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	11/07/2022

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: 11/07/22 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 106. Quality Review complerted on 11/10/22	E 0000	=”” span=””>Indiana Veterans' Home respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. =”” p=””> =”” span=””> =”” span=””> =”” span=”” deficiencies. the=”” law. the=”” 2022. indiana=”” respectfully=”” requests=”” desk=”” review=”” with=”” paper=”” compliance=”” be=”” considered=”” establishing=”” that=”” substantial=”” compliance.<=”” p=””>	
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: 11/0722 Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200 At this Life Safety Code survey, Indiana Veterans Home was found not in compliance with	K 0000	=”” span=””>Indiana Veterans' Home respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. =”” p=””> =”” span=””> =”” span=””> =”” span=”” deficiencies. the=”” law. the=”” 2022. indiana=”” respectfully=”” requests=”” desk=”” review=”” with=””	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Gibson	HFA, Superintendent	11/22/2022

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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	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 complerted on 11/10/22		paper="" compliance="" be="" considered="" establishing="" that="" substantial="" compliance.<="" p="">	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of over 25 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable	K 0291	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were	12/02/2022

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	facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect at least 10 residents, staff, and visitors in the vicinity of room 215. Findings include: Based on observation with the Facility Maintenance Manager on 11/07/22 during a tour of Mitchell Hall from 9:40 a.m. to 11:15 a.m., the battery-operated emergency light by resident room 215 failed to function when its respective test button was pushed five times. Based on interview at the time of observation, the Facility Maintenance Manager confirmed the aforementioned battery-operated emergency light failed to function when its respective test button was pushed. This finding was reviewed with the Administrator, Facility Maintenance Manager and Maintenance Supervisor at the exit conference. 3.1-19(b)		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 replaced the depleted battery found in the emergency light outside Mitchell room 215 that was observed to have failed a function test. Upon replacement of the battery a function test was performed on the light. The emergency light is now functioning properly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** All Emergency Lights within in the Indiana Veterans' Home will be inspected and tested by Facility Maintenance by 12/2/2022. Any deficiencies found will be documented and work orders will be issued for repair. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place Emergency Lighting compliance has been added as an objective on the Quality Assurance monthly compliance analysis and will be monitored monthly for 6 months. **Date of Compliance** December 2, 2022	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.			
	Based on observation and interview; the facility failed to maintain protection of 1 of 5 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient	K 0311	**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**	12/02/2022

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	practice could affect over 20 residents, staff, and visitors. Findings include: Based on observation with the Facility Maintenance Manager during a tour of Mitchell Hall from 9:40 a.m. to 11:15 a.m. on 11/07/22, the fire resistance rating label for the center stairwell door on the third floor was painted. The fire resistance rating for the stairwell door could not be determined because the label was painted. Based on interview at the time of the observation, the Facility Maintenance Manager agreed it could not be assured the interior stairwell was enclosed with a minimum 1-hr fire resistance rating. This finding was reviewed with the Administrator, Facility Maintenance Manager and Maintenance Supervisor at the exit conference. 3.1-19(b)		**identified and what corrective action(s) will be taken** All residents have the potential to be affected by this alleged deficiency. The fire resistance rating label on the Mitchell Hall 3rd floor center stairwell fire door will be cleaned with an adhesive remover in order for the fire rating to be legible. **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 members who paint to ensure fire labels on doors are not painted over by 12/2/2022. All fire doors within the Indiana Veterans' Home will be inspected to ensure the fire resistance rating label is legible by December 2, 20222. Any deficiencies found will be documented and work orders will be issues to correct the deficiencies. **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 door compliance has been added as an objective on the	

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			Quality Assurance monthly compliance analysis and will be monitored for no less than six months. **Date of Compliance** December 2, 2022	
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 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 1) Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in	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**	12/02/2022

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	any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation during a tour of Mitchell Hall with the Facility Maintenance Manager on 11/07/22 at 11:10 a.m., in the first floor Mechanical Room that housed the spare sprinkler box, there were no sidewall spare sprinklers. Based on interview at the time of observation, the Facility Maintenance Manager confirmed there were no sidewall spare sprinklers in the spare sprinkler cabinet of Mitchell Hall. During the tour of Mitchell Hall, sidewall sprinklers were observed installed in resident rooms. This finding was reviewed with the Administrator, Facility Maintenance Manager and Maintenance Supervisor at the exit conference. 3.1-19(b) Stephen M. Juday Sr. 2) Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be		**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 verified that spare sidewall sprinkler heads are currently in stock. Sidewall sprinklers relocated to the spare sprinkler box in all mechanical rooms. Sprinkler system control valve inspection completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education provided to maintenance staff on keeping spare sprinkler heads in mechanical rooms by 12/2/2022. All mechanical room spare sprinkler boxes will be inspected to ensure they contain the correct sprinkler heads by 12/2/22. Education provided to maintenance staff on completing inspection on pressure gauge and control valves by 12/2/22. The Building Fire Safety Preventive Maintenance checklist will be revised to add the sprinkler system pressure gauge and control valve as a monthly	

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	inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 11/06/22 at 11:12 am with the Maintenance Supervisor present, no documentation for monthly wet sprinkler system gauges could be located for review. Furthermore, monthly wet sprinkler system control valve inspection documentation was also not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged sprinkler system gauge and control valve inspection documentation for the last 12-month period of time could not be located as of the time of this survey. This finding was reviewed with the Administrator, Facility Maintenance Manager and Maintenance Supervisor at the exit conference. 3.1-19(b)		inspection checkpoint. **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** Spare sprinkler heads have been added as an objective on the Quality Assurance monthly compliance analysis and will be monitored for no less than six months. The sprinkler system control valve inspections 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 2, 2022	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles			

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	shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure 4 of 4 soiled linen receptacles in the corridor did not exceed 32 gallons in capacity within a 64 square foot area. This deficient practice could affect as many as 46 residents, 8 staff and 4 visitors. Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility on 11/07/22 from 12:29 p.m. to 3:13 p.m., the following was noted: A) There were 4 50-gallon trash / soiled linen containers located in the corridor on the 4th floor of the MacArthur building. B) There were 4 50-gallon trash / soiled linen containers located in the corridor on the 3rd floor of the MacArthur building. In addition to this there were also 3 15-gallon trash containers located in the corridor as well. C) There were 4 50-gallon trash / soiled linen	K 0754	**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. All 50- gallon trash containers have been removed from the corridors in MacArthur Hall on the 2nd – 4th floors.	12/02/2022

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	containers located in the corridor on the 2nd floor of the MacArthur building. In addition to this there were also 4 15-gallon trash containers located in the corridor as well. Based on interview at the time of each observation, the Maintenance Supervisor confirmed both the capacity and the locations of each of the noted receptacles adding that he has talked with nursing staff about them not being kept in the corridor numerous times with no success. This finding was reviewed with the Administrator, Facility Maintenance Manager and Maintenance Supervisor at the exit conference. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education to be provided to all staff that trash containers cannot be left in corridors by 12/2/22. Trash containers removed from corridors. **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 for items in corridors to be completed 5 times per week for 4 weeks, 1 time per week for 4 weeks and once monthly for 4 months. /b> Storage containers in corridors has been added as an objective on the Quality Assurance monthly compliance analysis and will be monitored for no less than three months. **Date of Compliance** December 2, 2022	