

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Pulaski Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 624 E 13th St Winamac, IN 46996	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>20580</p> <p>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)</p> <p>Finding includes:</p> <p>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.</p> <p>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 the open areas.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>This citation relates to Complaints IN00449796 and IN00451233.</p> <p>3.1-40(a)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>20580</p> <p>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.</p> <p>Finding includes:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>During an interview on 2/3/25 at 2:10 p.m. the Director of Nursing (DON) indicated the staff have been educated on the use of EBP.</p> <p>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.</p> <p>3.1-18(b)</p>