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	09/04/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 a Recertification and State Licensure Survey. Survey dates: August 31, September 1, 2, 3, & 4, 2015 Facility number: 000553 Provider number: 155660 AIM number: 100267430 Census bed type: SNF: 5 SNF/NF: 51 Total: 56 Census payor type: Medicare: 4 Medicaid: 34 Other: 18 Total: 56 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed by 26143, on September 10, 2015.	F 0000	The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency The Plan of Correction is prepared and executed solely because it is required by the provisions of the 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 licensor of the long term care facilities, and this plan of correction in its entirety, constitutes this provider's allegation of compliance Completion dates are provided for the procedural preceding 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 under the opinion it was in the requirements of participation or that the corrective action was necessary We are	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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			requesting a desk review to clear any and all proposed or implemented remedies that have been presented to date	
F 0246 SS=D Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview, the facility failed to ensure a resident's call button was in reach for 1 of 30 residents observed during Stage 1. (Resident #11) Finding includes: On 9/1/15 at 10:18 AM, Resident #11 was observed resting with her eyes closed in her bed and the call button was lying on the floor next to the bed. On 9/0/15 at 1:42 PM, Resident #11 was observed awake in bed after lunch. Her call button was lying on the floor next to the bed. On 9/1/15 at 2:29 PM, Resident #11 was observed resting in bed with her eyes closed. The call button remained in the same position on the floor next to the bed.	F 0246	F-246 Resident #11 call light was attached to hand rail of her bed in her room per nurse when noted to be on the floor. Resident #11 had no ill effect from the deficiency cited. All call lights were checked for every resident and all were within reach in rooms on 09-01-15. A memo 09-01-15 signed by all staff - that stated "I acknowledge the importance that call lights are within reach in the room@ all times as part of my daily duties. I should be looking for the call lights to ensure that they are within reach during my rounds. If not within reach or on floor etc, I will put in a place accessible to those residents I have the ability to ask questions." Quality Assurance- The Director of Nursing or her designee will make random audit (attached exhibit a) rounds throughout the week (@ least three) & on various shifts to ensure that call lights are within resident reach in rooms. The	10/04/2015

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	On 9/1/15 at 2:30 PM, Resident #11 was observed with the Administrator. The resident was still lying in bed and the call button remained on the floor. On 9/2/15 at 12:30 PM, Resident #11 was observed eating a chicken leg independently in the NE hall dining room. On 9/4/15 at 9:39 AM, Resident #11 was observed walking independently with her walker down the hallway. Interview with the Administrator at the time of the observation on 9/1/15, indicated Resident #11's call button should have been placed in reach of the resident and attached somewhere where it wouldn't slide to the floor. A policy titled "Pulaski Health Care Center Call Light Policy" was provided on 9/1/15 at 3:10 PM and deemed as current. The policy indicated, " .... Procedure: 1. Explain the reason and functioning of the call light to the resident. 2. Ensure that all residents (even those who are confused) have access to the call signal at all times and know how to use it ...." 3.1-3(v)(1)		outcome of these rounds will be reported in QA every month x's six (6) months and if no noted concerns will continue to be checked during random rounds. If no noted deficiencies the QA reporting will be stopped If deficiencies occur the reporting to QA will continue for 1 year until no deficiencies occur	

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F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure follow up dental services were scheduled and provided timely for 1 of 1 resident reviewed for dental status and services of the 1 resident who met the criteria for dental status and services. (Resident #34) Finding includes: On 9/1/15 at 11:08 AM, Resident #34 was observed to have some missing and jagged teeth on the top and bottom of her mouth. Resident #34's record was reviewed on 9/3/15 at 10:23 AM. Diagnoses included, but were not limited to, hypertension, senile dementia, situational anxiety, anemia, hypothyroidism, reflux, and chronic kidney disease. Review of Resident #34's quarterly MDS (Minimum Data Set) assessment dated	F 0250	F-250 Corrective actions accomplished for those residents found to have been affected by the deficient practice. Resident #34 was seen by Primesource Dentistry on 9-3-2015 for the follow -up appointment. (Dental Appointment and report attached Exhibit b) Corrective actions taken for other residents identified as having the potential to be affected by the same deficient practice: The Social Service Director performed an audit of all residents' ancillary appointments (Dental, Podiatry, Audiology, and Vision) and found no other deficiencies. Measures/Changes put into place Social Services will track all ancillary appointments (Dental, Podiatry, Audiology, and Vision) for all residents. Social Services will make sure that annual and follow-up appointments are completed on time for all residents. (Tracking reports attached exhibit c) Corrective actions will be monitored to ensure the deficient practice will	10/04/2015

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	7/29/15 indicated the resident was severely cognitively impaired. Review of the Oral Care Flow sheet dated July 2015 indicated, "I have: a few teeth, assist me with oral care ...." Review of Dental Exam records dated 2/5/15 indicated Resident #34 had multiple missing, "cracked & mobile" teeth to her upper and lower mouth. Tooth notes indicated, "periodic exam pt. (patient) oral hygiene is poor moist tissue is slightly red and swollen." Treatment plan indicated to follow up in six months. The record lacked any indication a dental exam had been performed for Resident #34 since 2/5/15. Interview with the Social Services Director (SSD) on 9/3/15 at 1:39 PM, indicated Resident #34 had not been seen by dental services since 2/5/15. She further indicated Resident #34 should have been seen by the dentist in August and was also not currently on the September list to be seen. The SSD also indicated it was her responsibility to ensure necessary services were obtained for residents, including dental, and would start to keep her own calendar of when services were due.		not recur through QA program: These new measures of Social Service tracking all residents' ancillary appointments will be monitored in Quality Assurance meeting monthly. social Service Director will report to Quality Assurance members all tracking and monitoring done for the previous month for one year. If no deficiencies are noted the tracking of appointments will be on-going.	

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	3.1-34(a)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure care plans were followed as written related to skin discolorations not assessed and monitored for 1 of 3 resident's reviewed for non pressure related skin conditions of the 3 who met the criteria for non pressure related skin conditions, and the provision of dental services for 1 of 1 residents reviewed for dental services of the 1 who met the criteria for dental services. (Residents #53 and #34) Findings include: 1. On 8/31/15 at 8:18 p.m., Resident #53 was observed sitting on the side of her bed in her room. The resident was observed to have purple discolorations to the top of the left hand, back of the left arm and also the left elbow. Interview with the resident at the time indicated she was unaware she had the discolorations and they had maybe come from a recent	F 0282	F 282 Immediate action taken for the resident identified. Resident #53 had no ill effect from the deficiency cited. Care-plan and treatments reviewed for resident. Head to toe assessment completed on 09-03-2015 on resident #53. Incident Report/Bruise(s) noted and investigation initiated which was shared with survey team and cause determined. No abuse noted. MD and POA notified. Resident #34 has no ill effect from deficiency cited. Prime Source Dental was notified and came in the facility on 09-03-2015 and performed follow-up assessment. 2. How facility will identify other residents: For citing on resident #53, full body skin assessments completed for all residents in the building on 09-03-2015 to check for discolorations/skin concerns. Resident #34 citing, an audit was performed on all residents ancillary (Dental, Podiatry, Audiology, Vision) appointments with no further concerns noted.	10/04/2015

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	hospitalization. On 9/2/15 at 12:10 p.m., Resident #53 was observed wheeling herself down the hallway in her wheelchair. The resident was observed to have purple discolorations to the top of the left hand, back of the left arm, and also the left elbow. On 9/3/15 at 10:48 a.m., Resident #53 was observed sitting in a wheelchair in her room. The discolorations were still able to be observed to the top of the left hand, back of the left arm and left elbow. Record review for Resident #53 was completed on 9/3/15 at 10:50 a.m. The residents diagnoses included, but were not limited to, hypertension, diabetes mellitus, history of a stroke, and dementia. A care plan dated 5/15/15, indicated the resident needed limited assist for activities of daily living. Nursing interventions included to observe skin condition with daily care. Review of the Weekly Skin Assessment Logs dated 8/3/15, 8/11/15, and 8/25/15 indicated the resident had no areas of discolorations observed.		3. System Change: Resident #53- Weekly skin assessment per skin nurse all residents will continue. Daily skin checks for Certified Nursing Assistants during care/showers on-going. the Director of Nursing or her designee will perform random full body skin assessments monthly on 4 residents and complete a full body assessment checking for any bruising/discolorations, checking for a pattern, previously documented bruises. An audit will then be completed for noted discolorations and care-plan for resident specific interventions. (Audit attached Exhibit d) This will be reported in Quality Assurance (QA) monthly x's 6 months. Quality Assurance Committee will then decide on further monitoring need and frequency. If no concerns are found after 6 months the reporting to QA will stop. If concerns continue the reporting to QA will continue for 6 more months until zero deficiencies/concerns are noted. Resident #34 Care Plan reviewed. Log developed to track appointments of all ancillary appointments on-going and log developed to track and ensure care plan (resident specific) is being followed. (Audit attached Exhibit e)	

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	Review of a Shower Report completed on 9/2/15 indicated the resident had no areas of discolorations observed. Interview with RN #1 on 9/3/15 at 11:39 a.m., indicated she was unaware the resident had any discolorations. She indicated the skin nurse does weekly skin assessments of the residents. She further indicated the CNAs do skin checks when they shower the residents. She also indicated since the resident had a shower the day before the discolorations should have been observed and reported to the nurse. Interview with LPN #1 on 9/3/15 at 11:57 a.m., indicated she was the skin nurse and would complete weekly skin assessments of the residents. She indicated she was unaware the resident had any discolorations and the discolorations should have been observed on the residents shower day. 2. On 9/1/15 at 11:08 AM, Resident #34 was observed to have some missing and jagged teeth on the top and bottom of her mouth. Resident #34's record was reviewed on 9/3/15 at 10:23 AM. Diagnoses included, but were not limited to, hypertension, senile dementia, situational			

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	anxiety, anemia, hypothyroidism, reflux, and chronic kidney disease. Review of Resident #34's quarterly MDS (Minimum Data Set) assessment dated 7/29/15 indicated the resident was severely cognitively impaired. Review of the Oral Care Flow sheet dated July 2015 indicated, "I have: a few teeth, assist me with oral care ...." Review of Dental Exam records dated 2/5/15 indicated Resident #34 had multiple missing, "cracked & mobile" teeth to her upper and lower mouth. Tooth notes indicated, "periodic exam pt. (patient) oral hygiene is poor moist tissue is slightly red and swollen." Treatment plan indicated to follow up in six months. The record lacked any indication a dental exam had been performed for Resident #34 since 2/5/15. Review of care plans indicated Resident #34 was "at risk for oral/ dental problems due to: missing teeth, has natural teeth, several missing in [lower]." Interventions included, but were not limited to: dental consult as needed, oral care - staff to assist. Interview with the Social Services			

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	Director (SSD) on 9/3/15 at 1:39 PM, indicated Resident #34 had not been seen by dental services since 2/5/15. She further indicated Resident #34 should have been seen by the dentist in August and was also not currently on the September list to be seen. The SSD also indicated it was her responsibility to ensure necessary services were obtained for residents, including dental, and would start to keep her own calendar of when services were due. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 3 residents who met the criteria for non	F 0309	F-309 Immediate action for the resident identified. Resident #53 had no ill effect from the deficiency cited. Care-Plan and treatments reviewed for resident. Head to toe assessment completed on 09-03-2015 on resident #53. Incident Report/Bruise(s) noted and investigation initiated which was	10/04/2015

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	pressure related skin conditions. (Resident #53) Finding includes: On 8/31/15 at 8:18 p.m., Resident #53 was observed sitting on the side of her bed in her room. The resident was observed to have purple discolorations to the top of the left hand, back of the left arm and also the left elbow. Interview with the resident at the time indicated she was unaware she had the discolorations and they had maybe come from a recent hospitalization. On 9/2/15 at 12:10 p.m., Resident #53 was observed wheeling herself down the hallway in her wheelchair. The resident was observed to have purple discolorations to the top of the left hand, back of the left arm, and also the left elbow. On 9/3/15 at 10:48 a.m., Resident #53 was observed sitting in a wheelchair in her room. The discolorations were still able to be observed to the top of the left hand, back of the left arm and left elbow. Record review for Resident #53 was completed on 9/3/15 at 10:50 a.m. The residents diagnoses included, but were not limited to, hypertension, diabetes		shared with survey team and cause determined. No abuse noted. MD and POA notified. 2. How facility will identify other residents: Full body skin assessments completed for all nursing residents in the building on 09-03-2015 and completed per nursing staff to check for discolorations/skin concerns. A memo (attached exhibit f1) dated 09-03-2015 for all staff indicating "The resident's skin is to be checked during routine care, showers, and just in general contact with the resident. Noting skin concerns is to be reported to the nurse immediately for further monitoring and investigation of the possible origin/cause. DO NOT assume that it has been reported already. I have read, acknowledge and understand the above. I am able to ask questions; as needed." 3. A Bruise In-Service will be conducted for all nursing staff (attached exhibit f2) Weekly skin assessment per skin nurse on all residents will continue. Daily skin checks for Certified Nursing Assistants during care/showers on-going. The Director of Nursing or her designee will perform random full body skin assessments monthly on 4 residents and complete a full body assessment checking for any bruising/discolorations, checking for a pattern, previously documented bruises. This will be reported in Quality Assurance	

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	mellitus, history of a stroke, and dementia. The Admission Minimum Data Set (MDS) assessment completed on 5/26/15 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 13 which indicated the resident was cognitively intact. The assessment indicated the resident needed limited assistance of 1 person with bed mobility, transfers, walking, locomotion, dressing, toileting, and personal hygiene. A care plan dated 5/15/15, indicated the resident needed limited assist for activities of daily living. Nursing interventions included to observe skin condition with daily care. Review of the Weekly Skin Assessment Logs dated 8/3/15, 8/11/15, and 8/25/15 indicated the resident had no areas of discolorations observed. A Nursing Note dated 8/28/15 at 11:15 p.m., indicated the resident was observed to be having a seizure while in bed and the resident's blood glucose level was low. The resident was transported to the hospital at 11:28 p.m. A Nursing Note dated 8/29/15 at 3:30 a.m., indicated the resident had returned		(QA) monthly x's 6 months. The Quality Assurance Committee will then decide on further monitoring need and frequency. If zero deficiencies are found in the 6 month time frame the reporting to QA will stop. If deficiencies are found the reporting to QA will continue for 6 more months until zero deficiencies are performed in a 6 month time frame.	

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	to the facility from the hospital. The note lacked any indication the resident was observed with any discolorations. Review of the Nursing Notes from 8/29/15 at 3:30 a.m., through 9/3/15 at 10:20 a.m., lacked any indication the resident had been observed with any discolorations. Review of a Shower Report completed on 9/2/15 indicated the resident had no areas of discolorations observed. Interview with RN #1 on 9/3/15 at 11:39 a.m., indicated she was unaware the resident had any discolorations. She indicated the skin nurse does weekly skin assessments of the residents. She further indicated the CNAs do skin checks when they shower the residents. She also indicated since the resident had a shower the day before the discolorations should have been observed and reported to the nurse. Interview with LPN #1 on 9/3/15 at 11:57 a.m., indicated she was the skin nurse and would complete weekly skin assessments of the residents. She indicated she was unaware the resident had any discolorations and the discolorations should have been observed on the residents shower day.			

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	A "Skin Tear/Bruise Policy & Procedure", received as current from the Unit Manager #1 on 9/3/15 indicated "... 5) If skin tears/bruises occur, assess and document in the nurses's notes"... 10) Bruises will be measured in cm (centimeters) when noted and followed up until healed/measurements will continue to be monitored of the bruise periodically until healed...." 3.1-37(a)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to store food under sanitary conditions, related to food stored on the floor of the walk in freezer. (Kitchen) Finding includes: On 8/31/15 at 5:18 p.m., during the initial Kitchen Sanitation Tour with the Cook	F 0371	F 371 1. The Dietary Manager immediately removed the box from the freezer floor and stored it appropriately on the freezer storage shelves on Sept 4, 2015 2. The Dietary Manager audited all the Food Storage areas for proper food storage with no deficiencies found 3. The Food Storage Policy and Procedure (attached exhibit g) was reviewed with all Dietary Personnel as an In-Service with signature as	10/04/2015

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	09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	#1 the following was observed: A cardboard box was observed on the floor of the walk in freezer. The box contained 3 tubs of ice cream. Interview with Cook #1 on 8/31/15 at 5:20 p.m. indicated the box on the floor contained food for activities and some resident's personal food items. She indicated she was unsure why the box was stored on the floor. Interview with the Assistant Dietary Manager on 9/4/15 at 10:00 a.m. indicated there should not have been anything stored on the floor. A facility policy titled, "Food Storage", dated 2010, and received as current from the Dietary Manager on 9/4/15, indicated "...15. Frozen Foods:...h. All foods will be stored off the floor..." 3.1-21(i)(3)		acknowledgment. 4 The Head Cooks will audit and check at the end of their shifts all storage room areas for proper sanitary food storage. The Dietary Manager or designee will do random weekly audits to ensure compliance with audit (attached exhibit h) by Head Cooks to ensure compliance with Sanitary Food Storage. The Dietary Manager will report to the monthly Quality Assurance (QA) Committee progress and compliance to proper food storage for 6 months. If no deficiency occurs the reporting to QA will stop. The auditing by the dietary department will be on-going.	