

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 04/07/2025
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>38768</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' grievances had follow ups that provided adequate/effective interventions to address and prevent reoccurring concerns related to staff interactions towards a dependent resident (Resident 9) and nursing staff call light response. This deficient practice had the potential to effect 4 of 4 residents from Resident Council who communicated facility concerns on behalf of all residents who resided in the facility (Residents 9, 21, 35, 26 and 70).</p> <p>Findings include:</p> <p>On 4/4/25 at 11:30 a.m., a Resident Council meeting was held with 4 residents present, Residents 21, 35, 26 and 70)</p> <p>The residents indicated there were not enough aides to help get to all the residents without having to wait a long time. All 4 residents agreed that the facility needed more nursing staff and laundry staff. The residents indicated, night shift was the worst because they could never find any staff to help, or if they put the light on they would have to wait a very long time. Sometimes the aides on night shift would come into the room and turn the light off, but never come back. Often, the aides on the day shift would be so far behind because they had to run around and look for washcloths, towels or bed sheets. Some residents wouldn't get their showers because the aides didn't have time, or didn't have linens. The residents had filed grievances about not receiving showers, but no one believed them because the results of the investigation was always that the aides would just say it wasn't true, they had been given showers, and the resident was shown a completed shower sheet. The residents indicated one of their peers, (Resident 9) would sit at the shower room door and call for help to go to the bathroom. Staff ignored her because she had dementia, and just kept going to help other residents, or would walk by her and tell her, you don't have to go to the bathroom, you just think you do. The residents felt bad for her because Resident 9 did know when she needed to go to the bathroom and it really upset her if she had an accident on herself. She could be confused at times but that didn't mean they should ignore her. The residents indicated when visitors or management came into the building, staff would, act right but as soon as they left it went back to the way it was. Residents individually complained about call lights and the Resident Council had brought it to the facility's attention several times, but kept being told, we did education on call lights, or we did audits but didn't find anything wrong. The Resident Council was discouraged because it seemed like no matter what they discussed, everything stayed the same, which might be why there were only 4 to 6 residents who participated in the monthly meeting, because what good does it do?</p> <p>(continued on next page)</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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow up interview on 4/4/25 at 12:10 p.m., the Activity Director (AD) indicated usually there were only about 4 to 6 residents who attended the monthly Resident Council Meetings. The majority of the council's reoccurring concerns were almost always related to call light response time and night shift. The council members had taken Resident 9 under their wings, and really tried to help look out for her since she was confused and had filed several grievances on her behalf.</p> <p>Resident Grievances were reviewed related to nursing concerns for the previous 6 months.</p> <p>A grievance was filed on behalf of Resident 9 on 10/29/24 which indicated, .Resident stated staff were being unprofessional The investigation indicated, .resident stated, 'I didn't say that.</p> <p>A second grievance was filed on behalf of Resident 9 on 12/10/24 which indicated, .after soiling herself, [Resident 9] is often left waiting for long periods before being cleaned and changed . The investigation indicated, .spoke to Resident. She has no concerns related to toileting or being changed at this time.</p> <p>A third grievance was filed on behalf of Resident 9 on 2/25/25 which indicated, .[Resident 9] was in her hallway and needed help. She continued yelling and being totally ignored by staff for 10 minutes. They continued walking by her like she wasn't there until I intervened Investigation indicated, .[Resident 9] did wait due to another resident being in spa room</p> <p>Resident 9's quarterly MDS assessment, dated 12/10/24, indicated she was severely cognitively impaired with a BIMS of 5 of 15 and was totally dependent on staff for transfers to the toilet.</p> <p>Seven additional grievances related to concerns with night shift call light response times/staff availability which included but were not limited to the following:</p> <p>a. a grievance filed on 10/29/24 indicated, care on night shift was not done gently. The grievance follow up was dated 11/6/24, spoke to staff about being mindful of wiping too hard during care. Staff verbalized understanding. Concerned party response was dated the same day on 11/6/24, no further issues at this time. [Resident] says they have been more gentle with peri-care.</p> <p>b. a grievance filed 1/27/25 indicated, .Saturday night, into Sunday morning, two different aides came in at varied times, they turned resident's call light off, then left the room . Investigation: staff denied that call light was turned off . Staff education was provided.</p> <p>c. a grievance filed 2/27/25 indicated, .night shift is rude . Investigation, .[staff] report that they did not tell her they [the nursing staff] are for emergencies only. Staff education was provided.</p> <p>Five additional grievances related to general call light response times/staff availability included, but were not limited to:</p> <p>a. a grievance filed 10/9/25 indicated, .it takes 30-45 minutes for her call light to be answered anytime she needs help . Investigation; a Call light audit was conducted on 10/22/24, a light (did not specify if it was this concerned resident or not) was activated at 2:07 p.m., and answered at 2:42 p.m. a period of 35 minutes. There response did not identify if this was too long, and/or if it had been reviewed with the concerned resident as the resolution was left blank.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. a grievance filed from the Resident Council on 10/31/24 indicated, . [Resident 36] is waiting for over and hour for her call light on 2nd and 3rd shift. Investigation: Call light audit performed by [management] showing < 15 minutes response time . This grievance was received by the Director of Nursing (DON) on 11/4/24 and completed/signed off by the DON and ADM on 11/6/24. The grievance did not specify when the call light audits were conducted.</p> <p>b. a grievance filed on 12/18/24 indicated, .frequently waits for long periods after using call light, happens more often in the morning. Investigation: call light audit was performed 12/31, Wait time 5-11 minutes. Resolution: relayed results of call light audit. Resident states, seems about right, but it sure feels longer</p> <p>Call light audits were provided during the survey exit conference on 4/27/25 at 12:00 p.m. The audits lacked documentation that a call light audit had been performed on 12/31/24. The audit log included five November audits as follows:</p> <ol style="list-style-type: none"> 1. 11/5/24; call light for RM 216 = 7 minutes. 2. 11/8/24; call light for RM 311 = 15 minutes. 3. 11/13/24; call light for RM 511 = 11 minutes. 4. 11/16/24; call light for RM 125 start time was 11:25 (did not specify a.m. or p.m.) and the end time was incomplete and not initialed by staff. 5. 11/17/24; call light for RM 209 = 14 minutes but was not initialed by staff. <p>The rest of the above page of audits with 15 additional observations, was not initialed by staff which included an audit conducted on 1/28, with no room, start or finish time specified, but yes written that staff were appropriate with resident.</p> <p>During an interview on 4/7/25 at 10:56 a.m., the Administrator indicated as a part Quality Assurance and Performance Improvement (QAPI) staff had conducted call light audits but had not identified any issues and staff had implemented new shower procedures for CNAs to follow. At that time, there were no QAPI performance improvements plans or other approaches in place to address the pattern of call light response times, staff availability, staff attitudes, and/or night shift grievances.</p> <p>On 4/7/25 at 11:00 a.m. the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, Grievances and Complaints, revised 8/2020. The policy indicated, Purpose: To ensure that residents, family members, and representatives know about the procedure for filing grievances and complaints . upon receiving a resident grievance/complaint form, the Grievance Official or designee begins and investigation into the allegations. The Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. The Department Director of an employee involved is notified of the nature of the complaint and that an investigation is underway. The investigation and report includes, as applicable .[i. - x.] . the Resident Grievance/Complaint log is reviewed by the Quality Assurance and Assessment Committee at least quarterly</p> <p>Cross Reference F725.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately coded to reflect residents' conditions and/or services for 6 of 23 residents reviewed (Residents 2, 35, 36, 39, 46, and 47).</p> <p>Findings include:</p> <p>1. On 4/2/25 at 10:26 a.m., the most recent comprehensive MDS assessments were reviewed for Residents 2, 35, 36, 39, 46, and 47.</p> <p>a. Resident 2 was a long-term care resident with a diagnosis which included, but was not limited to, bipolar disorder.</p> <p>She had a Pre-Admission Screen and Record Review (PASARR), dated 1/3/23, which indicated she was considered by the state to have a major mental illness (MMI).</p> <p>Resident 2's most recent comprehensive MDS assessment, dated 2/10/24, did not code her PASARR Level II status.</p> <p>b. Resident 35 was a long-term care resident with a diagnosis which included, but was not limited to, bipolar disorder.</p> <p>There was no PASARR level I or II on file. Cross reference F645.</p> <p>Resident 35's Admission MDS assessment, dated 9/11/24, did not code her PASARR level II status.</p> <p>c. Resident 36 was a long-term care resident with a diagnoses which included, but were not limited to Major Depressive disorder and post-traumatic stress disorder (PTSD).</p> <p>Her most recent comprehensive annual MDS, dated [DATE], did not code her PASARR Level II status.</p> <p>d. Resident 39 was a long-term care resident with a diagnoses which included, but were not limited to Major Depressive disorder and PTSD.</p> <p>Her most recent comprehensive admission MDS assessment, dated 3/10/25, did not code her PASARR Level II status.</p> <p>e. Resident 46 was a long-term care resident with a diagnoses which included, but were not limited to bipolar disorder and schizoaffective disorder.</p> <p>Her most recent annual MDS assessment, dated 3/25/25, did not code her PASARR Level II status.</p> <p>During an interview on 4/4/25 at 9:13 a.m., the Regional MDS Consultant indicated there had been a change in the facility's Social Service Director, and it appeared several items were incorrectly coded during that transition to the new Social Service Director.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46414</p> <p>2. On 4/3/25 at 10:12 a.m., a record review was completed for Resident 47.</p> <p>She had the following diagnoses which included but were not limited to senile degeneration of the brain, falls, and difficulty in walking.</p> <p>She had an order, dated 3/3/25, for hospice to evaluate and treat.</p> <p>In the profile section of the electronic record, it mentioned the hospice company's name and phone number.</p> <p>An MDS was completed on 3/20/25. Section O asks a question if resident was receiving hospice, and the box was marked no.</p> <p>On 4/3/25 at 2:03 p.m., during an interview with the MDS consultant, she indicated Resident 47 went on hospice services around 3/8/25. She had a significant change MDS completed, and hospice was not marked on the MDS. She indicated she was going to correct the mistake immediately.</p> <p>A policy titled, Rap Assessment Instrument (RAI) Process was provided by the MDS consultant on 4/4/25 at 12:41 p.m. It indicated, .To ensure that the RAI is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths, and needs, as well as offering guidance for further assessment once problems have been identified</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>38768</p> <p>Based on interview and record review, the facility failed to ensure a resident (Resident 35) who had a diagnosis of a major mental illness received and/or maintained on file a copy of her Pre-Admission Screen and Resident Review (PASARR) Level I & II for 1 of 5 residents reviewed for PASARR.</p> <p>Findings include:</p> <p>On 4/3/25 at 10:29 a.m., Resident 35's medical record was reviewed. She was a long-term care resident with a diagnosis which included, but was not limited to, bipolar disorder.</p> <p>There was no PASARR level I or II on file.</p> <p>On 4/3/25 at 11:09 a.m., the regional Minimum Data Set (MDS) Consultant (MDSC) accessed Resident 35's PASARR online and indicated she had a level II completed which approved her for long-term care without specialized services indefinitely. The level of care PASARRs had been completed at her previous facility and were on file online, but it appeared that in between the facility's change in Social Service Directors, no one followed up on Resident 35's PASARR to ensure it transferred to her record on file at her current facility. This would also have triggered her care plan for revision to include her Level II status, but since it was not on file, the care plan was not revised.</p> <p>Resident 35's admission MDS assessment, dated 9/11/24, did not code her PASARR level II status.</p> <p>The MDSC indicated there was no facility policy, but they follow federal and state regulations.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>46414</p> <p>Based on record review and interview, the facility failed to update a resident's care plan when a change had been made to his medications for 1 of 4 residents reviewed for care plan revision (Resident 28).</p> <p>Findings include:</p> <p>On 4/3/24 at 10:32 a.m., a record review was completed for Resident 28. He had the following diagnoses which included, but were not limited to, Alzheimer's disease, dementia, anxiety, hypertension, and reduced mobility.</p> <p>Resident 28's medication regimen did not include an antidepressant.</p> <p>Resident 28 had a care plan that indicated he required antidepressant medication for the diagnosis of depression date 11/7/24. The goal indicated he would be free from discomfort or adverse reactions to the antidepressant medication.</p> <p>During an interview with the Regional Nurse Consultant (RNC) on 4/7/25 at 11:15 a.m., he indicated Resident 28 went out to the hospital and his medications were changed and his care plan did not get updated with the changes.</p> <p>A policy titled, Care Plans was provided by the Minimum Data Set (MDS) consultant. It indicated, .Changes may be made to the comprehensive care plan on an ongoing basis for the duration of the resident's stay. These subsequent changes will not need to be reflected through updates to the baseline care plan</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768</p> <p>Based on observations, interview and record review, the facility failed to ensure Activities of Daily Living (ADL) care was provided for 2 of 2 dependent residents reviewed for ADLs (Resident 14 and 74).</p> <p>Findings include:</p> <p>1. During the survey, Resident 14 was observed at several intervals throughout the week.</p> <p>On 4/2/25 at 10:44 a.m. and 3:00 p.m., she was observed in bed, flat on her back. She wore a hospital gown, her nails were long with dark debris under them, her hair was greasy and matted at the back of her head. Resident 14 had a g-tube feeding, (a gastrostomy tube feeding, is a method of providing nutrition directly to the stomach through a tube inserted into the abdomen) and did not receive food/drink via mouth, and her lips were dry, her teeth and gums appeared tacky and her breath had a foul odor.</p> <p>On 4/3/25 at 10:53 a.m., 11:47 a.m. and 1:05 p.m., she remained the same as above.</p> <p>On 4/4/25 at 8:38 a.m., 12:01 p.m., and 2:00 p.m., she remained the same as above.</p> <p>On 4/7/25 at 9:33 a.m., Resident 14 had a strong odor of urine and bowel.</p> <p>On 4/7/25 at 9:46 a.m., a check/change was requested for Resident 14. Certified Nursing [NAME] (CNA) 18 checked the resident and found that her brief, folded bed sheet, pillow from under her knees, and hospital gown to be soaked with urine up to the middle of her back. She had also been incontinent of bowel.</p> <p>During an interview on 4/7/25 at 9:50 a.m., CNA 18 indicated it appeared night shift had not change Resident 14 at all through the night and he had not had a chance to get to her yet that morning.</p> <p>Resident 14's medical record was reviewed on 4/3/25 at 2:52 p.m.</p> <p>She was a long-term care resident with diagnoses which included, but were not limited to, history of a stroke which caused paralysis/weakness to her left side and a contracture to her left hand and muscle wasting/atrophy.</p> <p>She received end of life comfort care and was totally dependent on staff to meet all her ADL care/needs.</p> <p>She had a comprehensive care plan which was revised 11/23/24 which indicated she had an ADL-self care performance deficient and required up to total dependence to meet her ADL needs. Interventions included, but were not limited to; dependent for oral hygiene, personal hygiene, bed mobility, transfers to her wheelchair, dressing, and bowel/bladder/toileting needs.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Her care plan lacked implementation/revision to address behaviors related to ADLs such as refusing care/treatment.</p> <p>Resident 14's shower sheets and point of care tasks were reviewed which indicated her ADLs had been completed (including dressing, nail care, oral care and personal hygiene).</p> <p>2. During the survey, Resident 74 was observed at several intervals throughout the week.</p> <p>On 4/1/25 at 2:11 p.m., she was observed laying in bed, flat on her back. She wore a hospital gown and there was what appeared to be some dried drool at the corners of her mouth. Her hair was greasy and flattened to her scalp from the use of her helmet. There were several matted lock of hair.</p> <p>On 4/2/25 at 9:38 a.m. and 11:57 a.m., she was observed as she remained laying in bed, flat on her back in a hospital gown. Her hair was greasy and flattened to her scalp from the use of her helmet. There were several matted locks of hair.</p> <p>On 4/3/25 at 10:50 a.m., 1:04 p.m., and 3:00 p.m., she remained the same as above.</p> <p>On 4/4/25 at 8:42 a.m., 12:06 p.m. and 2:03 p.m., she remained the same as above.</p> <p>On 4/3/25 at 1:49 p.m., Resident 74's medical record was reviewed. She was a long-term care resident who admitted to the facility from a group home for rehabilitation and after-care from orthopedic surgery.</p> <p>She had diagnoses which included, but were not limited to, Cerebral Palsy (CP - a neurological condition that affects movement, posture, and muscle control, stemming from brain damage that occurs before, during, or shortly after birth) developmental disorder, and communication deficite.</p> <p>Her most recent comprehensive Minimum Data Set (MDS) assessment was an admission assessment, dated 2/13/25, which indicated she was rarely understood and rarely able to make herself understood and was severely cognitively impaired.</p> <p>She had a compressive care plan that was most recently reviewed/revisioned on 3/7/25 which indicated she was dependent on staff for all ADLs and ADLs performance.</p> <p>Her care plan lacked implementation/revision to address behaviors related to ADLs such as refusing care/treatment.</p> <p>Resident 74's shower sheets and point of care tasks were reviewed which indicated her ADLs had been completed (including dressing, nail care, oral care and personal hygiene) without complications or refusals, except one refused bed bath on 2/27/25.</p> <p>During a confidential interview, it was indicated, not everyone likes to give Resident 74 a bed bath because she can become combative and kick and try to bite. She refused her bed bath half of the time. Her hair was observed and it was indicated that it was matted and did not know the last time it was brushed or if Resident 74 would let anyone brush it or not.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/7/25 at 11:00 a.m. the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, Care and Services, revised 6/2020. The policy indicated, Purpose: To ensure through an interdisciplinary (IDT) process, that all residents receive the necessary care and services based on an individual comprehensive assessment process . The facility will have sufficient staff to provide services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being as determined by individualized resident assessment and plans of care . the IDT receives and reviews initial assessment information to ensure that members of the IDT interact with residents in a manner that enhances self-esteem and self-worth, such as activities related to bathing, grooming, dining, recreational and social opportunities</p> <p>Cross Reference F725.</p> <p>3.1-36(a)(3)</p>		

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 04/07/2025
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34438</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident who was occasionally incontinent of bowel received appropriate treatment to restore as much normal bowel function as possible for 1 of 1 resident reviewed for bowel incontinence.</p> <p>Findings include:</p> <p>During an observation and interview on 4/2/25 at 11:21a.m., Resident 366 indicated that the antibiotics were causing him to be incontinent of bowel. He had not been incontinent of bowel prior to all the antibiotics he took, and he knew it was related to the antibiotics. The CNAs put him into a brief as a prevention, which he understood. But the CNAs would tell him just to use the brief instead of the bed pan. This caused the wound vacuum on his sacrum to get dirty and then it had to be changed which was very painful. He wanted to use the bed pan if possible.</p> <p>Resident 366's record was reviewed on 4/3/25 at 11:06 a.m. Resident 366 had diagnoses to include, but not limited to, complete traumatic amputation at level between right hip and knee, type 2 diabetes, hypertension, moderate protein-calorie malnutrition, chronic osteomyelitis, muscle weakness, reduced mobility, and stage 3 (full thickness skin loss exposing subcutaneous tissues but not bone or muscle) pressure ulcer of sacral region. Resident 366's Profile indicated the resident was his own responsible party.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 4/5/25, indicated it was in progress and due 4/11/25.</p> <p>A General Progress Note, dated 3/29/25 at 7:45 p.m., indicated the resident had arrived via ambulance from the hospital on a stretcher. The resident had a recent above the knee amputation on the right extremity. The left thigh had a dressing in place and an order from the hospital to leave the dressing in place until it fell off. Resident 366's sacrum had two areas of skin impairment. His right buttock had an area of skin impairment with orders for a wound vacuum (vac) set at 125 millimeters of mercury (mmhg) suction. The wound vac was in place at time of admission.</p> <p>A physician order, dated 3/29/25, indicated to administer two tablets orally of senna-docusate sodium (stool softener) 8.650 milligrams (mg) two times a day for constipation.</p> <p>An admission assessment, dated 3/29/25, indicated resident was incontinent of bowel and his last bowel movement was 3/29/25.</p> <p>The Point of Care (POC) response history for the bowel continence task indicated Resident 366 was incontinent of bowel on 3/29/25 at 9:59 p.m. with formed stool.</p> <p>The Point of Care (POC) response history for the bowel continence task indicated Resident 366 was continent of bowel on 3/30/25 at 5:59 a.m. with diarrhea, and at 9:59 p.m. with formed stool.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Medication Administration Record (MAR) for March 2025 indicated the two tablets of Senna-Docusate Sodium Oral Tablet 8.6-50 mg were administered at 9 a.m. and 6 p.m. on 3/30/25.</p> <p>A physician order, dated 3/30/25, indicated to administer daptomycin (antibiotic) 750 mg intravenous (through a vein) in the evening for an infection.</p> <p>A physician order, dated 3/30/25, indicated to administer cefepime HCl (antibiotic) 1 gram intravenous (through a vein) three times a day for an infection.</p> <p>A care plan, dated 3/30/25, indicated Resident 366 was on antibiotic therapy for an infection. The goal was for the resident to be free from any discomfort or adverse effects of antibiotic therapy. The care plan indicated antibiotics may result in the eradication of beneficial microorganisms and cause secondary infections such as colitis, and any antibiotic may cause diarrhea. The interventions included, but were not limited to, staff were to monitor every shift for adverse reactions, and to observe for possible side effects.</p> <p>A care plan, dated 3/30/25, indicated Resident 366 had the actual impairment to his skin integrity related to infection and a surgical wound. Interventions included, but were not limited to, staff were to identify and document potential causative factors for skin impairment and eliminate or resolve the factors where possible.</p> <p>The Point of Care (POC) response history for the bowel continence task indicated Resident 366 was continent of bowel on 3/31/25 at 4:20 a.m. with formed stool, and at 12:59 p.m. with diarrhea. The response history indicated the resident was incontinent of bowel on 3/31/25 at 6:20 p.m. with diarrhea.</p> <p>The Medication Administration Record (MAR) for March 2025 indicated the two tablets of Senna-Docusate Sodium Oral Tablet 8.6-50 mg were administered at 9 a.m. and 6 p.m. on 3/31/25.</p> <p>A physician order, dated 3/31/25, indicated the resident was to have physical therapy was to treat the resident five times a week for sixty days to improve functional mobility.</p> <p>A physician order, dated 3/31/25, indicated the resident was to have occupational therapy five times a week for four weeks.</p> <p>A progress note, dated 3/31/25 at 2:20 p.m., indicated Resident 366 had impairment to his lower extremity on one side. He was dependent on staff during toileting and personal hygiene for the interim. He required partial and/or moderate assistance to roll left and right.</p> <p>A skilled evaluation note, dated 3/31/25 at 5:01 p.m., indicated Resident 366 admitted on [DATE] with complete traumatic amputation of the right leg between the hip and knee. The resident was alert and oriented times three and able to make his needs known. The wound vac was running without complications. The resident was continent of bowel. The resident had weakness and had weight bearing restrictions.</p> <p>The Point of Care (POC) response history for the bowel continence task indicated Resident 366 was incontinent of bowel on 4/1/25 at 11:50 a.m. with diarrhea. The response history indicated the resident was continent of bowel on 4/1/25 at 9:59 p.m. with formed stool.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The MAR for April 2025 indicated the two tablets of Senna-Docusate Sodium Oral Tablet 8.6-50 mg were administered at 9 a.m. and 6 p.m. on 4/1/25 at 9 a.m. and 6 p.m.</p> <p>A physician order, dated 4/1/25, indicated to administer two tablets orally of senna-docusate sodium 8.6-50 mg (Sennosides-Docusate Sodium) every 12 hours as needed for constipation.</p> <p>A physician order, dated 4/1/25, indicated to administer one capsule of Florastor (probiotic) 250 mg two times a day.</p> <p>The Point of Care (POC) response history for the bowel continence task indicated Resident 366 was continent of bowel on 4/2/25 at 3 a.m. with formed stool. The resident was incontinent at 12:56 p.m. and 9:52 p.m. with diarrhea.</p> <p>The Point of Care (POC) response history for the bowel continence task indicated Resident 366 was incontinent of bowel on 4/3/25 with diarrhea.</p> <p>During an interview on 4/4/25 at 10:04 a.m., Licensed Practical Nurse (LPN) 17 indicated she was aware that Resident 366 was incontinent of bowel. He had been incontinent of bowel since his admission so she assumed that was just his baseline. The resident had not mentioned to her that he had not been incontinent prior to admission or had concerns about being incontinent. When LPN 17 observed that the majority of bowel movements were documented as loose/diarrhea, she indicated that resident was also receiving a stool softener so that might be something they should review. LPN 17 indicated she did have to change the wound vac to the resident's sacrum daily at least due to the bowel movements and it was painful for the resident. She gave him two pain pills prior every time to help with the pain. The NP was in the building and LPN 17 would mention the diarrhea and the resident stating it started with the antibiotics to see if they should test for Clostridioides difficile (C-diff).</p> <p>During an interview on 4/4/25 at 11:00 a.m., LPN 13 indicated she was a nurse manager for the facility and would help cover the unit but was not as familiar with the residents. In general, if a resident was new and having loose stool or diarrhea for more than a day, they would notify the doctor to inform them and possibly get orders for a c-diff test. If a resident had orders for stool softeners and was having loose stools, then the stool softeners should be held.</p> <p>During an interview on 4/4/25 at 11:26 a.m., Nurse Practitioner (NP) 15 indicated they were aware Resident 366 had diarrhea and had stopped the stool softener and started him on probiotics at the beginning of the week. The Medical Director indicated the resident had been severely malnourished and they were working on fixing that and helping with wound healing. He was also a diabetic that was on medication that could cause diarrhea. NP 15 indicated they would test for c-diff since he was on antibiotics too. The Medical Director indicated the resident had just informed him that he was severely lactose intolerant so they would ensure that he was not receiving milk products or proteins as well. NP 15 indicated the resident's current dietary supplements did not have lactose.</p> <p>A policy related to bowel incontinence was requested from the Regional Nurse Consultant (RNC) on 4/4/25 at 11:29 a.m.</p> <p>The RNC was informed of the concern related to administering stool softeners to a resident with diarrhea for 3 days on 4/4/25 at 1:12 p.m. and a policy was requested.</p> <p>(continued on next page)</p>

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No policy was provided by the exit of the survey.

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768</p> <p>Based on observation, interview, and record review, the facility failed to ensure a sufficient amount of staff to provide nursing activities of daily living (ADL) care and laundry services so that residents received ADL care and did not have to wait a long time for assistance. This deficient practice had the potential to effect 114 of 114 residents who received nursing care.</p> <p>Findings include:</p> <p>During an interview on 4/1/25 at 11:43 a.m., Resident 12 indicated, there were not enough aides and he often had to wait a long time for assistance especially on the weekends. Sometimes, staff would tell him to do what he could on his own until they could come and help him, but that made him frustrated because he wouldn't be in the facility if he didn't need help. When he had to wait too long, it would often cause him to have accidents.</p> <p>On 4/1/25 at 1:30 p.m., the call light for room [ROOM NUMBER] was observed to be illuminated. At 1:32 p.m., Licensed Practical Nurse (LPN) 13 opened the door and asked the resident from the door what she needed, and told the resident she would find her aide. LPN 13 found Certified Nursing Aide (CNA) 14 (as she exited another resident's room with a bag of trash) and told CNA 14 that the resident in room [ROOM NUMBER] was ready to get up and dressed for therapy. At 1:35 p.m., CNA 14 knocked and entered room [ROOM NUMBER], turned off the call light and told the resident she had one more person ahead of her to get up and dressed, but she would be there as soon as possible to help her. LPN 13 left the unit.</p> <p>During an interview on 4/2/25 at 2:02 p.m., Resident 22 indicated there were not enough staff and it took a long time to get care sometimes. Resident 22 thought it would be good to have more help for the rehab hall.</p> <p>During an interview on 4/2/25 at 11:36 a.m., Resident 98 indicated there were not enough staff. The staff were great, but there were just not enough staff on the unit to assist without having to wait for long periods of time. There were usually only one nurse, and one CNA assigned on the rehab unit, when they really needed two CNAs for that unit. Resident 98 indicated she often had to wait a long time for assistance.</p> <p>During an interview on 4/2/25 at 11:10 a.m., Resident 366 indicated staffing was a problem especially during the evening shift he could hear staff outside his room having personal conversations and having a good time but they were not helping residents. This had happened more than once, and it was always after 5:00 p.m. Staff would just disappear and it was hard to get assistance in the evening and on night shift. The phone at the nurses' desk rang constantly at night since there was no staff to answer it. Resident 366 indicated the antibiotics he took caused him to have frequent diarrhea and the CNAs put him into a brief as a prevention which he understood. However, there were times when the CNAs told him just to use the brief instead of the bed pan. This caused the wound vacuum on his amputated leg to get dirty and then it had to be changed which was very painful.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During observations on the rehab hall on 4/3/25 at 2:33 p.m., no staff were observed in the hallway or at the nurses' desk.</p> <p>During observations on the rehab hall on 4/2/25 at 11:04 a.m., no staff were observed in the hallway or at the nurses' desk.</p> <p>During observations on the rehab hall on 4/3/25 at 2:33 p.m., no staff were observed in the hallway or at the nurses' desk.</p> <p>While waiting to interview the nurse on the rehab hall on 4/4/25 at 10:00 a.m., the CNA working on the unit was observed to open a resident's door and ask where the nurse was because she needed supplies. There were no staff observed in the hallway or at the nurses' station.</p> <p>On 4/4/25 at 10:58 a.m., the CNA on the rehab hall was observed as she took a Hoyer lift into a resident's room and then waited in the doorway for another staff member to assist her. There were no staff observed in the hallway or at the nurses' station. The nurse was observed as she assisted another resident down the hallway.</p> <p>During the survey, Resident 14 was observed at several intervals throughout the week. (4/2/25 at 10:44 a.m. and 3:00 p.m., 4/3/25 at 10:53 a.m., 11:47 a.m. and 1:05 p.m., 4/4/25 at 8:38 a.m., 12:01 p.m., and 2:00 p.m. and on 4/7/25 at 9:33 a.m.) Resident 14 remained in bed all week, she was not observed to be dressed and only wore a hospital gown, her nails were long with dark debris under them, her hair was greasy and matted at the back of her head. Resident 14 had a g-tube feeding (a gastrostomy tube feeding, is a method of providing nutrition directly to the stomach through a tube inserted into the abdomen) and did not receive food/drink via mouth, and it appeared she needed oral care as her lips were dry, her teeth and gums appeared tacky and her breath had a foul odor.</p> <p>On 4/7/25 at 9:33 a.m., Resident 14 had a strong odor of urine and bowel.</p> <p>On 4/7/25 at 9:46 a.m., a check/change was requested for Resident 14. CNA 18 checked her brief and found her brief, folded bed sheet, pillow from under her knees and hospital gown to be soaked with urine up to the middle of her back. She had also been incontinent of bowel.</p> <p>During the survey, Resident 74 was observed at several intervals throughout the week. (4/1/25 at 2:11 p.m., 4/2/25 at 9:38 a.m., 11:57 a.m. and 3:07 p.m., 4/3/25 at 10:50 a.m., 1:04 p.m., and 3:00 p.m., 4/4/25 at 8:42 a.m., 12:06 p.m. and 2:03 p.m. and 4/7/25 at 9:57 a.m.).</p> <p>On 4/2/25 at 3:07 p.m., Resident 74 was observed up in her wheelchair in the main dining room with her helmet in place.</p> <p>On 4/7/25 at 9:57 a.m., Resident 74 was being assisted into her wheelchair by a CNA, with her helmet in place.</p> <p>For the remainder of Resident 74's observations, she remained in bed in a hospital gown. Her hair was greasy and flattened to her scalp from the use of her helmet. There were several matted locks of hair.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/4/25 at 11:30 a.m., a Resident Council meeting was held with 4 residents present, (Residents 21, 35, 36 and 70).</p> <p>The residents indicated there were not enough aides to help get to all the residents without having to wait a long time. All 4 residents agreed that the facility needed more nursing staff and laundry staff. The residents indicated night shift was the worst because they could never find any staff to help, or if they put the light on they would have to wait a very long time. Sometimes the aides on night shift would come into the room and turn the light off, but never come back. Often the aides on the day shift would be so far behind because they had to run around and look for washcloths, towels or bed sheets. Some residents wouldn't get their showers, either because the aides didn't have time to, or didn't have linens. The residents had filed grievances about not receiving showers, but no one believed them because the results of the investigation was always that the aides would just say it wasn't true, they had been given showers, and the resident was shown a completed shower sheet. The residents indicated, one of their peers, (Resident 9) would sit at the shower room door and call for help to go to the bathroom. Staff ignored her as they rushed to get other residents what they needed, or would walk by her and tell her, you don't have to go to the bathroom, you just think you do. The residents felt bad for her because Resident 9 did know when she needed to go to the bathroom and it really upset her if she had an accident on herself. The residents indicated, when visitors or management came into the building, staff would, act right but as soon as they left it went back to the way it was. Residents individually complained about call lights and the Resident Council had brought it to attention several times, but kept being told, we did education on call lights, or we did audits but didn't find anything wrong. The Resident Council was discouraged because it seemed like no matter what they discussed, everything stayed the same, which might be why there were only 4 to 6 residents who participated in the monthly meeting, because what good does it do?</p> <p>During a confidential interview, it was indicated, one of the biggest struggles for nursing staff was catching up in the mornings depending on what had or had not been done on the night shift. Nursing staff on the night shift often left some residents all night without changing their briefs, so that when staff come in the mornings, they were already behind. This often caused a delay in care, residents often complained about how long they had to wait for staff to get to them. If night shift didn't help with briefs/showers/cleaning as they should, then day shift aides had to do it for them, and nurses had a hard time helping day shift aides because of morning medication administration.</p> <p>During a confidential interview, it was indicated, for the most part, having four CNAs for the long-term care hall was ok, as long as whoever was assigned the night before had their residents ready to go for the day especially on the Grove hall; That assignment had the most total care needs and was a heavy acuity hall. Having four aides for the long-term care residents was a stretch, but if there was a call-in that couldn't be filled and there were only three aides, then not everything could get done. Showers would be missed and passing ice water, all took a back seat to getting residents briefs changed and dressed/up for the day.</p> <p>During a confidential interview, it was indicated there were some good aides on night shift which made the morning assignment easier, but depending on who they came in after, they would be behind from the start. Residents did often complaint about how long it took to get assistance, but there was nothing they could do.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a confidential interview, it was indicated one of the biggest breakdowns for the CNAs was having available washcloths in order to clean residents because the facility was a wipe-less facility which meant, they used washcloths for incontinent care. Unless a resident was on Hospice and incontinent wipes were provided via their Hospice service, CNAs had to rely on a constant, fully stocked linen closet. Laundry staff/hours had been cut back, so after 3:00-5:00 p.m., it was unpredictable whether or not they would have supplies they needed through the night. No one liked to be assigned to the Grove because it was the heaviest hall and because everyone else was busy trying to keep up with their own assignment, it was difficult to get help when needed. It was indicated, it was nice to see the nursing staff posting which indicated up to nine CNAs a day, but in reality it was only four CNAs to about 60 residents, if you broke it down by shift. Day shift was also hard because the nurses, who are supposed to help with staff ADL care, really can't because they were on the med carts and passing meds or doing treatments.</p> <p>During a confidential interview, it was indicated, the Grove was a very hard assignment, but as long as the CNA was not new, and knew their people well enough they could get things done. It also depended on who they came in after on night shift. The hardest part was having to wait a long time for another CNA to be available as needed if a resident needed a 2-person transfer or help in the shower.</p> <p>The Centers for Medicaid and Medicare Services (CMS) Certification and Survey Provider Enhanced Reporting, (CASPER, a report to identify staffing levels and potential issues with staffing hours particularly those related to the Payroll Based Journal (PBJ) system and provides detailed staffing information for nursing homes) was reviewed and revealed staffing areas triggered for the 1st quarter of 2025 in both excessively low weekend staffing and one-start staffing.</p> <p>The required Staffing Posting for the New Year Holiday and weekends (Friday-Sundays) of January 2025 were requested, reviewed and revealed the following:</p> <p>On 1/1/25 New Years Day staffing was as follows:</p> <p>a. Licensed Nurse Coverage:</p> <p>Day and Evening Shift provided 40 hours; averaged over the 107 resident census amounted to 0.3 hours of direct patient care. Less than 30 minutes per resident, approximately 18 minutes per resident.</p> <p>Night Shift provided 30 hours; averaged of the 107 resident census amounted to 0.2 hours of direct patient care. Less than 30 minutes per resident, approximately 12 minutes per resident.</p> <p>b. Nurse Aide (CNA) Coverage:</p> <p>Day Shift provided 64 hours; averaged over the 107 resident census amounted to 0.6 hours of direct patient care, approximately 36 minutes per resident.</p> <p>Night shift provided 40 hours; averaged over the 107 resident census amounted to 0.3 hours of direct patient care. Less than 30 minutes per resident, approximately 18 minutes per resident.</p> <p>January 2025 Weekend Averages:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Fidays Licensed Coverage:</p> <ul style="list-style-type: none"> a. Day shift = 0.40 hours; approximately 21 minutes per resident. b. Evening = 0.35 hours; approximately 18 minutes per resident. c. Night shift = 0.20 hours; approximately 12 minutes per resident. <p>Fridays CNA Coverage:</p> <ul style="list-style-type: none"> a. Day and Evening shift averaged 0.50 hours; approximately 30 minutes per resident. b. Night shift averaged 0.30 hours; approximately 18 minutes per resident. <p>Saturday Licensed Coverage:</p> <ul style="list-style-type: none"> a. Day shift = 0.40 hours; approximately 24 minutes per resident. b. Evening shift = 0.37 hours; approximately 22 minutes per resident. c. Night shift = 0.52 hours; approximately 31 minutes per resident. <p>Saturday CNA Coverage:</p> <ul style="list-style-type: none"> a. Day shift = 0.52 hours; approximately 31 minutes per resident. b. Evening shift = 0.55 hours; approximately 33 minutes per resident. c. Night shift = 0.40 hours; approximately 24 minutes per resident. <p>Sunday Licensed Coverage:</p> <ul style="list-style-type: none"> a. Day shift = 0.40 hours; approximately 24 minutes per resident. b. Evening shift = 0.35 hours; approximately 21 minutes per resident. c. Night shift = 0.17 hours; approximately 10 minutes per resident. <p>Sunday CNA Coverage:</p> <ul style="list-style-type: none"> a. Day shift = 0.57 hours; approximately 34 minutes per resident. b. Evening shift = 0.60 hours; approximately 36 minutes per resident. c. Night shift = 0.35 hours; approximately 21 minutes per resident. <p>(continued on next page)</p>

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 04/07/2025
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident Grievances were reviewed related to nursing concerns for the previous 6 months. There were three grievances related staff attitude. There were to seven grievances related to Night Shift call light response times/staff availability. There were five additional grievances related to call light response times/staff availability in general.</p> <p>During an interview, on 4/4/25 at 9:18 a.m., with the Administrator and Staffing Coordinator present, the Staffing Coordinator indicated there were nurse staffing positions open but the schedule was balanced, and she did not believe there was a staffing issue. If there were call-in, there were usually specific people she could count on for pick-ups, and if that didn't work there was a rotation of management staff available as needed. The Administrator indicated staffing patterns did not change for weekends to differ from weekday staffing. The only thing that affected staffing ratios would be the facilities resident census.</p> <p>During an interview on 4/7/25 at 10:56 a.m., the Administrator indicated, as a part Quality Assurance and Performance Improvement (QAPI) staff had conducted call light audits but had not identified any issues and staff had implemented new shower procedures for CNAs to follow. At that time, there were no QAPI performance improvements plans or other approaches in place to address the pattern of call light response times, staff availability, staff attitudes, and/or night shift grievances.</p> <p>On 4/7/25 at 11:00 a.m. the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, Nursing Department- Staffing, Scheduling & Postings, revised 6/2020. The policy indicated, Purpose: to ensure adequate number of nursing personnel are available to meet resident needs . the facility sufficient Nursing Staff on a 24 hour basis that meet the appropriate competencies, skill set and required qualifications to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident. In staffing an adequate number of nursing services personnel, scheduling will be done as needed to meet resident needs and will account for the number, acuity and diagnoses the facilities resident population</p> <p>Cross Reference F565 and F677.</p> <p>3.1-17(a)</p>		

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

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46414</p> <p>Based on observations and interviews, the facility failed to date insulin pens, and an insulin bottle was expired for 1 of 3 medication carts reviewed and 1 of 2 medication rooms reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident 41 had a pen of insulin lispro not dated for 3 of 3 pens in the 500-hall medication cart. 2. Resident 96 had a pen of admelog insulin not dated and a insulin pen of lispro not dated in the 500-hall medication cart. 3. Resident 27 ad a vial of insulin lispro 100u/ml dated [DATE] in the Caring Heart medication room. The vial was expired. <p>On [DATE] at 1:45 p.m., RN 5 indicated there were too many nurses working on 500 hall to keep up.</p> <p>A policy titled, Medication Storage in the Facility revised 2024 was provided by the Minimum Data Set (MDS) Consultant. It indicated, .Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists .</p> <p>3XXX,d+[DATE](j)</p> <p>3XXX,d+[DATE](m)</p> <p>3XXX,d+[DATE](n)</p>

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 04/07/2025
NAME OF PROVIDER OR SUPPLIER Plainfield Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 Clarks Creek Rd Plainfield, IN 46168	
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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>46414</p> <p>Based on record review and interview, the facility failed to ensure that a resident was vaccinated against COVID for 1 of 5 residents reviewed for vaccinations (Resident 55).</p> <p>Findings include:</p> <p>On 4/4/25 at 12:47 p.m., a record review was completed for Resident 55. She had the following diagnoses which included but were not limited to migraines, muscle weakness, chronic pain syndrome, and acute respiratory failure.</p> <p>Resident 55's record lacked documentation of the COVID vaccination.</p> <p>On 4/7/25 at 11:15 a.m., during an interview with the Minimum Data Set (MDS) consultant, she indicated she looked in the system for the vaccination and for a vaccination declination and she could not find either one.</p> <p>A policy titled, Infection Prevention and Control Program COVID was provided by the Regional Nurse Consultant (RCS) on 4/4/25 at 9:17 a.m. It indicated, .The facility will follow centers for Medicare and Medicaid services (CMS) and centers for disease control and prevention (CDC) as well as state and local government guidance to mitigate the spread of COVID-19 and manage outbreaks in the facility</p>		