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	09/06/2024

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 IN00441980, IN00441976, and IN00442404. Complaint IN00442404 - Federal/state deficiencies related to the allegations are cited at F580, F695, and F755. Complaint IN00441976 - Federal/state deficiencies related to the allegations are cited at F580, F695, and F755. Complaint IN00441980 - Federal/state deficiencies related to the allegations are cited at F580, F695, and F755. Survey dates: September 5 and 6, 2024 Facility number: 000121 Provider number: 155215 AIM number: 100290940 Census Bed Type: SNF/NF: 112 Total: 112 Census Payor Type: Medicare: 3 Medicaid: 80 Other: 29 Total: 112 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 20, 2024.	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	10/02/2024

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.

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to notify the responsible party of a change in condition of 1 of 1 resident reviewed for change of condition and notification (Resident B). Findings include: On 9/5/24 at 11:56 p.m., the medical record of Resident B was reviewed. The resident was admitted to the facility on 7/25/24. Admission Diagnosis included but were not limited to, acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues), pneumonitis (Pneumonia, a bacterial infection of the lungs) due to inhalation of food and vomit. Physician Order, dated 8/15/24, indicated to administer 10 milliliters (ml) of Amoxicillin suspension (liquid) 250/5 ml via G-tube (a tube that is surgically inserted through the abdomen and into the stomach to provide nutrition, fluids, and medicine) every 12 hours for pneumonia for 7 days. Physician order, dated 8/16/24 at 1:12 p.m., indicated to administer 1 tablet of Augmentin Oral Tablet 500-125 milligrams (mg) (Amoxicillin and Pot Clavulanate) via G-Tube two times a day for PNA (pneumonia). Physician order, dated 8/13/24, indicated to administer albuterol nebulizer 0.083% 2.5 mg	F 0580	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. Other residents with medication changes and Oxygen changes have been reviewed by the DON/Designee to ensure all orders and medications are available. 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 Monday through Friday any change of conditions that have occurred and ensure that appropriate documentation has been completed. Nursing staff education on Change in Condition, pharmacy services, notification of changes was conducted beginning on September 9, 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?	09/21/2024

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	inhale orally via nebulizer (typically consist of a main nebulization unit, a reservoir for holding the liquid for nebulization, and a mouthpiece through which drug aerosol is inhaled) two times a day for SOB (shortness of breath). Physician order, dated 8/16/24 at 9 p.m., indicated to administer 1 tablet Augmentin Oral Tablet 500-125 mg via G-Tube two times a day for PNA. Physician order, dated 8/13/2024, indicated to administer albuterol nebulizer 0.083% 2.5 mg (milligrams) inhale orally via nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) two times a day for SOB (shortness of breath) 2.5 mg/0.5 ml (milliliters). Staff were to complete a respiratory evaluation before nebulizer treatment two times a day, respiratory evaluation after nebulizer treatment two times a day. On 8/15/24 at 2:46 p.m., the Nurse Practitioner (NP) visited the resident. The note indicated the patient was seen outside of the window of a federally mandated regulation visit. The patient had comorbidities that place him at higher risk and a change in condition may occur at any time. The chief complaint for this visit was lab and chest x-ray (CXR) review. The patient was seen in follow up to address an issue, change of medication, complaint, or change in condition that cannot otherwise be addressed or directed by phone or without a face-to-face encounter. This visit was deemed by me to be both necessary and reasonable. Results of Diagnostic Testing, CXR on 8/15/24 indicated left upper lobe infiltrate with a conclusion of mild left upper lobe infiltrate resulting in a diagnosis of pneumonitis due to inhalation of food and vomit.		Don/Designee will audit Change of Conditions 5 times a week for 4 weeks and then weekly for 4 weeks. IDT team will review Change of Conditions Monday through Friday to ensure all documentation is complete. 4-How will the corrective actions be monitored to ensure the deficient practice will not reoccur? All audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	

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	Review of the nurse progress notes indicated the resident's responsible party was not notified of the initial change in condition, the Nurse Practitioner (NP) visit, nor the diagnosis of pneumonia on 8/15/24. An anonymous interview during the survey, indicated Resident B's family was not notified of medication orders or change of conditions. On 9/6/2024 at 3:00 p.m., the Administrator provided a document titled, "Change of Condition Notification", dated 6/2020, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...II. The facility will promptly inform the residents 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 status ...V. Family Notification ...A. The Licensed Nurse will document the following ...iii. The time the family/responsible person was contacted ...." This citation relates to Complaints IN00441980, IN00441976, and IN00442404. 3.1-5(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on record review and interview, the facility failed to ensure respiratory services order was obtained and entered into the medical record for 1 of 1 resident reviewed for respiratory services (Resident B).	F 0695	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. Other residents with	09/21/2024

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	Findings include: On 9/5/24 at 11:56 p.m., the medical record of Resident B was reviewed. The resident was admitted to the facility on 7/25/24. Admission Diagnosis included but were not limited to, acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues), pneumonitis (pneumonia, a bacterial infection of the lungs) due to inhalation of food and vomit. Physician order, dated 8/13/2024, indicated to administer albuterol nebulizer 0.083% 2.5 mg (milligrams) inhale orally via nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) two times a day for SOB (shortness of breath) 2.5 mg/0.5 ml (milliliters). Staff were to complete a respiratory evaluation before nebulizer treatment two times a day, respiratory evaluation after nebulizer treatment two times a day. On 8/15/24 at 2:46 p.m., the Nurse Practitioner (NP) visited the resident. The patient had comorbidities that placed him at higher risk and a change in condition may occur at any time. The chief complaint for this visit was lab and chest x-ray (CXR) review. The patient was seen in follow up to address an issue, change of medication, complaint, or change in condition that cannot otherwise be addressed or directed by phone or without a face-to-face encounter. This visit was deemed by me to be both necessary and reasonable. Results of Diagnostic Testing, CXR on 8/15/24 indicated left upper lobe infiltrate with a conclusion of mild left upper lobe infiltrate		Oxygen changes have been reviewed by the DON/Designee to ensure all orders are available. 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? All residents have the potential to be affected. Nursing staff education on Respiratory Services orders was conducted beginning on September 9, 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 Oxygen use and orders 5 times a week for 4 weeks and then weekly for 4 weeks. IDT team will review Oxygen use and orders Monday through Friday to ensure all documentation is complete. 4-How will the corrective actions be monitored to ensure the deficient practice will not reoccur? All audit results will be reviewed in QAPI. Determination of ongoing	

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	resulting in a diagnosis of pneumonitis due to inhalation of food and vomit. Therapy reported hypoxia this morning. Oxygen applied and CXR completed with noted pneumonia. Resident was seen in bed and was minimally responsive with hot pale skin. Noted tachycardia and tachypnea. Oxygen reapplied. Lungs were coarse. Resident had history of aspiration pneumonia and noted to be non-complaint with keeping head elevated in bed while tube feeds infuse. The medical record indicated the NP ordered oxygen delivery to the resident in the progress notes, but the physician orders lacked evidence of an order to deliver oxygen. Nursing Progress note, dated 8/17/2024 at 12:52 a.m., indicated a Skilled Evaluation. Respiratory vitals were WNL (within normal limits). Resident had shortness of breath while lying flat. Oxygen Support Provided with 3 liters oxygen delivered via Nasal Cannula (a thin flexible tube device to provide supplemental oxygen therapy to people who have lower oxygen levels) continuous. Nursing Progress note, dated 8/18/2024 2:04 a.m., indicated a Skilled Evaluation. Respiratory vitals were WNL. Resident had Shortness of Breath while lying flat and on exertion, and labored Breathing. Oxygen Support Provided with 3 liters Oxygen delivered via Nasal Cannula continuous. Nursing Progress note, dated 8/18/2024 at 7:30 p.m., indicated at 4:30 p.m. this evening when checked resident blood sugar, the resident was resting in bed. When returned at 6:30 p.m. to give night meds and there was a rapid acute change. Resident was on 2 liters nasal cannula oxygen, oxygen saturation read 79. After rechecking it was 77. Increased the oxygen and administered his		monitoring will be completed within the QAPI process.	

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	breathing treatment. Patient started deteriorating fast. The ambulance, weekend supervisor who was on the floor, and other nurses for assistance to help with the resident were called. The resident's family was called, and it went to voicemail. At 7:00 p.m. the resident passed before the ambulance got to the facility. On 9/5/24 at 3:02 p.m., during an interview Licensed Practical Nurse (LPN) 10 indicated they would enter an order immediately after an NP or physician indicated an order was given. The LPN indicated the NP also had access to the medical record and entered orders at times. On 9/6/2024 at 3:00 p.m., the administrator provided a document, titled, "Oxygen Administration," dated, 6/2020 and indicated it was the policy currently being used by the facility. The policy indicated, "...1. Initiation of oxygen ...A. A physician's order is required to initiate oxygen therapy, except in an emergency situation ...." This citation relates to Complaints IN00441980, IN00441976, and IN00442404. 3.1-47(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure medications were provided as ordered by the physician for 1 of 3 residents reviewed for medication administration (Resident B). Findings include:	F 0755	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. Other residents with medication changes have been reviewed by the DON/Designee to	09/21/2024

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	On 9/5/24 at 11:56 p.m., the medical record of Resident B was reviewed. The resident was admitted to the facility on 7/25/24. Admission Diagnosis included but were not limited to, acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (low levels of oxygen in your body tissues), pneumonitis (pneumonia, a bacterial infection of the lungs) due to inhalation of food and vomit. Physician order, dated 8/13/24, indicated to administer albuterol nebulizer 0.083% 2.5 mg inhale orally via nebulizer (typically consist of a main nebulization unit, a reservoir for holding the liquid for nebulization, and a mouthpiece through which drug aerosol is inhaled) two times a day for SOB (shortness of breath). Physician order, dated 8/13/2024, indicated to administer albuterol nebulizer 0.083% 2.5 mg (milligrams) inhale orally via nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) two times a day for SOB (shortness of breath) 2.5 mg/0.5 ml (milliliters). Staff were to complete a respiratory evaluation before nebulizer treatment two times a day, respiratory evaluation after nebulizer treatment two times a day. Physician Order, dated 8/15/24, indicated to administer 10 milliliters (ml) of Amoxicillin suspension (liquid) 250/5 ml via G-tube (a tube that is surgically inserted through the abdomen and into the stomach to provide nutrition, fluids, and medicine) every 12 hours for pneumonia for 7 days.		ensure all orders and medications are available. 2-How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken? All residents have the potential to be affected. Nursing staff education on Medication availability was conducted beginning on September 9, 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 medication changes, orders and availability 5 times a week for 4 weeks and then weekly for 4 weeks. IDT team will review medication changes and orders Monday through Friday to ensure all documentation is complete. 4-How will the corrective actions be monitored to ensure the deficient practice will not reoccur? All audit results will be reviewed in QAPI. Determination of ongoing	

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	Physician order, dated 8/16/24 at 1:12 p.m., indicated to administer 1 tablet of Augmentin Oral Tablet 500-125 milligrams (mg) (Amoxicillin and Pot Clavulanate) via G-Tube two times a day for PNA (pneumonia). Physician order, dated 8/16/24 at 9 p.m., indicated to administer 1 tablet Augmentin Oral Tablet 500-125 mg via G-Tube two times a day for PNA. Nursing Progress note, dated 8/17/2024 at 12:52 a.m., indicated a Skilled Evaluation. Respiratory vitals were WNL (within normal limits). Resident had shortness of breath while lying flat. Oxygen Support Provided with 3 liters oxygen delivered via Nasal Cannula (a thin flexible tube device to provide supplemental oxygen therapy to people who have lower oxygen levels) continuous. Nursing Progress note, dated 8/18/2024 2:04 a.m., indicated a Skilled Evaluation. Respiratory vitals were WNL. Resident had Shortness of Breath while lying flat and on exertion, and labored Breathing. Oxygen Support Provided with 3 liters Oxygen delivered via Nasal Cannula continuous. Nursing Progress note, dated 8/18/2024 at 7:30 p.m., indicated at 4:30 p.m. this evening when checked resident blood sugar, the resident was resting in bed. When returned at 6:30 p.m. to give night meds and there was a rapid acute change. Resident was on 2 liters nasal cannula oxygen, oxygen saturation read 79. After rechecking it was 77. Increased the oxygen and administered his breathing treatment. Patient started deteriorating fast. The ambulance, weekend supervisor who was on the floor, and other nurses for assistance to help with the resident were called. The resident's family was called, and it went to voicemail. At 7:00 p.m. the resident passed before		monitoring will be completed within the QAPI process.	

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	the ambulance got to the facility. On 8/19/2024 at 1:23 p.m. noted as a late entry, a nurse progress note indicated Augmentin suspension had not arrived from pharmacy. Nurse Practitioner (NP) was notified and a new order was given to change to Augmentin 500/135mg tablet: take 1 tablet crushed via g-tube BID (two times a day) x 10 days for PNA. A review of medication orders and administration record, the record indicated on 8/15/24 Augmentin Suspension BID (two times a day) for 7 days was ordered at 2:46 p.m. The record indicated the medication order was sent to the pharmacy at on 8/15/24 at 9:00 p.m. On 8/19/24 at 1:23 p.m., a late entry note was entered and dated 8/16/24 at 1:25 p.m. (effective date) indicating the Augmentin suspension had not arrived from pharmacy. The NP was notified and ordered Augmentin 500/135 mg (milligram) tablet was ordered 1 tablet BID x 10 days. On 9/5/24 at 2:10 p.m., during an interview the Facility Pharmacist indicated the pharmacy received an order for Augmentin Suspension on 8/19/24. The medication was not available in the Emergency Drug Kit (EDK) referred to as the STAT Safe by the facility. It was not filled or sent by the pharmacy. The pharmacist indicated an order for Amoxicillin (Augmentin) suspension was ordered on 8/15/24. The pharmacy received the order at 9:00 p.m., the pharmacy was closed at that time. The order was processed on 8/16/24 but the order was cancelled. The pharmacist indicated a second order was entered for Augmentin tablets on 8/18/24 but was not processed till 8/18/24. The medication order was not filled by the pharmacy. The pharmacist verified Augmentin tablets were			

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	taken from the STAT safe on the following dates and times. August 17 at 10:00 p.m., August 18 at 5:21 a.m., August 18 at 4:31p.m. The pharmacist indicated the medication was not sent from pharmacy. Review of the Medication Administration Record (MAR) for August. The record indicated Augmentin Suspension was administered to the resident on the following dates and times: 8/16/24 at 9:00 p.m., 8/17/24 at 9:00 p.m., and 8/18/24 at 9:00 a.m. The MAR for August 2024 indicated, Augmentin tablets were administered to the resident on the following dates and times. On 8/16/24 at 9:00 p.m., 8/17/24 at 9:00 a.m. On 8/17/24 at 9:00 p.m. (the medication was removed from the STAT Safe at10:00 p.m.). On 8/18/24 at 9:00 a.m., (the medication was removed from the STAT Safe at 5:21 a.m.) On 8/18/24 at 9:00 p.m. (medication was removed from the STAT Safe 4:31 p.m.) The resident expired on 8/18/24 at 7:00 p.m. On 9/5/24 at 2:50 p.m. during an interview with Qualified Medication Aide (QMA) 9 indicated, for them to access the Stat Safe the nurse first enters the order into the medical record. The QMA or Nurse would then enter the residents name into the system and all the resident's medications would be listed. They would select the medication they needed and remove it from the STAT Safe. On 9/5/24 at 3:02 during an interview with Licensed Practical Nurse (LPN) 10 indicated, if they needed a medication from the STAT Safe, they would log in and select the resident name and their medications list and remove medication from the safe. The employee indicated the nurse must enter the order into the medical record before			

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	they can remove a medication from the safe. The LPN indicated if a medication was not available in the safe, they would call the pharmacy to STAT (immediate) the medication to the facility. The LPN indicated they would obtain the initial dose for an antibiotic from the safe. If the pharmacy was closed, they had an after-hours number to call. The nurse indicated they would enter an order as soon as it was given by the physician. On 9/6/24 at 2:00 p.m., during interview with QMA 6 and the Regional Nurse Consultant. The QMA verified she administered Augmentin suspension and Augmentin tablets as ordered. She verified the initials on the MAR were hers and the check above each initial indicated the medication was administered. The Regional Nurse Consultant indicated when an employee enters the temperature into the MAR the software system would record the medication as being administered. He indicated the medication was not administered but the temperature had been recorded. He acknowledged the temperature was recorded as supplemental and not part of the actual medication order. On 9/6/2024 at 3:00 p.m., the Administrator provided a document, titled, "Physician Orders", dated,6/2020 and indicated it was the policy currently being used by the facility. The policy indicated, "... I. Telephone orders ...V. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other healthcare disciplines will be transcribed onto the appropriate communication system for that discipline ...." This citation relates to Complaints IN00441980,			

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	09/06/2024

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

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	IN00441976, and IN00442404. 3.1-25(a)			