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	01/21/2026

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. Based on observation, record review, and interview, the facility failed to notify the physician or family following identifying an injury of unknown origin for 1 of 4 residents reviewed for accidents (Resident M).Findings include:During an interview on 1/15/26 at 2:53 p.m., Resident M's wife indicated on 1/10/26 at around 12:00 p.m., she visited her husband on the memory care unit. She found that he had a swollen, darkly bruised left eye. When she asked staff what had happened, they indicated to her they had no idea why he had a black eye. She had not received a call from the facility regarding his injury. It worried her that the staff was so dismissive about his injury. She had made arrangements for him to be discharged on 1/16/26 to another facility due to her fear for his safety and the lack of concern from the staff. There was another resident that resided at the facility who had been a boxer prior to being admitted to the memory care unit and was known to be violent. That resident made her feel unsafe when she visited. The staff also indicated they had not planned for any type of Xray or test to fully assess Resident M's injury. On 1/15/26 at 3:10 p.m., Resident M was observed seated in the common area at a table with another male resident talking. His left eye was observed to be swollen and discolored with varying shades of bruising. He appeared calm and engaged with his tablemate. The clinical record for Resident M was completed on 1/20/26 at 10:48 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, major depressive disorder, and cognitive communication deficit. A quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated the resident had severe cognitive impairment. The resident displayed no verbal or physical behaviors and no rejection of care. The resident required partial to moderate assistance for toilet hygiene, transfer, and bed mobility. A health care plan, dated 8/20/25, indicated Resident M was a high risk for falls related to lack of safety awareness. Interventions included to encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, ensure resident was wearing proper footwear and to review past falls, and attempt to determine cause of falls. A general progress note, dated 1/10/26 at 1:22 p.m., indicated the resident's left eye was puffed and was dark in color. Staff would continue to monitor. The clinical record lacked documented notification of black eye to the physician, appropriate personnel, or resident's spouse. During an interview on 1/21/26 at 12:07 p.m., the Director of Nursing (DON) indicated he had been covering for the Administrator who was on vacation beginning 1/9/26. He had not been informed about Resident M's injury until 1/12/26 in the morning meeting. He was not aware who discovered the resident's black eye; if it was the nurse or the resident's spouse. He had entered a Risk Management assessment on 1/12/26, but had not done any interviews or assessments. On 1/13/26, the staff talked about the injury again in morning meeting. No assessments or interviews had been completed on 1/13/26. On 1/14/26, he indicated he began to follow up on some suspicions it had been a fall. The facilities Clinical Education had begun interviewing staff regarding any injury seen on 1/9/26 or any report of the resident falling. All staff had responded with no. He counseled LPN 13 (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: 155215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2026

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	regarding her failure to report and assess Resident M's swollen, black eye. The clinical record had no assessment of the resident's injury. The incident had not been reported to the proper personnel and had not been thoroughly investigated. A current facility policy, revised 6/2011, titled, Incident/Accident Reporting, provided by the Regional Reimbursement Nurse on 1/17/26 at 11:40 a.m., included the following: Policy: It is the policy of this home for staff to report and investigate events, accidents or incidents. Definitions.3. Unexplained injury to a resident. No actual incident was observed, however, resident exhibits evidence of an injury such as a bruise or cut.Procedure-Resident.Notify physician and document the notification in the medical record. Cross Reference F609 and F610.This citation relates to Intake 2718719.

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 01/21/2026
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review, the facility staff failed to implement policies and procedures to immediately report an injury of unknown origin to the Administrator or Director of Nursing for 1 of 11 residents reviewed for abuse and neglect (Residents M). Findings include:During an interview on 1/15/26 at 2:53 p.m., Resident M's wife indicated on 1/10/26 at around 12:00 p.m. she visited her husband on the memory care unit. She found that he had a swollen, darkly bruised left eye. When she asked staff what had happened, they indicated to her they had no idea why he had a black eye. The staff also indicated they had not planned for any type of Xray or test to fully assess his injury. It worried her that the staff was so dismissive about his injury. She had made arrangements for him to be discharged on 1/16/26 to another facility due to her fear for his safety and the lack of concern from the staff. On 1/15/26 at 3:10 p.m., Resident M was observed seated in the common area at a table with another male resident talking. His left eye was observed to be swollen and discolored with varying shades of bruising. He appeared calm and engaged with his tablemate. The clinical record for Resident M was completed on 1/20/26 at 10:48 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, major depressive disorder, and cognitive communication deficit. A quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated the resident had severe cognitive impairment. The resident displayed no verbal or physical behaviors and no rejection of care. The resident required partial to moderate assistance for toilet hygiene, transfer, and bed mobility. A health care plan, dated 8/20/25, indicated Resident M was a high risk for falls related to lack of safety awareness. Interventions included to encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, ensure resident was wearing proper footwear and to review past falls and attempt to determine cause of falls. A health care plan, revised 11/28/25, indicated Resident M had a behavior of wandering and would go in other's rooms to use the bathroom and was non-compliant with wearing shoes and socks. Interventions included to anticipate and meet his needs, and to provide a program of activities of interest and accommodate resident.A general progress note, dated 1/10/26 at 1:22 p.m., indicated the resident's left eye was puffed and was dark in color; will continue to monitor. During an interview on 1/21/26 at 12:07 p.m., the Director of Nursing (DON) indicated he had been covering for the Administrator who was on vacation beginning 1/9/26. He had not been informed about Resident M's injury until 1/12/26 in the morning meeting. He was not aware who discovered the resident's black eye; if it was the nurse or the resident's spouse. He had entered a Risk Management assessment on 1/12/26, but had not done any interviews or assessments. He counseled LPN 13 regarding her failure to report and assess Resident M's swollen, black eye. The clinical record had no assessment of the resident's injury. The incident had not been reported to the proper personnel. A current facility policy, revised 6/2011, titled, Incident/Accident Reporting, provided by the Regional Reimbursement Nurse on 1/17/26 at 11:40 a.m., included the following: Policy.It is the policy of this home for staff to report and investigate events, accidents or incidents. Definitions.3. Unexplained injury to a resident. No actual incident was observed, however, resident exhibits evidence of an injury such as a bruise or cut.Procedure-Resident.The Administrator, Director of Nursing, or Department Head on Duty should be notified promptly if abuse or neglect is suspected or if there is a complaint of abuse or neglect. Cross reference F580 and F610.This citation relates to 2718719.3.1-28(c)

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	01/21/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review, the facility failed to investigate an injury of unknown origin following observation of a resident with swelling and discoloration of his left eye for 1 of 11 residents reviewed for abuse and neglect (Resident M).Findings include:During an interview on 1/15/26 at 2:53 p.m., Resident M's wife indicated on 1/10/26 at around 12:00 p.m., she visited her husband on the memory care unit. She found that he had a swollen, darkly bruised left eye. When she asked staff what had happened, they indicated to her they had no idea why he had a black eye. The staff also indicated they had not planned for any type of Xray or test to fully assess his injury. It worried her that the staff was so dismissive about his injury. She had made arrangements for him to be discharged on 1/16/26 to another facility due to her fear for his safety and the lack of concern from the staff. On 1/15/26 at 3:10 p.m., Resident M was observed seated in the common area at a table with another male resident talking. His left eye was observed to be swollen and discolored with varying shades of bruising. He appeared calm and engaged with his tablemate. The clinical record for Resident M was completed on 1/20/26 at 10:48 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, major depressive disorder, and cognitive communication deficit. A quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated the resident had severe cognitive impairment. The resident displayed no verbal or physical behaviors and no rejection of care. The resident required partial to moderate assistance for toilet hygiene, transfer, and bed mobility. A health care plan, dated 8/20/25, indicated Resident M was a high risk for falls related to lack of safety awareness. Interventions included to encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, ensure resident was wearing proper footwear, and to review past falls and attempt to determine cause of falls. A health care plan, revised 11/28/25, indicated Resident M had a behavior of wandering and would go in other's rooms to use the bathroom and was non-compliant with wearing shoes and socks. Interventions included to anticipate and meet his needs, and to provide a program of activities of interest and accommodate resident.A Skilled Evaluation progress note, dated 1/10/26 at 1:22 a.m. indicated there were no changes in skin integrity. A general progress note, dated 1/10/26 at 1:22 p.m., indicated the resident's left eye was puffed and was dark in color. Staff would continue to monitor. A Skilled Evaluation progress note, dated 1/11/26 at 9:28 p.m., indicated there were no changes in skin integrity. The clinical record lacked any assessment of the resident's vital signs, neurological status, or left orbital area upon discovery of the resident's injury. The record lacked documented notification of the physician, appropriate personnel, or resident's spouse. During an interview on 1/21/26 at 12:07 p.m., the Director of Nursing (DON) indicated he had been covering for the Administrator who was on vacation beginning 1/9/26. He had not been informed about Resident M's injury until 1/12/26 in the morning meeting. He was not aware who discovered the resident's black eye; if it was the nurse or the resident's spouse. He had entered a Risk Management assessment on 1/12/26, but had not done any interviews or assessments. On 1/13/26, the staff talked about the injury again in morning meeting. No assessments or interviews had been completed on 1/13/26. On 1/14/26, he indicated he began to follow up on some suspicions it had been a fall. The facilities Clinical Education had begun interviewing staff regarding any injury seen on 1/9/26 or any report of the resident falling. All staff had responded with no. He counseled LPN 13 regarding her failure to report and assess Resident M's swollen, black eye. The clinical record had no assessment of the resident's injury. The incident had not been reported to the proper personnel and had not been thoroughly investigated. A current facility policy, revised 6/2011, titled, Incident/Accident Reporting, provided by the Regional Reimbursement Nurse on 1/17/26 at 11:40 a.m., included the following: Policy It is the policy of (continued on next page)

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 01/21/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this home for staff to report and investigate events, accidents or incidents. Definitions.3. Unexplained injury to a resident. No actual incident was observed, however, resident exhibits evidence of an injury such as a bruise or cut .Procedure-Resident .The Administrator, Director of Nursing, or Department Head on Duty should be notified promptly if abuse or neglect is suspected or if there is a complaint of abuse or neglect.Complete the Incident/Accident Report. The Incident Investigation should be initiated.The Director of Nursing and the Administrator will review the incident. The Administrator will coordinate an investigation of the event as needed. Cross reference F580 and F609.This citation relates to 2718719.3.1-28(d)3.1-28(e)

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 01/21/2026
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)
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. A. Based on record review and interview, the facility failed to follow physician ordered parameters regarding medication administration of blood pressure medication for 2 of 11 residents reviewed for abuse and neglect (Residents E and L). B. Based on observation, interview, and record review, the facility failed to perform assessments following observation of a resident with swelling and discoloration of his left eye for 1 of 11 residents reviewed for abuse and neglect (Resident M). Findings include:A. 1. The clinical record for Resident E was completed on 1/15/26 at 11:12 a.m. Diagnoses included type two diabetes mellitus, stage three chronic kidney disease, heart failure, edema, and presence of a cardiac pacemaker. A current physician's order, dated 3/18/25, indicated to check heart rate daily and monitor for signs and symptoms of altered cardiac output or pacemaker malfunction. The resident's clinical record lacked a recorded heart rate for the reviewed months of November 2025, December 2025, and January 2026. During an interview on 1/15/26 at 12:42, the Regional Reimbursement Nurse (RRN) indicated the clinical record lacked the ordered heart rate and should have been completed daily per physician's order. A. 2. The clinical record for Resident L was completed on 1/16/26 at 2:00 p.m. Diagnoses included vascular dementia, essential hypertension, and stage two chronic kidney disease. A current physician's order, dated 3/18/25, indicated to administer losartan potassium (to treat high blood pressure) 100 mg (milligram) daily. Hold dose for systolic blood pressure less than 110. The electronic Medication Administration Record (eMAR) for December 2025 indicated Resident L's systolic blood pressure on 12/6/25 was 106; on 12/8/25 was 103; and on 12/10/25 was 104. The eMAR indicated the medication had been administered. The eMAR for January 2026 indicated Resident L's systolic blood pressure on 1/3/26 was 107; on 1/9/26 was 94; and on 1/14/26 was 106. The eMAR indicated the medication was administered. The eMAR for January 2026 indicated Resident L's systolic blood pressure on 1/3/26 was 107; on 1/9/26 was 94; and on 1/14/26 was 106. The eMAR indicated the medication had been administered. A current physician's order, dated 5/8/25, indicated to administer Metoprolol Tartrate (to treat high blood pressure) 25 mg, half tablet (12.5 mg) two times a day. Hold dose for a systolic blood pressure less than 100 or a heart rate less than 60. The eMAR for January 2026, indicated on 1/9/26, Resident L's systolic blood pressure was 96. The medication had been administered. During an interview on 1/16/26 at 1:59 p.m., the Director of Nursing (DON) indicated the resident's medication should have been held when a physician ordered parameters to do so. A current facility policy, revised 6/2020, titled, Physician Orders, provided by the Regional Reimbursement Nurse on 1/17/26 at 11:40 a.m., included the following: Purpose.This will ensure that all physician orders are complete and accurate.Procedure.II. Orders will include a description complete enough to ensure clarity of the physician's plan of care .VI. Documentation pertaining to physician orders will be maintained in the resident's medical record. Current month's administration records will be maintained in the MAR/TAR. B. During an interview on 1/15/26 at 2:53 p.m., Resident M's wife indicated on 1/10/26 at around 12:00 p.m., she visited her husband in the memory care unit. She found that he had a swollen, darkly bruised left eye. When she asked staff what had happened, they indicated to her they had no idea why he had a black eye. She had not received a call from the facility regarding his injury. It worried her that the staff was so dismissive about his injury. There was another resident that resided at the facility who had been a boxer prior to being admitted to the memory care unit and was known to be violent. The staff also indicated they had not planned for any type of Xray or test to fully assess his injury. On 1/15/26 at 3:10 p.m., Resident M was observed seated in the common area at a table with another male resident talking. His left eye was observed to be swollen and discolored with varying shades of bruising. He appeared calm and engaged with his tablemate. The clinical (continued on next page)

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 01/21/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record for Resident M was completed on 1/20/26 at 10:48 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, major depressive disorder, and cognitive communication deficit. A quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated the resident had severe cognitive impairment. The resident displayed no verbal or physical behaviors and no rejection of care. The resident required partial to moderate assistance for toilet hygiene, transfer, and bed mobility. A general progress note, dated 1/10/26 at 1:22 p.m., indicated the resident's left eye was puffed and was dark in color. Staff would continue to monitor. The clinical record lacked any assessment of the resident's vital signs, neurological status, or left orbital area upon discovery of the resident's injury. The record lacked documented notification of the physician, appropriate personnel, or resident's spouse. During an interview on 1/21/26 at 12:07 p.m., the Director of Nursing (DON) indicated he had been covering for the Administrator who was on vacation beginning 1/9/26. He had not been informed about Resident M's injury until 1/12/26 in the morning meeting. He was not aware who discovered the resident's black eye; if it was the nurse or the resident's spouse. He had entered a Risk Management assessment on 1/12/26, but had not done any interviews or assessments. On 1/13/26, the staff talked about the injury again in morning meeting. No assessments or interviews had been completed on 1/13/26. On 1/14/26, he indicated he began to follow up on some suspicions it had been a fall. The facilities Clinical Education had begun interviewing staff regarding any injury seen on 1/9/26 or any report of the resident falling. All staff had responded with no. He counseled LPN 13 regarding her failure to report and assess Resident M's swollen, black eye. The clinical record had no assessment of the resident's injury. The incident had not been reported to the proper personnel or the physician and had not been thoroughly investigated. A current facility policy, revised 6/2011, titled, Incident/Accident Reporting, provided by the Regional Reimbursement Nurse on 1/17/26 at 11:40 a.m., included the following: Policy It is the policy of this home for staff to report and investigate events, accidents or incidents. Definitions.3. Unexplained injury to a resident. No actual incident was observed, however, resident exhibits evidence of an injury such as a bruise or cut.Procedure-Resident.Immediately assess the condition of the resident involved. Initiate emergency first aid, and when necessary, transfer to hospital. The Neurological Assessment will be used immediately following any injury resulting in actual or suspected head trauma, or un-witnessed falls.Document medical facts of the incident and follow up in the medical record. (Notifications will be made at least every shift for a minimum of 72 hours, or longer as appropriate, until such time as the resident is deemed stable and/or has returned to their previous level of functioning.) Cross reference F609 and F610. This citation relates to Intakes 2671298 and 2718719. 3.1-37(a)

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 01/21/2026

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and record review, the facility failed to provide supervision and interventions for an aggressive dementia resident (Resident L) on the locked dementia unit resulting in the resident forcibly removing another resident (Resident N) out of her wheelchair causing bruising to her eye and nose. This deficiency had the ability to affect 21 of the 21 residents residing on the locked dementia unit. The immediate jeopardy began on 12/30/25 when Resident L wanted Resident N's wheelchair and forcibly removed her from the wheelchair resulting in bruising and swelling to Resident N's right eye and nose. Resident L had previously wandered into another resident's room and punched a staff member when they attempted to re-direct him on 12/12/25. On 1/8/26 the Nurse Practitioner documented that Resident L was a risk to himself and others. On 1/13/26 Resident L was found lying in a bed in a female resident's room while she was in her own bed. Resident L became aggressive to staff when they attempted to remove him. On 1/15/26 Resident L was observed with items from another resident's room and observed attempting to enter other residents' rooms. Resident L's care plans had not been updated to indicate the resident had been physically aggressive to staff or residents and his current care plans lacked interventions related to his physical aggression and wandering. The Director of Nursing and Regional Resource Nurse were notified of the Immediate Jeopardy on 1/16/26 at 2:44 p.m. The Immediate Jeopardy was removed on 1/18/26, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:On 1/15/26 at 2:26 p.m., during a random observation, Resident L was observed to be a tall muscular man residing on the 500 hallway the Memory Care unit. Resident L was observed removing a wheelchair from a resident's room. He re-entered the room and rolled out an overbed table. CNA 11 asked an unidentified CNA to accompany her to re-direct Resident L. She approached the resident and indicated they needed to return the overbed table to the resident's room. Resident L continued to hold onto the table. CNA 11 repeated that the table would need to be returned to the other resident's room. He eventually let go of the table and she redirected him to his room. The unidentified CNA had remained at a small distance from the resident and returned the overbed table and wheelchair to the room after CNA 11 escorted Resident L down the hall. Following the observation, CNA 11 indicated Resident L could be unpredictable and violent. He had hit a CNA in the face on another occasion, so staff used caution when re-directing him. On 1/16/26 at 1:20 p.m., during an observation of the Memory Care unit, Resident L was seated at a table in the common area, finishing his lunch. He rose from his chair and walked to the locked unit doors. He pulled on the doors several times, becoming more aggressive with pulling on the door. CNA 8 asked if he would have a seat for her. The Memory Care Manager approached and asked if he would help her with something. The resident took her outstretched hand and moved to a table with magnetic plastic tiles on top. He sat down at the table and looked at them briefly, then stood from his chair and began to walk towards the locked unit doors. CNA 8 approached him and asked if he would come with her and began to walk toward the resident hallway. He eventually turned and followed her down the hallway. A review of Resident L's clinical record was completed on 1/16/26 at 2:00 p.m. Diagnoses included severe vascular dementia with other behavioral disturbance, anxiety disorder, history of alcohol dependence, and major depressive disorder. His record indicated he was 6 feet tall and weighed 219 pounds. A health care plan, dated 3/18/25, indicated the resident had behaviors of hiding and/or refusing medications in his pockets. Resident L could become verbally aggressive and stand by exit doors in an attempt to exit seek. Resident L refused showers, moved furniture around, and made comments such as: I'm going to hit you. Interventions included: Monitor behavioral episodes and attempt to determine (continued on next page)

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 01/21/2026
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)
F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	underlying cause; consider location, time of day, persons involved, and situation; document behavior and potential causes; staff to intervene as needed to protect the rights and safety of others; and divert attention, remove from situation and take to alternate location as needed. A health care plan, dated 5/7/25, indicated the resident required psychotropic medications for the diagnosis of vascular dementia with aggressive behavior management. Interventions included: administer medications as ordered and monitor/document for side effects and effectiveness; monitor and record an occurrence of target behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff and others; and document per facility protocol. A psychiatric progress note, dated 11/10/25, indicated Resident L was an Olympic boxer. An Adverse Incident Report, dated 12/12/25, indicated on 12/12/25 around 7:30 p.m. Resident L was observed attempting to enter another resident's room with a visitor present. Staff attempted to redirect the resident away from the doorway when Resident L balled up his fist and hit CNA 4 in the face and stated he was going to get them all. He proceeded into the room and sat in a chair. Another CNA attempted to approach the resident, and he balled up his fists and stood from the chair and attempted to hit the CNA. The nurse on the unit was able to get Resident L to sit back onto the chair and offered him snacks and a drink. After a period, Resident L allowed staff to remove him from the room and perform incontinent care when he proceeded to bed. An Incident Report, dated 12/30/25 at 5:00 p.m., indicated Resident N was in her wheelchair in the common area. Resident L believed she was in his car and grabbed the handles on her wheelchair and began to pull the wheelchair back at an angle causing Resident N to fall to the floor. Resident N hit her eyeglasses on the floor, and this caused bruising and swelling to her right eye and nose. A review of 15-minute Behavior Monitoring Sheets indicated Resident L displayed agitation as follows:On 12/30/25 from 7:45 p.m. to 8:30 p.m.On 1/1/26 from 9:45 a.m. to 10:00 a.m.On 1/2/26 from 7:30 p.m. to 8:00 p.m.On 1/3/26 from 7:45 a.m. to 8:00 a.m.On 1/5/26 from 6:15 p.m. to 8:00 p.m. On 1/5/26 from 8:15 p.m. to 10:15 p.m. A review of 15-minute Behavior Monitoring Sheets indicated Resident L displayed wandering into other resident's rooms as follows:On 1/1/26 from 9:15 a.m. to 9:45 a.m.On 1/3/26 from 9:45 a.m. to 10:00 a.m.On 1/6/26 from 9:00 a.m. to 9:30 a.m. A review of 15-minute Behavior Monitoring Sheets indicated Resident L displayed combativeness on 1/6/26 from 9:30 a.m. to 9:45 a.m. A Nurse Practitioner's progress note, dated 1/8/26 entered on 1/12/26, indicated Resident L was being seen due to an incident when Resident L pulled a wheelchair out from under another resident resulting in the other resident falling to the floor. Resident L had a history of medication refusals which made care challenging for staff. The resident had been accepted to a neuropsychiatric unit for medication and psychiatric stabilization on 12/31/25. The resident's wife had initially agreed but changed her mind and refused. Resident L continued intermittent aggressive behaviors, resistance to staff assistance for care, and medication refusals. An on-call provider had ordered an as needed dose of injectable Haldol (a medication used to treat psychosis), but the resident's wife declined the order. The resident was at high risk to himself and others. If behaviors persisted, it may require a physician ordered emergency detention due to the resident's wife declining the resident to receive certain medications and declining the resident be treated at an inpatient neuropsychiatric facility. A general progress note, dated 1/13/26 at 5:36 a.m., indicated Resident L was roaming the common area and hallway on the 500 hall. CNA 10 reported to nurse that resident was in a female resident's room and had refused to come out. When the nurse arrived at the room, Resident L was in the other bed in the resident's room. When attempting to re-direct Resident L out of the bed, he became combative. CNA 10 went to another unit in the facility and asked two male CNAs for help. They were able to get the resident out of the female resident's room and to the common (continued on next page)

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 01/21/2026
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)
F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	area. Resident L's record lacked documentation of care plans or interventions related to his aggressive physical behavior or the incidents from 12/12/25, 12/30/25, or 1/13/26. Resident L's record lacked documentation of behavior monitoring prior to the 15 minute monitoring. During a confidential interview on 1/15/26 at 1:42 p.m., another memory care resident's family member indicated she was afraid of Resident L and would ask for an escort off the unit after visiting her mother due to his aggressive behavior. During an interview on 1/16/26 at 12:50 p.m., QMA 9 indicated on 12/30/25 she had observed Resident N on the floor with Resident L holding onto her wheelchair handles. Resident L would not let go of the wheelchair. He was agitated and wanted the wheelchair. When Resident L got agitated, he yelled and cursed. He would get into a fighting stance. Residents stayed away from him. His aggression was worsening and incidents were occurring more frequently. The staff were scared of him. When Resident L said no to something, the staff would back off immediately, especially since he had hit a CNA. He would often refuse or spit out his medications. The staff kept other residents away when he became agitated. She observed today when a female resident approached the area where Resident L had rearranged some chairs and the staff moved the female resident out of the way quickly to assure her safety. During an interview on 1/16/26 at 1:59 p.m., the DON indicated Resident L frequently refused medication and redirection by staff. After the incident with Resident N, they attempted to send him to a neuropsychiatric facility for evaluation and treatment, but the resident's wife refused to send him out. They had him on one-to-one staff monitoring following the incident and staff had since been monitoring him more frequently. His care plan should have been updated to reflect his aggressive behaviors and updated interventions when dealing with those behaviors. He was unsure why the resident had no specific behavioral monitoring order. During an interview on 1/18/26 at 12:40 pm, with the Regional Resource Nurse and DON, the DON indicated the resident remained on one on one supervision and was currently calm. The Regional Resource Nurse indicated a care plan meeting was scheduled for Wednesday with Resident L's wife, but they were going to attempt to call Monday for an unofficial meeting to let her know that family needed to be with resident if he remained at the facility, or he could be sent to the neuropsychiatric hospital, or go home with her. The DON and the Regional Resource Nurse indicated the resident was sent to an acute care hospital emergency room (ER) instead because that was the only place the wife would allow the resident to go. Neither knew why the wife was allowed to make this decision if the resident was deemed to be a risk to himself and others. The resident went to the ER, but the wife refused care for the resident and he was returned to the facility. The acute care hospital would only admit if there was a medical reason to keep the resident. Since the wife refused care/denied concerns he was not admitted . The DON indicated the nurse from the ER reported the resident was aggressive to the ER doctor, but it was not documented. The bed hold policy was sent with the resident so when he was not admitted he was sent back to the facility despite the fact that the risk had not changed. The DON and the Regional Resource Nurse confirmed that the resident was currently doing ok with one on one supervision, but they were not sure how long they could provide this with staffing. They were not sure if he would become agitated with staff in the future. They were both concerned about staff safety as well as resident safety. The Regional Resource Nurse indicated they would call the wife to see if they could talk with her regarding the need to send him out to a neuropsychiatric hospital instead due to resident and staff safety. On 1/18/26 at 1:15 p.m., Resident L was observed walking down the hall with CNA 7. As he passed the cleaning cart, he attempted to take the cart. CNA 7 redirected him and indicated Housekeeper 1 needed to push the cart down the hall. The resident continued down the hall with CNA 7. On 1/18/26 at 1:37 p.m., Resident L was observed in the dining room refusing to take his medications. QMA 5 was seated with him (continued on next page)

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 01/21/2026
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)
F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and attempted to give him his medications that had been crushed and placed in applesauce using a spoon. The DON and QMA 5 continued to encourage him to take his medication, while he refused to open his mouth with a hand in front of his face. The DON indicated to Resident L that his wife would like him to take his medications while QMA 5 indicated the same. Resident L indicated he would like to call his wife. QMA 5 indicated to Resident L they would call her after he took his medication. The resident continued to refuse and lifted his right hand to his mouth, resting on his chin. QMA 5 waited and Resident L eventually allowed a spoonful in his mouth. During an interview on 1/18/26 at 2:20 pm the Regional Resource Nurse indicated she had done some digging and found the resident had attacked his wife with a pen before being admitted to the facility and that she was afraid of him. So, she was aware of his behaviors and aggression. She spoke with his wife and told her that the resident was a continued risk to himself, residents and staff. He would need to be transferred to a neuropsychiatric hospital, or a skilled facility with a locked psychiatric unit, or go home. The wife indicated she did not want him to go to the neuropsychiatric hospital, the skilled units with psychiatric care were too far away, and she refused to take him home because she could not care for him. She informed the wife they were making referrals and he would be sent out because he could not stay at the facility safely. The facility had placed eight referrals that afternoon. She indicated all staff were re-educated on dementia care and behavioral care on 1/17/26. When asked if the staff providing one on one were educated for aggressive behavior, no answer was given. During an interview on 1/19/26 at 10:30 a.m., the Corporate Nurse Consultant indicated the resident was sent out 1/18/26 around 7:45 p.m. to the acute care hospital. The Regional Resource Nurse indicated the management team was worried since the resident had been attempting to refuse medications during the day on 1/18/26 with extra management staff in the building that the regular night shift staff may not be enough to keep him and other residents safe. So, they called the acute care hospital and arranged for the resident to be admitted to an inpatient psychiatric bed. The Corporate Nurse Consultant indicated they had to provide the documentation to the hospital to prove that the resident was a risk for the residents at the facility and needed to be admitted . They made it clear that he was not safe to return to the facility and they were working on placement somewhere else more appropriate. The Regional Resource Nurse indicated as far as they knew the resident was admitted to the unit and was in four-point-restraints. The facility still did not have access to the resident's notes from the hospital. A current facility policy, revised 8/2020, titled, Violence Between Residents, provided by the Corporate Nurse Consultant on 1/17/26 at 11:40 a.m., included the following: Purpose To protect the health and safety of residents by ensuring that altercations between residents are promptly reported, investigated, and addressed by the Facility .Procedure.II. Response to an Altercation.J. If, after carefully evaluating the situation, it is determined that care cannot be readily given within the Facility, transfer the resident. The immediate jeopardy that began on 12/30/25 was removed on 1/18/26 when Resident L was admitted to an acute care hospital psychiatric unit. The facility ensured a systemic plan to include staff education and monitoring of residents to ensure staff provided dementia care and supervision. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. This citation relates to Intake 2718719. 3.1-37