STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155215	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainfield Health Care Center	3700 Clarks Creek Rd Plainfield, IN 46168

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview, the facility failed to notify the responsible party of a change in condition of 1 of 1 resident reviewed for change of condition and notification (Resident B). Findings include: On 9/5/24 at 11:56 p.m., the medical record of Resident B was reviewed. The resident was admitted to the facility on [DATE]. Admission Diagnosis included but were not limited to, acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues), pneumonitis (Pneumonia, a bacterial infection of the lungs) due to inhalation of food and vomit. Physician Order, dated 8/15/24, indicated to administer 10 milliliters (ml) of Amoxicillin suspension (liquid) 250/5 ml via G-tube (a tube that is surgically inserted through the abdomen and into the stomach to provide nutrition, fluids, and medicine) every 12 hours for pneumonia for 7 days. Physician order, dated 8/16/24 at 1:12 p.m., indicated to administer 1 tablet of Augmentin Oral Tablet 500-125 milligrams (mg) (Amoxicillin and Pot Clavulanate) via G-Tube two times a day for PNA (pneumonia). Physician order, dated 8/13/24, indicated to administer albuterol nebulizer 0.083% 2.5 mg inhale orally via nebulizer (typically consist of a main nebulization unit, a reservoir for holding the liquid for nebulization, and a mouthpiece through which drug aerosol is inhaled) two times a day for SOB (shortness of breath). Physician order, dated 8/16/24 at 9 p.m., indicated to administer 1 tablet Augmentin Oral Tablet 500-125 mg via G-Tube two times a day for PNA. Physician order, dated 8/13/2024, indicated to administer albuterol nebulizer 0.083% 2.5 mg (milligrams) inhale orally via nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) two times a day for SOB (shortness of breath) 2.5 mg/0.5 ml (milliliters). Staff were to complete a respiratory evaluation before nebulizer treatment two times a day, respiratory evaluation after nebulizer treatment two times a day. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155215	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainfield Health Care Center	3700 Clarks Creek Rd Plainfield, IN 46168

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 2:46 p.m., the Nurse Practitioner (NP) visited the resident. The note indicated the patient was seen outside of the window of a federally mandated regulation visit. The patient had comorbidities that place him at higher risk and a change in condition may occur at any time. The chief complaint for this visit was lab and chest x-ray (CXR) review. The patient was seen in follow up to address an issue, change of medication, complaint, or change in condition that cannot otherwise be addressed or directed by phone or without a face-to-face encounter. This visit was deemed by me to be both necessary and reasonable. Results of Diagnostic Testing, CXR on 8/15/24 indicated left upper lobe infiltrate with a conclusion of mild left upper lobe infiltrate resulting in a diagnosis of pneumonitis due to inhalation of food and vomit. Review of the nurse progress notes indicated the resident's responsible party was not notified of the initial change in condition, the Nurse Practitioner (NP) visit, nor the diagnosis of pneumonia on 8/15/24. An anonymous interview during the survey, indicated Resident B's family was not notified of medication orders or change of conditions. On 9/6/2024 at 3:00 p.m., the Administrator provided a document titled, Change of Condition Notification, dated 6/2020, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy . II. The facility will promptly inform the residents legal representative when the resident endures a significant change in their condition caused by, but not limited to .B. A significant change in the resident's physical status .V. Family Notification .A. The Licensed Nurse will document the following .iii. The time the family/responsible person was contacted This citation relates to Complaints IN00441980, IN00441976, and IN00442404. 3.1-5(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview, the facility failed to ensure respiratory services order was obtained and entered into the medical record for 1 of 1 resident reviewed for respiratory services (Resident B). Findings include: On 9/5/24 at 11:56 p.m., the medical record of Resident B was reviewed. The resident was admitted to the facility on [DATE]. Admission Diagnosis included but were not limited to, acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues), pneumonitis (pneumonia, a bacterial infection of the lungs) due to inhalation of food and vomit. Physician order, dated 8/13/2024, indicated to administer albuterol nebulizer 0.083% 2.5 mg (milligrams) inhale orally via nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) two times a day for SOB (shortness of breath) 2.5 mg/0.5 ml (milliliters). Staff were to complete a respiratory evaluation before nebulizer treatment two times a day, respiratory evaluation after nebulizer treatment two times a day. On 8/15/24 at 2:46 p.m., the Nurse Practitioner (NP) visited the resident. The patient had comorbidities that placed him at higher risk and a change in condition may occur at any time. The chief complaint for this visit was lab and chest x-ray (CXR) review. The patient was seen in follow up to address an issue, change of medication, complaint, or change in condition that cannot otherwise be addressed or directed by phone or without a face-to-face encounter. This visit was deemed by me to be both necessary and reasonable. Results of Diagnostic Testing, CXR on 8/15/24 indicated left upper lobe infiltrate with a conclusion of mild left upper lobe infiltrate resulting in a diagnosis of pneumonitis due to inhalation of food and vomit. Therapy reported hypoxia this morning. Oxygen applied and CXR completed with noted pneumonia. Resident was seen in bed and was minimally responsive with hot pale skin. Noted tachycardia and tachypnea. Oxygen reapplied. Lungs were coarse. Resident had history of aspiration pneumonia and noted to be non-complaint with keeping head elevated in bed while tube feeds infuse. The medical record indicated the NP ordered oxygen delivery to the resident in the progress notes, but the physician orders lacked evidence of an order to deliver oxygen. Nursing Progress note, dated 8/17/2024 at 12:52 a.m., indicated a Skilled Evaluation. Respiratory vitals were WNL (within normal limits). Resident had shortness of breath while lying flat. Oxygen Support Provided with 3 liters oxygen delivered via Nasal Cannula (a thin flexible tube device to provide supplemental oxygen therapy to people who have lower oxygen levels) continuous. Nursing Progress note, dated 8/18/2024 2:04 a.m., indicated a Skilled Evaluation. Respiratory vitals were WNL. Resident had Shortness of Breath while lying flat and on exertion, and labored Breathing. Oxygen Support Provided with 3 liters Oxygen delivered via Nasal Cannula continuous. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Progress note, dated 8/18/2024 at 7:30 p.m., indicated at 4:30 p.m. this evening when checked resident blood sugar, the resident was resting in bed. When returned at 6:30 p.m. to give night meds and there was a rapid acute change. Resident was on 2 liters nasal cannula oxygen, oxygen saturation read 79. After rechecking it was 77. Increased the oxygen and administered his breathing treatment. Patient started deteriorating fast. The ambulance, weekend supervisor who was on the floor, and other nurses for assistance to help with the resident were called. The resident's family was called, and it went to voicemail. At 7:00 p.m. the resident passed before the ambulance got to the facility. On 9/5/24 at 3:02 p.m., during an interview Licensed Practical Nurse (LPN) 10 indicated they would enter an order immediately after an NP or physician indicated an order was given. The LPN indicated the NP also had access to the medical record and entered orders at times. On 9/6/2024 at 3:00 p.m., the administrator provided a document, titled, Oxygen Administration, dated, 6/2020 and indicated it was the policy currently being used by the facility. The policy indicated, .1. Initiation of oxygen .A. A physician's order is required to initiate oxygen therapy, except in an emergency situation This citation relates to Complaints IN00441980, IN00441976, and IN00442404. 3.1-47(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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview, the facility failed to ensure medications were provided as ordered by the physician for 1 of 3 residents reviewed for medication administration (Resident B). Findings include: On [DATE] at 11:56 p.m., the medical record of Resident B was reviewed. The resident was admitted to the facility on [DATE]. Admission Diagnosis included but were not limited to, acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues), pneumonitis (pneumonia, a bacterial infection of the lungs) due to inhalation of food and vomit. Physician order, dated [DATE], indicated to administer albuterol nebulizer 0.083% 2.5 mg inhale orally via nebulizer (typically consist of a main nebulization unit, a reservoir for holding the liquid for nebulization, and a mouthpiece through which drug aerosol is inhaled) two times a day for SOB (shortness of breath). Physician order, dated [DATE], indicated to administer albuterol nebulizer 0.083% 2.5 mg (milligrams) inhale orally via nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) two times a day for SOB (shortness of breath) 2.5 mg/0.5 ml (milliliters). Staff were to complete a respiratory evaluation before nebulizer treatment two times a day, respiratory evaluation after nebulizer treatment two times a day. Physician Order, dated [DATE], indicated to administer 10 milliliters (ml) of Amoxicillin suspension (liquid) , d+[DATE] ml via G-tube (a tube that is surgically inserted through the abdomen and into the stomach to provide nutrition, fluids, and medicine) every 12 hours for pneumonia for 7 days. Physician order, dated [DATE] at 1:12 p.m., indicated to administer 1 tablet of Augmentin Oral Tablet , d+[DATE] milligrams (mg) (Amoxicillin and Pot Clavulanate) via G-Tube two times a day for PNA (pneumonia). Physician order, dated [DATE] at 9 p.m., indicated to administer 1 tablet Augmentin Oral Tablet ,d+[DATE] mg via G-Tube two times a day for PNA. Nursing Progress note, dated [DATE] at 12:52 a.m., indicated a Skilled Evaluation. Respiratory vitals were WNL (within normal limits). Resident had shortness of breath while lying flat. Oxygen Support Provided with 3 liters oxygen delivered via Nasal Cannula (a thin flexible tube device to provide supplemental oxygen therapy to people who have lower oxygen levels) continuous. Nursing Progress note, dated [DATE] 2:04 a.m., indicated a Skilled Evaluation. Respiratory vitals were WNL. Resident had Shortness of Breath while lying flat and on exertion, and labored Breathing. Oxygen Support Provided with 3 liters Oxygen delivered via Nasal Cannula continuous. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Progress note, dated [DATE] at 7:30 p.m., indicated at 4:30 p.m. this evening when checked resident blood sugar, the resident was resting in bed. When returned at 6:30 p.m. to give night meds and there was a rapid acute change. Resident was on 2 liters nasal cannula oxygen, oxygen saturation read 79. After rechecking it was 77. Increased the oxygen and administered his breathing treatment. Patient started deteriorating fast. The ambulance, weekend supervisor who was on the floor, and other nurses for assistance to help with the resident were called. The resident's family was called, and it went to voicemail. At 7:00 p.m. the resident passed before the ambulance got to the facility. On [DATE] at 1:23 p.m. noted as a late entry, a nurse progress note indicated Augmentin suspension had not arrived from pharmacy. Nurse Practitioner (NP) was notified and a new order was given to change to Augmentin ,d+[DATE]mg tablet: take 1 tablet crushed via g-tube BID (two times a day) x 10 days for PNA. A review of medication orders and administration record, the record indicated on [DATE] Augmentin Suspension BID (two times a day) for 7 days was ordered at 2:46 p.m. The record indicated the medication order was sent to the pharmacy at on [DATE] at 9:00 p.m. On [DATE] at 1:23 p.m., a late entry note was entered and dated [DATE] at 1:25 p.m. (effective date) indicating the Augmentin suspension had not arrived from pharmacy. The NP was notified and ordered Augmentin ,d+[DATE] mg (milligram) tablet was ordered 1 tablet BID x 10 days. On [DATE] at 2:10 p.m., during an interview the Facility Pharmacist indicated the pharmacy received an order for Augmentin Suspension on [DATE]. The medication was not available in the Emergency Drug Kit (EDK) referred to as the STAT Safe by the facility. It was not filled or sent by the pharmacy. The pharmacist indicated an order for Amoxicillin (Augmentin) suspension was ordered on [DATE]. The pharmacy received the order at 9:00 p.m., the pharmacy was closed at that time. The order was processed on [DATE] but the order was cancelled. The pharmacist indicated a second order was entered for Augmentin tablets on [DATE] but was not processed till [DATE]. The medication order was not filled by the pharmacy. The pharmacist verified Augmentin tablets were taken from the STAT safe on the following dates and times. [DATE] at 10:00 p.m., [DATE] at 5:21 a.m., [DATE] at 4:31p.m. The pharmacist indicated the medication was not sent from pharmacy. Review of the Medication Administration Record (MAR) for August. The record indicated Augmentin Suspension was administered to the resident on the following dates and times: [DATE] at 9:00 p.m., [DATE] at 9:00 p.m., and [DATE] at 9:00 a.m. The MAR for [DATE] indicated, Augmentin tablets were administered to the resident on the following dates and times. On [DATE] at 9:00 p.m., [DATE] at 9:00 a.m. On [DATE] at 9:00 p.m. (the medication was removed from the STAT Safe at10:00 p.m.). On [DATE] at 9:00 a.m., (the medication was removed from the STAT Safe at 5:21 a.m.) On [DATE] at 9:00 p.m. (medication was removed from the STAT Safe 4:31 p.m.) The resident expired on [DATE] at 7:00 p.m. On [DATE] at 2:50 p.m. during an interview with Qualified Medication Aide (QMA) 9 indicated, for them to access the Stat Safe the nurse first enters the order into the medical record. The QMA or Nurse would then enter the residents name into the system and all the resident's medications would be listed. They would select the medication they needed and remove it from the STAT Safe. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:02 during an interview with Licensed Practical Nurse (LPN) 10 indicated, if they needed a medication from the STAT Safe, they would log in and select the resident name and their medications list and remove medication from the safe. The employee indicated the nurse must enter the order into the medical record before they can remove a medication from the safe. The LPN indicated if a medication was not available in the safe, they would call the pharmacy to STAT (immediate) the medication to the facility. The LPN indicated they would obtain the initial dose for an antibiotic from the safe. If the pharmacy was closed, they had an after-hours number to call. The nurse indicated they would enter an order as soon as it was given by the physician. On [DATE] at 2:00 p.m., during interview with QMA 6 and the Regional Nurse Consultant. The QMA verified she administered Augmentin suspension and Augmentin tablets as ordered. She verified the initials on the MAR were hers and the check above each initial indicated the medication was administered. The Regional Nurse Consultant indicated when an employee enters the temperature into the MAR the software system would record the medication as being administered. He indicated the medication was not administered but the temperature had been recorded. He acknowledged the temperature was recorded as supplemental and not part of the actual medication order. On [DATE] at 3:00 p.m., the Administrator provided a document, titled, Physician Orders, dated,,d+[DATE] and indicated it was the policy currently being used by the facility. The policy indicated, . I. Telephone orders . V. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other healthcare disciplines will be transcribed onto the appropriate communication system for that discipline This citation relates to Complaints IN00441980, IN00441976, and IN00442404. 3XXX,d+[DATE](a)