

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2025
NAME OF PROVIDER OR SUPPLIER Plainfield Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to contact the physician for blood sugar values outside the ordered parameters for 1 of 4 residents reviewed for quality of care (Resident B). Findings include: The clinical record for Resident B was completed on 9/10/25 at 11:19 a.m. Diagnoses included diabetes mellitus type II, dementia, exocrine pancreatic insufficiency, and need for assistance with personal care. A health care plan, revised on 4/5/25, indicated the resident had diabetes mellitus related to pancreatogenesis diabetes and received insulin. Interventions included: administer diabetes medication as ordered by physician. A physician's order, dated 6/3/25, indicated to administer Admelog SoloStar (insulin to treat diabetes mellitus), inject six units before meals. Hold for blood sugar less than 110 and call for blood sugar less than 70 or greater than 400. A health care plan, revised on 4/5/25, indicated the resident had diabetes mellitus related to pancreatogenesis diabetes and received insulin. Interventions included: administer diabetes medication as ordered by physician. A review of Resident B's electronic Medication Administration Record (eMAR) and the resident's clinical record, indicated the following: For the morning doses of insulin administration, the record lacked documentation of physician notification on 6/9/25 with a blood sugar (BS) value of 68; on 6/11/25 with a BS value of 453; on 6/16/25 for a BS value of 541; on 7/5/25 the record lacked a recorded BS with an indication the dose was held due to vitals outside of parameters, on 7/8/25 with a BS value of 62; on 7/20/25 with a BS value of 68, and on 7/21/25 with a BS value of 56. For the morning doses of insulin administration, the record indicated the resident received the insulin dose with no documented physician notification on 6/10/25 with a BS value of 83, and on 6/17/25 with a BS value of 81; and on 7/5/25 with a BS value of 75. For the morning dose on 7/24/25, the record indicated a BS of 112 and that the dose was held due to vitals outside of parameters. The record lacked further documentation. For the evening doses of insulin administration, the record lacked documentation of physician notification on 6/16/25 with a BS value of 429 and on 6/22/25 for a BS value of 61. During an interview on 9/15/25 at 3:00 p.m., the Corporate Nurse Consultant indicated there was no documentation of the physician being notified of the BS values that were out of the ordered parameters for physician notification. She indicated the physician may or may not have been notified but the clinical record lacked documentation of the notification. All physician notifications should be recorded in the clinical record and the physician's orders followed. A current facility policy, revised 6/2020, titled, Change of Condition Notification, provided by the Corporate Nurse Consultant on 9/15/25 at 2:18 p.m., included the following: .VI. Documentation A. A Licensed Nurse will document the following.ii. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. This citation is related to Intake 2563360. 3. 1-5(a)(2)</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to complete ordered skin assessments for 1 of 4 residents reviewed for quality of care (Resident D). Findings include: The clinical record for Resident D was completed 9/10/25 at 12:12 p.m. Diagnoses included Alzheimer's disease, diabetes mellitus type II, and major depressive disorder. A quarterly Minimum Data Set (MDS) assessment, dated 8/13/25, indicated the resident had severe cognitive impairment, used a wheelchair for mobility, and was dependent on staff for all activities of daily living. A physician's order, dated 11/14/24, indicated to complete weekly skin assessments every Friday. A review of Resident D's Assessment record on 9/15/25 indicated the most recent skin assessment was 8/22/25. The record lacked assessment on 8/29/25, 9/5/25, and 9/12/25. During an interview on 9/15/25 at 3:00 p.m., the Corporate Nurse Consultant indicated all ordered skin assessments were to be completed and documented on the day the assessment was due, weekly. The missing assessments should have been completed and documented in the clinical record to assure resident had not developed any skin impairment. A current facility policy, revised 6/2020, titled, Wound Management, provided by the Administrator on 9/15/25 at 4:00 p.m., included the following: .Procedure I. Assessment A. A Licensed Nurse will perform a skin assessment upon admission, readmission, weekly and as needed for each resident. This citation is related to Intake 2580813. 3.1-47(a)</p>		