STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155215	A. BUILDING 00 B. WING	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINFIELD HEALTH CARE CENTER	3700 CLARKS CREEK RD PLAINFIELD, IN 46168

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00374298 and IN00374482. Complaint IN00374482 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00374298 -Substantiated. Federal/state deficiencies related to the allegations are cited at F580, F600, and F684. Survey dates: March 8 and 9, 2022 Facility number: 000121 Provider number: 155215 AIM number: 100290940 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 17 Medicaid: 50 Other: 19 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 21, 2022.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the			

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

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	resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			

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	§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the resident representative was notified of a change in condition, for 1 of 5 residents reviewed for notification and communication (Resident D). Findings include: Review of a Grievance document, dated 2/25/22, indicated the Social Service Director (SSD) received a call from the resident's responsible party who indicated he was upset due to no one notifying him of the resident having COVID-19. The facility conducted an investigation of the grievance. The documents reviewed as part of the investigation included, but were not limited to, the resident's progress notes. The investigation indicated the progress notes lacked documentation of any notification to the resident's responsible party which related to her positive COVID-19 tests results, at the time of her positive test. The grievance document further indicated the grievance resolutions included, but were not limited to, the education of the Unit Manager to be the designated person for notification to resident's families of any positive COVID-19 results and for the documentation of such notification in the resident record. The document indicated the resident's responsible	F 0580	Preparation and/or execution of this plan of correction does not constitute admission or agreement with by the provider of the truth or the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed because it is required by the provisions of federal and state law. Plainfield Health Care Center maintains the alleged deficiencies do not individually jeopardize the health/safety of its residents nor are they of such character as to limit the providers capacity to render adequate resident care. Plainfield Health Care Center asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes the providers credible allegation of compliance. F580 **1) How will corrective action be accomplished for those**	04/08/2022

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	party had been notified of the resolution on 2/25/22, by telephone. Resident D's record was reviewed on 3/9/22 at 11:22 a.m. The profile indicated the resident's diagnoses included, but were not limited to, alcohol dependence with alcohol-induced persisting dementia (a deterioration of mental function resulting from the persisting effects of alcohol abuse). The profile further indicated the resident had been diagnosed with COVID-19 on 12/31/21. Review of the resident's progress notes lacked documentation of the responsible party being notified of the COVID-19 positive test results on 12/31/21. A physician's progress note, dated 1/3/22 at 12:33 p.m., indicated the reason for the physician's visit was for new COVID-19 diagnosis. The resident had tested positive for COVID-19 on 12/31/21, during a facility wide testing. A social services progress note, dated 2/25/22 at 8:26 a.m., indicated the SSD spoke with the responsible party about the resident and answered questions about condition change. During an interview, on 3/8/22 at 11:54 a.m., the SSD indicated, on 2/25/22, she had received a call from the resident's responsible party. He indicated no one had ever contacted him when the resident had tested COVID-19 positive. She opened a grievance at that time. The grievance had been investigated and had determined that no had contacted him about the positive COVID-19 test.		**residents found to have been affected by the deficient practice?** A. DON immediately re-educated nursing staff on facility Policies and Procedures to promptly notify the resident/responsible party and his or her attending physician, of any changes in the resident's medical/mental condition and/or status changes in level of care, billing/payments, resident rights, etc. Nursing staff educated on policy to ensure notification to resident/family, physician is documented in resident's EMAR via progress note. B. In-service on prompt notification of change in condition policy and documentation procedures added to Contract Staff Information Packet to ensure proper education. **2) How will the facility identify other resident having the potential to be affected by the same deficient practice?** A. DON identified all residents have the potential to be affected by the alleged deficient practice. **3) What measures will be put in place or systematic changes made to ensure the deficient practice will not recur?** A. DON/designee to audit Resident/Family, Physician	

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	On 3/9/22 at 1:35 p.m., the Director of Nursing (DON) provided a document, with a revised date of February 2021, titled, "Change in a Resident's Condition or Status," and indicated it was the policy currently being used by the facility. The policy indicated, "...Our facility promptly notifies...the resident representative of changes in the resident's medical/mental condition and/or status...Policy Interpretation and Implementation...4...a nurse will notify the resident's representative when...f. COVID test results...." This Federal finding relates to Complaint IN00374298. 3.1-5(a)(2)		Notification of Change in Condition weekly x's 4 weeks, biweekly x's 8 weeks then monthly x's 3 months to ensure completion of prompt notification/documentation of resident/family, physician of any changes in the resident's medical/mental condition and/or status changes in level of care, billing/payments, resident rights, etc. B. In-service on prompt notification of change in condition policy and documentation procedures added to Contract Staff Information Packet to ensure proper education. **4) How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** A. DON/Designee will complete random audits of resident change in condition notification and documentation weekly x's 4 weeks, then bi-weekly x's 8 weeks and then monthly x's 3 months with results reported during monthly QAPI meeting.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to			

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	freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to prevent misappropriation of resident property when a resident's cell phone was stolen for 1 of 3 residents reviewed for misappropriation of property (Resident F). Findings include: Resident F's record was reviewed on 3/8/22 at 1:17 p.m. The profile indicated the resident had admitted to the facility on 1/18/22, for diagnoses which included, but were not limited to, type 2 diabetes mellitus (an impairment in the way the body regulates and uses sugar [glucose] as a fuel) and mild cognitive impairment (the stage between the expected cognitive decline of normal aging and the more serious decline of dementia). On 3/9/22 at 10:10 a.m., a review of an Indiana Department of Health (IDOH) Reportable Incident document, dated 2/25/22 at 7:10 a.m., indicated the resident's family had indicated the resident's phone was missing. The resident's son indicated the family had tracked the phone and it had been tracked to an area outside of the facility. The facility initiated an immediate investigation which consisted of staff and resident interviews. Law enforcement had been notified by the family. A police officer had	F 0600	Past noncompliance: No POC required. There is plenty of precedence that an issue would be substantiated (i.e. it did occur) without deficient practice on the part of the facility. There's no explanation of what deficient practice occurred, simply that an incident of misappropriation of resident property occurred and recapitulated in laborious detail on the 2567. It summarizes that "the deficient practice was corrected on 03/03/22;" however, there is no specific deficient practice identified in the findings. I think further inquiry should be done with the office on the specific deficient practice being cited. We cannot prevent someone from a criminal act if they are intent on doing so … as indicated in this case by the admission of guilt and being charged with a felony theft.	04/03/2022

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	contacted the facility and provided a case number related to the police department's investigation. Review of the facility's investigation documents indicated the following: a. During an interview, on 2/28/22, Certified Nursing Assistant (CNA) 7 indicated on or around 5:35 a.m., on 2/25/22, agency Qualified Medication Aide (QMA) 6 had come back to the Memory Care Unit and started a conversation with Personal Care Assistant (PCA) 5. CNA 7 felt that that was odd because agency QMA 6 had been working on the 200 hall all day and had not come back to the memory care unit all night. CNA 7 indicated he did not see any transaction take place, but only noticed that agency QMA 6 was very talkative. b. During an interview, on 3/1/22, agency QMA 6 indicated at the beginning of the evening shift, he had received $50.00 from PCA 5. PCA 5 had indicated to him that she had got a new cell phone. c. An "Employee Corrective Action Form," dated 2/26/22, indicated PCA 5's employment had been terminated, related to her involvement in the theft of a resident's cell phone. The PCA indicated she had been given the cell phone by agency QMA 6. d. A follow-up report, dated 3/3/22, indicated on 2/25/22, a facility nurse had been notified by the resident's son that the resident's phone had been taken from the facility and had been tracked to PCA 5's address at approximately 6:45 a.m. The Administrator (ADM) and the Director of Nursing (DON) were notified, and an investigation was initiated. Staffing assignment			

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	sheet and schedule were reviewed to determine what staff worked on the overnight shift. The DON began notifying staff of allegation and collecting statements. Agency QMA 6 had been assigned to the resident from 11:00 p.m., to 6:00 a.m., on 2/25/22. When questioned, the agency QMA denied any involvement with the missing phone. Per the agency QMA's statement to the DON, he had been accused of stealing a phone from a previous facility, but the allegation had been unsubstantiated. Law enforcement had been notified and the facility was cooperating with their investigation. The facility began a review of personnel files of the staff who worked on the 11:00 p.m., to 6:00 a.m., shift on 2/25/22, and noted that PCA 5 had a current home address that matched the address where the cell phone had been tracked to. At approximately 8:00 p.m., the ADM was notified by the family that the phone had pinged again at a location close to the facility. The DON contacted the facility and discovered that the only staff that was out on break and not in the facility, at that time, was PCA 5 The ADM contacted the resident's family and law enforcement to request that they all meet at the facility to question PCA 5 when she returned to the facility. The ADM and the police officer interviewed PCA 5 and she denied any involvement with the missing cell phone. The police officer explained to the PCA that he had enough evidence to charge her and through further questioning, the PCA admitted that she had been given the cell phone by agency QMA 6 in exchange for $50.00, which he would collect from her on 2/28/22. PCA 5 indicated she had destroyed the cell phone and agreed to show the police officer the whereabouts of the phone. The ADM and DON followed the police officer to the nearby business parking lot near the facility. The destroyed phone was located in the parking			

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	lot. Once the phone was recovered, the police officer placed PCA 5 under arrest for felony theft. PCA 5 was terminated from employment at the facility. The investigation was ongoing to attempt to determine if agency QMA 6 was involved with the theft of the phone. The facility was working with the resident's family to replace the phone. Based on the findings of the investigation, the facility was able to substantiate the allegation of misappropriation of the resident's property. During an interview, on 3/9/22 at 10:29 a.m., the ADM indicated on 2/25/22, the resident's family contacted the facility and told them the phone had been missing and they had already called the police. The police came to the facility and talked with the ADM who explained that the facility had opened an investigation. Later that evening the family pinged the phone and contacted the ADM to let him know the phone had pinged across the street from the facility. The ADM called the DON who contacted the facility and asked the charge nurse for the name of any employee who was out of the facility at that time and was told PCA 5 was on her break. The ADM and DON came into the building to speak with PCA 5 when she returned to work. They also called the resident's family and requested that they contact the police meet them at the facility. The police officer and ADM interviewed the PCA, who denied any involvement. The police asked where she had gone when she left the facility, to which she indicated she had gone to her mother's home, where she was currently living. The police officer then asked about her brother's home address, where the resident's family indicated the phone had also pinged. The PCA indicated her brother did live at that address but she had not been there for at least a week. The police			

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	requested to search the PCA's vehicle. She gave permission and the vehicle was searched, but the phone was not found. The police then talked to the PCA alone and at that time she admitted that she had taken the phone from a QMA at the facility and was planning to pay him $50 for the phone. She admitted that she had broken the phone and that it was in a nearby business parking lot. The police requested that the ADM and DON follow him to that specific nearby parking lot. The police officer took the PCA with him. The phone was found, broken into pieces with a shattered screen. The police officer then placed the PCA under arrest. The ADM and DON terminated the PCA's employment on 2/26/22. They also requested the PCA came back into the facility, on 2/28/22, the date the PCA had agreed to pay the agency QMA for the phone. The ADM indicated a cell phone was set up to record the transaction. The ADM then notified the police of the recording of the transaction, but to this date, he was not aware of any action had been taken by the police. The ADM met with the QMA to get his statement on 3/1/22, but the QMA denied any involvement with the theft of the phone. On 3/9/22 at 3:25 p.m., a copy of the police report was obtained from the local police department. The police officer's summary of the investigation indicated on 2/25/22 at 9:00 p.m., he was dispatched to a delayed theft report where new information had been obtained about a stolen cell phone whereabouts. The victim's daughter indicated the phone had pinged to a nearby address at approximately 6:30 p.m., but then had been turned off again. The police office conducted a grid search of the field where the phone had pinged but did not find the phone. He then drove to the facility to continue to gather evidence regarding the locations of the pings			

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	from the phone and the employee's whereabouts for the phone movements. The facility ADM informed the police officer that the only employee on staff when the theft occurred, who had left the building, was PCA 5. The ADM stated to the police officer that PCA 5 had got off of work at 6:30 a.m., on 2/25/22, after working through the previous night at the facility. The missing phone had alerted the victim's at 6:35 a.m., that it was moving, and someone was driving with it on the roadway. The ADM indicated PCA 5 returned to work at 2:00 p.m., that afternoon and left for her lunch at approximately 6:30 p.m., to get lunch at a local fast food restaurant. Simultaneously, during that timeframe, the phone turned back on, live pinged at a location around a nearby business parking lot, and then stopped pinging a few minutes later. According to the facility administration, the PCA returned to the facility shortly before 7:00 p.m. The police officer went to the facility, and at approximately 10:15 p.m., pulled the PCA into the conference room, read her Miranda rights to her, and the PCA indicated she was okay talking to the police officer about the incident. She indicated she had left the facility from her night shift at 6:15 a.m., that morning and not 6:30 a.m., as reported. She had gone to lunch at approximately 8:00 p.m., this evening and not 6:30 p.m., as the administration had indicated. She told the police officer that she no longer lived at her brother's home address and that she had moved a couple of months ago. The police officer confronted her as to why the phone would ping at that address. She continued to deny any involvement or knowledge about the phone. He questioned her about the phone pinging at the nearby business parking lot which was approximately 500 yards from the facility when she was recorded being out of the facility during			

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	her lunch break. The PCA emphatically denied going to the nearby business parking lot and indicated she was being set up by other employees. The police officer then stepped out to talk with the ADM. When he stepped out of the meeting with the ADM, the PCA approached him and asked to speak with him again. At that point, the PCA indicated to the police officer that she wanted to tell him the truth. She indicated she no longer had the phone but could take him to where it was. She had brought the phone to her home at 6:30 a.m., that morning. That was where the resident's family had attempted to contact her on the stolen phone, she got scared, so she shut the phone off. When she returned to work at 2:00 p.m., she became aware that management was involved in the investigation along with the police. She left the facility and said she was going to a local fast food restaurant, but actually took the phone to the nearby business parking lot and destroyed it because she was afraid that the phone would be found inside her vehicle, and then returned to work. The PCA and police officer drove to the west side of the nearby business parking lot and the broken phone was located. The police officer gathered the phone into an evidence bag and place PCA 5 into custody. On 3/9/22 at 11:26 a.m., the DON provided a document, dated 2/1/17, titled, "Abuse, Neglect, Exploitation, and Misappropriation of Property Prevention, Protection and Response Policy and Procedures," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: ...Misappropriation of Property...will not be tolerated by anyone, including staff, patients, volunteers, family members or legal guardians, friends or any other individuals...Definitions: ...Misappropriation of			

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	Patient Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patent's consent...III. Prevention Issues: Policy: The Center will provide supervision and staff support services designed to reduce the likelihood of abusive behaviors...." The deficient practice was corrected by 3/3/22, prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included staff education on abuse and misappropriation of resident property, and ongoing monitoring for abuse was put in place. This Federal finding relates to Complaint IN00374298. 3.1-28(c)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure physician's orders were followed when a resident returned from the emergency room (ER) for 1 of 5 residents reviewed for quality of care (Resident C). Findings include:	F 0684	**1) How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** A. DON immediately educated nursing staff on facility policy and	04/08/2022

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	155215	A. BUILDING 00 B. WING	03/09/2022

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	Resident C's record was reviewed on 3/8/22 at 11:25 a.m. Diagnoses on the resident's profile included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 12/22/21, indicated the resident had a severe cognitive impairment. A progress note, dated 2/24/22, indicated a Certified Nursing Assistant (CNA) notified the nurse regarding a skin issue with the resident. The resident was assessed, and a large laceration was noted to the back of the left calf. Pressure was applied to the wound and a pressure dressing was placed. The nurse practitioner (NP) and resident's representative were notified of the incident. The resident was sent to the emergency room (ER) for evaluation and treatment. A progress note, dated 2/25/22, indicated the long term care (LTC) ombudsman was notified of the transfer out to the hospital for laceration to the leg. The record lacked documentation of any further progress notes, including when the resident returned from the hospital and any new orders upon return. A reportable investigation file, dated 2/25/22, indicated there was an incident on 2/24/22. The resident had a 13 centimeter (cm) laceration to the left lower leg. The incident follow up indicated the cover on the wheelchair to adjust the leg rests was noted with a sharp edge on the cap. Therapy replaced the padding. ER discharge		procedures on Reconciliation of Medication and Monitoring for Transcription on Admission/Re-admission **2) How will the facility identify other resident having the potential to be affected by the same deficient practice?** A. DON identified all residents have the potential to be affected by the alleged deficient practice. **3) What measures will be put in place or systematic changes made to ensure the deficient practice will not recur?** A. DON/designee to use Reconciliation of Medications on Admissions/Re-admission and Monitoring Transcription Audit Tool weekly X 4 weeks, biweekly X 8 weeks then monthly X 3 months to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or re-admission. B. In-service on Reconciliation of Medications on Admission policy and documentation procedures added to Contract Staff Information Packet to ensure proper education. **4) How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** A. DON/Designee will complete random audits of Reconciliation of Medications on	

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	paperwork included in the file indicated there was a large, deep defect to the left calf with muscles and tendons visible but no obvious tendon injury, very thin skin, atrophic (shrunken) muscles, semi lunar in shape. A physician's order in the hospital documentation indicated cephalexin (an antibiotic) 500 milligram (mg) by mouth twice daily for five days. Care for the laceration repair with stitches at home included, but was not limited to, keep the wound clean and dry for the first 24 hours. After the first 24 hours the wound could be washed with soap and water or a shower. An antibiotic ointment could be applied to the wound one to two times each day. Physician's orders lacked documentation an order was obtained for the cephalexin or a treatment to the left lower leg. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated February 2022, lacked documentation cephalexin was administered or any treatments were ordered or completed to the left lower leg. The MAR and TAR, dated March 2022, lacked documentation cephalexin was administered or any treatments were ordered or completed to the left lower leg. A weekly wound observation, dated 3/1/22, indicated it was the first observation of the wound. Measurements were 11 cm in length, 4 cm in width, and 0.1 cm in depth. Sutures were in place and the tissue was boggy (soft) and ecchymotic (skin discoloration). The current treatment plan was xeroform (a non-adherent dressing) weekly by wound nurse, however, the resident's record lacked documentation any treatments were completed.		Admission/Re-admission and implementation of MD orders upon admission/re-admission, weekly x's 4 weeks, then bi-weekly x's 8 weeks and then monthly x's 3 months with results reported during monthly QAPI meeting.	

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	A care plan, initiated 3/1/22, indicated the resident had a full thickness wound, skin tear to the left lower leg. Interventions included, but were not limited to, treat per facility protocol. During an interview, on 3/9/22 at 1:37 p.m., the Director of Nursing (DON) indicated she did not think the hospital sent the paperwork with the resident to the facility with the orders for the antibiotic and treatment to left lower extremity. She thought facility management printed that for the investigation file later. The facility staff should have called the hospital and requested discharge paperwork if it was not sent. She thought the wound nurse was following the area on the resident's left lower leg, but there should have been a treatment order on the TAR. On 3/9/22 at 1:35 p.m., the DON provided a document titled, "Reconciliation of Medications on Admission," and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Preparation: 1. Gather the information needed to reconcile the medication list: ...b. Discharge summary from referring facility...General Guidelines: 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care...4. Medication reconciliation helps to ensure that			

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	medications, routes and dosages have been accurately communicated to the Attending Physician and care team...." This Federal finding relates to Complaint IN00374298. 3.1-37(a)			