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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00445177, IN00445565, IN00445570 and IN00445476. Complaint IN00445177 - Federal/State deficiencies related to the allegations are cited at F580 and F656. Complaint IN00445565 - Federal/State deficiencies related to the allegations are cited at F580 and F656. Complaint IN00445570 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00445476 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: October 23, 24, and 25, 2024 Facility number: 000121 Provider number: 155215 AIM number: 100290940 Census Bed Type: SNF/NF: 107 Total: 107 Census Payor Type: Medicare: 6 Medicaid: 85 Other: 16 Total: 107 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs and to provide the best possible care to our residents as possible. The facility respectfully requests a desk review for this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Burton	Administrator	11/14/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0580 SS=D Bldg. 00	Quality review completed on November 6, 2024. 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to ensure the resident's representative was notified of a left hip wound for 1 of 3 residents reviewed for wounds (Resident C). Findings include: Resident C's record was reviewed on 10/23/24 at 10:05 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 10/9/24, indicated the resident had a severe cognitive impairment and had an arterial ulcer (a sore caused by poor perfusion [delivery of nutrient-rich blood] to the lower extremities). Diagnoses on the resident's profile included, but were not limited to, unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with behavioral disturbance, generalized anxiety disorder (persistent worrying or anxiety about a number of areas that are out of proportion to the impact of the events), and peripheral vascular disease (a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm, or become blocked which can lead to reduced blood flow and potential tissue damage). A nursing progress note, dated 9/27/24 at 2:12 p.m., indicated Resident C had a blister to the left hip which measured 1 centimeter (cm) by (x) 0.5 cm with no signs or symptoms of infection. The area	F 0580	F580 1—What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident C no longer resides in the facility. Other residents with changes in condition have been reviewed by the DON/Designee to ensure all residents with changes in condition have had responsible parties notified. 2—How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? The IDT team will review any change of conditions that have occurred and ensure that appropriate documentation has been completed. Nursing staff education on Change in Condition and notification of Changes was conducted beginning October 28, 2024. 3—What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? DON/Designee will audit Change of Conditions and telemediq five times a week for 8 weeks and	11/03/2024

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	was covered with a dressing with no complaints of pain from the resident. Resident C's medical record lacked documentation the resident's responsible party was notified of the left hip wound. During an interview, on 10/24/24 at 8:55 a.m., DON indicated, on 9/27/24, Resident C had developed a fluid filled blister/abrasion on her left hip and Resident C's representative should have been notified. On 10/25/24 at 10:08 a.m., Resident C's representative indicated she had not been notified by the facility of the resident's left hip wound. The Administrator (ADM), on 10/25/24 at 8:55 a.m., provided and identified an undated document as a current facility policy, titled "Change of Condition Notification." The policy indicated, "...Purpose...To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner...Policy...II. The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to...B. A significant change in the resident's physical, cognitive, behavioral or functional status...." During the exit conference on 10/25/24, the DON and Administrator did not provide any additional documentation of Resident C's representative being notified of the wound. No additional documents were emailed after the survey to indicate the representative had been notified.		then weekly for 8 weeks and then monthly for 2 months. 4—How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0656 SS=D Bldg. 00	This citation relates to Complaints IN00445177 and IN00445565. 3.1-5(a) 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan A. Based on record review and interview, the facility failed to implement care plan interventions to prevent further development of wounds for 1 of 3 residents reviewed for wounds (Resident C). Findings include: Resident C's record was reviewed on 10/23/24 at 10:05 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 10/9/24, indicated the resident had a severe cognitive impairment and had an arterial ulcer (a sore caused by poor perfusion [delivery of nutrient-rich blood] to the lower extremities). Diagnoses on the resident's profile included, but were not limited to, unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with behavioral disturbance, generalized anxiety disorder (persistent worrying or anxiety about a number of areas that are out of proportion to the impact of the events), and peripheral vascular disease (a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm, or become blocked which can lead to reduced blood flow and potential tissue damage). A nursing progress note, dated 9/13/24 at 7:00 p.m., indicated Resident C's right hip had an open	F 0656	F656 1—What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident C no longer resides in the facility. 2—How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? Facility audit was conducted on skin impairment care plans to ensure residents with skin impairments are appropriately care planned. The IDT team will review Monday through Friday for any skin impairments that have occurred and ensure that appropriate documentation has been completed. 3—What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? The IDT team will review Monday through Friday any skin impairments that have occurred and ensure that appropriate	11/03/2024

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	area measuring 2 centimeters (cm) by (x) 0.8 cm and an unopen blister measuring 1 cm x 0.5 cm with redness and swelling noted around the wound bed. The area was cleansed with wound cleanser and a dry dressing was applied. Resident C was repositioned to the left side. Nurse Practitioner (NP) and Director of Nursing (DON) were notified. New orders received for wound team consultation and to apply Medihoney to wound bed with island foam dressing over wound daily and as needed (PRN). A nursing progress note, dated 9/13/24 at 7:06 p.m., indicated Resident C's responsible party was notified of the right hip open area and blister. A nursing progress note, dated 9/27/24 at 2:12 p.m., indicated Resident C had a blister to the left hip, 1 cm x 0.5 cm with no signs or symptoms of infection. The area was covered with a dressing with no complaints of pain from the resident. Resident C's medical record lacked documentation a care plan with interventions was created for the right hip wound, the left hip wound, and lacked documentation the resident's responsible party was notified of the left hip wound. During an interview, on 10/24/24 at 8:55 a.m., DON indicated Resident C had acquired an opened area and a fluid filled blister on the right hip on 9/13/24 and on 9/27/24, the resident developed a fluid filled blister/abrasion on her left hip with the root cause of the right hip due to skin failure and the left hip root cause was due to the resident's brief, clothing, and movement in bed. The blisters were started by the brief rubbing of the resident's skin. Care plans should have been developed with interventions for the right hip wound and the left hip wound. The resident's responsible party		documentation has been completed. 4—How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	should have been notified of the resident's new left hip wound. On 10/24/25 at 10:25 a.m., the DON provided and identified a document as a current facility policy titled, "Wound Management," dated 06/2020. The policy indicated, "...Purpose...To provide a system for the treatment and management of residents with wounds including pressure and non-pressure injury...Policy...A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing...Procedure...II. Wound Management...B. Licensed Nurse will notify the responsible part of the presence of a pressure injury...III. Documentation...F. Update the resident's care plan as necessary...." This citation relates to Complaints IN00445177 and IN00445565. 3.1-35(a) 3.1-35(b)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure a resident who fell was not moved before seeking treatment, and was subsequently diagnosed with a hip fracture for 1 of 3 residents reviewed for accidents (Resident B). Findings include: An Indiana State Department of Health Survey Report System report, dated 10/12/24 at 2:01pm, indicated Resident B was in the main dining room	F 0684	F684 1—What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident B no longer resides in the facility. 2—How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken?	11/03/2024

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	having lunch when he stood up and tripped on the chair leg and fell to his right. Nursing immediately assessed the resident who complained of lower extremity pain and was unable to bend his leg. Pain medication was given, and the Physician (MD) was notified and gave an order to send to the emergency room (ER) for evaluation and treatment. Resident B was diagnosed with a left femur fracture and the femur was surgically repaired. Resident B's record was reviewed on 10/23/24 at 10:04 a.m. Diagnoses on Resident B's profiled included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions, memory loss and confusion being the main symptoms), and generalized weakness. A fall care plan for Resident B, dated 3/23/24, indicated the resident was at risk for falls related to confusion, cognitive impairment, psychotropic and diuretic medication use, and unsteady gait. Interventions included a night light, anticipating and meeting resident needs, call light within reach and encourage the resident to use it for assistance as needed, and appropriate footwear when ambulating or mobilizing in a wheelchair. A quarterly assessment and a State Optional assessment, both completed on 9/19/24, assessed Resident B as having the ability to make herself understood and understand others. A Brief Interview for Mental Status (BIMS) score 3/15 indicated severe cognitive impairment. The resident was extensive assistance of 1 person physical assist for bed mobility, and limited assistance of 1 person physical assist for ambulation. No falls were documented since the last assessment.		Nursing staff education on resident falls and response to falls was conducted beginning October 28, 2024. The IDT team will review any falls that have occurred and ensure that appropriate documentation has been completed. 3—What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? The IDT team will review Monday through Friday any falls that have occurred and ensure that appropriate documentation has been completed. DON/Designee will audit falls five times a week for 8 weeks and then weekly for 8 weeks and then monthly for 2 months. 4—How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A Medication Administration Record (MAR), dated 10/12/24 at 10:30 a.m., indicated acetaminophen (Tylenol, analgesic) 325 milligram (mg) give 3 tablets by mouth every 4 hours as needed for pain was documented as administered. A Fall Risk Evaluation, dated 10/12/24, indicated a score of 14 high risk for falls. Resident B was ambulatory and had 1 to 2 falls in the past 3 months. He was disoriented times 3 (person, place, and time) at all times. Resident B was unable to stand, and staff were unable to assess his gait or balance after the fall. Text messages between Licensed Practical Nurse (LPN) 8 and NP, dated 10/12/24: At 10:22 a.m., LPN 8 indicated Resident B tripped and had an unwitnessed fall. Resident B had pain of 10 in right leg and was unable to move. Resident B would not lay it straight. Pain increased when positioned into a chair, normally ambulates, and resident was not able to put pressure on it. At 10:27 a.m., NP indicated to get a hip and femur x-ray. Ordered orthostats every shift for 3 days, indicated to push fluids, and asked if the resident was on blood pressure medicine. At 10:31 a.m., LPN 8 indicated at this time the patient was having trouble sitting or standing related to pain. At 10:55 a.m., LPN 8 indicated the patient was in his room moaning and indicated he wanted to go to ER because the pain was excruciating and Tylenol wasn't touching it. At 10:56 a.m., NP indicated ok. An eInteract Transfer Form, dated 10/12/24 at 10:59 a.m., indicated Resident B was sent to a local hospital on 9/20/24 at 4:06 p.m. for a fall.			

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

A progress note, dated 10/12/24 at 12:52 p.m., indicated staff heard a noise and found Resident B lying on his right side. The resident complained of right lower extremity (RLE) pain and was unable to straighten his leg. The Nurse Practitioner (NP) was notified and gave orders for x-rays. The NP was aware the resident was in pain and unable to bear weight.

A progress note, dated 10/12/2024 at 1:05 p.m., indicated when doing a neurological evaluation Resident B was noted to still have pain in the RLE, the Tylenol was not effective, his pain was 10/10 (a numeric pain scale 7-10 was severe with 10 meaning the worst pain possible) and he requested to go to the ER. The NP was notified and gave approval, and the resident was sent to a local hospital for evaluation and treatment.

An Interdisciplinary Team (IDT) note, dated 10/14/24 at 10:56 a.m., indicated Resident B fell on 10/12 at 10:00 a.m. The resident was found lying on his right side by a dining room table and "they" stated he had tripped on a leg of a chair. Resident B was assessed by staff and found having pain in the RLE, and he was assisted up into a wheelchair by staff. The resident was having difficulty with his RLE and ROM (range of motion)/straightening out. Orders were obtained for x-rays for right hip/leg and pain medication was administered. The resident continued to have pain and was sent out to the ER for evaluation and treatment.

A progress note, dated 10/20/24 at 9:30 a.m., indicated Resident B remained in the hospital with no plans for discharge at that time.

During an interview on 10/24/24 at 11:30 a.m., the

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Assistant Director of Nursing (ADON) indicated after a fall, the nurse was supposed to assess the resident to include vital signs, range of motion, and injuries to include skin tears, broken bones, or head injuries. If the fall was unwitnessed, neurological checks would be initiated, and pain medication would be administered if appropriate. The on call person for nursing, MD/NP, and resident responsible party were notified. New orders for treatment were obtained and started. If a resident was suspected of having a broken bone, the resident would not be moved, the MD would be contacted for orders, and the resident sent 911 to the hospital. A confidential interview during the survey indicated that the resident had been independent with ambulation before a recent fall although he had a shuffling gait. On 10/12/24 around 10:00 a.m., the resident tripped over a chair leg getting up from a table. After the resident fell the staff had put him in a wheelchair, had him walk, possibly placed him in bed, and he had not been sent to the ER for evaluation and treatment until hours later between 4:00 p.m. or 5:00 p.m. when he continued to complain of pain and requested to be sent to the hospital. During an interview on 10/25/24 at 6:30 p.m., the Director of Nursing (DON) indicated on 10/12/24 nursing staff had moved Resident B after he fell onto the floor in the dining room and put him into a wheelchair. Documentation indicated that the resident was complaining of pain and could not straighten his leg. The DON indicated it was her opinion that the resident was timely sent to the hospital. On 10/23/24 at 2:20 p.m., the Executive Director Provided a Response to Falls policy, undated, and			

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	10/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	indicated the policy was the one currently being used by the facility. The policy indicated, "To ensure the Facility response quickly and appropriately to resident falls in a manner that addresses both the resident's immediate needs and long-term fall prevention. Policy I. Residents experiencing a fall will be promptly assessed and treated for injuries. Procedure I. Immediate Post Falls Response. A. Upon witnessing a fall or finding a resident in a position indicating a fall, stay with the resident and send another staff member to notify a Licensed Nurse if the first responder is not a licensed personnel. B. Do not move the resident initially until after an assessment has been completed. Call for assistance ...ii. If the Licensed Nurse suspects a fractured hip, back or other injury, the Licensed Nurse will make the resident comfortable until emergency medical services arrives ..." This citation relates to Complaints IN00445570 and IN00445476. 3.1-37(a)			