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	12/08/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity for 2 of 2 residents reviewed for resident rights. (Resident B and 73)Findings include:1. A facility witness statement, dated 9/22/25, indicated LPN 4 told CNA 6 she needed to give Resident B a suppository and advised CNA 6 when she provided resident care, LPN 4 would give it to him. When CNA 6 provided care, LPN 4 came into the room. As the resident was facing the wall, LPN 4 put on her gloves, gave the suppository, and the resident immediately yelled out. Resident B said the nurse was supposed to ask him before she gave him the suppository and Resident B did not want the suppository. LPN 4 told the resident he had not had a bowel movement in days and he needed it. Resident B again told the nurse he did not want it. LPN 4 told him he could push it out, like if he had a bowel movement, and left the room. A facility incident report, dated 9/23/25, indicated LPN 4 administered Resident B a suppository and did not inform or get permission from the resident first. The resident was displeased he was not informed and received the suppository. The clinical record for Resident B was reviewed on 12/3/25 at 1:13 p.m. The diagnoses included, but were not limited to, bradycardia, hypotension, congestive heart failure, and obstructive hypertrophic cardiomyopathy. A physician's order, dated 7/17/24, indicated to administer a bisacodyl 10 milligram (mg) suppository per the rectum every three (3) days as needed (prn) for no bowel movement. A care plan, dated 2/9/23, indicated the resident displayed paranoia and inappropriate sexual behaviors. Interventions included, but were not limited to, when providing care, such as hygiene or changing, allow the resident to complete as many tasks independently as he can to minimize touching or opportunities for inappropriateness, prior to providing care, remind the resident he needed to keep his hands away from staff members and provide cues to the resident as needed. A care plan, dated 9/17/25, indicated Resident B was at risk of constipation. Interventions included, but were not limited to, administer medication when needed. During an interview, on 12/3/25 at 2:02 p.m., the Director of Nursing (DON) indicated LPN 4 gave Resident B a suppository without permission and did not tell him what she was going to do. The nurse should always inform the resident when doing any type of care. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 12/3/25 at 3:04 p.m., CNA 6 indicated LPN 4 informed her Resident B needed a suppository and when she provided the resident care to find her. CNA 6 was in the resident's room, and the resident was lying on his left side facing the wall. LPN 4 entered the resident's room and without saying a word, LPN 4 put on gloves, approached the resident facing the wall and gave the resident the suppository. The resident did not see LPN 4 and was extremely upset when he received the suppository. LPN 4 did not notify the resident he was getting a suppository or of the option to refuse the suppository. LPN 4 turned around without saying a word to the resident, removed her gloves, and walked out of the room. During an interview, on 12/8/25 at 11:42 a.m., LPN 3 indicated a nurse should explain to a resident what was going to happen and the option to refuse. 2. a. A facility witness statement, dated 10/17/25, indicated CNA 7 told Resident 73 he needed to stop hitting his call light and she wasn't dealing with his crap today. During lunch, CNA 7 yelled at Resident 73 when she dropped a plate and told him it was his fault, she dropped the plate and stated, look what you made me do. A facility incident report, dated 10/17/25, indicated CNA 7 made rude and inappropriate statements to Resident 73 about the use of his call light. b. A facility witness statement, dated 11/25/25, indicated CNA 7 told Resident 73 she wasn't going to lay him down after lunch and he was not allowed to sit there and press his call light repeatedly. CNA 7 was informed she had to lay the resident down as it was his right to do so. A facility incident report, dated 11/25/25, indicated CNA 7 talked inappropriately to Resident 73. A facility witness statement, dated 11/25/25, indicated CNA 9 helped CNA 7 lay Resident 73 down in bed. While care was being provided, CNA 7 talked over Resident 73 when he was trying to say something and told him, We are laying you in bed like you wanted, you got your way. The clinical record for Resident 73 was reviewed on 12/5/25 at 11:53 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, cardiomegaly, dementia, depression, cerebrovascular accident (stroke), and hemiplegia and hemiparesis affecting the left side. A care plan, dated 10/28/25, indicated the resident needed assistance with care tasks due to weakness, decreased mobility, and decreased cognition related to a history of a stroke with left side contractures. Interventions included, but were not limited to, the resident needed assistance with sitting and lying and chair to bed transfers, transfer with mechanical lift and 2 staff assist, and to encourage the use of the call light as needed. During an interview, on 12/3/25 at 2:05 p.m., the Director of Nursing (DON) indicated CNA 7 would get irritated with Resident 73. Staff should not talk to the residents in a negative way. A current facility policy, titled Liberalized medication pass, dated as revised 10/2025 and received by the Superintendent on 12/5/25 at 12:42 p.m., indicated .to administer medications in a safe manner while honoring the resident's wishes in their daily activity .provide an environment as close to homelike as possible for all the residents residing in this population and give as many choices as possible to its residents .follow 6 rights when passing medication (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Implementation of resident rights, dated as revised 8/2013 and received by the Superintendent on 12/5/25 at 12:42 p.m., indicated .annual in-services and ongoing training will be performed with the protection of Resident rights promoted in all applicable aspects of the staffs' performance of duties .Contract service providers shall also be provided training as indicated .Facility staff and contract health care providers will inform Residents in advance, in language and terms the Resident understands, of any changes in care and treatment. Information will be provided whenever the Resident asks, when an assessment is performed, during treatments, medication administration . in order to assure the Resident is able to give informed consent .dignity and respect of each resident.staff are trained to assure this quality of life is maintained by .residents will be included in conversations being held in their presence and spoken to when being provided care or assistance with activities of daily living .residents will be supported in their desire to choose activities, schedules and health care consistent with their own interests and needs This citation relates to Intake 2624760. 3.1-3(t)