DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155787	A. BUILDING -- B. WING	11/28/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/28/23 Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200 At this Emergency Preparedness survey, Indiana Veterans Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 331 certified beds. At the time of the survey, the census was 116. Quality Review completed on 11/30/23	E 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 a Recertification and Life Safety Survey dated November 28, 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.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/28/22	K 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Gibson	Superintendent	12/14/2023

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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	Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200 At this Life Safety Code survey, Indiana Veterans Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC),Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility located in three separate buildings identified as: Mitchell Hall, a 3-story building with a partial basement, Pyle Hall, a 3-story building with a basement and MacArthur Hall, a 4- story building with a basement, was determined to be of Type 1 (442) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 331 and had a census of 106 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the detached generator building and maintenance shop. Quality Review completed on 11/30/23		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 a Recertification and Life Safety Survey dated November 28, 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.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of			

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	all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain the means of egress free from obstructions in 1 of 16 corridors within the buildings. LSC 19.2.3.4 (2) states "Where the corridor width is at least 6 feet, (1830 mm.) noncontinuous projections not more than 6 in. (150 mm) from the corridor wall , above the handrail height, shall be permitted." LSC 19.2.3.4(5) states, "Where the corridor width is at least 8 feet, projections into the required width for fixed furniture, provided that all of the following conditions are met: (b) The fixed furniture does not reduce the clear unobstructed corridor width to less that 6 ft. (1830 mm) except as permitted by 19.2.3.4 (2) This deficient practice could affect approximately 15 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Miantenance Supervisor on 11/28/23 at 9:35 a.m., the 3rd floor - B Hall in the Mitchell building, there were two reclining chairs in the corridor directly across from the nurses' station. When the footrest of these recliners was raised, the clear width in the corridor was reduced to approximately 36 inches. Based on interview with the Maintenance Supervisor at the time of the observation, he acknowledged that the two recliners in the corridor did indeed obstruct the clear width of the corridor to less than four feet (48 in) and stated that he would have them removed and placed in a more appropriate area for the residents to keep the corridor unobstructed. This item was discussed with the Superintendent	K 0211	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficiency. The two recliners were removed from corridor. **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 this alleged deficiency. Facility Maintenance removed the two recliner chairs in the Mitchell 3rd floor corridor directly across from the nursing station. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education will be provided to all staff members to ensure corridor width remains unobstructed by no less than 6 ft from any fixed	12/26/2023

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	at the exit conference. 3.1-19(b)		furniture or equipment by 12/23/2023. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Audits will be completed to ensure corridors are unobstructed for the next six months in the following intervals: 5 inspections per week, for 4 weeks – *starting 12/17/2023* 1 inspection per week, for 4 weeks – *starting 1/14/2024* 1 inspection per month, for 4 months - *starting 2/11/2023* Corridor means of egress compliance has been added as an objective on the Quality Assurance monthly compliance analysis and will be monitored for no less than six months. **Date of Compliance** December 26, 2023	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of			

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	Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to ensure all automatic sprinkler piping systems were examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review on 11/28/23 from 9:15 a.m. to 12:45 p.m. with the Maintenance Supervisor, the annual Sprinkler System Inspection dated 05/05/2023 for Pyle Hall indicated the date of last 5-year internal inspection was 03/2017. Additionally, the annual Sprinkler System	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficiency. **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 this alleged deficiency. Facility Maintenance scheduled Koorsen Fire & Security to complete the 5-year internal pipe inspection on the fire system at the contractor's earliest availability. The 5-year pipe inspection was completed on 12/6/2023. No deficiencies were found and the fire system is fully	12/26/2023

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	Inspection dated 05/05/2023 for Macarthur Building indicated the date of last 5-year internal inspection was 04/2017. Based on interview with the Maintenance Supervisor at the time of record review, he stated he contacted the sprinkler inspection vendor who confirmed that internal pipe inspections have not been conducted since the above mentioned dates and he would get them scheduled. This finding was reviewed with the Superintendent, Field Maintenance Manager and Maintenance Supervisor at the exit conference. 3.1-19(b)		operational. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** The Facility Maintenance Manager met with service provider Koorsen Fire & Security to ensure the facility is compliant with all required inspections per NFPA 101. Koorsen Fire & Security has assured future inspections will be scheduled in advance to ensure the facility remains compliant. Additional internal controls have been implemented on our digital calendar system to alert Maintenance Department for scheduling future fire system inspections. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Fire sprinkler system maintenance & testing has been added as an objective on the Quality Assurance monthly compliance analysis and will be monitored for no less than six months. **Date of Compliance**	

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K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 1) Based on observation and interview, the facility failed to ensure 1 of 1 Trust Department door to the corridor would completely resist the passage of smoke. This deficient practice could affect as many as 6 staff only. Findings include: Based on observations made during a tour of the facility with the Miantenance Supervisor on 11/28/23 at 1:55 p.m., the corridor door to the Trust office had a one-half inch in diameter hole in it leading to the corridor. Based on an interview at the time of the observation, the Maintenance Supervisor acknowledged the hole in the door stating that they would have it repaired as soon as possible. This item was discussed with the Superintendent at the exit conference. 3.1-19(b)2) Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observations and interview during a tour of Pyle Hall with the Field Maintenance Manager on 11/28/23 between 12:45 p.m. and 1:40 p.m., the corridor door to resident room 227 failed to close and latch positively into the door frame.	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficiency. **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 this alleged deficiency. Facility Maintenance repaired and sealed the Trust Department corridor door opening to ensure it would resist any smoke passage. A brass plate was installed to cover the one-half inch diameter hole. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education will be provided to all maintenance staff to ensure no doors will have any hole penetrations and the procedure on	12/26/2023

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	Based on interview at the time of observation, the Field Maintenance Manager confirmed the corridor door failed to positively latch into the frame. This finding was reviewed with the Superintendent, Maintenance Supervisor and Field Maintenance Manager at the exit conference. 3.1-19(b)		how to fill/cover any holes found by 12/26/2023. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** The fire door penetrations have been added as an objective on the Quality Assurance monthly compliance analysis and will be monitored for no less than six months. **Date of Compliance** December 26, 2023	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 1000 electrical outlets throughout the facility were maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers	K 0511	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficiency.	12/26/2023

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	compatible with the box. This deficient practice could affect as many as 8 employees. Findings include: Based on observations made during a tour of the facility with the Miantenance Supervisor on 11/28/23 at 2:00 a.m., there was a two-plug electric outlet hanging from the wall without a cover plate on it that had exposed wires on it. This was immediately adjacent to a small copper tube that provided water for the removed water fountain in the basement of the MacArthur building that was being serviced or removed. Based on an interview at the time of the observation, the Miantenance Supervisor agreed that the 110-volt electric outlet not only had exposed wires in it but was also right next to a water source and could be a shock hazard. It was later revealed that the person working on the water fountain was called away and neglected to replace the cover on the electric outlet. This item was discussed with the Superintendent at the exit conference. 3.1-19(b)		**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 this alleged deficiency. The open wall where the deenergized exposed two-plug electrical outlet has been repaired. Dry wall has been installed over the exposed enclosure, the water line has been isolated, and the electrical outlet is safely installed with cover. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education will be provided to all maintenance staff reiterating that all electrical wiring worked on must be deenergized and tagged out. Under no circumstances is exposed electrical wiring to be left unattended. The education will be completed by 12/26/2023. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Electrical wiring has been added	

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			an objective on the Quality Assurance monthly compliance analysis and will be monitored for no less than six months. **Date of Compliance** December 26, 2023	