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	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pulaski Health Care Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a speech therapy evaluation was completed as ordered for 1 of 4 residents reviewed for nutrition and also failed to ensure there was documentation and interventions in place for bowel management for 1 of 5 residents reviewed for unnecessary medications. (Residents B and D)Findings include: 1. The closed record for Resident B was reviewed on 8/19/25 at 3:48 p. m. Diagnoses included, but were not limited to, myasthenia gravis, cyclical vomiting syndrome and pervasive developmental disorder. The resident was admitted on [DATE] for a respite stay. The Quarterly Minimum Data Set (MDS) assessment, dated 5/6/25, indicated the resident had severe cognitive deficits and required moderate assistance with eating and substantial assistance with bed mobility and transfers. A Progress Note, dated 4/28/25, indicated the resident had arrived at the facility accompanied by family. The family indicated he was only to drink from a slow flow sippy cut, could not have milk and should have medications crushed and given in applesauce. The Baseline Care Plan, dated 4/28/25, indicated food should be provided in bite size pieces. A Care Plan Summary, dated 4/30/25, indicated the resident needed weighted silverware and a plate guard. A Progress Note, dated 5/2/25, indicated the Physician gave verbal orders to obtain a Speech Therapy evaluation due to special diet recommendations from the family. The record lacked documentation that a Speech Therapy evaluation had been completed. During an interview on 8/20/25 at 4:25 p.m., the Speech Therapist indicated she had never evaluated the resident. During an interview on 8/21/25 at 3:25 p.m., the Administrator indicated she had no information why the evaluation had not been completed, and it may have been entered by error. 2. Resident D's record was reviewed on 8/19/25 at 10:37 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, developmental disorder, cognitive communication deficit, and iron deficiency anemia. (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set assessment, dated 7/30/25, indicated the resident was severely cognitively impaired. In the 7-day look-back period, the resident received an antipsychotic, antianxiety, opioid, and hypoglycemic medication. The resident was frequently incontinent of bowel and bladder and required substantial to maximal assistance with toileting hygiene. The August 2025 Physician Order Summary indicated the resident received hydrocodone-acetaminophen 5-325 milligram tablet twice daily and iron tablet 325 milligrams daily. A Care Plan, dated 11/12/24, indicated the resident was at risk for low hemoglobin (protein in red blood cells) and hematocrit (percentage of red blood cells) related to iron deficiency anemia. Interventions included, but were not limited to, administer medications as ordered and monitor effectiveness. A Care Plan, dated 11/12/24, indicated the resident was at risk for pain related to a history of right humerus fracture and chronic pain which the resident received routine pain management to address. Interventions included, but were not limited to, analgesics as ordered and observe for effectiveness of medications. The Output: Bowel Movement documentation was reviewed from 7/1/25 thru 8/19/25. Bowel movements were documented on 7/15/25, 7/19/25, 7/22/25, 7/27/25, 8/2/25, 8/4/25, 8/5/25, 8/8/25, 8/11/25, and 8/17/25. There was no documentation related to acquiring orders for treatment or intervention attempts related to the lack of bowel movements. During an interview on 8/22/25 at 1:00 p.m., the Director of Nursing and Regional Nurse Consultant were notified of the concern and provided no further information. A policy related to bowel protocols and monitoring was requested and was not received. This citation relates to Intake 1759620. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were accurate and complete related to incomplete meal intakes, snack intakes and fluid intakes for 3 of 13 resident records reviewed. (Residents B, E, and C)Findings include: 1. The closed record for Resident B was reviewed on 8/19/25 at 3:48 p.m. Diagnoses included, but were not limited to, myasthenia gravis, cyclical vomiting syndrome and pervasive developmental disorder. The resident was admitted on [DATE] for a respite stay. The Quarterly Minimum Data Set (MDS) assessment, dated 5/6/25, indicated the resident had severe cognitive deficits and required moderate assistance with eating and substantial assistance with bed mobility and transfers. The Nutrition Care Plan, dated 5/7/25, indicated the resident was at nutritional risk due to dysphagia, feeding problems and vomiting syndrome. Interventions included, but were not limited to, monitor oral intakes. The Task Meal Consumption Logs were documented with percentage of meals eaten. The May 2025 log lacked documentation for the following meals: Breakfast: 5/1, 5/2, 5/5, 5/7, 5/8, 5/9, 5/12, 5/13, 5/15, 5/16, 5/19, 5/20, 5/21, 5/22, 5/23, 5/24, 5/25, 5/27, 5/28, 5/29, 5/30 Lunch: 5/1, 5/2, 5/4, 5/5, 5/6, 5/7, 5/8, 5/9, 5/13, 5/14, 5/15, 5/16, 5/18, 5/19, 5/20, 5/21, 5/22, 5/23, 5/24, 5/25, 5/26, 5/27, 5/28, 5/29, 5/30 Dinner: 5/1, 5/2, 5/3, 5/4, 5/5, 5/7, 5/8, 5/9, 5/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/17, 5/18, 5/19, 5/20, 5/21, 5/23, 5/24, 5/25, 5/26, 5/27, 5/28, 5/29, 5/30During an interview on 8/21/25 at 3:25 p.m., the Administrator was made aware of the missing documentation, there was no additional information provided. 2. Resident E's record was reviewed on 8/19/25 at 12:08 p.m. Diagnoses included, but were not limited to, diabetes mellitus, dementia and end stage renal disease dependent on dialysis. The Significant Change MDS assessment, dated 6/11/25, indicated the resident was cognitively intact and required set up assistance for eating and toileting. A Physician's Order, dated 7/6/23, indicated the resident was on a 1200 milliliters (ml) daily fluid restriction. Nursing was to provide a total of 480 ml, and dietary was to provide 720 ml divided by 240 ml for breakfast, 240 ml for lunch and 240 ml for dinner. A Dialysis Care Plan, dated 7/19/23, indicated the resident required dialysis related to end stage kidney disease. Interventions included, but were not limited to, monitor fluid intake (fluid restriction) and ensure that resident understands importance of dietary and fluid restrictions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The August 2025 Vitals Report lacked fluid documentation for the following meals: Breakfast: 8/2, 8/3, 8/4, 8/5, 8/6, 8/8, 8/10, 8/11, 8/12, 8/15, 8/17. Lunch: 8/3, 8/4, 8/6, 8/8, 8/9, 8/10, 8/11, 8/15, 8/18, 8/21. Dinner: 8/1, 8/2, 8/3, 8/4, 8/5, 8/6, 8/7, 8/8, 8/9, 8/10, 8/12, 8/14, 8/17, 8/18, 8/20, 8/21. During an interview on 8/21/25 at 3:25 p.m., the Administrator was made aware of the missing documentation, there was no additional information provided. 3. Record review for Resident C was completed on 8/19/25 at 12:33 p.m. Diagnoses included, but were not limited to, Parkinson’s disease, Lewy body dementia, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 6/5/25, indicated the resident was severely cognitively impaired. The resident was dependent on staff for eating and drinking. A Care Plan, dated 3/20/25 and revised 8/18/25, indicated the resident was on a mechanically altered diet texture related to Lewy body dementia. An intervention included to monitor and record intakes. The August 2025 Physician’s Order Summary (POS) indicated orders for the following:-Chart morning snack intake daily-Chart afternoon snack intake daily-Chart evening snack daily at bedtime -Chart breakfast intake daily-Chart lunch intake daily-Chart dinner intake daily The Task Meal Consumption Logs were documented with percentage of snacks and meals eaten. The last 30 days lacked documentation for the following snacks and meals:-Morning snack: 7/22, 7/24, 7/25, 7/27, 7/31, 8/3, 8/4, 8/6, 8/7, 8/8, 8/13, and 8/17/25-Afternoon snack: 7/19, 7/20, 7/22, 7/23, 7/24, 7/26, 7/27, 7/29, 7/30, 8/2, 8/3, 8/4, 8/5, 8/7, 8/8, 8/9, 8/10, 8/12, 8/14, 8/15, 8/16, 8/17, 8/18, and 8/19/25-Evening snack: 8/7/25-Breakfast: 7/22, 7/24, and 8/8/25-Lunch: 7/25, 8/8, and 8/10/25-Dinner: 7/19, 7/20, 7/23, and 8/18/25 During an interview on 8/20/25 at 3:59 p.m., the Director of Nursing (DON) indicated she was unable to provide any documentation the resident's meal consumption logs were completed on the above dates. This citation relates to Intake 1759620. 3.1-50(a)(1)