STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155787	A. BUILDING 00 B. WING	10/26/2023

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

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00415054, IN00418944, IN00419799, and IN00420264. Complaint IN00415054 - No deficiencies related to the allegations were cited. Complaint IN00418944 - Federal/State deficiencies related the allegaitons are cited at F740. Complaint IN00419799 - No deficiencies related to the allegations were cited. Complaint IN00420264 - No deficiencies related to the allegations were cited. Survey dates: October 19, 20, 23, 24, 25 and 26, 2023 Facility number: 001134 Provider number: 155787 AIM number: 200817200 Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicare: 1 Medicaid: 71 Private: 3 Other: 39 Total: 114 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during an Recertification and State Licensure Survey dated October 26, 2023. Please accept this plan of correction as the Indiana Veterans' Home credible allegation of compliance. Indiana Veterans' Home respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Indiana Veterans' Home will be submitting an IDR for deficiencies related to F740.	

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

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	Quality review was completed on November 6, 2023.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.			

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	§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure a resident had a door to the bathroom in his room for 1 of 1 resident reviewed for dignity. (Resident J) Finding includes: During an observation, on 10/19/23 at 2:54 p.m., Resident J did not have a door for the bathroom in his room. The sink and toilet were visible when entering the resident's room. The record for Resident J was reviewed on 10/23/23 at 2:08 p.m. Diagnoses included, but were not limited to, dementia with mood disturbance, restlessness and agitation, type 2 diabetes mellitus, and history of a traumatic brain injury. During an interview, on 10/23/23 at 2:31 p.m., Social Services 9 indicated she did not know the reason the resident did not have a door to his bathroom. During an interview, on 10/23/23 at 2:52 p.m., CNA 8 indicated the resident was getting a sliding door for his bathroom. She thought the door might have been taken off since the resident would slam the door at times. During an observation and interview, on 10/23/23 at 3:03 p.m., CNA 8 observed Resident J's bathroom and indicated she did not know the reason he did not have a door for his bathroom.	F 0550	What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident J bathroom door replaced. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions will be taken: All residents are at risk of this alleged deficient practice. An audit of all occupied resident rooms will be conducted to ensure all rooms have doors to bathrooms to be completed by 11/22/2023. What measures will be put into placed and what systemic changes will be made to ensure that the deficient practice does not recur: All staff educated on resident rights. A room readiness checklist will be utilized that includes checking for bathroom doors. How the corrective action will be monitored to ensure the deficient practice will not recur: Maintenance Director/Designee	11/22/2023

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	The other residents' rooms had sliding doors for the bathroom. During an interview, on 10/23/23 at 3:44 p.m., Social Services 10 indicated the door for Resident J's bathroom was in the process of being replaced. She did not know the reason there was no bathroom door. During an interview, on 10/23/23 at 4:07 p.m., Social Services 10 indicated she checked with the facility Superintendent and no one knew what happened to the previous bathroom door for Resident J. A current policy, titled "Indiana Veteran's Home Resident Rights," dated April 1, 2006 and received from the Superintendent at entrance, indicated "...The resident has a right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility, including those specified in this section. The facility muse provide equal access to quality care regardless of diagnosis, severity, condition, or payment source. A facility must protect and promote the rights of each resident...The resident has the right to personal privacy...Personal privacy includes accommodations...." 3.1-3(p)(1) 3.1-3(t)		will audit 5 resident rooms bathroom doors per day, 5 days per week for 4 weeks, 5 resident rooms bathroom doors 1 day per week for 4 weeks, and 5 resident rooms bathroom doors 1 day per month for 4 months. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 11/22/2023.	
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			

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	subpart. This includes but is not limited to 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 interview and record review, the facility failed to ensure a cognitively impaired resident who received hospice services was free from abuse for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes: The record for Resident B was reviewed on 10/23/23 at 11:27 a.m. Diagnoses included, but were not limited to, encounter for palliative care, pain of the left hip, dementia with anxiety, hearing loss, and cognitive communication deficit. A physician's order, dated 7/14/23, indicated to discontinue weights and labs due to hospice and end stage dementia. A care plan, dated 7/12/23, indicated the resident was receiving hospice services due to Alzheimer's disease. The goal was for the resident to be kept comfortable, to have her pain managed throughout the progression of the disease, and to have psychosocial support through the end-of-life care. A facility reported incident (FRI), dated 8/8/23, indicated an incident occurred at 7:34 a.m., when QMA 2 was observed to pull Resident B's face	F 0600	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B no longer resides at facility. Prior to resident discharge, resident was provided with psychosocial support, however, did not show any signs of distress. QMA 2 is no longer employed by the facility. How 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 by the alleged deficient practice. Education to be provided to all staff who pass medications on abuse and re-approach by 11/22/2023. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur All staff to be educated on abuse by 11/22/23. Medication passers to be educated on re-approach by	11/22/2023

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	towards her to administer medication when the resident was being resistive to taking the medications. An investigation was initiated. A statement of witness dated 8/8/23 at 7:15 a.m., from QMA 2 indicated she was attempting to give Resident B her morning medications. The resident was hard of hearing, was distracted, and looking away. QMA 2 touched/gently tapped the resident's arm and then touched her face to get her attention. A statement of witness dated 8/8/23 at 7:35 a.m., from CNA 3 indicated she witnessed QMA 2 talk in an aggressive manner towards Resident B. QMA 2 was repeating "look at me" then pushed the resident's food away from her and said "Jesus Christ". Then QMA 2 grabbed the resident's face and pulled it towards her to give the resident the medications. A statement of witness dated 8/8/23 at 7:38 a.m., from LPN 4 indicated CNA 3 told her QMA 2 was attempting to administer medications to Resident B who was seated at a dining room table for breakfast. QMA 2 verbally prompted the resident several times without success since the resident was preoccupied with her meal and fidgeting with her napkin. QMA 2 then pushed the resident's food and other items away from her and continued to attempt to administer the medications. QMA 2 then grabbed the resident's chin to turn the resident's face towards her and administered the medication. A statement of witness dated 8/8/23 at 7:35 a.m., from CNA 5 indicated during breakfast QMA 2 approached Resident B with her medications and asked the resident several times to open her mouth. The resident seemed to be "zoned out".		11/22/23. An audit of medication pass for 5 residents per day 5 days per week for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months to be completed. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 11/22/2023.	

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	QMA 2 stated for the resident to look at her. Then she grabbed the resident's face and the resident groaned. QMA 2 gave the resident her medication and stated, "if I wait until after she is done eating, she will be too full to take her medicine". A statement of witness dated 8/8/23 at 7:30 a.m., from Staff 6 indicated on the morning of 8/8/23, the residents were in the dining room having breakfast. Resident B was eating her breakfast and QMA 2 came in the room to give the resident her medication. The resident was resistant and QMA 2 kept telling the resident to open her mouth. Then QMA 2 took her hand and pulled the resident's face towards her to give the resident the medication. During an interview, on 10/24/23 at 2:22 p.m., the Mitchel Building Unit Manager indicated the resident's dementia had progressed and she was strictly on comfort care. On 8/8/23, QMA 2 was attempting to give the resident her medications. The resident was fiddling with her food and ignoring the QMA. The QMA pushed the resident's food away and grabbed the resident's face towards her and gave the medications. An investigation was completed and the QMA 2 was terminated. The UM did not know the exact reason QMA 2 was terminated. During an interview, on 10/24/23 at 3:19 p.m., the Superintendent indicated, on 8/8/23, the Mitchell Building Unit Manager called her to let her know about the medication administration interaction with QMA 2 and Resident B. She watched the facility video, interviewed staff, and got their statements. After the investigation was completed, it was determined it was in the best interest to not have QMA 2 work at the facility any longer. QMA 2's actions were considered			

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	verbal abuse according to the facility policy. A current policy, titled "Abuse: Identification, Prevention, and Reporting," revised on 5/7/20 and received from the Superintendent upon entrance, indicated "...It is the intent of the Indiana Veteran's Home to assure that all residents of their facility are free from physical, sexual, verbal and/or mental abuse, corporal punishment and involuntary seclusion...Abuse...Physical Abuse...Includes but is not limited to hitting, slapping, pinching, or corporal punishment...Staff or contractor to resident abuse with or without injury...Verbal Abuse...The use of oral, written and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability...Examples of verbal abuse include but are not limited to...threats of harm, statements to frighten a resident, or belittling a resident...Mistreatment...Inappropriate treatment or exploitation of a resident...." 3.2-27(a)(1)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for PASARR (Preadmission Screening and Resident Review). (Resident 101) Finding includes: The record for Resident 101 was reviewed on	F 0641	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 101's MDS with inaccurate diagnosis corrected. How other residents having the potential to be affected by the same deficient practice will be	11/22/2023

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	10/23/23 at 9:48 a.m. Diagnoses included, but were not limited to, unspecified mood disorder with paranoia and behaviors, vascular dementia with psychotic disturbance, cerebrovascular disease, and post-traumatic stress disorder (PTSD). A PASRR level 1 screening, dated 9/14/23, indicated the resident had a diagnosis of bipolar disorder added from a MDS assessment. The resident did not have a diagnosis of bipolar disorder. A MDS assessment, dated 8/16/23, indicated the resident was marked to have a diagnosis of bipolar disorder. During an interview, on 10/25/23 at 4:13 p.m., the Social Service Director indicated the MDS assessment was coded incorrectly by the previous MDS Coordinator by mistake. The resident did not have bipolar disorder. The MDS assessment incorrectly coded the resident had a diagnosis of bipolar disorder and incorrectly led the facility to screen the resident for a level 2 PASARR. During an interview, on 10/26/23 at 5:04 p.m., the Assistant Superintendent indicated the facility used the RAI (Resident Assessment Instrument) manual for their policy. A RAI manual, titled "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual," Version 1.18.11, dated October 2023, indicated "...nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment...."		identified and what corrective action(s) will be taken. All residents with mental health diagnoses are at risk for the same alleged deficient practice. An audit of all most recently submitted MDS's to be completed by 11/22/23. Any incorrect diagnoses will be corrected if found. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur MDS nurses to be educated on appropriate coding of mental health diagnoses by 11/22/23. An audit of 5 MDS 5 days per week for 4 weeks, 5 MDS 1 day per week for 4 weeks, and 5 MDS 1 day per month will be completed. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 11/22/2023.	

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	3.1-31(a)			
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 interview and record review, the facility failed to notify the provider when blood sugars were out of call parameters for 1 of 1 resident reviewed for insulin. (Resident 62) Findings include: The record for Resident 62 was reviewed on 10/23/23 at 11:19 a.m. Diagnoses included, but were not limited to, dementia with mood disturbance, Alzheimer's disease, and type 2 diabetes. A physician's order, with a start date of 7/9/23 and an end date of 1/16/23, indicated to call the provider for a blood sugar above 351. A current physician's order, dated 1/30/2023, indicated if a blood sugar was greater than 351, call the NP (Nurse Practitioner) or PA (Pysician's Asistant). The following blood sugars were noted: a. On 10/20/22 at 4:54 p.m., the resident's blood sugar was 381.	F 0684	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Nurse who did not notify provider of elevated blood sugar for resident 61 provided education on notifications. How 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 diabetic residents have the potential to be affected by the alleged deficient practice. Education to be provided to nursing staff on appropriate provider notification of blood sugars by 11/22/2023. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur Nursing staff to be educated on	11/22/2023

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	b. On 12/8/22 at 11:45 a.m., the resident's blood sugar was 375. c. On 4/26/23 at 8:00 p.m., the resident's blood sugar read "high" (above 400). d. On 5/17/23 at 8:00 p.m., the resident's blood sugar was 361. There were no notes indicating the facility notified the provider for these blood sugars. During an interview, on 10/25/23 at 9:10 a.m., the IP (Infection Preventionist) indicated a "high" blood sugar was over 400. During an interview, on 10/25/23 at 2:07 p.m., RN 15 indicated blood sugars over 351 should be called into the provider. During an interview, on 10/26/23 at 10:18 a.m., the IP indicated a blood sugar should be called to the provider if the monitor was saying "high". The resident had call orders to notify the provider for blood sugars greater than 351. There was no documentation for the provider being notified for the blood sugars out of range. The nurse should always call the provider if the meter read high or the resident had call orders parameters. A current policy, titled "POLICY AND PROCEDURE: PHYSICIAN CONTACT," dated as reviewed in September 2023 and received from the Social Service Director on 10/26/23 at 9:45 a.m., indicated "...The following symptoms/signs and examples of situations that require immediate notification are not to be all-inclusive...Change in vital signs outside ordered parameters or general guidelines...diabetics that are outside or exceed the specific call orders for care...." 3.1-37(a)		provider notification of blood sugars by 11/22/23. An audit of resident blood sugars for 5 residents per day 5 days per week for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months to be completed to ensure notification for any blood sugars outside of parameters. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 11/22/2023.	

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F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident in a wheelchair was assisted to get off the facility vehicle safely for 1 of 5 residents reviewed for falls. (Resident O) Resident O sustained a subdural hematoma and was hospitalized for 2 days. The deficient practice was corrected on 8/27/23, prior to the start of the survey and was therefore past noncompliance. Findings include: A Facility Reported Incident (FRI), dated 8/25/23 at 8:33 a.m., indicated Facility Driver 7 reported an accident while he was transporting Resident O. The driver was getting Resident O off the van at the hospital when he lost control of the resident's wheelchair while moving it toward the back of the van. The lift was down, and the resident fell backwards off the van and hit his head. Driver 7 fell on top of the resident. The facility had maintenance assess the van and lift, reviewed their transportation policies, and provided education and skills checks to staff. The follow up included the resident had a subdural hematoma and was admitted to the hospital. All staff received education on proper procedures for transferring residents on and off the facility buses. Driver 7 was no longer employed by the	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident O was seen and treated by hospital staff at time of incident. Driver 7 is no longer employed by facility. Resident 80's roam alert bracelet assessed and removed. How 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 by the alleged deficient practice. Education to be provided to transport drivers on appropriate bus safety by 11/22/23. Education to all staff on appropriate use of roam alters to be completed by 11/22/23. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur Transport drivers to be educated	11/22/2023

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	155787	A. BUILDING 00 B. WING	10/26/2023

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	facility. During an interview, on 10/20/23 at 11:30 a.m., Resident O indicated he fell out of the back of the facility van during a trip to a doctor's appointment. He spent three days in the hospital for a brain bleed. The facility terminated the staff who was driving the van. The staff did not raise the lift in the back. He thought the staff lost his balance, grabbed the resident to hold onto, fell, and pulled them both off the van. The record for Resident O was reviewed on 10/23/23 at 4:34 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, acquired absence of the right leg below the knee, age related nuclear bilateral cataracts, difficulty in walking, generalized anxiety disorder, and major depressive disorder. A witness statement by Driver 7, dated 8/25/23, indicated Driver 7 lost control of Resident 0's wheelchair while removing him from the bus. The wheelchair lift had not been raised and both the resident and Driver 7 fell off the bus. A hospital discharge summary, dated 8/26/23, indicated the resident presented to the hospital for trauma care after sustaining a fall from a vehicle. He fell backwards in a wheelchair and hit the back of his head. He sustained a subdural hematoma. A Passenger Transportation Safety In-Service, not dated and received from the Superintendent on 10/23/23 at 4:15 p.m., indicated "...Off-loading your Passenger...Make sure that the vehicle is in the parked position...Make sure that the parking brake is engaged...Make sure the passenger restraints are still fastened prior to checking the		on bus safety by 11/22/23. All staff to be educated on roam alerts on by 11/22/23. An audit bus safety for 1 residents per day 5 days per week for 4 weeks, 1 residents 1 day per week for 4 weeks, and 1 residents 1 day per month for 4 months to be completed. An audit for proper use of roam alerts for 1 resident per day 5 days per week, 1 resident per week for 4 weeks and 1 resident per month for 6 months to be completed. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 11/22/2023.	

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	lift for proper usage...Make sure the lift is in the up position...." During an interview, on 10/24/23 at 3:08 p.m., the Superintendent indicated she received a phone call, on 8/25/23 at 8:33 a.m., from Driver 7. Driver 7 reported he was trying to get Resident O to the back of the bus, lost control of the resident's wheelchair, and fell off the back of the bus. The wheelchair ramp/lift was on the ground. When getting a resident off the bus, the lift/ramp should be in the "up" position. The Driver 7 did not have the lift in the up position prior to moving the resident. Resident O was in a regular wheelchair and Driver 7 lost control of the wheelchair, fell back, and tried to catch the resident and the wheelchair. Both Driver 7 and Resident O fell out of the bus onto the ground. The resident was admitted to the hospital for a subdural hematoma and right shoulder pain. A current policy, titled "Transportation Drivers' Safety," indicated "...safety precautions regarding residents should be always followed... residents must be securely fastened in the vans...safety precautions should be followed for pushing wheelchairs, the residents should be forward facing at all times...in the event of an accident the driver should first make sure the residents are safe...." The deficient practice was corrected by 8/27/23 after the facility terminated Driver 7, maintenance assessed the van and lift, the facility reviewed their transportation policies, and all staff received education on proper procedures for transferring residents on and off the facility buses. 3.1-45(a)(1)			
F 0695 SS=D	483.25(i) Respiratory/Tracheostomy Care and			

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Bldg. 00	Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure oxygen tubing was dated and initialed for 2 of 2 residents reviewed for oxygen. (Resident C and 23) Findings include: 1. During an observation, on 10/19/23 at 12:40 p.m., Resident C was wearing a nasal cannula with oxygen at 2 LPM (liters per minute). The oxygen tubing was not dated or initialed. The record for Resident C was reviewed on 10/23/23 at 10:24 a.m. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, heart failure, dependence on supplemental oxygen, chronic obstructive pulmonary disease, and emphysema. A care plan, revised on 7/11/22, indicated the resident was at risk for shortness of breath, dyspnea, and respiratory distress. The interventions included, but were not limited to, encourage resident to wear oxygen as ordered and to administer oxygen as ordered. A physician's order, dated 9/22/23, indicated oxygen by nasal cannula set at 4 LPM (liters per minute)	F 0695	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents C and 23 O2 tubing replaced and initialed and dated. How 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 receiving oxygen therapy have the potential to be affected by the alleged deficient practice. Education to be provided to Respiratory Therapy and nursing on dating and initialing by 11/22/23. An audit of all oxygen tubing for proper dating and initials will be completed by 11/22/23. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur Respiratory and nursing staff to be educated on oxygen tubing dating and initialing by 11/22/23. An audit of oxygen tubing dating for 5 residents per day 5 days per week	11/22/2023

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	at night and when napping. A physician's order, dated 9/22/23, indicated oxygen at 2 LPM per nasal cannula when needed. During an interview, on 10/19/23 at 12:45 p.m., RN 11 indicated there was not a date on the oxygen tubing. The oxygen tubing should be dated and initialed when the tubing was changed. During an interview, on 10/19/23 at 1:05 p.m., RN 11 indicated the Respiratory Therapy (RT) staff was responsible for changing oxygen tubing. During an interview, on 10/19/23 at 2:50 p.m., the Respiratory Therapy Supervisor 12 indicated oxygen tubing was changed once a week by the RT department and the oxygen tubing was dated and initialed by the RT staff. The nurses could also change the tubing when needed. The nursing staff could have changed the tubing and not dated or initialed.2. During an observation, on 10/19/23 at 1:50 p.m., Resident 23 was resting in bed and had oxygen on. The oxygen tubing was not dated. The record for Resident 23 was reviewed on 10/23/23 at 3:27 p.m. Diagnoses included, but were not limited to, dementia, insomnia, and hypertension. A physician's order, date 8/17/23, indicated the resident was to wear oxygen at 1 liter continuously. During an interview, on 10/19/23 at 2:57 p.m., the Respiratory Therapy Supervisor indicated the oxygen tubing was not dated. The oxygen tubing should be dated.		for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months to be completed. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 11/22/2023.	

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	During an interview, on 10/19/23 at 2:58 p.m., the Respiratory Therapy Supervisor indicated the facility did not have a policy for labeling or dating oxygen tubing. The oxygen tubing should be changed and dated once a week. 3.1-47(a)(6)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to include a resident's family/healthcare representative (HCR) in decisions about a staff who made visits outside of work hours to a resident with dementia, delusions, and aggressive behaviors and to include the resident's negative interactions with male staff on his plan of care for 1 of 2 residents reviewed for dementia care. (Resident J) Finding includes: During a telephone interview, on 10/4/23, an anonymous complainant indicated RN 14 was causing emotional distress to Resident J and continued to visit the resident even though he was no longer on the unit RN 14 worked. The resident had pictures of RN 14's children and she	F 0740	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident J family notified and agrees with visitation and careplan updated. How 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 by the alleged deficient practice. Education to be provided to all staff on visitation to residents on their off time by 11/22/23. What measures will be put in	11/22/2023

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	was emotionally attached to the resident. During an interview, on 10/23/23 at 2:31 p.m., Social Services 9 indicated Resident J had early onset dementia and was agitated at times. He was moved to another building because he was struggling with the male staff and always wanted to oversee the staff and residents. The resident was young and could intimidate staff. RN 14 looked like the resident's ex-wife, and he thought she was his ex-wife. Some other staff had complained RN 14 spent too much time with Resident J and it was keeping her from doing her job and paying attention to the other residents. Resident J's family was involved, they helped with interventions, and took the resident on outings. The record for Resident J was reviewed on 10/23/23 at 2:08 p.m. Diagnoses included, but were not limited to, dementia with mood disturbance and psychotic disturbance, restlessness and agitation, history of traumatic brain injury, and type 2 diabetes mellitus. A physician's order, dated 9/29/23, indicated the resident's behaviors to monitor for were intrusive invasion of privacy, disrobing, insufficient clothing in public areas, pacing, wandering, sexual aggression, delusions, hallucinations, rummaging, restlessness, verbal agitation, irritability, and short temperedness. Note any of the behaviors and the interventions attempted and notify the Nurse Practitioner and Social Services as needed. The physician's order did not include the resident's negative interactions with males. A care plan, dated 12/15/22, indicated the resident had a diagnosis of dementia with mood disturbance, agitation, trouble sleeping, and little		place and what systemic changes will be made to ensure that the deficient practice does not recur Education to be provided to all staff on visitation to residents on their off time by 11/22/23. An audit of residents receiving visits from staff members on off time care plans and notifications for 1 residents per day 5 days per week for 4 weeks, 1 residents 1 day per week for 4 weeks, and 1 residents 1 day per month for 4 months to be completed. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed:Date of compliance 11/22/2023. IVH respectfully requests an IDR for this alleged deficiency. 42 CFR § 483.10 - Resident rights: (f) Self-determination. The resident has the right to, and the facility must promote and facilitate, resident self determination through the support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that	

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	interest in activities. The interventions included, but were not limited to, administer medications as appropriate, report significant changes in mood and/or behavior to the nurse practitioner and physician, refer to psychiatry as needed, assist the resident with communicating with family members and friends, help with phone calls, encourage the resident to attend activities, encourage socialization with peers and refer to social services as needed. The care plan did not include getting RN 14 involved with care or the need for female staff to assist instead of male staff. A care plan, dated 9/21/23, indicated the resident was at a risk for mood distress related to a recent room and unit change. The resident needed time to adjust to the new setting. The goal was for the resident to display positive adjustment to the new room and unit by a positive affect and participation in the daily routine. The interventions included, but were not limited to, allow the resident time to express thoughts and feelings, encourage daily activities of interest, help the resident to maintain a consistent routine, introduce the resident to the new surroundings and peers, to provide cues as needed, report adjustment concerns to social services, and report signs of increased mood distress to the nurse practitioner and physician. The care plan did not include having staff from the previous unit to visit or to have female staff help the resident adjust to the new surroundings. A care plan, dated 10/3/23, indicated the resident declined care at times including clothing change, showers, and meals. The goal was for the resident to accept care necessary for overall health and		does not impose on the rights of another resident. State Regulations Regarding Visitation: 410 IAC 16.2-3.1-8 Access and visitation rights Authority: IC 16-28-1-7 Affected: IC 16-28-5-1 Sec. 8. (a) Residents have the right to choose with whom they associate. These codes do not state that visitors must be approved, POA notified, and care planned as this alleged deficiency states. If a resident desires to visit with a chosen individual, regardless of cognition, they have the right to do so without family consent. In addition, there is no documentation that supports Resident J had adverse behavioral outcomes from RN 14. Resident J's documentation demonstrates consistent behaviors across various shifts and staff, including when RN 14 was a caregiver. The federal and state code have no restrictions to visitors, and do not require family notification or care plans for visitors. In addition, Resident J had no adverse outcomes from visits from RN 14 according to documentation.	

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	well-being. The interventions included, but were not limited to, allow the resident time to process information and to express thoughts and feelings, assess for hunger, thirst, toileting and pain, notify the nurse practitioner, physician and social services of concerns related to care, notify the resident of what to expect before providing care, offer cues and guidance as needed, offer verbal reassurance as needed, re-approach at a later time or with alternate staff and to use simple terms and phrases. The care plan did not include the resident had negative interactions with male staff and did not include to get a female staff to provide care. A facility pharmacy review note, dated 10/17/23, indicated the resident had delusions about re-deployment and was moved to another building after a verbal aggression against another resident. During an interview, on 10/23/23 at 2:52 p.m., Certified Nursing Assistant (CNA) 8 indicated quite a few of the resident's family visited last week. RN 14 also visited the resident on the days she worked and would go to his building on her breaks and her lunch time. Resident J would get irate when RN 14 left and then wouldn't take his medications for the male nurse. During an interview, on 10/23/23 at 3:07 p.m., Social Services 10 indicated RN 14 knew Resident J well when he resided in his previous building. RN 14 would visit the resident in his new building and provided one on one. Social Service 10 was not sure how often RN 14 visited. During an observation with Social Services 10, on 10/23/23 at 3:14 p.m., Resident J had pictures of RN 14's three children in his room along with his			

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	family's photographs. Social Services 10 was not aware the pictures of RN 14's children were in the resident's room. During an interview, on 10/23/23 at 3:44 p.m., Social Services 10 indicated the resident talked about kids at times and the facility tried to promote a homelike environment. She did not know if Resident J had asked for the photographs of RN 14's children. During an interview, on 10/24/23 at 2:28 p.m., the Mitchell building Unit Manager (UM) indicated the resident had fast moving, early onset dementia. He was paranoid, did a lot of pacing. The UM limited his presence with Resident J since the resident was agitated by males. He knew RN 14 came to visit Resident J although he did not know the frequency of the visits. During an interview, on 10/24/23 at 2:44 p.m., Social Services 10 indicated she did not know if the resident's HCR was aware of the continued visits from RN 14. She tried to call Resident J's family today to ask if they were aware of the visits and frequency of the visits from RN 14. The Health Care Representative did not answer, and a message was left to ask her to return the call. During an interview, on 10/24/23 at 3:25 p.m., the Superintendent indicated she was not aware of how frequently RN 14 visited Resident J. It was not an expectation for all staff to bring in pictures of their families and give them to the residents. RN 14 had been helping Resident J adjust and she could spend time with the residents during her break if she chose to do so. The family had not been notified of RN 14 spending her break time with the resident and the facility should notify the family of the visits and would need to include the			

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	visits in the care plan so everyone would understand. A social services progress note, dated 10/25/23 at 9:30 a.m., indicated the resident's Health Care Representative (HCR) called back and was notified RN 14 who worked on the resident's previous unit was making visits with the resident since he was moved to the Mitchell building. The HCR indicated the resident seemed very obsessed with RN 14. The RN was appropriate with the resident although the HCR worried for RN 14's safety since the resident had misconceptions and thought they had a romantic relationship. The HCR also had a concern about Resident J's negative perception of a male peer on his unit. During an interview, on 10/25/23 at 10:29 a.m., RN 14 indicated Resident J was very funny and would talk to her at the nurse's station when he was in the MacArthur building. RN 14 would visit the resident at the Mitchell building and he smiled when he would see her. She usually went to visit the resident on one or two of her breaks when working and she enjoyed visiting him. She had asked Social Services 10 if she could continue to visit the resident. Resident J had a lot of abandonment issues and she wanted to make sure he did not feel abandoned. She was aware the resident had thought he had a romantic relationship with a female staff. When she visited the resident, it was as friends, and she would keep the door open. She had brought in pictures of her children and Resident J and another resident had the pictures. During an interview, on 10/25/23 at 10:45 a.m., the Superintendent indicated the facility did not have any specific training about relationships with resident who had dementia. There was no			

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	documentation in Resident J's record about RN 14 asking Social Services 10 if she could still visit Resident J when he moved to the different unit. During an interview, on 10/25/23 at 3:32 p.m., the facility psychiatrist indicated the resident had Wernicke-Korsakoff syndrome (alcohol related dementia). He was young, delusional, at risk of hurting others, and had poor impulse control. He did not know the resident was not cooperative with male staff and was only aware of negative interactions with male residents. He had observed RN 14 and Resident J talking at the nurses' station. He did not know about any pictures of RN 14's children being at the facility. The facility had implemented behavioral interventions for the resident. There was a boundary between being professional and talking about personal family with residents. There would be concerns about clinicians referring to residents as friends. A current policy, titled "Behavioral Health Policy," revised on 2/18 and received from the Director of Nursing on 10/25/23 at 12:55 p.m., indicated "...It is the policy of IVH [Indiana Veterans' Home] to ensure all resident receive timely, effective interventions and treatment for mental, behavioral or social dysfunction and/or difficulties. The behavior health policy exists to promote the residents optimal functioning level including emotional, behavioral, and social components in the least restrictive environment. The behavior health committee's functions to provide a holistic comprehensive review of the issue[s] and establish a comprehensive recommendation for the resident's plan of care...." This Federal Tag relates to Complaint IN00418944. 3.1-37(a)			

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	155787	A. BUILDING 00 B. WING	10/26/2023

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F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and			

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	§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on interview and record review, the facility failed to schedule follow-up care on recommendations from the dentist for 1 of 1 resident reviewed for dental services. (Resident G) Finding includes: During an interview, dated 10/20/23 at 11:45 a.m., Resident G indicated he lost his "uppers" when he was here the last time and was trying to get new ones. The record for Resident G was reviewed on 10/23/23 at 10:06 a.m. Diagnoses included, but were not limited to, dysphagia, pain, type 2 diabetes, and cerebral infarction. A dental visit note, dated 1/17/23, indicated the resident needed a tooth extraction. The son was contacted and agreed with the extraction. A dental visit note, dated 10/2/23, indicated the dentist discussed with the resident the need to have his remaining teeth extracted and have dentures fabricated. No acute infections were noted, and he ate puree food well. During an interview, on 10/26/23 at 2:49 p.m., the Assistant Superintendent indicated the resident had not been scheduled for a dental extraction. A current policy, titled "Dental Services," dated as reviewed 9/2023 and received from the Assistant Superintendent on 10/30/23 at 10:37	F 0791	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident G tooth extraction completed. How 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 by the alleged deficient practice. Education to be provided to IVH clinic staff when dental referrals are made for outside treatment by 11/22/2023. An audit of all residents receiving dental services in the last 30 days to be completed to ensure no outside referrals made, if any referrals are found from the audit, services referred will be scheduled. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur Education to be provided to IVH clinic staff when referrals are made for outside dental treatment by 11/22/2023. An audit of residents receiving dental services with referrals made 5 residents per day 5 days per week for 4 weeks, 5	11/22/2023

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	a.m., indicated "...It is the intent...to ensure residents have access to routine and 24 - hour emergency dental care...If there is a dental emergency the dentist should be contacted immediately...." 3.1-24(b)		residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months to be completed. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 11/22/2023.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure an ice machine was clean and room tray drinks were covered for 1 of 5 units reviewed for dining. (MacArthur 2). Findings include: 1. During an observation, on 10/23/23 at 9:59 p.m., the ice machine on MacArthur 4 appeared dirty. The piece where the ice came out had a lot of crusted white hard water areas with unidentified brown areas stuck to both the inside and outside of the plastic piece. During an interview, on 10/24/23 at 3:10 p.m., the Maintenance Manager indicated the ice machines were cleaned once a month by maintenance. He was unsure what the brown areas around the plastic piece of the ice machine were. It might have been soda which had crusted over. 2. During an observation, on 10/23/23 at 12:14 p.m., Residents 1, 16, and 77 were observed to have trays delivered with drinks not covered. During an interview, on 10/23/23 at 12:15 p.m., CNA 17 indicated the drinks did not have covers. During an interview, on 10/23/23 at 12:16 p.m., RN 18 indicated the drinks should have been covered. A current policy, titled "POLICY/PROCEDURE: FOOD SERVICES," dated as last revised in May 2009 and received from the Infection Preventionist on 10/26/23 at 5:04 p.m., indicated "...Tray service to the resident's floor shall be provided in	F 0812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 1, 16 and 17 had no adverse outcomes from having cups uncovered, lids and/or covers have been provided for all cups for delivery. No residents were affected by the soiled ice machine. Ice machine has been cleaned. How 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 by the alleged deficient practice. Education to be provided to all staff on covering cups when delivering to residents and on cleanliness of ice machines by 11/22/2023. An audit of all ice machines for cleanliness will be completed by 11/22/2023. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur Education to be provided to all staff on covering cups when delivering to residents and on cleanliness of ice machines by 11/22/2023. An audit of residents receiving cups on units 5 residents	11/22/2023

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	accordance with the resident's plan of care. Each tray shall be appropriately covered...All trays, set up in advance of serving, shall be appropriate covered...." There was no policy received for cleaning the ice machines by exit conference. 3.1-21(i)(3)		per day 5 days per week for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months to be completed. An audit of ice machines for cleanliness will be completed 1 per day 5 days per week for 4 weeks, 1 per week for 4 weeks and 1 per month for 4 months. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 11/22/2023.	