

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

PRINTED: 03/06/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155787	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2024
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NAME OF PROVIDER OR SUPPLIER  INDIANA VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP COD 3851 N RIVER RD WEST LAFAYETTE, IN 47906
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00427195, IN00427614 and IN00427908.</p> <p>Complaint IN00427195 - Federal/State deficiencies related the allegaitons are cited at F604.</p> <p>Complaint IN00427614 - No deficiencies related to the allegations were cited.</p> <p>Complaint IN00427908 - No deficiencies related to the allegations were cited.</p> <p>Survey dates: February 9 and 12, 2024</p> <p>Facility number: 001134 Provider number: 155787 AIM number: 200817200</p> <p>Census Bed Type: SNF/NF: 112 Total: 112</p> <p>Census Payor Type: Medicare: 1 Medicaid: 58 Other: 53 Total: 112</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review was completed on February 20, 2024.</p>	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 Complaint Survey dated February 12. 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 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Gibson	Superintendent	02/26/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>Based on observation, interview and record review, the facility failed to ensure a moderately impaired resident was free from restraints for 1 of 6 residents reviewed for abuse. (Resident B)</p> <p>Finding includes:</p> <p>An incident report sent to the Indiana Department of Health indicated, on 1/26/24, Resident B was found during morning rounds to have the foot of</p>	F 0604	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident B had dining room chair removed from under the footrest of his recliner upon discovery of alleged restraint. Resident B was monitored for signs of distress</p>	03/08/2024

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	<p>his recliner elevated with a dining room chair to prevent him from lowering the legs of his recliner during the night. It was reported CNA 9 had elevated the resident's recliner legs during the night to prevent the resident from lowering his legs. Resident B was allowed out of his recliner after discovery and was monitored for any signs and symptoms of distress.</p> <p>The clinical record for Resident B was reviewed on 2/12/24 at 12:15 p.m. Diagnoses included, but were not limited to, hypertensive heart disease, major depressive disorder, dementia, osteoporosis, and hyperlipidemia.</p> <p>The resident had a BIMS (Brief Interview for Mental Status) score of 10 which indicated the resident's cognition was moderately impaired.</p> <p>A nursing note, dated 1/26/24 at 3:34 p.m., indicated CNA 8 reported to Assistant Director of Nursing (ADON) 10 when she was making her rounds with CNA 9, a chair was noted to be under the foot of the recliner for Resident B. She indicated she asked CNA 9 if the resident had requested the chair and leg elevation. CNA 9 indicated the resident kept putting his feet down while he was in the chair. CNA 9 indicated Resident B had swelling in his legs and feet and he needed his chair legs elevated. CNA 9 indicated she did not know if it was a restraint, but she did it to keep his feet elevated.</p> <p>A facility conducted interview, on 1/26/24, noted CNA 8 indicated she observed during her morning rounds with CNA 9 Resident B had a dining room chair under the foot area of his resident recliner. CNA 9 indicated the resident needed his legs elevated when he was in his recliner and the resident did not keep his legs elevated. CNA 9</p>		<p>with no signs noted. Resident B's family was notified of dining room chair being placed under footrest causing alleged restraint. CNA 9 was removed from care of all residents at Indiana Veterans' Home.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents are at risk for this alleged deficient practice. Inservice education will be provided by DON/Designee to all staff regarding restraints by March 8, 2024. An audit of all residents will be completed by March 8, 2024 to check for restraints.</p> <p><b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:</b> DON/Designee will provide education to all staff on restraints by March 8, 2024.</p> <p><b>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:</b> DON/Designee will audit 5 residents daily for 5 days per week for 4 weeks, 5 residents once per week for 4 weeks, and 5 residents once per month for 4 months for restraints. Results from</p>		

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	<p>indicated she did not know if it was a restraint, but it did keep the resident's feet elevated. CNA 8 told CNA 9 it was a restraint, and she removed the chair. CNA 8 reported the incident.</p> <p>A nursing progress note, dated 1/30/24, indicated the resident was interviewed. He indicated he did not use a chair to elevate his feet when he was in the recliner. He demonstrated he could lower his recliner footrest without a chair underneath. The resident could not move a chair and put it in place to elevate the recliner. The resident did not show any distress when the chair placement and incident, on 1/26/24, was discussed.</p> <p>A facility conducted interview, on 2/2/24, noted CNA 9 indicated when she came to work, on 1/25/2024, the chair was under the footrest of the resident's recliner. She told the resident it was not safe to have the chair in that position and she removed the chair. She reported during the shift, she saw the resident place the chair under his recliner. She told the resident it was not safe, and the resident told her to go away. She told the supervisor the resident had a chair under his footrest, and it was an unsafe situation with the chair placement. CNA 9 indicated she did not know the supervisor's name.</p> <p>During an interview, on 2/9/24 at 1:45 p.m., CNA 8 indicated she observed during her morning rounds on 1/26/24 with CNA 9, Resident B had a dining room chair under the footrest of his recliner. CNA 9 indicated the resident needed his legs elevated when he was in his recliner, and he did not keep his feet up while sitting in his chair. She indicated he had edema in his feet. She asked CNA 9 if she knew the chair was a restraint. CNA 9 said she did not know. She told CNA 9 it was a restraint, and she removed the chair. She assisted</p>		<p>audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits.</p> <p><b>By what date systemic changes will be completed:</b> March 8, 2024</p>	

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	<p>the resident to lower his footrest and reported the incident to her supervisor.</p> <p>During an interview, on 2/9/24 at 1:50 p.m., ADON 5 indicated she was aware of the situation with CNA 9. The staff member was sent home while the investigation was ongoing. The resident could not have moved the chair by himself or placed it under the footrest of his recliner. The resident needed stand by assist to self-transfer, walked with a shuffling gait, and he needed an assist of one staff for support and transfer. She indicated the chair placement was considered a restraint.</p> <p>During an interview, on 2/9/24 at 1:54 p.m., RN 6 indicated Resident B was not able to lift one of the dining room chairs, place the object under his recliner, and then climb into the recliner. The resident had mobility and cognitive issues. The chair placement was considered a restraint.</p> <p>During an interview, on 2/9/24 at 1:58 p.m., the Director of Nursing (DON) indicated Resident B had a care plan for dementia and cognitive loss, for walker utilization for mobility and a wheelchair for long distance, and for falls. She indicated CNA 9 was an agency staff member and she was asked not to return to the facility for employment after the investigation of the incident was completed. Resident B was not able to place the dining room chair under his recliner footrest and then climb into his recliner. The chair placement was considered a restraint.</p> <p>During an interview, on 2/9/24 at 1:22 p.m., Resident B indicated he did not need a chair to elevate his feet while in his recliner. He demonstrated he could elevate the footrest of the recliner. There was no dining room chair in his room. The resident did not want to discuss the</p>			

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	<p>incident when a chair was used to keep his footrest elevated. The resident was observed to be unsteady in his gait and his ability to move without assistance from a staff member. The resident had difficulty with speech and cognition when answering questions.</p> <p>A current facility policy, titled "ABUSE; IDENTIFICATION, PREVENTION, AND REPORTING," dated as revised 5/7/20 and received from the DON on 2/9/2024 at 4:50 p.m., indicated "...Abuse: the willful infliction of injury, unreasonable confinement intimidation or punishment...Involuntary Seclusion/ abandonment: Action or inaction that leaves the resident without ability to obtain food, clothing, shelter or care...or confinement to his/her room against the resident's will...."</p> <p>This citation relates to Complaint IN00427195.</p> <p>3.1-3(w)</p>			