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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to touching food with gloved hands after touching other items for 1 of 1 kitchen observed. (The Main Kitchen). This had the potential to affect 44 residents who received food from the kitchen. Finding includes: During the follow-up tour of the kitchen on 8/20/25 at 10:01 a.m., [NAME] 1 was observed preparing pureed enchiladas. The cook had donned clean gloves. She had an enchilada prepared in a mixing bowl. Using her gloved hands, she scooped out the enchilada into the blender. She removed a set of gloves, as she had another pair of gloves on underneath. The Dietary Food Manager brought [NAME] 1 a container of broth mix from the cooler. [NAME] 1 opened the container, scooped out a small amount using a measuring spoon, and used her gloved finger to remove the broth mix into another container. She mixed the broth mix with water to create the beef broth mixture to add to the enchilada in the blender. She changed her gloves and did not perform hand hygiene before donning a new pair of gloves. She opened a drawer, with her gloved hands, to retrieve a measuring cup, then opened the shredded cheese container and scooped the shredded cheese with her gloved hands. She then put the cheese into the blender. She added a small amount of beef broth and continued to blend until the appropriate consistency was achieved. During an interview at the time, [NAME] 1 indicated she usually always washed her hands between glove changes and understood she should not touch food directly after touching other items/surfaces in the kitchen. She had no further information to provide. A policy titled, Handwashing/Hand Hygiene, indicated .Use an alcohol-based hand rub .or soap and water for the following situations .m. after removing gloves .o. before and after eating or handling food . 3.1-21(i)(3)

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review and interview, the facility failed to provide a safe, comfortable environment related to elevated hot water temperatures in 2 of 5 units observed for water temperatures. (North and Northeast Units)Finding includes:During the initial facility tour on 8/18/25 at 2:45 p.m., observations by hand of the water temperature were felt to be elevated in resident bathrooms on the North and Northeast Units. The Maintenance Assistant checked the water temperature in Rooms NE4, N2 and N3 and indicated it was 130 degrees Fahrenheit.During an interview at that time, the Maintenace Assistant indicated that was hottest he had seen the water temperature. He indicated rooms were checked randomly once a week. During an interview on 8/18/25 at 2:55 p.m., the Maintenance Director indicated water temperature should be around 111 degrees.The current policy, Weekly Water Temperatures, indicated, .if a water temperature is below or above the set temperature of 100-120, the maintenance supervisor or designee will adjust the mixing valve to bring water to the proper temperature

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review and interview, the facility failed to ensure documentation for residents' transfer to the hospital was complete and accurate related to lack of documentation of preparation for transfer or discharge, assessment of the resident at the time of transfer, and notification to the physician at the time of transfer for 2 of 3 residents reviewed for hospitalization. (Residents 8 and 45) Findings include: 1. Resident 8's record was reviewed on 8/20/25 at 3:44 p.m. Diagnosis included, but were not limited to, intellectual disabilities, aphasia, and type 2 diabetes mellitus. The Quarterly Minimum Data Set assessment, dated 7/9/25, indicated the resident was severely cognitively impaired. A Progress Note, dated 3/19/25 at 12:49 p.m., indicated the resident was in the main dining room and was observed to be shivering, hands cyanotic (blue) from proximal knuckle to the tips of his fingers. The physician was notified, and new orders were received for labs. He had elevated finger sticks into the 300s and new orders were placed for glucose monitoring twice daily. A Progress Note, dated 3/19/25 at 11:27 p.m., indicated results were received for a CT scan and chest x-ray from the hospital. The resident was still in the emergency department. There was no documentation of the resident and or representative being prepared for transfer to the hospital. There was no documentation of an evaluation of the resident at the time of the transfer. There was no documentation of communication to the physician related to the hospital transfer. During an interview on 8/22/25 at 1:00 p.m., the Director of Nursing and Regional Nurse Consultant indicated they were unable to find any further information related to the hospital transfer. 2. Resident 45's closed record was reviewed on 8/20/25 at 4:04 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, type 2 diabetes mellitus, and major depressive disorder. The Discharge Return Anticipated Minimum Data Set assessment, dated 6/5/25, indicated the resident was moderately cognitively impaired. She was dependent on staff for toileting hygiene, showering, bed mobility, and transfers. She had 1 stage 2 pressure ulcer, 2 stage 3 pressure ulcers, 1 stage 4 pressure ulcer, and 1 unstageable pressure ulcer all present on admission. A Progress Note, dated 6/4/25, indicated the resident was receiving antibiotics at the time. She had her catheter changed/placed due to low output and leakage which was tolerated well. 30 milliliters of dark yellow urine was observed for return. The physician was updated on the lab results, catheter replacement, and treatments for wounds. A Progress Note, dated 6/5/25 at 12:57 p.m., indicated the resident was mouth breathing. Vital signs were 18 breaths per minute, blood pressure 51/29, pulse 61, and temperature 96.8. She was pale, diaphoretic, appetite poor, and had to give medications with applesauce to help with her swallowing. Urinary output was less than 200 milliliters during the shift. The resident was unable to follow directions, held food and pills in her mouth. Lab results were faxed to the physician, and she continued to receive antibiotics for infection. A Progress Note, dated 6/5/25 at 3:30 p.m., indicated new orders were received and noted to send the resident to the emergency department for hypotension and altered mental status. Resident was transferred to the hospital and report was called. The resident was accompanied by her son. The record lacked documentation of a current assessment of the resident and documentation the resident and/or representative were oriented and prepared for the resident to transfer out of the facility. During an interview on 8/22/25 at 1:00 p.m., the Director of Nursing and Regional Nurse Consultant indicated there was no further documentation in the record related to the resident's transfer.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure to send the facility's bed-hold and reserve bed payment policy before and upon transfer to the hospital and transfer or discharge form to the resident and/or representative. The facility also failed to ensure appropriate information was conveyed to the receiving provider for 3 of 3 residents reviewed for hospitalization. (Resident 3, 8, and 45)1. Resident 3's record was reviewed on 8/21/25 at 12:28 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, chronic obstructive pulmonary disease, heart failure, and high blood pressure. The Quarterly Minimum Data Set assessment, dated 7/7/25, indicated the resident was cognitively intact. She was dependent on staff for toileting, showering, bed mobility, and transfers. A Progress Note, dated 6/24/25 at 12:20 a.m., indicated the resident did not respond per normal when trying to wake the resident to take scheduled medications. She would open her eyes but not keep them open for long when rubbing her chest. She was slow to respond verbally. The physician was called and gave orders to send the resident to the hospital. She was coughing frequently. Resident was alert and oriented to person and place. Vital signs were blood pressure of 136/64, temperature 98.4, heart rate 68, respirations 20, and oxygen at 92% at 5 liters per nasal cannula. Report was called to the receiving hospital, and papers went with the EMTs to the hospital. The emergency contact was called but did not answer. The record lacked documentation of the notice of transfer or discharge form, and bed hold was sent to the resident and/or representative. There was no documentation of the information provided to the receiving provider, including but not limited to contact information for the resident's practitioner, resident representative information, advance directive information, ongoing treatments, and medications that the resident received at the facility. During an interview on 8/22/25 at 1:00 p.m., the Director of Nursing and Regional Nurse Consultant indicated they had no further information to provide. 2. Resident 8's record was reviewed on 8/20/25 at 3:44 p.m. Diagnosis included, but were not limited to, intellectual disabilities, aphasia, and type 2 diabetes mellitus. The Quarterly Minimum Data Set assessment, dated 7/9/25, indicated the resident was severely cognitively impaired. A Progress Note, dated 3/19/25 at 12:49 p.m., indicated the resident was in the main dining room and was observed to be shivering, hands cyanotic (blue) from proximal knuckle to the tips of his fingers. The physician was notified, and new orders were received for labs. He had elevated finger sticks into the 300s and new orders were placed for glucose monitoring twice daily. A Progress Note, dated 3/19/25 at 11:27 p.m., indicated results were received for a CT scan and chest x-ray from the hospital. The resident was still in the emergency department. The record lacked documentation of the notice of transfer or discharge form, and bed hold was sent to the resident and/or representative. There was no documentation of the information provided to the receiving provider, including but not limited to contact information for the resident's practitioner, resident representative information, advance directive information, ongoing treatments, and medications that the resident received at the facility. During an interview on 8/22/25 at 1:00 p.m., the Director of Nursing and Regional Nurse Consultant indicated they were unable to find any further information related to the hospital transfer. 3. Resident 45's closed record was reviewed on 8/20/25 at 4:04 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, type 2 diabetes mellitus, and major depressive disorder. The Discharge Return Anticipated Minimum Data Set assessment, dated 6/5/25, indicated the resident was moderately cognitively impaired. She was dependent on staff for toileting hygiene, showering, bed mobility, and transfers. She had 1 stage 2 pressure ulcer, 2 stage 3 pressure ulcers, 1 stage 4 pressure ulcer, and 1 unstageable pressure ulcer all present on admission. A Progress Note, dated 6/4/25, indicated the resident was receiving antibiotics at the time. She had her catheter changed/placed due to low output and leakage which was tolerated well. 30 milliliters of dark yellow urine was observed for return. The physician was updated on the lab results, catheter replacement, and treatments for wounds. A Progress Note, dated (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/5/25 at 12:57 p.m., indicated the resident was mouth breathing. Vital signs were 18 breaths per minute, blood pressure 51/29, pulse 61, and temperature 96.8. She was pale, diaphoretic, appetite poor, and had to give medications with applesauce to help with her swallowing. Urinary output was less than 200 milliliters during the shift. The resident was unable to follow directions, held food and pills in her mouth. Lab results were faxed to the physician, and she continued to receive antibiotics for infection. A Progress Note, dated 6/5/25 at 3:30 p.m., indicated new orders were received and noted to send the resident to the emergency department for hypotension and altered mental status. Resident was transferred to the hospital and report was called. The resident was accompanied by her son. The record lacked documentation of the notice of transfer or discharge form, and bed hold was sent to the resident and/or representative. There was no documentation of the information provided to the receiving provider, including but not limited to contact information for the resident's practitioner, resident representative information, advance directive information, ongoing treatments, and medications that the resident received at the facility. During an interview on 8/22/25 at 1:00 p.m., the Director of Nursing and Regional Nurse Consultant indicated there was no further documentation in the record related to the resident's transfer. A policy titled, Transfer or Discharge, Emergency, indicated .4. should it be necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: a. Notify the attending physician; b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident e. Notify the representative or other family member .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed and in place for resident receiving an antidepressant medication for 1 of 13 care plans reviewed. (Resident 2) Finding includes: Resident 2's record was reviewed on 8/19/25 at 3:03 p.m. Diagnoses included, but were not limited to, paraplegia, schizoaffective disorder, and chronic pain. The Significant Change in Status Minimum Data Set assessment, dated 7/15/25, indicated the resident was cognitively intact for daily decision making. In the 7-day look-back period, he had received injections, antipsychotic, antidepressant, antibiotic, opioid, and hypoglycemic medications. The August 2025 Physician Order Summary indicated the resident received amitriptyline (an antidepressant medication) 50 milligram tablet twice daily since 7/12/25. There was no care plan related to antidepressant medication use. During an interview on 8/22/25 at 1:00 p.m., the Director of Nursing and Regional Nurse Consultant indicated there was no care plan initiated for the antidepressant use because the resident was actually taking that medication for pain. There should have been a care plan related to the antidepressant use. 3.1-35(a)

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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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and interview, the facility failed to ensure a splinting device was in place as ordered for a resident with a limited range of motion for 1 of 1 resident reviewed for range of motion. (Resident 13) Finding includes:During random observations on 8/18/25 at 2:52 p.m., 8/19/25 at 12:45 p.m., 8/21/25 at 10:01 a.m. and 4:01 p.m., Resident 13 was observed sitting in his wheelchair. At that time, his right arm was in his lap with no splinting devices observed on the right hand. Resident 13's record was reviewed on 8/21/25 at 10:07 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and paralysis) following a stroke affecting the right dominant side, vascular dementia, and cognitive communication deficit. The Annual Minimum Data Set assessment, dated 6/18/25, indicated the resident was rarely or never understood. The resident had limited range of motion impairment to one side for the upper and lower extremity. He was dependent on staff for toileting, showering, personal hygiene, bed mobility, and transfers. A Care Plan, dated 12/16/23, indicated the resident required substantial/maximal up to total assistance with mostly all activities of daily living related to hemiplegia and hemiparesis following a stroke affecting the right side. The approaches were for the resident to use a right hand splint while up in the wheelchair. A Physician's Order, dated 7/31/25, indicated the resident was to wear a right hand splint when up in the wheelchair. The August 2025 Medication Administration Records (MAR) indicated the right hand splint was checked off as administered every shift (3 times a day) for every shift from 8/1/25 thru the morning of 8/21/25. There were no documented refusals of the right hand splint. During an interview on 8/21/25 at 3:59 p.m., the Director of Nursing and Regional Nurse Consultant indicated the resident has been refusing to wear the splint lately. No further information was provided at the time. A policy titled, Assistive Devices and Equipment, indicated, 1. Devices and equipment that assist with resident mobility, safety, and independence are provided for residents. These include .splints. 2. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident's plan of care . 3.1-42(a)(2)

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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. The August 2025 Vitals Report lacked fluid documentation for the following meals: (continued on next page)

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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	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)

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents that received antibiotics met the criteria of a true infection or provide a rationale for use if infection criteria were not met for 2 of 2 residents reviewed for antibiotic stewardship. (Residents 51 and 2)Findings include:1.The record for Resident 51 was reviewed on 8/19/25 at 3:00 p.m. Diagnoses included, but were not limited to, acute kidney failure, unspecified dementia and congestive heart failure. The resident was admitted on [DATE]. A Physician's Order, dated 8/15/25, indicated to obtain a urinalysis with reflex culture and sensitivity if indicated for mental status changes. The urinalysis results, dated 8/16/25, indicated there were moderate bacteria present, and a culture and sensitivity had not been done with a note, Recollect? An Observation McGeer's Criteria (tool used to determine true infections), dated 8/17/25, indicated the resident had no catheter, no dysuria, no fever and no pain. The resident's urinalysis results indicated there was at least 100,000 bacteria present. The indicators did not meet McGeer's criteria of a urine infection. A Physician's Order, dated 8/18/25, indicated to give cephalexin (an antibiotic), 500 milligrams every 12 hours x 8. There was no rationale documented in the resident's notes as to why the antibiotic was given. During an interview on 8/21/25 at 12:21 p.m., the Infection Preventionist (IP) Nurse indicated if an antibiotic was prescribed without meeting infection criteria, the physician should be notified to see if they wanted to continue or discontinue the medication. The IP Nurse indicated she had not been asking the physicians to provide a rationale to continue the antibiotics if criteria was not met but was now aware it should be documented. 2.Resident 2's record was reviewed on 8/19/25 at 3:03 p.m. Diagnoses included, but were not limited to, paraplegia, schizoaffective disorder, and neuromuscular dysfunction of the bladder. The Significant Change in Status Minimum Data Set assessment, dated 7/15/25, indicated the resident was cognitively intact for daily decision making. The resident had an indwelling catheter. A Progress Note, dated 6/24/25 at 5:32 p.m., indicated the hospice nurse returned a call to the facility and gave new order for ciprofloxacin (antibiotic) 250 milligrams twice daily for 7 days due to abnormal urine complaints by the resident. The June 2025 Medication Administration Record indicated the resident received the ciprofloxacin antibiotic as ordered. There were no physician's orders for a urinalysis culture and sensitivity or further information related to a urinary tract infection available for review in the record. During an interview on 8/22/25 at 1:00 p.m., the Director of Nursing and Regional Nurse Consultant indicated there was no further testing completed for the resident. The hospice company had started (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the antibiotic medication due to the reported symptoms given by the resident and did not order any urinalysis culture and sensitivity to be completed. The reported infection did not meet criteria for antibiotic use. A policy titled, Antibiotic Stewardship, indicated .11. When a culture and sensitivity is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.