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	11/13/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, observation, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing related to a lack of treatment change or new interventions implemented timely after the pressure ulcer had worsened for 1 of 3 residents reviewed for pressure ulcers. (Resident C)Finding includes: Record review for Resident C was completed on 11/12/25 at 2:13 p.m. Diagnoses included, but were not limited to, anemia, diabetes mellitus, and end stage renal disease.The Quarterly Minimum Data Set (MDS) assessment, dated 10/13/25, indicated the resident was cognitively intact. The resident was dependent on staff for bed mobility and transfers. The resident was admitted to the facility with two stage 2 pressure ulcers. A Care Plan, dated 1/22/25 and revised 8/25/25, indicated the resident had a pressure wound to the left ischium (curved bone forming the base of each half of the pelvis). On 7/23/25 the pressure wound healed. On 8/22/25 the resident returned from the hospital with the left ischium open again as a stage 2. The Goal indicated the resident would not experience any worsening of the pressure wound by the next review date. An intervention included to measure and record description of the pressure wound with included size, color, and drainage, and then to notify the physician with any changes or worsening of the wound. A Wound Management Assessment, dated 8/25/25, indicated the resident returned from the hospital on 8/22/25 with a stage 2 to the left ischium. The wound was noted to have a superficial opening that measured 8 cm (centimeters) in length x 6 cm wide with a 0.1 cm depth. A Physician's Order, dated 8/23/25 and discontinued on 11/11/25, indicated to cleanse the left ischium with wound cleanser and apply Puracol (collagen wound dressing) to the wound bed and cover with a gauze dressing.A Wound Management Assessment, dated 10/1/25, indicated the resident had a stage 2 ulcer to the left ischium that measured 4.1 cm in length x 4 cm wide with a 0.1 cm depth. The wound was noted to have 10% slough (dead, non-viable tissue only in wounds stage 3 or higher) in the wound bed. The physician was aware of the wound status.There was a lack of documentation to indicate that when the pressure ulcer had worsened on 10/1/25, the facility changed the wound treatment or new interventions were implemented.A Wound Management Assessment, dated 10/28/25, indicated the resident had a stage 2 to the left ischium that measured 3.6 cm in length x 3.5 cm wide with a 0.1 cm depth. The wound was noted to have 10% slough in the wound bed. The physician was aware of the wound status.A Physician's Order, dated 11/3/25, indicated to cleanse the left ischium with wound cleanser and apply silver alginate (antimicrobial wound dressing) to the wound bed and cover with gauze dressing.The wound had worsened from stage 2 on 10/1/25. There was a lack of documentation to indicate any new treatment orders or new interventions were attempted until 11/3/25 or any physician documentation related to the wound status worsening. On 11/12/25 at 2:27 p.m., a wound treatment was observed with the DON (Director of Nursing) and QMA 1. The wound to the left ischium was reddened, shallow, and about the size of a nickel. There were no odors or drainage observed to the wound. During an interview on 11/13/25 at 2:50 p.m., the DON indicated she could not provide any documentation that any interventions were changed (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when the resident's pressure had worsened to a stage 3. The wound should have been classified as a stage 3 with slough and not a stage 2. They did put in a new treatment order for the wound, but it was a month later. The wound had not worsened during that time, but they should have attempted a new treatment timely after the wound had worsened.A facility policy, titled Pressure Ulcers/Skin Breakdown - Clinical Protocol and received as current from the DON on 11/13/25, indicated, .Monitoring 1. During resident visits, the physician will evaluate and document the progress of wound healing - especially for those with complicated, extensive, or poorly-healing wounds. 2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. a. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified. b. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision-maker.This citation relates to Intake 2659878. 3.1-40(a)(2)