

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155215	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/14/2015
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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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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 7, 8, 9, 10, 13 &amp; 14, 2015.</p> <p>Facility number: 000121 Provider number: 155215 AIM number: 100290940</p> <p>Census bed type: SNF/NF: 87 Total: 87</p> <p>Census payor type: Medicare: 8 Medicaid: 62 Other: 17 Total: 87</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on April 17, 2015.</p>	F 000	Facility Requests a Desk Review	
F 170 SS=A Bldg. 00	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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	<p>unopened.</p> <p>Based on interview and record review, the facility failed to ensure a resident received unopened mail on the weekend for 1 of 1 resident interviewed (Resident #3).</p> <p>Findings include:</p> <p>During an interview on 4/14/15 at 12:10 p.m., Resident #3 indicated the weekend receptionist had opened a resident's mail.</p> <p>During an interview on 4/14/15 at 3:34 p.m., the Business Office Manager indicated the weekend receptionist was new and had mistakenly opened a resident's greeting card.</p> <p>On 4/14/15 at 3:34 p.m., the current Resident's Rights policy was provided by the Administrator and Director of Nursing. The policy indicated the resident had a right to receive unopened mail. The policy also indicated the resident had a right to privacy including mail.</p> <p>3.1-3(s)(1)</p>	F 170	2567 states no POC required	05/14/2015

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F 174 SS=E Bldg. 00	<p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY</p> <p>The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>Based on observation, interview and record review, the facility failed to ensure the right of the resident to have phone conversations without being overheard for 3 of 3 residents reviewed for privacy of phone calls (Resident #10, #44, and #68).</p> <p>Findings include:</p> <p>During an interview on 4/9/2015 at 3:01 p.m., Resident #10 indicated she made calls at the nurses station. She indicated, "it is not always convenient for them or myself, I don't want everybody to hear my conversations."</p> <p>During an interview on 4/9/2015 at 3:15 p.m., Resident # 44 indicated she made phone calls at the nurses station and did not have a private place to make calls.</p> <p>During an observation on 4/13/2015 at 2:19 p.m., Resident #68 was observed being escorted to the nurses station by Certified Nursing Assistant (CNA) #30 to make a phone call. CNA #30 dialed a number for the resident. CNA #30 made</p>	F 174	<p>Administrator will implement corrective actions for Residents (#10, #44, and #68) affected by this practice, including: Residents have been given a reasonable access to privacy, when making telephone calls. A specific private location has been provided for phone calls to be used by residents. The telephone process was discussed and approved by resident council on 5/1/2015. Administrator will assess residents having the potential to be affected by this practice, including: Residents needing to make or take phone calls have private access in a designated room. DON will implement measures to ensure that this practice does not recur, including: Staff was in-serviced on private phone use. Residents rights "were reviewed along with "right to telephone access with privacy". Private phone use will be monitored by the Administrator and DON DON will monitor corrective actions to ensure the effectiveness of these actions, including: New phone policy will be presented by the DON or designee at monthly quality assurance meetings for review and recommendations. This will</p>	05/14/2015			

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	<p>no offer to escort the resident to a private location to make her call.</p> <p>During a tour of the facility on 4/14/2015 at 1:59 p.m., a phone was observed in the hallway of the rehab unit, on a side table. There was a sign posted above the phone that indicated, "Resident Phone," with an arrow pointing to the phone. The same phone set up and sign were observed in the chapel alcove.</p> <p>During an interview on 4/14/2015 at 2:08 p.m., CNA #30 indicated residents had used the phone at the nurses stations, and in the hallway on the rehab unit.</p> <p>During an interview on 4/14/2015 at 2:33 p.m., the Assistant Director of Nursing (ADON), indicated, the residents used the phones at the nursing stations, in the hallway on the rehab unit, and the chapel. When asked if the residents had a private place to use the phone she indicated residents used the chapel alcove which had no door and included an exit to an outdoor area.</p> <p>A policy entitled, "Resident Rights," indicated, "You have the right to use the telephone in private."</p> <p>3.1- 3(f)</p>		<p>be ongoing for six months, or until this procedure is proven without fault.</p>				

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F 242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents' choices were assessed regarding their preferences for frequency of showers for 1 of 2 residents reviewed who met the criteria for choices (Resident #50).</p> <p>Findings include:</p> <p>During an interview on 4/9/2015 at 10:52 a.m., Resident #50 indicated that she had not been provided a choice regarding her shower schedule. She indicated that she had received a shower twice a week at the facility and her preference had been to receive showers daily.</p> <p>During an interview on 4/14/2015 at 2:48 p.m., the Director of Nursing (DON) indicated that Resident #50's preferences for showers had been assessed on admission to the facility to receive her showers on Monday, Wednesday, Friday, and Sunday. She indicated Resident #50 had received showers two days a week,</p>	F 242	DON will implement corrective actions for residents "50 affected by this practice, including: Resident #50 has been care planned to receive daily showers. DON will assess residents having the potential to be affected by this practice. including: Residents were reviewed for choices of shower times. Care plans and CNA assignment sheets were revised if necessary. DON will implement measures to ensure that this practice does not recur, including: Nursing staff will be in-serviced on shower preferences by DON. DON or designee will monitor process weekly. DON will monitor corrective actions to ensure the effectiveness of these actions, including: "Right of choice for showers" will be presented at monthly quality assurance meeting by DON or Designee for review and recommendations. This will be done monthly for six months, until this procedure is proven without fault.	05/14/2015			

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	<p>on Wednesday and Saturday evening since her admission to the facility.</p> <p>Resident #50's record was reviewed on 4/10/2015 at 1:30 p.m. A Minimum Data Set (MDS) assessment tool, dated 12/4/2014, indicated Resident #50 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, required physical assistance from staff for bathing, and indicated it had been very important for her to make decisions regarding bathing.</p> <p>An undated "My Personal History" assessment, provided by the DON on 4/14/2015 at 3:19 p.m., indicated Resident #50 had preferred to shower around 2 p.m., on Monday, Wednesday, Friday, and Sunday.</p> <p>A policy titled "Resident Rights" identified as current by the Administrator on 4/14/2015 at 3:34 p.m., indicated, "...Resident Behavior and Facility Practices...Self Determination: You may choose your own activities, schedules and health care and any other aspect significant to and affecting your life within the facility...Accommodation of Needs: You have the right to receive services with reasonable accommodations to individual needs and preferences...."</p>			

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F 244 SS=E Bldg. 00	<p>3.1-3(u)(3)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to follow up on residents' grievances related to dirty water pitchers, dirty wheelchairs, and not answering call lights for 3 of 9 months of resident council minutes reviewed.</p> <p>Findings include:</p> <p>On 4/14/15 at 2:00 p.m., the resident council minutes and resident council concern follow-up forms were reviewed from August 2014 to April 2015. The resident council minutes listed dirty water pitchers not being changed as a current or continued problem on the following dates: 8/1/14, 9/5/14, 10/3/14, 2/6/15, and 3/6/15. A resident council concern follow-up form was recorded regarding dirty water pitchers, but no plan of action forms were recorded for the following dates: 8/1/14, 9/5/14, and 10/3/14.</p>	F 244	<p>DON will implement corrective actions for residents affected by this practice, including: Residents water pitchers and wheelchairs were clean during the time of survey. Call lights were answered promptly as observed by management staff. Administrator and DON will assess residents having the potential to be affected by this practice, including: Staff will be in serviced on cleanliness of water pitchers and wheelchairs along with call light response time by DON. Administrator met with Resident council on 5/1/2015 to review resident council grievance procedure. Administrator and DON will implement measures to ensure that this practice does not recur, including: Any further grievances or complaints will be addressed by the Administrator or DON and put through the quality assurance program. Administrator will monitor corrective actions to ensure the effectiveness of these actions, including: The grievance log will be reviewed monthly at the quality</p>	05/14/2015			

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	<p>The resident council minutes listed dirty wheelchairs not being cleaned as a current or continued problem on the following dates: 10/3/14, 11/7/14, 12/5/14, 1/2/15, and 2/6/15. No resident council concern follow-up or plan of action forms were recorded for the following dates: 10/3/14, 12/5/14, and 1/2/15.</p> <p>The resident council minutes listed call lights not being answered as a current or continued problem on the following dates: 12/5/14, 1/2/15, 2/6/15, 3/6/15, and 4/3/15. No resident council concern follow-up or plan of action forms were recorded for the following dates: 12/5/14, 1/2/15, and 4/3/15.</p> <p>During an interview on 4/14/15 at 12:10 p.m., Resident #3 indicated the resident council concerns regarding call lights not being answered had not been resolved and water pitchers were still not changed regularly.</p> <p>During an interview on 4/14/15 at 3:40 p.m., the Director of Nursing (DON) and the Administrator indicated the resident council's grievances were reviewed monthly, a resident council concern follow-up form was created for each concern, and a plan of action was to be created by the appropriate department to</p>		assurance meeting by Social Services or Designee.	

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F 314 SS=D Bldg. 00	<p>resolve the grievance.</p> <p>On 4/14/15 at 3:40 p.m., the Administrator and DON provided the current resident council policy. The policy indicated resident's concerns and any planned resolutions were to be documented. The policy indicated the appropriate department personnel or administrator was to follow up on the resident's concerns. The policy also indicated the staff resolutions and participation were to be documented.</p> <p>3.1-3(l)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p>			

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	<p>Based on observations, interview, and record review, the facility failed to ensure care plan interventions were implemented for 1 of 1 resident reviewed for pressure ulcers. (Resident #22).</p> <p>Findings include:</p> <p>During an observation on 4/10/2015 at 1:57 p.m., Resident #22 was observed in bed wearing a soiled adult brief and pants. Upon providing incontinence care, the Assistant Director of Nursing (ADON) was observed to leave the resident in bed with no adult brief or pants on.</p> <p>During an interview on 4/10/15 at 2:15 p.m., the ADON indicated, Resident #22 was not supposed to be put to bed with an adult brief on. She indicated the adult brief and the residents pants should have been removed when the resident was put to bed as a part of her plan of care to facilitate wound healing.</p> <p>Resident #22's chart was reviewed on 4/9/15 at 2:20 p.m. A care plan, dated 12/30/14, indicated, "Resident is always incontinent of bladder and uses adult briefs when up and incontinent pads when in bed."</p> <p>A policy entitled, "Prevention of Pressure</p>	F 314	ADON will implement corrective actions for residents #22 affected by this practice, including: Resident #22 immediately had adult brief removed and incontinence care provided. Adult brief was not replaced while resident #22 remained in bed per care plan. DON and ADON will assess residents having the potential to be affected by this practice, including: ADON reviewed CNA assignment sheets for accuracy and reviewed assignment sheets with direct care staff. DON will in service nursing and therapy staff on following care plan interventions. DON will implement measures to ensure that this practice does not recur, including: Facility developed audit tool for care plan interventions. This will be completed at random by DON or Designee on a weekly basis. DON will monitor corrective actions to ensure the effectiveness of these actions, including: Audit process will be reviewed and reported monthly during the quality assurance meeting. This will be ongoing for six months or until this procedure is proven without fault.	05/14/2015			

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F 371 SS=E Bldg. 00	<p>Ulcers," received from the ADON 4/14/15 at 9:15 a.m., indicated the facility should, "Provide identification of pressure ulcer risk factors and interventions for the risk factors."</p> <p>3.1-35(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure adequate hand sanitation during food distribution and while providing feeding assistance to 3 residents for 2 of 4 dining observations in 2 of 5 (Caring Hands, Washington) dining rooms (Residents #37 and #80).</p> <p>Findings include:</p> <p>1. On 4/7/2015 from 12:21 p.m. to 12:23 p.m., during the lunch dining observation, Certified Nursing Assistant (CNA) #2 was observed to serve Resident #80 a spoonful of food that had</p>	F 371	DON will implement corrective actions for residents (#80,#37 and #77) affected by this practice, including: Staff members (Unit Manager#1 and CNA #2) were educated on feeding, food handling and hand hygiene. DON will assess residents having the potential to be affected by this practice,including: All direct care staff (Nurses and CNA) will be in serviced on feeding, food handling and hand hygiene. DON will implement measures to ensure that this practice does not recur,including: random audits of the dining rooms to insure proper hand washing and feeding techniques are being followed. DON will monitor corrective	05/14/2015

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	<p>dropped onto his clothing protector before it reached his mouth. CNA #2 then picked up the dropped food with her bare right hand and placed it back onto the spoon and fed it to Resident #80. As CNA #2 continued to assist with feeding, she was observed to wipe below her nose with her right hand before she picked up food that had dropped onto Resident #37's clothing protector and placed the food on the table. She was then observed to serve Resident #80 a spoonful of food. CNA #2 had not been observed to perform hand sanitation in between feeding assistance.</p> <p>During an interview on 4/14/2015 at 8:57 a.m., CNA #2 indicated staff should perform hand sanitation before feeding assistance would be provided to each resident.</p> <p>During an interview on 4/14/2015 at 12:40 p.m. the Director of Nursing (DON) indicated it had been her expectation that staff not touch resident food with their bare hands and perform hand sanitation when hands became soiled as they provided feeding assistance.</p> <p>2. On 4/7/15 at 12:09 p.m., during the</p>		<p>actions to ensure the effectiveness of these actions, including: Random audits of dining rooms which will be reviewed at the monthly quality assurance meetings, this will be ongoing for six months or until this procedure can be proven without fault.</p>	

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	<p>lunch dining observation, Unit Manager (UM) #1 was observed to pull a chair out from the dining room table and assist Resident #77 to sit. Once Resident #77 was seated in the chair, UM #1 moved the resident's walker out from in front of the resident, and pushed the chair up to table. UM #1 was then observed to pick up Resident #77's tray and placed it in front of the resident. Then, UM #1 removed the lid from Resident #77's plate and opened two condiment packages. UM #1 had not been observed to wash her hands as she assisted Resident #77.</p> <p>On 4/14/15 at 9:10 a.m., the Assistant Director of Nursing provided the current policy entitled, "Hand washing," dated 8/14/2008. The policy indicated staff had been required to wash hands with soap and water under certain conditions including but not limited to the following: when hands were visibly soiled with body fluids or secretions, after contact with body fluids or mucous membranes, and after handling items potentially contaminated with body fluids or secretions. The policy indicated staff was required to use an alcohol based hand rub under certain conditions including but not limited to the following: before direct contact with residents, after contact with a resident's intact skin, and after contact with objects</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155215	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  04/14/2015
NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD PLAINFIELD, IN 46168		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	in the immediate vicinity of the resident.  3.1-21(i)(2)				