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	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indiana Veterans Home	3851 N River Rd West Lafayette, IN 47906

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 32362 Based on interview and record review, the facility failed to ensure a resident with a diagnosis of dementia was free from a physical restraint used to inhibit freedom of movement for 1 of 2 residents reviewed for restraints. (Resident B) The deficient practice was corrected on 3/31/25, prior to the start of the survey, and therefore was past noncompliance. Findings include: A facility reported incident (FRI) indicated, on 3/29/25 at 9:25 a.m., Resident B was found to have the foot of his bed elevated to prevent him from getting out of his bed during the night. Resident B was on a locked memory care unit. It was discovered Resident B's bed was elevated and a pillow was placed under his mattress. The night shift indicated the resident was restless and had attempted to get out of his bed multiple times during the shift. The clinical record for Resident B was reviewed on 4/11/25 at 10:30 a.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, major depressive disorder, and unsteadiness on feet. A Brief Interview for Mental Status (BIMS) assessment indicated the resident was severely cognitively impaired. A nursing progress note, dated 3/29/25, indicated Resident B was trying to get out of bed. A pillow had been placed under the edge of the mattress and the foot of his bed was significantly elevated upon entering the resident's room this morning. Shift-to-shift report indicated the resident had been restless and attempted to get out of his bed multiple times throughout the night shift. During a facility documented interview, on 3/29/25, LPN 10 indicated she was summoned to Resident B's room by CNA 11 and 12 at 8:30 a.m. Upon entering the resident's room, she observed a pillow had been placed under the edge of the resident's mattress and the bed frame which propped the center of the mattress up. The foot of his bed was elevated significantly. LPN 10 indicated during shift change report she was told the resident had made several attempts to get out of bed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a facility documented interview, on 3/29/25, CNA 11 indicated she went into Resident B's room with another staff member, at 8:30 a.m., to get the resident up for his shower. When she pulled down his blanket, she noticed a pillow under his mattress and reported it to the nurse. During shift change report, it was indicated Resident B had tried to get up a lot during the night. The foot of the bed was also elevated quite a bit. During a facility documented interview, on 3/29/25, CNA 12 indicated she went with another staff member to transfer Resident B to his wheelchair. When his blankets were lifted, she noticed a pillow under the mattress and the foot of the bed was elevated. She indicated during shift change a comment had been made regarding the resident having made several attempts to get out of bed last night. During a facility documented interview, on 4/1/25, CNA 13 indicated she worked the evening shift, on 3/28/25. She did notice a pillow was placed at the foot of Resident B's bed as she assisted the resident to get up. She did not think anything about the situation at the time. During an interview, on 4/10/25 at 3:50 p.m., the Assistant Director of Nursing (ADON) 4 indicated he had interviewed staff regarding the incident with Resident B. The night shift staff reported that the resident was restless and had attempted to get out of bed multiple times during the night. The staff did not admit to elevating the resident's bed or placing a pillow under his mattress. He indicated those actions were considered a restraint and abuse. All staff members on the memory care unit received an in-service on abuse and the unit was monitored for restraints. During an interview, on 4/10/25 at 4:30 p.m., the Superintendent indicated the resident should not have had the foot of his bed elevated to prevent him from exiting his bed. The staff did not admit to elevating the resident's bed. The residents were being monitored for restraints and staff were in-serviced on abuse. A current facility policy, titled ABUSE; IDENTIFICATION, PREVENTION, AND REPORTING, dated as revised 4/1/24 and received from the Superintendent on 4/10/25 at 4:50 p.m., indicated .Abuse: the willful infliction of injury, unreasonable confinement intimidation or punishment .Involuntary Seclusion: Involuntary seclusion is defined as separation from other residents or from the resident's room or confinement to resident's room (with or without roommates) against the resident's will The deficient practice was corrected by 3/31/25, after the facility implemented a systemic plan which included a thorough investigation, an in-service of staff regarding abuse, a room sweep for restraints of residents and rooms, and on-going audits. This citation relates to Complaint IN00456532. 3.1-3(w)