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	06/25/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on record review and interview, the facility failed to protect a resident's psycho-social well-being by not addressing trauma related triggers for a resident with post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying or life-threatening event) for 1 of 1 resident reviewed for PTSD (Resident B). Findings include:On 6/23/26 at 11:08 a.m., during an interview with Resident B, he indicated he was sexually touched inappropriately as a child and did not like his genitalia to be touched by anybody. He indicated he was told he could take his showers independently when he was admitted to the facility. He indicated a CNA came to get him for a shower and insisted on washing him even after he told her not to touch him. The CNA used two washcloths; she took one washcloth and washed his legs, feet, genitals, and then faced his head and face. She kept washing him even after the resident asked her to stop several times. Washing his genitals triggered him. He indicated he wanted to shower every other day, but he wanted to do it by himself because he did not like being touched by others. He indicated other triggers for his PTSD were fire alarms, smoke, verbal, and physical violence. Another incident occurred when a nurse came into his room and shoved his medication in his mouth between 5:45 a.m. and 6:00 a.m. The nurse didn't turn his light on and did not tell him what she was doing. This provoked a response in him which included throwing water pitchers and law enforcement being called on him. On 6/23/26 at 12:01 p.m., a record review was completed for Resident B. He had the following diagnoses which included, but were not limited to, cerebral palsy (a group of neurological disorders that affect a person's ability to move, maintain balance, and posture), PTSD, attention-deficit-hyperactivity disorder (ADHD, a common neurodevelopmental disorder), anxiety, and autistic disorder (a neurological and developmental condition that affects how a person communicates, interacts, learns, and behaves). On 2/25/26 his Brief Interview for Mental Status (BIMS) assessment indicated he was cognitively intact with a score of 15 out of 15. Resident B had a care plan, dated 5/23/26, that indicated he had a history of trauma related to sexual abuse. The goal dated 5/23/26 indicated to create an emotionally and physically safe environment. Approaches indicated to help residents deal with anxiety producing experiences and to provide him with Play-Doh or another preferable activity when expressing anxiety or agitation. Resident B had a trauma informed assessment completed on 5/22/26. It indicated abuse, violence, or sexual assault had been an event for him in his life that had caused problems for him. In the description, it indicated resident was abused as a child but he did not want to go into details. Resident B had a trauma informed assessment completed on 2/12/26. It indicated abuse, violence, or sexual assault had been an event for him in his life that had caused problems for him. Again, in the description, it indicated he was abused as a child, but he did not want to go into details. Resident B's record lacked documentation of the resident's PTSD and/or trauma triggers. The record lacked documentation of ways to ensure his environment was emotionally or physically safe for him related to his PTSD and trauma. A policy titled, Care Planning, was provided by the Executive Director (ED) on 6/25/26 at 8:55 a.m. It indicated, .A comprehensive person-centered care plan will be developed for each resident. The care plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs. A policy titled, Social Service Assessment and Documentation was provided by the ED on 6/25/26 at (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

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:57 a.m. It indicated, .The facility will use a multi-pronged approach to identifying a resident's history of trauma as well as his or her cultural preferences. This includes asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event.The facility will identify triggers which may re-traumatize residents with a history of trauma. A trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. This citation relates to Intakes 3027633 and 3050779.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure vital sign equipment was cleaned, hand hygiene was completed between residents, and enhanced barrier precautions (EBP) (infection control practices designed to prevent the spread of multidrug-resistant organisms in nursing homes) during a medication pass observation (Residents S, T, and U). Findings include:During a continuous observation of a medication pass with Licensed Practical Nurse (LPN) 6, on 6/24/26, from 5:06 a.m. to 5:55 a.m., the following was observed. -LPN 6 prepared medications for Resident S and took the medications and vital signs machine to the resident's room. LPN 6 used the pulse oximeter (device that clips on the finger to check the oxygen level) to check Resident S's oxygen level. LPN 6 gave the resident his medications. She then adjusted his blankets, left the room to obtain new oxygen tubing, and returned to apply the resident's oxygen. LPN 6 adjusted Resident S's blankets, left the room to obtain another blanket, and placed it on the resident. LPN 6 removed the vital signs machine from the resident's room and placed it back in the hallway. LPN 6 did not clean the vital signs machine before, or after, she used it. -LPN 6 proceeded to Resident T's room after the resident's feeding tube pump (set up to administer artificial nutrition) alarmed. LPN 6 did not complete hand hygiene after completing Resident S's care and proceeding to Resident T. LPN 6 obtained a new container of feeding and replaced Resident T's feeding bag and tubing connected to the gastrostomy tube (g-tube) (tube inserted into the stomach for artificial nutrition and medications). LPN 6 flushed the g-tube before hanging the new system. LPN 6 wore gloves but did not wear a gown while caring for the resident's g-tube. -LPN 6 returned to the medication cart, prepared, and administered medication to Resident U. -LPN 6 returned to the medication cart and prepared medication for Resident T. LPN 6 returned to Resident T's room and administered a liquid medication through the resident's g-tube. LPN 6 flushed the g-tube before and after the medication administration. LPN 6 wore gloves for the procedure but did not wear a gown. Resident T's record was reviewed on 6/24/26 at 6:43 a.m. A physician's order, dated 4/23/26, indicated enhanced barrier precautions (EBP) (infection control practices designed to prevent the spread of multidrug-resistant organisms in nursing homes) related to g-tube. The order indicated the staff should have worn a clean gown and gloves while performing high contact care activities, including caring for the feeding tube. A care plan, initiated on 5/19/26, indicated the resident required EBP related to the g-tube. Interventions included, but were not limited to, staff members wore clean gowns and gloves while performing high contact resident care activities, including caring for the feeding tube. During an interview, on 6/24/26 at 6:29 a.m., the Director of Nursing (DON) indicated the staff should have completed hand hygiene before, and after, entering a room or completing a medication pass. During an interview, on 6/24/26 at 9:43 a.m., the DON indicated EBP should have been used when the staff provided care for the resident's g-tube. EBP included wearing a gown and gloves. During an interview, on 6/24/26 at 9:55 a.m., the DON indicated vital sign equipment should have been cleaned between each resident, after each use. On 6/25/26 at 8:55 a.m., the Executive Director (ED) provided a document titled, Hand Hygiene, last revised in June 2020, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: The Facility considers hand hygiene the primary means to prevent the spread of infections. Procedure.V. Facility Staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited to.B. Alcohol-based hand hygiene products can and should be used to decontaminate hands: i. Immediately upon entering a resident occupied area.regardless of glove use; ii. Immediately upon exiting a resident occupied area.regardless of glove use.iii. Before moving from one resident to another in a multiple-bed room or procedure area regardless of glove use. On 6/25/26 at 8:55 a.m., the ED provided a document titled, Standard and Enhanced Precautions, dated 4/1/24, and indicated it was the policy currently being used by the facility. The policy indicated .Purpose: To ensure the use of appropriate personal protective equipment to improve infection control as required in the care of residents.Procedure.IV. Standard (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Precautions.E. Resident-Care Equipment: I. Resident care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of other microorganisms to other residents and environments.V. Enhanced Barrier Precautions.B. For residents whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities.vii. Device care or use.feeding tube. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)