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	03/11/2026

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 0684 Level of Harm - 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 identify and provide wound care services by ensuring wound assessments and treatments were provided to prevent worsening wounds for 1 of 3 residents reviewed for wound care (Resident B).Findings include:On 3/11/26 at 3:00 p.m., during a phone interview, Resident B indicated she received good care, but the facility did not change her wound dressings for 10 days after admission. She indicated the staff looked at her leg wounds but did not change the dressings. On 3/10/26 at 10:30 a.m., the medical record of Resident B was reviewed. The resident was admitted to the facility from a local hospital on 1/8/26. admission diagnoses included, but were not limited to, kidney failure (occurs when kidneys lose the ability to adequately filter waste products, excess fluid, and toxins from the blood), edema (swelling), and hypotension (low blood pressure). Review of the hospital discharge instructions, dated [DATE], included a diagnosis of deep tissue injury (a serious form of pressure injury where soft tissue beneath the skin is damaged by intense or prolonged pressure which appears as intact skin with purple/maroon discoloration or a blood-filled blister) to bilateral lower extremities (BLE). An admission nursing skin assessment note, dated 1/8/26, indicated bruises to buttock, edema to BLE, weeping areas to BLE, bruising behind knees, redness under breasts and groin. On 1/9/26 the facility Nurse Practitioner (NP) visit note indicated no wounds. On 1/12/26 a Physician Assistant (PA) visit note indicated no wounds. Review of the medical record indicated documentation of skin assessment on 1/12/26 indicated an open area right lower leg front and front left lower leg. The assessment lacked documentation of additional wound assessment including description or measurements of wounds. On 1/13/26 a NP visit note indicated dressings present but did not observe wounds. A care plan, dated 1/14/26, indicated the resident had potential for pressure ulcer development related to immobility. The goal indicated, pressure ulcer will show signs of healing and remain free from infection by/through review date. The record lacked documentation of a care plan for non-pressure wounds or interventions to treat and prevent non-pressure wounds. On 1/15/26 a Physician Assistant (PA) visit note indicated they did not observe wounds. An admission Minimum Data Set Assessment, dated 1/15/26, indicated the resident was alert and oriented and had no cognitive deficits. She required assistance for daily care needs. From 1/16/26 to 1/22/26 daily skilled nurse's notes indicated No change in skin integrity. On 1/18/26 and 1/19/26, skin assessments were not completed in the daily skilled note. The medical record lacked documentation of skin assessment completion on 1/19/26. On 1/20/26 an NP visit note indicated, Her leg pain has improved. She says her bandages on anterior bilateral LE have not been changed since the hospital. The wound on her left leg has some drainage. Not warm to the touch and no spreading erythema. Wounds to be cleaned and bandages changed. The medical record lacked documentation of physician orders for wound care from admission on [DATE] until 1/21/26. A Physician order, dated 1/21/26, indicated to cleanse area to the left inner leg with normal saline, apply hydrogel (high water content wound dressing) to area and cover with foam dressing every day shift for wound care and as needed for soilage. Order was discontinued on 1/23/26. A Physician Order, dated 1/21/26, indicated cleanse right anterior leg with normal saline, apply xerofoam (sterile, non-adherent, petrolatum soaked gauze dressing containing an antimicrobial) (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	to site, and cover with a foam dressing every day shift for wound care and as needed (PRN) for soilage wound care. Order was discontinued on 1/23/26. On 1/23/26 an NP visit note indicated a diagnosis of cellulitis (a potentially serious bacterial infection affecting the deep layers of the skin and underlying tissue). The record lacked documentation of interventions of treatment or antibiotic. A Physician order, dated 1/23/26, indicated cleanse right anterior leg with normal saline, apply xerofoam to site, and cover with a foam dressing every evening shift for wound care and as needed for soilage wound care. Order was discontinued on 1/29/26. A Physician order, dated 1/23/26, indicated cleanse area to the left inner leg with normal saline, apply hydrogel to area, and cover with a foam dressing every evening shift for wound care and as needed for soilage. Order was discontinued on 1/29/26. Review of the Treatment Administration Record (TAR) a weekly skin assessment was signed as being completed on 1/12/26, 1/19/26, and 1/26/26. On 1/26/26 and 1/27/26 skilled nursing notes indicated no changes in skin integrity. Dressing changes per treatment orders. Preventive skin cream/ointment. Review of the medical record indicated documentation of skin assessment on 1/26/26 indicated an open area to right lower leg front and front left lower leg. The assessment lacked documentation of additional wound assessment including description or measurements of wounds. On 1/27/26 an NP visit note indicated dressings intact and change dressings daily. The record lacked documentation of an assessment of the wounds under the dressings. A Physician order, dated 1/29/26, indicated wound care left lower leg, cleanse open area with normal saline NO WOUND CLEANSER, pat dry, skin prep peri wound, apply Santyl (topical medication to remove dead tissue) to wound bed, pack lightly with Calcium Alginate (a highly absorbent, biodegradable wound dressing derived from brown seaweed, designed for moderate-to-heavy draining wounds), cover. Change daily and PRN every day shift for skin impairment and as needed for soilage/dislodgement. On 1/29/26 an NP visit note indicated, The chief complaint for this visit is wound follow up. This visit is requested by the patient. [Resident B] is here for Long Term Care. Resident.seen for wound follow up. Visit requested by [Resident B] and her sister due to concerns regarding wound to BLE. Seen in bed .Alert and oriented. BLE with wound dressing in place. RLE [right lower extremity] with quarter size ulceration to mid shin. No signs of infection. Nursing dresses areas daily. LLE [left lower extremity] with large ulceration with slough [soft, moist, stringy, and usually yellow or white] and eschar [eschar is dead] tissue. No signs of infection. Assessed with wound nurse. Plan to add Santyl ointment to debride LLE wound. [Resident B] to be placed on wound team rounds with wound NP.BLE wound dressing in place. RLE quarter size open area on right shin. Large ulceration on the LLE with slough in wound bed. Ordered Santyl ointment for debridement. Indicated heavy edema. A Physician order, dated 1/29/25, indicated wound care right lower leg. Cleanse with normal saline, pat dry, apply Medihoney (a medical-grade, antibacterial honey used for managing acute and chronic wounds, burns, and ulcers) to wound beds, cover with foam dressing, change daily and PRN every day shift for skin impairment and as needed for soilage/dislodgement. A Physician order, dated 1/29/26, indicated to refer to consultant wound care to evaluate and treat. A Physician order, dated 1/30/26, indicated Santyl ointment 250 grams apply to left lower leg topically, every day shift for skin impairment. On 1/30/26, 1/31/26, and 2/3/26 a skilled nurse note indicated no changes in skin integrity. Dressing changes per treatment orders. Preventive skin cream/ointment. On 2/4/26 a daily skilled nurse note indicated treatable wound, dressing changes as ordered. A Physician order, dated 2/4/26, indicated doxycycline hyclate (antibiotic) 100 milligram by mouth two times a day for LLE cellulitis (bacteria infection) for 7 days. On 2/5/26 an NP visit note indicated cellulitis and extreme edema. The record lacked documentation of assessment of wounds or of interventions or initiation of antibiotic. On 2/10/26 a physician visit note indicated, the resident requires ongoing skilled medical management due to persistent erythema [redness], drainage, and slow healing of bilateral lower extremity wounds, despite current antibiotic therapy and wound care interventions. She is under the care of the wound team and is receiving doxycycline for cellulitis. Antibiotic medication ordered. On 2/11/26 a wound assessment was (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	completed by the facility wound nurse. The assessment indicated a wound was observed on the right lower extremity. The wound was identified as a Venous Stasis Ulcer (a shallow, slow-healing open sore, usually on the lower leg or ankle, caused by chronic poor circulation) and indicated it was present on admission to the facility. The wound measured 3 cm (centimeters) long by (x) 2.5 cm wide x 1cm deep. The record lacked documentation of wounds on the left lower extremity. On 2/11/26 the NP from the wound care service provider visited the resident. Assessment note indicated four wounds on the BLE. The NP identified wounds as abscesses. She indicated wound measurements were as follows:Right lower leg proximal (closer to the upper leg) 3 cm wide x 2.5 cm long x 1 cm deep.Right distal lower leg (closer to the lower leg) 2.5 cm wide x 2.5 cm long x 2.5 cm deep.Right proximal medial lower leg (middle front of the leg) 1 cm wide x 1.5 cm long x 0.1 cm deep.Left lower leg wound measurements were 13 cm wide x 11 cm long x 0.3 cm deep. Review of the February TAR indicated a weekly skin assessment was documented as been completed on 2/12/26 and 2/19/26. The medical record lacked documentation of skin assessments. On 2/11/26 at 10:20 a.m., Resident B's blood pressure was extremely low and she was experiencing difficulty breathing. The resident was sent to the emergency room of a local hospital and admitted into intensive care unit (ICU) for care. An infectious disease physician consult indicated the resident had septic shock (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to tissue damage, organ failure, and potential death) secondary to her wounds. admission final diagnoses included, but were not limited to, pulmonary embolism (blood clot in the lung), multiple wounds on the lower extremities, cellulitis, significant hypotension (low blood pressure). Wounds were assessed, and the following measurements were obtained on 2/11/26:Lower right leg 11.5 cm x 10 cm x 1 cm with 3 cm tunneling (open under the skin like a tunnel)Lower left leg wound proximal to knee 14.5 cm x 13 cm x1 cm.Lower left leg wound distal to the knee. 16 cm x 10 cmx 1.5 cmRight pretibial (top of leg) 12 cm x 9 cm x 1 cmLeft pretibial 13 cm x 10 cm x 0.7 cm On 3/11/26 at 11:07 a.m., during a phone interview the former facility NP indicated when she visited Resident B on 1/9/26 the resident had a lot of pink foam dressings on her leg she indicated she referred the facility wound care nurse to contact the consultant wound service provider. She indicated she peaked under the dressings but did not assess the wounds. She indicated the wounds were decent, then they got bad quickly. She indicated she did not always look at wounds when visiting residents. She indicated the documentation by the facility staff was not good and a lot of things fell through the cracks. She indicated the facility nurse should assess wounds and enter information under the wound documentation tab of the electronic record. She acknowledged documentation should include pictures and measurements of all wounds on admission and in the weekly wound assessments. On 3/11/26 at 11:55 a.m., during a phone interview, Resident B's responsible indicated when the resident left the hospital on 1/8/26, she had wounds on her legs. She had received treatments in the hospital. Her legs were not wrapped but she had large bandages on them. She indicated the resident would not be returning to the facility. On 3/11/26 at 3:20 during an interview, Licensed Practical Nurse (LPN) 6 indicated if a resident was admitted to the facility with wounds she would remove the dressings and assess the wounds. She would record wounds on the skin assessment, notify family and physician to obtain treatment orders. On 3/11/26 at 3:23 p.m., during an interview LPN 7 indicated the regular nurse practitioner did not look at wounds when she was in the facility. On 3/11/26 at 3:43 p.m., during an interview LPN 5 who was formerly the wound nurse indicated if a nurse advised her a resident had wounds she would see the resident and assess them. She indicated most of the time the wound information was in the wound record within the electronic medical record. She indicated the nurses were to complete skin assessments for all residents weekly. She indicated she was advised Resident B did not have any wounds on admission. On 3/11/26 at 2:50 p.m., the Regional Nurse indicated all residents were to have a weekly skin assessment completed. On 3/11/26 at 3:01 p.m., the Director of Nursing provided a document titled, Wound Management, dated 1/2025, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: A resident who has a wound will receive necessary (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing. Residents with wounds will receive individualized care to support healing and prevent complications. Wound management will include thorough assessment, evidence-based interventions, ongoing monitoring, and interdisciplinary collaboration. Wound Management Principles.I. Assessment.1. A Licensed Nurse will conduct skin assessments. Upon admission and re-admission. Weekly and as needed. Document findings in PointClickCare (PCC) or the facility's electronic health record (EHR). 2. When a new wound is identified measure the wound (length, width, depth in cm).implement physician-ordered treatment immediately.II. Wound Treatment & Management. 7. The Attending Physician & IDT will be notified of new wounds or pressure injuries. This citation relates to Intake 2794977. 410 Indiana Administrative Code (IAC) 3.1-37

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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 and interview, the facility failed to ensure documentation of assessment and treatment progress of pressure ulcers (localized damage to the skin and underlying soft tissue, usually over a bony prominence, caused by prolonged pressure, shear, or friction) were completed for 1 of 3 residents reviewed for wounds (Resident C). Findings include:Resident C's record was reviewed on 3/10/26 at 2:15 p.m. The profile indicated the resident's diagnoses included, but were not limited to, dislocation of internal left hip prosthesis (the artificial ball has popped out of the artificial socket), age-related osteoporosis (a common condition, particularly in adults over 50, where bones naturally lose density, becoming porous, brittle, and weak), and unspecified protein-calorie malnutrition (a medical condition where the body does not get enough protein and energy [calories] to function properly, resulting in muscle wasting, weight loss, and weakened immunity). An admission skins assessment, dated 1/23/26, indicated the resident had re-admitted to the facility from the hospital with open area to her coccyx and an open area on her left thigh. A care plan, dated 1/22/26, and revised on 2/11/26, indicated the resident had actual impairment to skin integrity related to pressure ulcer stage 3 (a deep, full-thickness wound where the skin is gone, exposing the subcutaneous fat layer) to her coccyx (the small, triangular bone located at the very bottom of the spine) and a stage 2 pressure ulcer (a shallow, open wound caused by prolonged pressure, resulting in partial-thickness skin loss) to her left thigh. Interventions included, but were not limited to, follow facility protocols for treatment of pressure ulcer injury and monitor/document location, size and treatment of skin injury. A 5-day Medicare Minimum Data Set (MDS) assessment, dated 2/11/26, indicated the resident had severe cognitive deficit and had unhealed pressure ulcers. The record lacked documentation of any weekly skin assessments. A facility wound report, dated 3/11/26 at 10:47 a.m., indicated the resident had the following wounds: a. Stage 3 pressure wound to her coccyx. The report documented the last wound assessment date was 1/23/26. b. Stage 2 pressure wound to her left thigh. The report documented the last wound assessment date was 1/23/26. c. Unstageable pressure wound (a severe sore where the depth cannot be determined because the wound base is completely covered by dead, damaged tissue). The report indicated the wound had been assessed on 3/11/26 at 9:21 a.m. During an interview, on 3/11/26 at 9:37 a.m., the Regional Clinical Consultant indicated that the wound Nurse Practitioner (NP), who came to the facility, did not have access to documents in the facility's electronic medical record (EMR) system. Access had been requested but had not yet been set up. During an interview, on 3/11/26 at 10:00 a.m., the wound NP indicated Resident C had just been referred to her to see a couple of weeks ago and she had started seeing the resident at that time. She did not have access to the facility's EMR and was unable to review any of the resident's documentation or to document directly into the EMR. When she began to see the resident, she did not find any ulcerations on her coccyx or left knee area. Because she could not review the resident's wound history, she did not know what wounds she had in the past or how they were treated and healed. She had been shown the wound rounds report and had observed that the last time an assessment had been documented was on 1/23/26. She had only seen the resident's heel wound. She wanted to order some tests related to the heel wound but wanted to review the resident's wound history first. She was hopeful that she would be provided with access to the EMR system soon. It was very hard for her to provide proper care without having full access to the resident's information. During an interview, on 3/11/25 at 10:43 a.m., the Administrator indicated she and the Director of Nursing (DON) had only been at the facility for a short time. To her knowledge, there was not currently a wound nurse on staff at the facility. The wound NP did come weekly, and a staff nurse wound round with her. Staff nurses working on the halls were responsible for providing the wound dressing treatments as ordered. She was not familiar with what wounds notes were available in the EMR or where they would be located. On 3/11/26 at 3:31 p.m., the Regional Clinical Nurse provided a document, with a revision date of 6/2020, titled, Pressure Injury Prevention, and indicated it was the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy currently being used by the facility. The policy indicated, .Procedure.I. Risk Identification and Assessment: .B.Results of weekly skin assessments will be documented.III. Ongoing Monitoring.B. The Licensed Nurse will document effectiveness of pressure injury prevention techniques in the resident's medical record on a weekly basis. This citation relates to intake 2794977. 410 Indiana Administrative Code (IAC) 16.2-3.1-40(a)(2)