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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155787	A. BUILDING -- B. WING	01/07/2025

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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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: 01/07/25 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 212 certified beds. At the time of the survey, the census was 116. Quality Review completed on 01/10/25	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Life Safety Survey dated January 7, 2025. Please accept this plan of correction as the Indiana Veterans' Home credible allegation of compliance. Indiana Veterans' Home respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/07/25 Facility Number: 001134 Provider Number: 155787	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ay Gibson	Superintendent	01/24/2025

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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	AIM Number: 200817200 At this Life Safety Code survey, Indiana Veterans Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility located in three separate buildings identified as: Mitchell Hall, a 3-story building with a partial basement was determined to be Type I (442) construction, MacArthur Hall, a 4 - story building with a basement, was determined to be of Type 1 (442) construction and fully sprinklered, and Pyle Hall, a 3-story building with a basement that has now been made into an independent living facility and was therefore not surveyed. 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 212 and had a census of 116 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the detached generator building and maintenance shop. Quality Review completed on 01/10/25		and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Life Safety Survey dated January 7, 2025. Please accept this plan of correction as the Indiana Veterans' Home credible allegation of compliance. Indiana Veterans' Home respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0291 SS=D Bldg. 01	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure all battery powered emergency lights were maintained in accordance with LSC 7.9.	K 0291	What corrective action(s) will be accomplished for those residents found to have been affected by the	02/05/2025

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	LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable 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 staff and visitors by the Mitchell Hall dock. Findings include: Based on observation with the Maintenance Director and Facility Maintenance Manager on 01/07/25 during a tour of the facility from 10:40 a.m. to 2:20 p.m., the battery operated emergency light at the Mitchell Hall dock exit failed to function when its respective test button was pushed four times. Additionally, the battery operated emergency light by the restrooms near the Mitchell Hall dock exit failed to function when it's respective test button was pushed four times. The battery operated emergency light in the first floor Mitchell Hall Mechanical room failed to function when it's test button was pushed three times. Based on interview at the time of the observations, the Maintenance Director stated battery operated lights in the facility are tested monthly and confirmed that the aforementioned three battery operated emergency lights failed to function when the respective test button was pushed. This finding was reviewed with the Superintendant, Facility Maintenance Manager and Maintenance Director at the exit conference.		deficient practice? No residents were affected by this alleged deficiency. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by this alleged deficiency. Facility Maintenance repaired the battery-operated emergency lights in question located at the Mitchell Hall dock exit, outside the Mitchell Hall 1st floor restrooms, and the Mitchell Hall mechanical room on 1/15/2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education will be provided to all Maintenance staff members on the requirements for monthly inspections of emergency lighting and expectations for repairs upon finding deficiencies by 2/5/2025. 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 Facility Maintenance will complete monthly inspections of all emergency lighting system as part of our preventive maintenance program. Emergency Lighting compliance has been added as an objective on	

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	3.1-19(b)		the Quality Assurance monthly compliance analysis and will be monitored for no less than six months. Date of Compliance February 5, 2025	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills			
	Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 states "Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all residents, staff, and visitors. Findings include: Based on record review of the documents entitled "Indiana Veterans Home - Fire Drill Report" form with the Maintenance Supervisor on 01/07/25 at 12:25 p.m., there was no documentation for a second shift fire drill in the second quarter (April, May, and June) of 2024. Additionally, the time frame for the following fire drills was not varied: a) All first shift fire drills for the Macarthur building were conducted between 8:29 a.m. and 9:00 a.m. b) All second shift fire drills for the Macarthur building were conducted between 8:00 p.m. and 8:30 p.m. c) All third shift fire drills for the Macarthur building were conducted between 1:00 a.m. and 2:00 a.m. Based on interview at the time of record review, the Maintenance Supervisor agreed that all fire	K 0712	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this alleged deficiency. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by this alleged deficiency. Facility Maintenance revised the annual fire drill calendar to ensure drills are completed quarterly for each building with a varied time of greater than two hours for consecutive quarterly drills. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education will be provided to all staff members on the requirements for conducting quarterly fire drills at the specified intervals for 1st Shift, 2nd Shift, and 3rd Shift to be completed by	02/05/2025

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	dills conducted for the Macarthur building were not varied by a time of greater that two hours and stated that he would speak to his security team that conducted the fire drills about the issue. This finding was reviewed with the Superintendent, the Facilities Manager, and the Maintenance Supervisor at the exit conference on 01/07/25. 3.1-19(b) 3.1-51(c)		2/5/2025. 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 A Fire Drill Report will be completed for every fire drill and reviewed for completion by Facility Maintenance. Fire drill compliance has been added as an objective on the Quality Assurance monthly compliance analysis and will be monitored for no less than six months. Date of Compliance February 5, 2025	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 6 staff and residents. Findings include: Based on observation with the Maintenance Director on 01/07/25 during a tour of the facility between 10:40 a.m. and 2:20 p.m. in resident room 321 in MacArthur Hall, a power strip was plugged	K 0920	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The two power strips discovered in violation were removed from MacArthur Hall, Room # 321 by Facility Maintenance during the Life Safety Inspection conducted on 1/7/2025. 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	02/05/2025

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	into and was supplied power by another power strip for personal electronic equipment. Based on interview at the time of observation, the Maintenance Director agreed the two powerstrips were daisy chained together and unplugged and removed one of the power strips upon observation. This finding was reviewed with the Superintendant, Facility Maintenance Manager and Maintenance Director during the exit conference. 3.1-19(b)		and Nursing staff members will continuously inspect Resident rooms for unauthorized use of power strips. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education will be provided to all staff members on the utilization of power strips within the Facility to be completed by 2/5/2025. 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 Power strip usage within Resident rooms will be inspected on the Monthly Facility Safety Inspection. Power strips and extensions cords 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 February 5, 2025	
K 0927 SS=D Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99, Health Care Facilities, 2012 edition, Section 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain	K 0927	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	02/05/2025

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	a negative pressure in the space continuously. This deficient practice could affect staff near the first floor oxygen transfill/storage room in Mitchell Hall. Findings include: Based on observation on 01/07/25 at 2:17 p.m. during a tour of the facility with the Maintenance Director and Facility Maintenance Manager, the mechanically ventilated exhaust fan on the wall in the oxygen transfill/storage room was not working at the time of observation. The oxygen room contained at least five liquid oxygen containers. Based on interview at the time of observation, the Maintenance Director confirmed the fan in the oxygen room was not working at the time of observation. This finding was reviewed with the Superintendant, Facility Maintenance Manager and Maintenance Director at the exit conference. 3.1-19(b)		same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by this alleged deficiency. Facility Maintenance repaired the exhaust ventilation fan on 1/22/2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education will be provided to all maintenance staff members on ensuring the oxygen room ventilation fan is to be operating at all times by 2/5/2025. 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 Facility Maintenance has revised the monthly maintenance checklist for Mitchell Hall to include inspecting the oxygen room ventilation exhaust fan for operation as part of our preventive maintenance program. The oxygen storage room has been added as an objective on the Quality Assurance monthly compliance analysis and will be monitored for no less than six months. Date of Compliance February 5, 2025	