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	09/14/2022

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 6, 7, 8, 9, 12, 13 and 14, 2022 Facility number: 001134 Provider number: 155787 AIM number: 200817200 Census Bed Type: SNF/NF: 106 Total: 106 Census Payor Type: Medicare: 2 Medicaid: 63 Other: 41 Total: 106 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 26, 2022.	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 September 9-14, 2022. 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.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph			

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 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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	should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure a resident or resident representative's preferences for advanced directives was assessed and clearly documented for 1 of 3 residents reviewed for advanced	F 0578	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	10/12/2022

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	directives (Resident 100). Finding includes: The record for Resident 100 was reviewed on 9/8/22 at 10:24 a.m. Diagnoses included, but were not limited to, mild intellectual disabilities, obstructive sleep apnea, solitary pulmonary nodule, abnormal weight gain, polyneuropathy and chronic pain. An Advanced Directive Acknowledgement, dated 1/9/2020, indicated the resident had received a copy of "Your Right to Decide" which explained the right to determine medical decisions for the resident in the event of being unable to speak for themselves. The resident was also given a copy of the Indiana Veterans' Home Advance Directives Policy. The resident's signature was on the form. A State of Indiana Advance Directive form, dated 1/9/2020, indicated the resident would like to speak with Social Services at the Indiana Veterans' Home about Advance Directives options. The resident did not wish to establish a Code Status at this time. The resident would be considered a full code until a do not resuscitate was established. A social services progress note, dated 1/9/2020 at 4:30 p.m., indicated the resident wished for a full code status. The documentation did not include if the progress note was before or after the resident had indicated she did not want to make a decision about the code status as indicated on the State of Indiana Advance Directive form. The documentation was prior to the resident being admitted to the skilled facility.		Resident 100 responsible party contacted and given information about Advanced Directives, including Indiana POST form. An order for Resident 100 received from Resident's physician reflecting code status. **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 are at risk of this alleged deficient practice. Information regarding Advanced Directives provided to residents and/or Responsible Parties by Social Services by 10/12/2022. An audit for code status orders for all residents to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Social Services Director/Designee will provide education to all Social Services staff and licensed nurses on Advanced Directives and code status order by 10/12/2022. **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:** Social Services Director/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5	

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	A care plan, dated 3/10/22 and last reviewed/revised on 9/1/22, indicated the resident had requested a full code status. The resident's wishes for a full code status would be honored. The interventions included, but were not limited to, inform the resident and representative of their right to make an advanced directive and to review code status during quarterly reviews. The documentation was not clear if the resident had requested to be a full code or still had not made a decision about the code status. The physician orders did not include a code status for the resident. During an interview, on 9/12/22 at 4:11 p.m., the assistant superintendent indicated the resident's husband could have helped the resident with her decisions about advanced directives prior to his death. He had just recently died. The resident had a mental capability of a third grader, she could read and write but that was about it. The documentation did not include the resident's husband being asked about advanced directives. During an interview, on 9/12/22 at 4:21 p.m., the Social Services Director (SSD) indicated the resident's code status would be talked about during care plan meetings. She did not "imagine the staff would talk to the resident about advanced directives such as artificial nutrition and that stuff." The resident's documentation for code status was from the independent living stay and there was no documentation about the code status since she was admitted to the skilled facility. A current policy, titled "Advance Directives," dated 2/21/06 and received from the Assistant		residents once per week for 4 weeks, and 5 residents per month for 4 months for documentation of Advanced Directives discussion and physician order for Code Status. 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 systemic changes will be completed:** 10/12/2022	

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	Administrator on 9/8/22 at 12:15 p.m., indicated "...The facility recognizes the dignity and value of each residents life and the residents right to participate in all healthcare decisions, including the right to accept or refuse surgical or medical treatment. When the wishes or a competent resident and his/her family conflict, the Resident wishes will prevail...At the time of admission, the Social Services Department shall provide each resident or their legal representative, educational information regarding state and federal laws. Information shall include copies of the following... [Your Right to Decide]...The competent resident, their legal representative or individual who has been authorized as the resident's health care representative will be asked if an Advanced Directive, recognized under state law, has been executed...Documentation concerning this inquiry and the individual's response shall include the date the inquiry was made and the individual making the inquiry...This information shall then be included in the resident's medical record in the Social Service Progress Notes...When a resident is incapable of making health care decisions and there is no written advance directive the persons previously designated by the resident as health care representative or 'person to be notified in case of emergency 'will be consulted...Advanced Directives shall be reviewed by the care plan team when completing the comprehensive assessment and addressed on the resident's plan of care as appropriate, and in Social Services Progress Notes...A written physician's order is required in response to the resident's Advanced Directives regarding CPR. Written physician orders shall be specific and address each Advanced Directive as appropriate...." 3.1-(l)(4)(ii)			

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to update the care plan with new interventions after a fall for 1 of 3 residents reviewed for falls. (Resident 20) Finding includes: The record for Resident 20 was reviewed on 9/12/22 at 2:35 p.m. Diagnoses included, but were	F 0657	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 20 fall care plan reviewed and updated to reflect fall intervention for phone cord. **How other residents having the**	10/12/2022

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	not limited to, diabetes mellitus, hypertension, falls, basal cell and squamous cell carcinoma (skin cancer), alcohol dependence (in remission) and bipolar disorder. A Safety Event Fall form, dated 4/25/22 at 2:30 p.m., indicated the resident was found on the floor in his room on 4/25/22 at 2:30 p.m. He reported tripping on his phone cord. The fall interventions were not updated until 6/21/22. A care plan, updated on 6/21/22, indicated the resident was at risk for falls due to weakness and balance impairment. The goal was to be free from significant injury. The interventions included, but were not limited to, mount a phone on the wall by the resident's recliner, post a sign on the closet door and the door to the room as a reminder to use walker, wear nonskid footwear and for physical therapy and occupational therapy to evaluate. During an interview, on 9/14/22 at 2:51 p.m., the Assistant Superintendent indicated she would check on why the fall care plan interventions were not updated until 6/21/22. During an interview, on 9/14/22 at 4:20 p.m., the Director of Nursing indicated the resident refused the intervention on 4/25/22. The intervention was to have his phone mounted on the wall. When asked if they tried other interventions when the resident refused, she indicated they tried other interventions and updated the care plans. The care plan did not include further interventions for the phone cord. At the time of exit the facility had not provided a policy on care plans.		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with falls are at risk of this alleged deficient practice. An audit will be completed by Director of Nursing/Designee to ensure all residents that have fallen in previous 30 days have intervention care planned for falls. Audit to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Nursing/Designee will provide education to all licensed nurses on updating care plan for fall interventions by 10/12/2022. No policy was requested at time of survey for care plans. **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:** Director of Nursing/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months for fall intervention care plans. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits.	

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	3.1-35(b)(1)		**By what date systemic changes will be completed:** 10/12/2022	
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 observation, interview and record review, the facility failed to identify and document bruising for 1 of 1 resident reviewed for non-pressure skin conditions. (Resident 51) Finding includes: During an observation, on 9/7/22 at 3:09 p.m., Resident 51 had two quarter sized bruises noted on his right forearm. The resident indicated he was not sure what happened. The record for Resident 51 was reviewed on 9/8/22 at 12:24 p.m. Diagnoses included, but were not limited to, atrial fibrillation, chronic kidney disease, adjustment disorder with depressed mood and anemia. A physician's order, dated 8/15/22, indicated a weekly head to toe skin assessment and foot checks were to be completed weekly on Wednesdays. A progress note, dated 9/5/22 at 10:29 p.m.,	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 20 received head to toe skin assessment with no further areas of skin alteration or bruising noted. **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 are at risk of this alleged deficient practice. An audit will be completed by Director of Nursing/Designee to ensure all residents have weekly skin assessments completed and that Nurse Aide Skin Checklist is completed . Audit to be completed by 10/12/2022. **What measures will be put into**	10/12/2022

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	indicated the resident's roommate alerted staff the resident had fallen. He was found sitting on the floor, next to his recliner and facing his bed. The resident indicated he got up from the recliner to turn off his light and his feet slipped. No visible injuries. A nurse practitioner progress note, dated 9/7/22 at 12:27 p.m., indicated the resident was found to have atrial fibrillation and was not a candidate for anticoagulation due to bleeding risk with frequent falls. He was positive for easy bruising. A Medication Administration Record (MAR), for September 7, 2022, indicated the resident had no skin issues. A Nurse Aide Skin Checklist, dated 9/7/22 and not timed, indicated the directions were to examine the skin from head to toe during the bath or shower. None was written. During an interview, on 9/8/22 at 2:15 p.m., LPN 7 indicated she had not seen the bruise like spots on the resident's right forearm. The resident had a recent fall and she was not sure if the areas were bruising from the fall or not. There was no documentation of the bruised spots in the electronic health record. A progress note, dated 9/8/22 at 10:53 p.m., indicated the resident had light red areas to his right forearm and denied pain. A progress note, dated 9/9/22 at 5:32 a.m., indicated the resident had 3 small, light brown and yellow bruises to the fight hip area. A current policy, titled "Checking Resident's Skin," dated as revised 2/09 and received from the		**place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Nursing/Designee will provide education to all nursing staff on completion of skin assessment and completion of Nurse Aide Skin Checklist by 10/12/2022. **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:** Director of Nursing/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months for completion of skin assessment and completion of Nurse Aide Skin Checklist. 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 systemic changes will be completed:** 10/12/2022	

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	Assistant Superintendent on 9/14/22 at 4:46 p.m., indicated "...Resident in bed or shower...Check bony prominences...for redness and warmth...Check friction areas including under breasts and arms, between buttocks, groin and thighs, skin folds...Report any unusual findings to the nurse immediately...." 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on interview and record review, the facility failed to document, inform the resident and follow up on cataract surgery for 1 of 1 residents reviewed for vision services. (Resident 18) Finding includes: During an interview, on 9/6/22 at 3:331 p.m., Resident 18 indicated he was supposed to get cataract surgery and the hospital needed something from the VA outpatient clinic to verify the surgery was needed. The facility could not seem to get this set up and it had been going on for a year.	F 0685	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 18 seen by Ophthalmologist on 10/5/2022. **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 are at risk of this alleged deficient practice. An audit	10/12/2022

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	The record for Resident 18 was reviewed on 9/8/22 at 2:54 p.m. Diagnosis included, but were not limited to, age related cataract of the left eye, type 2 diabetes mellitus and acquired absence of the left and right legs above the knee. An eye exam, dated 11/3/2021, indicated the resident had nuclear (center of eye) cataracts in both eyes. The treatment options were discussed including the referral to consider cataract removal. The resident was scheduled for surgical consultation. The electronic health record did not have information about a surgical consultation or a progress note to indicate the resident was notified of a surgical consultation. A care plan, dated 3/28/22, indicated the resident was at a risk of injury/decline in vision due to visual impairment related to having a cataract. The interventions included, but were not limited to, refer to optometrist as needed between routine visits, encourage the resident to report changes in vision and to observe for signs and symptoms of declining vision. During an interview, on 9/13/22 at 3:22 p.m., the Social Services Director (SSD) indicated the resident was diagnosed with bilateral cataracts on 6/9/21. The doctor who gave the diagnosis could not do the surgery since the resident required a Hoyer lift. The resident had to wait on a VA appointment which took a while to schedule. On 8/31/22, the VA had approved for the cataract surgery to be done in the community. The cataract surgery was scheduled for 10/5/22 with a doctor at the [name of] clinic.		will be completed by Director of Nursing/Designee to ensure all residents have follow up eye appointments scheduled as needed and are notified of those appointments with documentation of notification. Audit to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Nursing/Designee will provide education to all nursing staff on referrals procedure by 10/12/2022. **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:** Director of Nursing/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months for referral to eye providers. 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 systemic changes will be completed:** 10/12/2022	

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	During an interview, on 9/14/22 at 2:50 p.m., the Assistant Administrator indicated there was no documentation in the electronic record about the approval of the cataract surgery or the resident being notified of the approval for the surgery. A current policy, titled "Referrals[Dental, Podiatrist, Optometrist]," dated as revised on 4/09 and received from the Assistant Superintendent on 9/14/22 at 11:00 a.m., indicated "...It is the intent of the Indiana Veterans' Home that residents would be provided routine dental, podiatry and eye appointments...Optometry...After the initial examination, resident will be schedule yearly unless a diabetic and they are scheduled every 6 months...Appointments required sooner than those above are done by physician referral...." 3.1-39(a)(1) 3.1-39(a)(2)			
F 0689 SS=D 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 observation, interview and record review, the facility failed to ensure interventions were implemented after a fall for 1 of 3 residents reviewed for falls (Resident 20), cognitively impaired residents were safe from elopement for 1 of 3 residents reviewed for wandering (Resident	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 20 fall care plan reviewed	10/12/2022

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	09/14/2022

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	20 and 37) and medications were not left unattended for 1 of 6 residents observed for medication administration. (Resident 42) Findings include: 1. During an interview, on 9/06/22 at 12:40 p.m., Resident 20 indicated he had a fall about 1 month ago and broke his right wrist. He also went out of the building alone and the weather was cold. He was sitting on the bench outside when staff assisted him back inside the building and to his room. The record for Resident 20 was reviewed on 9/06/22 at 2:58 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, falls, alcohol dependence with alcohol induced dementia and bipolar disorder. a. A Post Fall Huddle form, dated 4/25/22 at 2:30 p.m., indicated the resident had a fall with a injury on 4/25/22. The resident was tangled in his phone cord and tripped. He was found on the floor in his room and received an abrasion to his left elbow and forearm. A Post Fall Huddle form, dated 4/26/22 at 9:20 a.m., indicated the resident had a fall with a injury on 4/26/22. The resident was walking in the hall unassisted and fell. The resident received a fracture of the right 5th metacarpal (bones from wrist to fingers). The resident was taken to an orthopedic clinic on 4/28/22. The resident was placed in a short arm cast on his right hand. The cast was ordered to stay on 3 to 4 weeks. A care plan, updated on 6/21/22, indicated the		and updated to reflect fall intervention for phone cord. Resident 20 and 37 elopement assessments updated. Resident 37 may only leave unit with staff or specified family member. Resident 20 now resides on secured memory care unit. Resident 42 observed during medication pass and medication not left at bedside. QMA 2 no longer works at 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 are at risk of this alleged deficient practice. An audit will be completed by Director of Nursing/Designee to ensure all residents that have fallen in previous 30 days have intervention care planned for falls. An audit will be completed by Director of Nursing/Designee to ensure all residents have elopement assessments completed. Education will be provided to all licensed nursing staff and QMAs on medication pass. Audits and education to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Nursing/Designee will	

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	resident was at risk for falls due to weakness and balance impairment. The goal was to be free from significant injury. The interventions included, but were not limited to, mount a phone on the wall by the resident's recliner, post a sign on the closet door and the door to the room as a reminder to use walker, wear nonskid footwear and for physical therapy and occupational therapy to evaluate. The care plan did not include further interventions for the phone cord. b. An Incident Report, dated 2/13/22 at 7:29 p.m., indicated the resident was seen by a CNA getting on the elevator. The resident's roam alert was found in the resident's room and the resident was found outside the building unattended. A care plan, updated on 2/14/22, indicated the resident was at risk elopement due to impaired safety awareness and wears a roam alert. The goal was to leave the unit when accompanied by approved staff, volunteers and family daily through next review. The interventions included, but were not limited to, relocated to a secure unit, one to one observation, check roam alert placement and function every shift. During an interview, on 9/13/22 at 9:46 a.m., the Director of Nursing indicated the resident had a roam alert. He removed the roam alert and exited out of the building. He was only out for a few minutes. The resident was not dressed appropriately for the temperature and not sure if he was barefoot. The cameras were hard to see the images clearly. During an interview, on 09/13/22 at 10:33 a.m., Maintenance 3 indicated he was called to the		provide education to all licensed nurses on updating care plan for fall interventions by 10/12/2022. No policy was requested at time of survey for falls. Director of Nursing/Designee will provide education to all staff on resident elopement policies by 10/12/22. Director of Nursing/Designee will provide education on medication pass by 10/12/22. **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:** Director of Nursing/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months for fall intervention careplans. Director of Nursing/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months that roam alert placement is checked. Director of Nursing/Designee will observe medication pass for 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months to ensure no medications left at bedside. Results from audits will be brought to QAPI for review monthly for a	

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	facility. The resident was outside and it was cold. The resident was wearing a T-shirt and pants. He was not aware if the resident was wearing shoes. The resident told him he was looking for a cat to feed. Maintenance 3 went inside the building and left the resident outside unattended. The resident was behind a fence. He was unaware if the entrance doors to the building had alarms. During an interview, on 9/13/22 at 3:35 p.m., RN 4 indicated she was unaware the resident went down the elevator. CNA 9 told her he just saw the resident get on the elevator and handed her the resident's roam alert. She called downstairs to security and notified the night supervisor. She stayed by the elevator, the doors opened and the resident walked off the elevator. The resident was wearing a T-shirt and pants. 2. During an observation, on 9/07/22 at 3:10 p.m., the resident was lying in his bed. The resident had a roam alert on his right ankle. The record for Resident 37 was reviewed on 9/09/22 at 2:58 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, type 2 diabetes mellitus, atrial fibrillation (irregular heartbeat) and hypertension. An incident report, dated 4/23/22 at 12:05 p.m., indicated the resident was taken off the unit and outside through the entrance of the building by a visiting friend. Staff on the unit noticed the resident outside unattended. Maintenance, nursing supervisor and unit nurse located the resident unattended by the rear entrance of a different building. The resident was returned to his room. The resident's son indicated he did not want the resident to leave the unit with anyone but staff or himself.		minimum of 6 months. QAPI will determine need for further audits. **By what date systemic changes will be completed:** 10/12/2022	

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	A physician's order, dated 4/25/22, indicated to check placement and function of the roam alert twice a shift. A care plan, revised on 4/25/22, indicated the resident was at risk of elopement due to impaired safety awareness and he wore a roam alert. The goal was to only leave the unit when accompanied by approved staff, volunteers or family. The interventions included, but were not limited to, at son's request resident was not be taken off the unit except by staff and himself. A care plan, revised on 4/25/22, indicated the resident was at risk of elopement due to impaired cognition. The goal was to have no incident of exiting the facility unescorted. The interventions included, but were not limited to, check placement, functioning and skin integrity at location of wanderguard twice per shift, encourage resident to wear his identification badge for safety. During an interview, on 9/09/22 at 3:15 p.m., LPN 8 indicated she did not usually work on this unit and knew little about the resident. She was unaware if the resident had been exit seeking. He had a wander guard on his right ankle. During an interview, on 9/13/22 at 10:06 a.m., the DON indicated the resident was taken to the first floor of the residents building by a visitor. The visitor left and the resident was found walking alone in the parking lot. The resident then was taken into the building and taken to his unit. During an interview, on 9/13/22 at 10:33 a.m., Maintenance 3 indicated he was getting ready to enter the facility and located the resident outside wearing only a t-shirt and pants. It was cold and			

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	he did not remember if the resident was wearing shoes. The resident was looking for a cat to feed. Maintenance 3 went inside to the building to notify staff and left the resident unattended outside. The resident was behind a fence and could not be seen from inside the facility. During an interview, on 9/14/22 4:51 p.m., the Superintendent indicated the roam alerts did not alarm at the front door. The range only went to the elevator and she was still trying to figure out some things. The roam alarm was on when he was outside with the family friend. 3. During an observation, on 9/14/22 at 9:21 a.m., Resident 42 was lying in bed with his eyes shut. A medication cup containing fourteen pills were found sitting on the residents bedside table. The record for Resident 42 was reviewed on 9/08/22 at 2:58 p.m. Diagnoses included, but were not limited to, bipolar disorder, hypertension, type 2 DM, cirrhosis of the liver, congestive heart failure, glaucoma and heart failure. A physician's order, dated 8/4/21, indicated acetaminophen 325 mg (milligram) tablets, give 2 tablets by mouth three times a day. A physician's order, dated 8/4/21, indicated alogliptin (diabetes) 25 mg tablet, give 1 tablet by mouth daily. A physician's order, dated 4/19/22, indicated abilify (antidepressant) 10 mg tablet, give 1 tablet by mouth daily. A physician's order, dated 8/4/21, indicated aspirin 81 mg tablet, give 1 tablet by mouth daily.			

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	A physician's order, dated 8/4/21, indicated docusate sodium (stool softener) 100 mg capsule, give 1 tablet by mouth daily. A physician's order, dated 8/4/21, indicated metoprolol tartrate (for high blood pressure) 100 mg tablet, give 1 tablet by mouth two times a day. The medication was not to be given if the SBP (systolic blood pressure) was less than 100 beats per minute (BPM) and apical pulse less than 60 BPM. A physician's order, dated 8/4/21, indicated metoprolol tartrate 50 mg tablet, give 1 tablet by mouth two times a day. Give this medication with metoprolol tartrate 100 mg. The medication was not to be given if the SBP was less than 100 BPM and apical pulse less than 60 BPM. A physician's order, dated 4/20/22, indicated venlafaxine (bipolar disorder) 150 mg capsule, give 1 capsule by mouth daily. A physician's order, dated 6/29/22, indicated magnesium oxide (supplement) 400 mg tablet, give 2 tablets by mouth twice a day. A physician's order, dated 7/11/22, indicated lithium carbonate extended release (bipolar disorder) 300 mg tablet, give 1 tablet by mouth daily. A physician's order, dated 8/6/21, indicated tramadol (pain) 50 mg tablet, give 1 tablet by mouth twice a day. A physician's order, dated 4/20/22, indicated furosemide (diuretic) 40 mg tablet, give 1 tablet by mouth daily.			

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	A physician's order, dated 12/21/21, indicated Wellbutrin XL (bipolar disorder) 150 mg tablet, give 1 tablet by mouth daily. A physician's order, dated 2/7/22, indicated metformin (diabetes) 1000 mg tablet give 1 tablet by mouth twice a day. There were no physician orders indicating Resident 42 could self medicate. During an interview, on 9/14/22 at 9:23 a.m., QMA 2 indicated she did not normally leave medication at the bedside. The resident sat up and she thought he was taking the pills. The medication cup had all of his morning pills. QMA 2 started to cough and left the resident's room to get a drink. A current policy, titled "Roam Alert System, " dated 02/91 and received by the Assistant Superintendent on 9/12/22 at 12:32 p.m., indicated "...The Indiana Veterans' Home will utilize the Roam Alert System to assist with monitoring of residents who have been assessed as being at risk for roaming, wandering, and elopement...The resident will be assessed to determine if the use of the Roam Alert System is appropriate...If the resident is assessed as being appropriate for Roam Alert use, the nursing unit manager will request a physician's order for application of the Roam Alert...The use of the Roam Alert monitoring will be reviewed quarterly by the Interdisciplinary Team...Nursing staff will apply Roam Alert wrist bracelets to residents. Application and removal of bracelets will be done in a private area...Safety and maintenance departments will maintain access codes and change codes as needed. Nursing staff is responsible for checking bracelet placement and function once every shift...An alarm will sound if a			

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	resident enters the elevator. If a staff member is escorting the resident, the staff member can use a bypass code to silence the alarm. If an elevator alarm sounds, the elevator door will remain open and will remain on the floor until the alarm is reset. All Roam Alert alarms will be responded to by nearest staff...." A current policy, titled "Elopement Risk Assessment," dated as revised 5/07 and received by the Assistant Superintendent on 9/12/22 at 12:32 p.m., indicated "...The Indiana Veterans' Home to make every effort to provide for the safety and security of each resident while maintaining the lease restrictive environment and preserving their independence in mobility. Some residents may become missing, wander, display exiting behaviors and/or be at risk for elopement...if the resident is found outside the facility and is cognitively impaired, the resident is considered to have eloped...." A current policy, titled "Resident Elopement," dated as revised 4/14/15 and received by the Assistant Superintendent on 9/12/22 at 12:32 p.m., indicated "...When staff member from the unit will search on of the following areas: All stairwells in building...As the search of each of these initial areas is concluded, notify the charge nurse of findings and if the resident still has not been located, a Code 6 will be initiated. The Director of Nursing or designee will be notified...The entire campus will observe the "Code 6" protocol...." At the time of exit the facility had not provided a policy on falls. 3.1-45(a)(2)			

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to prevent urinary tract infections for 3 of 3 residents reviewed for	F 0690	**What corrective action(s) will be accomplished for those residents found to have been**	10/12/2022

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	catheter care. (Residents 49, 50 and 85) Findings include: 1. The record for Resident 49 was reviewed on 09/08/22 at 10:45 a.m. Diagnoses included, but were not limited to, urinary tract infection, obstructive and reflux uropathy. During an observation, on 09/08/22 at 10:53 a.m., the resident was sitting in a Broda chair with the catheter tubing protruding from his pant leg into a catheter bag which was covered with a dignity bag. Yellow urine was observed in the catheter tubing. The catheter bag was at an angle to prevent urine from flowing into the catheter bag. During an observation, on 09/09/22 10:53 a.m., the resident was sitting in a Broda chair with the catheter tubing protruding from his pant leg into the catheter bag which was covered with a dignity bag. Yellow urine was observed in the catheter tubing. The catheter bag was at an angle to prevent urine from flowing into the catheter bag. A care plan, dated 7/9/21, indicated the resident was at risk for bladder infection due to indwelling Foley catheter, related to obstructive uropathy and ventral erosion of the penis. Approaches included, but were not limited to, administer flushes as ordered, encourage fluid intake and provide catheter care every shift. A physician's order, dated 7/9/22, indicated to provide suprapubic catheter care every shift with soap and water only. A physician's order, dated 8/30/22, indicated Cephalexin (antibiotic) milligrams twice daily was ordered for a urinary tract infection.		**affected by the deficient practice:** Residents 49, 50 and 85 catheter bags placed correctly allow appropriate flow of urine. **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 requiring catheters are at risk of this alleged deficient practice. An audit will be completed by Director of Nursing/Designee to ensure all residents have catheter bags positioned appropriately. Audit to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Nursing/Designee will provide education to all nursing staff on catheter bad placement by 10/12/2022. **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:** Director of Nursing/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months for catheter bag placement. Results from audits will be brought	

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	A progress note, dated 9/1/22 at 5:42 p.m., indicated the resident had an order for an antibiotic for a urinary tract infection. A urine culture result, dated 9/1/22, indicated Escherichia coli (a bacteria found in stool) and proteus mirabilis (a bacteria spread through contact with contaminated persons and objects) were present in the culture. 2. During an observation, on 9/9/22 at 12:00 p.m., the resident was sitting in his motorized wheel chair with the Foley catheter tubing looping from under his pant leg up to the Foley bag, in a dignity bag, on the seat between his legs. Cloudy yellow urine was present in the tubing. During an observation, on 9/12/22 at 2:10 p.m., the resident was sitting in his motorized wheel chair with the Foley catheter tubing looping from under his pant leg up to the Foley bag, in a dignity bag, on the seat between his legs. Yellow urine was present in the tubing The record for Resident 50 was reviewed on 09/12/22 at 2:48 p.m. Diagnoses included, but were not limited to, paraplegia, UTI and neuromuscular dysfunction of bladder. A care plan, dated 7/21/22, indicated the resident was at risk for bladder infection due to indwelling Foley catheter, and neuromuscular dysfunction of the bladder. Approaches included, but were not limited to, change catheter as ordered, keep drainage bag below bladder level, administer flushes as ordered, encourage fluid intake, and provide catheter care every shift. A physician's order, dated 7/18/22, indicated to		to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. **By what date systemic changes will be completed:** 10/12/2022	

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(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
	flush the suprapubic catheter with 60 cc of normal saline every shift as a preventative measure. A physician's order, dated 8/24/22, indicated to give Cefepime (an antibiotic) 2 grams IM (intramuscularly) every 12 hours for seven days for urinary tract infection. A physician's order for catheter care was not present. A urinalysis, dated 8/18/22, indicated cloudy urine with large amount of blood, protein count of 30 and large leukoesterase (white blood cells in the urine). A urine culture, dated 8/20/22, indicated greater than 100,000 pseudomonas aeruginosa (a bacteria which lives in the environment and can be spread to people in a healthcare setting). 3. The record for Resident 85 was reviewed on 09/08/22 at 11:36 a.m. Diagnoses included, but were not limited to, retention of urine, unspecified, an indwelling urinary catheter was placed, hydronephrosis with renal and ureteral calculus obstruction and malignant neoplasm of the prostate. A review of the resident census indicated three hospital events since admission on 5/17/22. A hospital discharge summary, dated 6/18/22, indicated a urinary tract infection sepsis (a potentially life threatening condition which occurred when the body's response to an infection damaged its own tissue), as the admitting diagnosis. The infection was treated with Vancomycin and Zosyn (antibiotics) intravenously which was started from admission.			

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	155787	A. BUILDING 00 B. WING	09/14/2022

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	Later the antibiotic was changed to cefepime (antibiotic), and then Keflex (antibiotic). The urine culture grew Proteus mirabilis. A seven day antibiotic treatment was finished during the hospitalization. He was seen by a urologist and the possibility of a suprapubic catheter replacement was discussed. A hospital discharge summary, dated 7/28/22, indicated the diagnosis of sepsis secondary to complicated proteus mirabilis urinary tract infection. He was treated with intravenous Zosyn (antibiotic), and intravenous fluids. The urine culture grew proteus mirabilis greater that 100,000. He was discharged with Levaquin (antibiotic) for ten days. A physician's order, dated 8/5/22, indicated to change the urinary foley catheter every month 12fr/10cc. A physician's order, dated 8/5/22, indicated to flush the Foley catheter with 30-60 cc of normal saline as needed to maintain patency. A physician's order, dated 8/5/22, indicated to flush the Foley catheter with 60 cc of normal saline every shift. A physician's order, dated 8/5/22, indicated to provide catheter care every shift. During an interview, on 9/12/22 at 3:08 p.m., the Assistant Superintendent indicated she was aware of trending with urinary infections had occurred in the that building. Education for handwashing was provided to staff. She was not aware of attempts to use a leg bag on the resident. During an interview, on 9/12/22 at 3:12 p.m., the			

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	Assistant Director of Nursing indicated she was not aware if repositioning of the Foley catheter bag or a leg bag had been tried to prevent the tubing from causing an upward flow of the urine to the Foley catheter bag. A current policy, titled "Indwelling Urinary Catheters," dated 10/20/07 and received from the Assistant Superintendent on 9/13/22 at 2:30 p.m., indicated "...hand washing should be done immediately before and after any manipulation of the catheter site or apparatus...a sterile, continuously closed drainage system should be maintained...irrigation of the catheter should be avoided unless obstruction is anticipated...indwelling catheters should not be changed at arbitrary fixed intervals...." 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;			

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	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to recognize and notify the physician of a weight loss for 1 of 4 resident reviewed for nutrition. (Resident 84) Finding includes: The record for Resident 84 was reviewed on 9/13/22 at 10:53 a.m. Diagnoses included, but were not limited to, cerebral aneurysm, mixed receptive-expressive language disorder, pain, vascular dementia with behavioral disturbance, cerebral infarction, complete loss of teeth and type 2 diabetes mellitus. A care plan, dated 4/17/2017, indicated the resident was at a risk for poor nutritional status related to diagnoses of diabetes mellitus, hypertension, dementia, depression and anemia. The interventions included, but were not limited to, obtain weight as ordered/needed and review. The resident had the following weights: 1. On 5/17/22 was 201.3 pounds. 2. On 5/24/22 was 196.1 pounds. 3. On 5/24/22 was 196.1 pounds. 4. On 6/1/22 was 182 pounds which was a 7.19% weight loss in 7 days. 5. On 6/7/22 was 182.9 pounds. 6. On 6/14/22 was 181.2 pounds. A physician progress note, dated 6/7/22 at 11:15 a.m., indicated the resident was being seen for hyponatremia. The assessment and plan included to continue the sodium tablets, not to resume hydrochlorothiazide (a diuretic) and follow up in	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 84 NP notified of weight changes. **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 are at risk of this alleged deficient practice. An audit will be completed by Director of Nursing/Designee to ensure all residents weights reviewed and notification and documentation completed for significant changes completed. Audit to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Nursing/Designee will provide education to all nursing staff on notification of weight change by 10/12/2022. **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:**	10/12/2022

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	one month for hyponatremia. The progress note did not include the resident's weight or recent significant weight loss. A nursing progress note, dated 6/7/22 at 5:58 p.m., indicated the resident had a weekly weight done the same day. He had gained 1.9 pounds. The nurse practitioner, registered dietician and the resident was informed of the weight gain. A registered dietician progress note, dated 6/14/22 at 12:13 a.m., indicated the resident had a significant weight loss of 9.1% in 30 days. The resident's intakes were likely suboptimal to estimated needs due to weight loss and continued decreased appetite. The recommendation was to start health shakes twice daily in between meals. During an interview, on 9/14/22 at 4:25 p.m., Unit Manager (UM) 6 indicated there was no documentation in the electronic health record (EHR) to show the significant weight loss was recognized until the dietician note on 6/14/22 and no documentation to show the nurse practitioner of the physician was notified of the significant weight loss. The resident also had a weight loss in May. He was having pain and wasn't eating. A current policy, titled "Nutritional Intervention," dated as revised 5/2020 and received from the Superintendent on 9/12/22 at 2:20 p.m., indicated "...A licensed nurse shall be responsible for...Analyzing nursing home residents nutritional consumption by reviewing intakes in Matrix of all meals, between meal nourishments and physician ordered supplements...Overseeing weights and re-weights, review intake records and diagnosis, and document pertinent notes in the progress notes.. Weekly weights must be submitted to the		Director of Nursing/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months for notification of weight change. 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 systemic changes will be completed:** 10/12/2022	

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	dietician within one[1]business day of completion...Review significant weight changes...The Physician...Re-evaluates resident's condition on an ongoing basis and whenever notified by Nursing staff to determine causes of unplanned weight loss/gain, underweight/overweight condition or other significant change of condition which could affect the resident's nutritional status...Problems and significant changes in the resident's nutritional status requires notification of the clinical dietician and PAR Committee...." 3.1-46(a)(1)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose			

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	reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure diagnoses were appropriate for the use of psychotropic medications for 2 of 6 residents reviewed for unnecessary medication. (Resident 44 and 49) Findings include: 1. The record for Resident 44 was reviewed on 9/12/22 at 3:30 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, post traumatic stress disorder, personal history of traumatic brain injury and psychotic disorder with delusions. An initial psychiatric evaluation, dated 11/12/21,	F 0758	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 44 and 49 reviewed with Psychiatrist for GDR. **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 psychotropic medications are at risk of this alleged deficient	10/12/2022

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	indicated the resident's diagnoses were senile dementia Alzheimer type, major neurocognitive disorder with behaviors, psychotic disorder secondary to senile dementia Alzheimer type. The Preadmission Screening and Resident Review, dated 11/23/21, indicated the resident was prescribed quetiapine (Seroquel) for dementia with behaviors. A physician's order, dated 8/22/22, indicated to administer Seroquel (antipsychotic) 25 milligrams at bedtime for psychotic disorder with delusions. A care plan, dated 7/29/22, indicated the resident had a psychotic disorder with delusions. The resident was prescribed an antipsychotic medication to help manage behavior symptoms. Approaches included, but were not limited to, provide medication, observe for and document any symptoms or change in routine. During an interview, on 09/12/22 at 04:46 p.m., the facility psychiatrist indicated the resident had dementia and was admitted with the current medications. He received a diagnosis of psychotic disorder with delusions. The dementia may be Alzheimer or alcohol related. The resident came from a memory care/assisted living with a history of dementia, post traumatic stress disorder and alcoholism. He would assume the psychosis was related to the alcoholism and dementia and it was not known which came first with him. The medications were not FDA approved and would be considered off label use. 2. The record for Resident 49 was reviewed on 9/8/22 at 10:45 a.m. Diagnoses included, but were not limited to, pseudobulbar effect, Alzheimer disease, dementia with behavioral disturbance,		practice. An audit will be completed by Director of Nursing/Designee to ensure all residents have diagnosis reviewed by psychiatrist for psychotropic medications. Audit to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Nursing/Designee will provide education to all licensed nursing staff on appropriate diagnoses for psychotropic medications by 10/12/2022. **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:** Director of Nursing/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months for appropriate diagnosis for psychotropic medications. 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 systemic changes will be completed:** 10/12/2022	

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	mood disorder, Parkinson disease and psychotic disorder. A care plan, dated 7/13/22, indicated the resident had a diagnosis of psychotic disorder with delusions. He was prescribed an antipsychotic medication to assist in managing symptoms which included periods of consistently yelling out for people who were deceased, believed deceased people were living and a history of threats of self-harm. Approaches included, but were not limited to, contact wife as needed or requested, observe for and document behaviors. A physician's order, dated 7/8/22, indicated quetiapine (antipsychotic used for schizophrenia) 25 milligrams twice daily for psychotic disorder with delusions. A physician's order, dated 9/3/22, indicated divalproex (for use with seizures and bipolar disorder with mania) 250 milligrams twice daily for dementia with behaviors. A current policy, titled "Psychoactive Medication Management," dated as revised on 8/10/2012 and received from the Assistant Superintendent on 9/13/22 at 2:20 p.m., indicated "...All residents on psychoactive medications will be monitored for efficacy and adverse events...When a resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmalogical interventions, including behavioral interventions, have been effective in reducing the symptoms, the resident is evaluated for the appropriateness of a taper or gradual dose reduction in medication...Antipsychotics...The continued use is in accordance with relevant current standard of practice...Psychoactive drug therapy monitoring			

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	will occur for all applicable residents per F329 regulation requirements...." A current publication of PDR.net, indicated the approved use for "divalproex in adults was for seizures, acute mania associated with bipolar disorder, with or without psychotic features and migraines...the black box warning indicated the medication was not for the treatment of dementia-related psychosis in geriatric patients. The use of antipsychotics should be avoided in the geriatric population, if possible due to the increased morbidity and mortality in the elderly...." A current publication of PDR.net, indicated the approved use for "quetiapine was for the treatment of schizophrenia, mania associated with bipolar I disorder, bipolar depression...the black box warning indicated the medication was not for the treatment of dementia-related psychosis in geriatric patients. The use of antipsychotics should be avoided in the geriatric population, if possible due to the increased morbidity and mortality in the elderly...." 3.1-48(a)(4)			
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:			

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	(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 §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 provide routine dental services for 1 of 1 resident reviewed for dental services. (Resident 18) Finding includes:	F 0791	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 18 seen by dentist on 9/28/22.	10/12/2022

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	During an interview, on 9/6/22 at 3:30 p.m., Resident 18 indicated he did not think the facility had a dentist. The record for Resident 18 was reviewed on 9/8/22 at 2:54 p.m. Diagnoses included, but were not limited to, congestive heart failure, acquired absence of the right and left leg above the knee, type 2 diabetes mellitus and major depressive disorder. A physician's order, dated 3/21/22, indicated the resident may see dentist, optometrist, podiatrist, endocrinologist, nephrologist and pulmonary at facility clinic. A dental note, dated 6/7/21, indicated the resident was to return to the dental clinic in 6 months. The date for the return appointment would be December of 2021. During an interview, on 9/13/22 at 4:39 p.m., the Assistant Administrator indicated the facility had no dental services on site. The facility dentist retired on 1/13/22. During an interview, on 9/14/22 at 4:24 p.m., the Assistant Administrator indicated there was no notes in the electronic health record about the missed dental appointment in December 2021 and she did not have an explanation why the resident was not seen by the dentist as this was prior to the facility dentist retiring. A current policy, titled "Referrals [Dental, Podiatrist, Optometrist]," dated as revised on 4/09 and received from the Assistant Superintendent on 9/14/22 at 11:00 a.m., indicated "...It is the intent of the Indiana Veterans' Home that		**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 are at risk of this alleged deficient practice. Contract with on-sight dental providers initiated. Until contract completion, those residents requiring dental services to have appointments scheduled without outside providers. An audit will be completed by Director of Nursing/Designee to ensure all residents have dental services scheduled if requested. Audit to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Nursing/Designee will provide education to all licensed nursing staff on scheduling dental appointments by 10/12/2022. **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:** Director of Nursing/Designee will audit 5 residents per day 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents per month for 4 months for appointments scheduled with dentist.	

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	residents would be provided routine dental, podiatry and eye appointments...Dental...after the initial examination, resident will be scheduled every 66 days per Medicaid guidelines...." 3.1-24(a)(1)		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 systemic changes will be completed:** 10/12/2022	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure pureed foods were prepared according to the recipes for residents who required a pureed diet for 1 of 1 staff member observed preparing puree foods. (Cook 1) Finding includes: During an observation, on 9/7/22 at 9:50 a.m., Cook 1 put salmon patties in a Robo coupe (blender machine) and was going to put water into the machine. The registered dietician stopped the cook and told him to put broth into the Robo coupe with the salmon. The facility cook was not using a recipe to puree the salmon patties.	F 0804	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Cook 1 provided education on following recipes for puree foods by Registered Dietitian. **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 pureed foods are at risk of this alleged deficient practice. Education to be provided to dietary staff on following puree recipes by	10/12/2022

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	09/14/2022

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

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	A current recipe, not dated, for salmon patties indicated to place prepared salmon patty into the food processor, add liquid, butter or margarine, and lemon juice and process until smooth in texture. During an interview, on 9/6/22 at 4:11 p.m., the Registered Dietician indicated the new facility recipe indicated broth or gravy should be added to the salmon patties for flavor and desired consistency. Cook 1 should have been using a recipe to puree foods. There was no facility policy for pureed foods. 3.1-21(a)(1)		Registered Dietitian/Designee. Education to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Registered Dietitian/Designee will provide education to dietary staff on following pureed recipes by 10/12/2022. **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:** Registered Dietitian/Designee will observe cooks 5 days per week for 4 weeks, once per week for 4 weeks, and once per month for 4 months to ensure following puree recipes. 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 systemic changes will be completed:** 10/12/2022	
F 0812 SS=E 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			

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	155787	A. BUILDING 00 B. WING	09/14/2022

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INDIANA VETERANS HOME	3851 N RIVER RD WEST LAFAYETTE, IN 47906

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	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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure the dishwasher had reached and maintained the appropriate temperature during the final rinse cycle. This deficient practice had the potential to affect 106 of 106 residents who received food from the kitchen. Finding includes: During an observation, on 9/6/22 at 12:02 p.m., the facility dishwasher final rinse was 120 degrees. The kitchen staff was stacking the dishes and pans which had just run through the dishwasher onto the clean shelves. The final rinse should have reached 180 degrees or above according to the sign on the dishwasher. During an interview, on 9/6/22 at 12:07 p.m., the Dietary Manager had the kitchen staff run the dishes and pans through the dishwasher again. She indicated the final rinse should have been 180 degrees or higher.	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Kitchen staff educated on appropriate dish machine temperatures. **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 are at risk of this alleged deficient practice. Education to be provided to dietary staff on checking for dish machine temperatures. Education to be completed by 10/12/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	10/12/2022

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	155787	A. BUILDING 00 B. WING	09/14/2022

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	Upon exit, the facility had not provided a policy on dishwashing temperatures. 3.1-21(i)(3)		**practice does not recur:** Registered Dietitian/Designee will provide education to dietary staff on checking dish machine temperatures by 10/12/2022. **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:** Registered Dietitian/Designee will audit 5 days per week for 4 weeks, once per week for 4 weeks, and once per month for 4 months dish machine temperature log to ensure dish machine is appropriate temperature. 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 systemic changes will be completed:** 10/12/2022	