STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155787	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA VETERANS HOME	3851 N RIVER RD WEST LAFAYETTE, IN 47906

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F000000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00147617. Survey dates: April 9,10,11,14,15,16,17, 2014 Facility number : 155787 Provider number: 001134 AIM number: 200817200 Survey Team: Rita Mullen, RN-TC Bobette Messman, RN Maria Pantaleo, RN Holly Duckworth, RN Census bed type: SNF/NF: 155 NCC: 14 Total: 169 Census Payor type: Medicare: 6 Medicaid: 128 Other: 35 Total: 169 NCC Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 Quality Review was completed by Tammy Alley RN on April 23, 2014.	F000000	Preparation and/or execution of the Plan of Correction in general, or these corrective actions in particular, does not constitute an admission or agreement by this facility of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction and specific actions are prepared and/or executed in compliance of the Indiana State Department of Health Guidelines. This plan of correction is not meant to establish a standard of care, contract, obligation or position and the Indiana Veterans' Home reserves all possible contentions and defenses to the allegations and conclusions made by the inspection team.	
F000278 SS=D	483.20(g) - (j) ASSESSMENT			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the hospice status, terminal diagnosis, and life expectancy for 1 of 1 resident reviewed for hospice (Resident #154). Findings include: A record review for Resident #154 was completed on 4/15/14 at 1:45 p.m.	F000278	I. Action taken to correct deficiency: 1. MDS obtained a list of all Hospice residents and are verifying all residents are coded correctly on Significant Change assessment when admitted to Hospice and subsequent assessments thereafter. All	05/09/2014

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	Diagnoses included, but were not limited to, leukemia, dementia, and depression. A Physician's Order, dated 10/04/13, "...Admit to Guardian Angel Hospice per family request for chronic Leukemia [sic]...." A significant change in status MDS assessment was completed on 10/20/13. Resident #154's active diagnoses included, but were not limited to, depression, dementia, thyroid disorder, hypertension, and leukocytosis. The MDS did not mention the resident's diagnosis of leukemia. The MDS did not acknowledge Resident #154 was on hospice services. The MDS indicated Resident #154 did not have a condition or chronic disease that may result in a life expectancy of less than six months. A physician's note from the hospice chart, dated 12/31/13 indicated "...The patient is a [identifying information] with a dx [diagnosis] of Leukemia who continues to decline. Comorbitities include dementia, HTN [hypertension], hypothyroidism, insomnia, abdominal mass of undetermined origin/etiology, frequent UTIs [urinary tract infections]. hypotension, syncope, depression. [The resident] is more confused and asks repetitive questions, [The resident] is bed and wheel chair bound. [The resident] is no longer ambulating as before with her rollator walker due to syncopal episodes and unsteady gait...[The resident] sleeps 18 or more hours per day...." A quarterly MDS was completed on 01/13/14. Resident #154's active diagnoses included, but were not limited to, depression, hypertension, Alzheimer's disease, hypothyroidism, syncope and collapse, hypopotassemia, other specified disease of		inaccurate assessments will be modified and submitted to CMS by 5/9/14. 2. The nurse that was identified as failing to accurately code the resident's Hospice status was educated by the DON. 2. Corrective actions monitored so that deficient practice does not recur: 1. MDS Supervisor will conduct an audit of every Significant Change Assessment for Admission to Hospice to assure accurate coding for one month. MDS Supervisor will then conduct random audits 2 days a week for 30 days, then 1 day a week for 30 days to assure that the plan of correction is followed consistently on an ongoing basis. 3. Systemic changes put in place: 1. A resident Hospice list has been created and will be maintained by	

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	white blood cells, and chronic pain. The MDS did not acknowledge Resident #154 was on hospice services. The MDS indicated Resident #154 did not have a condition or chronic disease that may result in a life expectancy of less than six months. During an interview with LPN #3 on 04/16/14 at 10:45 a.m., she indicated information for the MDS was obtained by going through the chart, medication administration records, treatment administration records, and supportive documentation for 7 day lookbacks, which are completed by floor nursing staff. LPN #3 indicated it should have been acknowledged within the significant change MDS, completed on 10/20/13, and the January quarterly MDS that Resident #154 received hospice services. She indicated both MDS assessments should have indicated the resident may have had a life expectancy of less than 6 months due to a condition or chronic disease. 3.1-31(a) 3.1-31(c)(1)		Nursing/MDS 4. How will the changes be monitored: 1. MDS Supervisor will conduct and audit of every Significant Change Assessment for Admission to Hospice to assure accurate coding for one month. MDS Supervisor will then conduct random audits 2 days a week for 30 days, then 1 day a week for 30 days to assure that the plan of correction is followed consistently on an ongoing basis. 5. Changes take place: 1. The MDS nurses will check the resident Hospice list during each resident assessment period to assure that all assessments are coded accurately.	
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and			

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	mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview , the facility failed to ensure a resident, had a care plan for diagnosis and treatment of edema, for 1 of 5 residents assessed for nutrition care plans. (Resident #3) Findings include: The record for Resident #3 was reviewed on 4/15/2014 at 10:30 a.m. Diagnoses for Resident #3 included , but were not limited to, vascular dementia, anemia, depression, chronic hyponatremia, pulmonary hypertension, osteoporosis, Vitamin B and D deficiency, bilateral lower extremities, (BLE) edema and rhinitis. A dietitian note dated 2/18/2014, indicated Resident #3's weight loss may be attributed to edema and diuretic usage. The resident had an order for compression wraps for BLE edema, the wraps were discontinued on 2/6/2014 due to improved edema. A dietetic note dated 2/20/2014 indicated Resident #3's weight loss was likely due to diuresing as evidenced by edema improvement.	F000279	I. Action taken to correct deficiency: 1. In-services were given on documentation, care plans and physical assessments. These in-services will be completed by all LPN's and RN's by 5/17/14. 2. Nurse Unit Manager will audit resident's records/care plans with potential change of condition and Significant Change of Condition per RAI guidelines. 2. Corrective actions monitored so that deficient practice does not recur: 1. Nursing Unit Manager's	05/17/2014

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	No care plan or resident assessments could be found for care of a resident with BLE edema. The physician orders indicated orders for: furosemide 20 mg (milligrams) tablet, 1 tablet by mouth at bedtime for edema, and furosemide 40mg, 1 tablet by mouth every day in a.m., for edema. A physicians order for December 2013, indicated wrap legs with compression wraps in a.m., and remove in p.m., for edema. A physicians order for February 2014, indicated discontinue compression wraps to lower legs. During an interview with Unit Manager #1 at 9:15 a.m., on 4/17/2014 regarding edema assessments and care plans for Resident# 3, she indicated there were no care plan or assessments for Resident #3's diagnosis of edema or compression wrap treatments. During an interview with Unit Manager #2, at 1:30 p.m., on 4/17/2014, she indicated there were no nursing care plan or assessments done for compression wrap treatments from 12/24/13 thru 2/5/2014 for Resident #3's diagnosis for edema. 3.1-35(a)		will conduct random audit of resident's record/care plans with potential change of conditions and Significant Change of Conditions per RAI guidelines, 3 days a week for 30 days, then 2 days a week for 30 days, then 1 day a week for 30 days to assure the plan of correction is followed consistently on an ongoing basis. 3. Systemic changes put in place: 1. Nurse Unit Manager will audit resident's records/care plans with potential change of condition and Significant Changes of Condition per RAI guidelines. 4. How will the changes be monitored: 1. Nursing Unit Manager's will conduct random audit of resident' record/care plans with potential change of conditions and Significant Change of Conditions per RAI guidelines, 3 days a	

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			week for 30 days, then 2 days a week for 30 days, then 1 day a week for 30 days to assure plan of correction is followed consistently on an ongoing basis. 5. Changes take place: 1. The in-services were given on documentation, care plans and physical assessments. These in-services will be completed by all LPN's and RN's by 5/17/14	
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure Resident, was assessed for diagnosis of edema, in 1 of 5 residents assessed for nutrition.(Resident #3) Findings include: The record for Resident #3 was reviewed on 4/15/2014 at 10:30 a.m. Diagnoses for Resident #3 included , but were not limited to, vascular dementia, anemia, depression, chronic hyponatremia, pulmonary	F000309	I. Action taken to correct deficiency: 1. In-services were given on documentation and physical assessments. These in-services will be completed by all LPN's and	05/17/2014

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	hypertension, osteoporosis, Vitamin B and D deficiency, bilateral lower extremities, (BLE) edema and rhinitis. A dietitian note dated 2/18/2014, indicated Resident #3's weight loss may be attributed to edema and diuretic usage. The resident had order for compression wraps for BLE edema, the wraps were discontinued on 2/6/2014 due to improved edema. A dietetic note dated 2/20/2014 indicated Resident #3's weight loss was likely due to diuresing as evidenced by edema improvement. No resident assessments could be found for care of resident with BLE edema. The physician orders indicated orders for: furosemide 20 mg (milligrams) tablet, 1 tablet by mouth at bedtime for edema, and furosemide 40mg, 1 tablet by mouth every day in a.m., for edema. During an interview with Unit Manager #1, at 9:15 a.m., on 4/17/2014, regarding edema assessments for Resident# 3, she indicated there were no assessments for Resident #3's diagnosis of edema or compression wrap treatments. During an interview with Unit Manager #2, at 1:30 p.m., on 4/17/2014, she indicated there were no assessments done for compression wrap treatments from 12/24/13 thru 2/5/2014 for Resident #3's diagnosis for edema. 3.1-37(a)		RN's by 5/17/14. 2. Nurse Unit Manager will audit resident's records with potential change of condition and Significant Change of Condition per RAI, to assure appropriate assessment and documentation was completed. 2. Corrective actions monitored so that deficient practice does not recur: 1. Nursing Unit Manager's will conduct random audits 3 days a week for 30 days, then 2 days a week for 30 days, then once a week for 30 days to assure that the plan of correction is followed consistently on an ongoing basis. 3. Systemic changes put in place: 1. Nurse Unit Manager will audit resident's records with potential change of condition and Significant Change of Condition per RAI. 4. How will the changes be	

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			monitored: 1. Nursing Unit Manager's will conduct random audits 3 days a week for 30 days, then 2 days a week for 30 days, then once a week for 30 days to assure that the plan of correction is followed consistently on an ongoing basis. 5. Changes take place: 1. In-services were given on documentation and physical assessments. These in-services will be completed by all LPN's and RN's by 5/17/14.	
F000371 SS=F	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 properly date and store dry foods in 1 of 1 dry storage areas. This deficit practice had the potential to affect 151 of 155 residents residing in the facility. Findings include: During an initial tour of the dry food storage area, on 4/09/14 at 10:25 a.m., undated food	F000371	1. What did you do to correct the deficient practice in the residents identified? Product was discarded immediately. 2. What did you do to be sure the deficient practice would not occur with other	05/02/2014

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	and dried food stored in an opened box were observed. Brown rice was observed on a shelf, dated 1-11-12 (purchase date), with no use by date. Dried noodles were observed in a clear container with no purchase date, open date, or use by date. Dried green split peas were located in an opened box, resting on top of the flour bin. The box had visible handle holes on the sides, which exposed the peas to air. The box did not have a visible open date. During an interview with the Food Service Director on 4/09/14 at 10:47 a.m., she indicated once food is open, it should be placed in a container, and all containers should have a sign with the name of the food company, the date purchased, opened date, and the use by date. A policy was reviewed on 4/16/14 at 1:08 p.m. The policy, titled, " Usage & Storage of Leftovers and Precooked Items," dated April 2008, indicated "...leftover foods will be refrigerated, covered, labeled, and dated immediately...." On 4/16/14 at 1:10 p.m., The Food Service Director indicated this policy applies to all foods, but that not all foods need to be refrigerated. A Policy was reviewed on 4/16/14 at 1:08 p.m. The policy, titled, "Dating Products," dated February 2010, indicated ..."Upon delivery, Commissary will label each case of food with the vendor it was received from and the delivery date...Any item removed from its original case will be labeled with the vendor it was received from and the delivery date...."		residents with like diagnoses? Any products that were found not labeled or dated were thrown away immediately 3. What systemic changes will you put in place to be sure this does not recur? Checking for labeling and dating in the dry storage area will be added to the supervisor daily check list. An in-service on covering, labeling and dating will be done by all food service employees. 4. How will you be sure the changes are monitored? Spot checking the dry storage area. 5. When will changes take place? Immediately.	

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	3.1-21(i)(2)			