or use (central line, urinary catheter, feeding tube) and wound care. 3.1-18(b)			