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	07/18/2023

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 the Investigation of Complaint IN00412481. Complaint IN00412481 - Federal/State deficiencies related to the allegations are cited at F604. Survey dates: July 17 and 18, 2023. Facility number: 001134 Provider number: 155787 AIM number: 200817200 Census bed type: SNF/NF: 119 Total: 119 Census payor type: Medicare: 3 Medicaid: 71 Other: 45 Total: 119 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 21, 2023.	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 July 17 and 18, 2023. Please accept this plan of correction as the Indiana Veterans' Home credible allegation of compliance. Indiana Veterans' Home respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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. The resident has a right to be treated with respect and dignity, including: §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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Gibson	Superintendent	08/02/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	symptoms, consistent with §483.12(a)(2). §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. §483.12(a) The facility must- §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.			
	Based on interview and record review, the facility failed to ensure a resident was free from restraints for 1 of 6 residents reviewed for abuse allegations. (Resident C) Findings include: An incident report sent to the Indiana Department of Health indicated on 7/8/2023 at 6:30 a.m., Resident C was found during morning rounds to have the foot of his bed elevated to prevent him from getting out of his bed during the night. Resident C was on a locked memory unit. It was reported CNA 2 had elevated the resident's bed during the night to prevent the resident from exiting the bed. Resident C was allowed out of his bed after discovery and was monitored for any	F 0604	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident C's foot of bed was lowered upon discovery of alleged restraint. Resident C was monitored for signs of distress with no signs noted. Resident C's family was notified of foot of bed elevated causing alleged restraint. CNA 2 was removed from care of all residents at Indiana Veterans' Home and reported to the Attorney General for restraint of a resident. **How other residents having the**	08/11/2023

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	signs and symptoms of distress. The record for Resident C was reviewed on 7/18/2023 at 12:15 p.m. Diagnoses included, but were not limited to, hypertension, cognitive communication deficit, dementia, insomnia, violent behavior, and muscle weakness. The resident had a BIMS (Brief Interview for Mental Status) of 00 which indicated the resident was severely impaired cognitively. A nursing note, dated 7/8/2023, indicated CNA 2 gave report to the oncoming morning staff. She indicated she had elevated Resident C's foot of his bed to prevent him from getting out of bed throughout the night. She indicated the resident had been out of bed twice that night. A facility conducted interview, on 7/8/2023, noted CNA 7 indicated during report CNA 2 reported the resident had been up a couple of times during the night and she then raised the foot of his bed all the way up so he could not get out of bed. A facility conducted interview, on 7/9/2023, noted LPN 3 indicated the CNA staff on duty in the a.m. shift of 7/8/2023 informed her CNA 2 reported she had elevated the resident' bed to keep him from getting up on the night shift. The CNA staff found the resident with his legs elevated and head lowered so he could not get out of bed. A facility interview with CNA 2 conducted by ADON 5 (Assistant Director of Nursing), on 7/10/2023 at 10:45 a.m.., indicated she did elevate the bed of Resident C. She elevated the foot of the bed high enough so he could not get out of bed. She indicated she did not think it was a restraint.		**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 for this alleged deficient practice. Inservice education will be provided by DON/Designee to all staff regarding restraints by August 11, 2023. An audit of all residents will be completed by August 11, 2023 to check for restraints. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** DON/Designee will provide education to all staff on restraints by August 11, 2023. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** 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 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:** August 11, 2023	

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	A facility conducted interview, on 7/10/2023, noted Social Service staff 9 indicated the resident was not able to recall the incident, and had no concerns with the staff member involved in the incident. His conversation was non-sensical. The resident was in no distress and there were no psychosocial concerns at the time of her visit. A facility conducted interview, on 7/11/2023, noted CNA 8 indicated during report when they got to the resident's room CNA 2 reported the resident had been up a couple of times during the night and she then raised the foot of his bed all the way up so he could not get out of bed. The resident's bed was legs high and head low. During an interview, on 7/17/2023 at 1:50 p.m., ADON 5 indicated he interviewed CNA 2, on 7/10/2023, and she admitted to raising the resident's bed to keep him from getting out of bed during the night shift. She indicated the resident had been up twice during the night and he needed to stay in bed so to prevent him from getting out of the bed, she elevated the leg section of his bed. CNA 2 did not think elevating the bed and keeping the resident from getting out of bed was a restraint. CNA 2 was an agency staff member, and the agency was notified of the incident. The action by CNA 2 was a restraint and was considered abuse. During an interview, on 7/17/2023 at 1:50 p.m., Resident C indicated the foot of his bed had been put up by a staff member one time. When asked if he could get out of bed when the foot part of his bed was in the up position, the resident answered yes. The resident did not exhibit any violet behavior or signs or symptoms of distress during the interview. The resident did have a speech			

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	problem which made it difficult to understand some of his conversation, which was non-sensical. During an interview, on 7/17/2023 at 2:20 p.m., LPN 3 indicated she was made aware of the situation, and immediately assessed the resident. The resident had no signs or symptoms of distress. The resident was allowed to get out of bed, the foot of the bed was lowered, and an investigation was started. During an interview, on 7/18/2023 at 3:30 p.m., the Superintendent indicated CNA 2 was suspended from the facility indefinitely. CNA 2 did restrain the resident. The resident did not show any signs or symptoms of distress from the restraint. CNA 2 willfully restrained Resident C to prevent him from getting out of his bed. CNA 2 was reported to the Attorney General for abuse. During an observation and interview, on 7/18/2023 at 4:00 p.m., with the Superintendent a visual tape for the night of 7/8/2023 showed the resident was last up at 4:04 a.m. The tape did not show the resident up after 4:04 a.m. A current facility policy, titled "ABUSE; IDENTIFICATION, PREVENTION, AND REPORTING," revised 5/7/20 and received from the Superintendent on 7/17/2023 at 4:50 p.m., indicated "...Abuse: the willful infliction of injury, unreasonable confinement intimidation or punishment...4. 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...." This Federal tag relates to Complaint IN00412481			

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