	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILD	IPLE CONSTRUCTION DING <u>00</u>	(X3) DATE SURVEY COMPLETED	
		155780	B. WING		02/	16/2022
NAME OF	PROVIDER OR SUPPLIE	R		TREET ADDRESS, CITY, STATE, ZI 465 MADISON AVE	P COD	
HOMES	TEAD HEALTHCA	RE CENTER	11	NDIANAPOLIS, IN 46227		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		D PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI	CORRECTION IN SHOULD BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	T.	AG DEFICIENCY		DATE
0000						
Bldg. 00						
0	This visit was for t	the Investigation of Complaint	F 0000	This Plan of Correc	tion is the	
		0372387, IN00373289, and		center's credible al	llegation of	
		s visit resulted in a Partially		compliance.		
		Substandard Quality of Care-		Preparation and/or		
	Immediate Jeopard	ıy.		this plan of correct constitute admission		
	Complaint IN0037	73289- Substantiated.		agreement by the p		
	-	viencies related to the		the truth of the fact		
	allegations are cite	ed at F684 and F558.		conclusions set for		
	Complaint IN0037	2277 Substantiated.		statement of deficient of deficient of correction in the state of correction in the state of the		
	-	ciencies related to the		and/or executed so		
		ed at F600, F609, F610, F580,		it is required by the	-	
	F656, F657, F689,	F726, F742, F745, and F835.		of federal and state	-	
	Complaint IN0037	2387. Substantiated.				
	Federal/State defic	viencies related to the				
	allegations are cite	ed at F690, F641, F558, and F684.				
	Complaint IN0037	2425 - Substantiated.				
	Federal/State defic	ciencies related to the				
	U	ed at F684, F656, F558, F600,				
	F609, and F610.					
	Survey dates: Febr	ruary 2, 7, 8, 9, 10, 11, 14, 15,				
	and 16, 2022					
	Facility number: 0	12225				
	Provider number:					
	AIM number: 200	983560				
	Census Bed Type:					
	SNF/NF: 103					
	Total: 103					
	Census Payor Typ	e:				
	Medicare: 6					

#### CTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

	Г OF HEALTH AND HU R MEDICARE & MEDIO						TED: 03/31/2022 RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		-	7465 N	ADDRESS, CITY, STATE, ZIP COD IADISON AVE IAPOLIS, IN 46227	-	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0558 SS=D Bldg. 00	accordance with 4 Quality review con 483.10(e)(3) Reasonable Acco Needs/Preference §483.10(e)(3) Th services in the fa accommodation of preferences exce endanger the heat or other residents Based on interview failed to ensure a r in relationship to t obesity and fractur residents reviewed (Resident H) Finding includes: The clinical record on 2/7/22 at 2:40 p (Minimum Data So indicated the resid diagnoses included morbid obesity, fra chronic lympheder A review of Residu 12/24/21, indicated wheelchair. There	<ul> <li>mpleted on February 24, 2022.</li> <li>pommodations</li> <li>es</li> <li>e right to reside and receive cility with reasonable of resident needs and ept when to do so would alth or safety of the resident s.</li> <li>w and record review, the facility esident had a means of mobility heir diagnoses of morbid e of the left lower leg for 1 of 2 for accommodation of needs.</li> <li>I for Resident H was reviewed o.m. An Admission MDS et) assessment, dated 12/18/21, ent was cognitively intact. The l, but were not limited to, acture of left lower leg, and</li> </ul>	F 05	558	1) Immediate actions taken for those residents identified: Resident H was not harmed by alleged deficient practice. Resident H was interviewed by surveyor and it was determine that she had a proper and accessible wheelchair for transportation and mobility. Resident H also acknowledged that she was able to attend he appointments in her wheelchai the facility van without difficulti The ED/DON have interviewed resident H who confirmed to the that her current wheelchair me her needs and she has not mis any appointments since she received this wheelchair. The MDS assessment does not require assessment of need for	y the d d r ir via ies. d nem eets ssed	03/25/2022

residents need for a bariatric wheelchair due to

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Facility ID: 012225

bariatric wheelchair versus a

If continuation sheet Pa

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#### DEPARTMENT OF HEALTH AND H

	Г OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED IB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155780		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING			survey leted /2022
	PROVIDER OR SUPPLIE			7465 M	ADDRESS, CITY, STATE, ZIP COD ADISON AVE APOLIS, IN 46227	-	
(X4) ID PREFIX TAG	TIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	12/18/22, indicated document to be 44	ent H's care plan, dated l Resident H's weight was 5 pounds and would require a ir and/ or a bariatric stretcher for			standard wheelchair; the MDS requires documentation of wh assistive device is utilized for mobility such as a wheelchair walker.	at	
	mobilization and the ability to get to appointments.				2) How the facility identified other residents: All residents who require		
	1:15 p.m., she indi	w with the DON, on 2/14/22 at cated she had made several ariatric stretcher for Resident H.			wheelchairs have the potentia be affected by the alleged def practice. All residents requirin	icient	

method.

wheelchair will have an audit

conducted to ensure that each

resident has a means of mobility

and that they are able to attend

appointments without difficulty related to their transportation

3) Measures put into

place/System changes:

continuing to ensure that appointments are made and

appointments.

will be monitored:

The Director of Nursing/Designee

proper equipment is provided prior to resident's appointments so that the residents can safely attend

4) How the corrective actions

The DON/Designee will audit all admissions to ensure that each resident has the appropriate means for mobility based upon their assessed condition. This is an ongoing facility practice. The DON/designee will audit 3

will in-service nursing staff on

This Federal tag relates to Complaints IN00372425, IN00373289, and IN00372387.

The DON indicated Resident H was only able to

use one type of transportation company. As of

January 12, Resident H had been able to attend

wheelchair and transportation via the facility van.

During an interview with Resident H, on 2/15/22 at

2:50 p.m., Resident H indicated her new wheelchair was comfortable and she had been able to make it

scheduled appointments with a "larger"

3.1-3(v)(1)

to her appointments.

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155780	A. B	MULTIPLE CO SUILDING /ING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE			7465 N	ADDRESS, CITY, STATE, ZIP IADISON AVE JAPOLIS, IN 46227	COD	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
= 0580 SS=D Bldg. 00	§483.10(g)(14) N (i) A facility must resident; consult physician; and no her authority, the when there is- (A) An accident in results in injury a requiring physicia (B) A significant of physical, mental, (that is, a deterion psychosocial stat	s (Injury/Decline/Room, etc.) otification of Changes. immediately inform the with the resident's otify, consistent with his or resident representative(s) nvolving the resident which and has the potential for			residents' transportati arrangements 3 times weeks and 3 residents time weekly thereafter months to ensure that transportation is arran proper equipment on appointments. Audits/ will be conducted rand across all 3 shifts, and weekends. DON/Designee is resp the compliance. The r these audits will be re Quality Assurance Co monthly meetings for until 100% compliance x 3 consecutive month Committee will identify or patterns and make recommendations to r plan of correction as i	a week x 4 s' records 1 r for 5 t nged with hand before domly, d will include ponsible for results of eviewed in ommittee 6 months or e is achieved hs. The QA y any trends	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	COM	(X3) DATE SURVEY COMPLETED 02/16/2022	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CO MADISON AVE	D		
HOMES	HOMESTEAD HEALTHCARE CENTER			ANAPOLIS, IN 46227			
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF	ULD BE	(X5) COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	(that is, a need to form of treatment consequences, or of treatment); or (D) A decision to resident from the §483.15(c)(1)(ii). (ii) When making (g)(14)(i) of this se ensure that all per in §483.15(c)(2) upon request to to (iii) The facility m resident and the any, when there (A) A change in r assignment as sp (B) A change in r or State law or re paragraph (e)(10 (iv) The facility m	r to commence a new form transfer or discharge the facility as specified in notification under paragraph section, the facility must ertinent information specified is available and provided he physician. ust also promptly notify the resident representative, if is- oom or roommate becified in §483.10(e)(6); or esident rights under Federal egulations as specified in ) of this section. ust record and periodically ess (mailing and email) and the resident					
	facility that is a c defined in §483.5 admission agree configuration, inc that comprise the and must specify room changes be under §483.15(c)	eluding the various locations composite distinct part, the policies that apply to etween its different locations (9).					
	failed to notify the that had been drin	v and record review, the facility physician for a male resident king alcohol in the facility behavioral symptoms of	F 0580	1) Immediate actions ta those residents identifi Resident B no longer res the facility. The physicia	<b>ed:</b> sides in	03/25/202	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465 M	ADDRESS, CITY, STATE, ZIP COD ADISON AVE APOLIS, IN 46227		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
TAG	<ul> <li>physical, sexual, a residents for 1 of 2 notification. (Residential Finding includes:</li> <li>During an interviee indicated on 1/28/2 out of a cup that success could be verbally a drinking alcohol. I Resident D severa overheard other stanurse's station. The been reported but have been reported was unable to rem heard discussing the During an interviee Resident E indicate he would get violed before last, Resident and in her face and knock you out of the a member of the rew would take care of The clinical record on 2/2/22 at 12:30 but were not limited and alcohol abuse.</li> <li>The Quarterly Min assessment, dated was cognitively in assistance of one set</li> </ul>	f for Resident B was reviewed p.m. The diagnoses included, ed to, major depressive disorder	TAG	notified of resident B's alcohol consumption upon the facility becoming aware of the informat through investigation. <b>2) How the facility identified</b> <b>other residents:</b> Any resident residing in the fac who consumes alcohol withour physician's order has the potent to be affected by the alleged deficient practice. An audit was conducted on all residents wh have a history of alcohol use a the physician and family were notified of any findings. If justiff the resident's plan of care was updated accordingly, a behavio contract was initiated, and alco counseling was offered. If a resident consumes alcohol witt a physician's order, the physic and family will be or were notifi and behavior modifications implemented, if warranted. <b>3) Measures put into</b> <b>place/System changes:</b> The DON/Designee in-serviced nursing staff on the facility's existing policy identified as "Change in Condition" with emphasis on notification made immediate Supervisor/MD/PO/ with any change of condition/behavior/alcohol consumption, including the expectation that staff would adhere to the exiting policy and	ation bility t a ntial s o nd ied, or ohol hout ian ied d all t to A	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/16/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
HOMESTEAD HEALTHCARE CENTER				NAPOLIS, IN 46227		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	Resident B's alcoh During an intervie Director of Nursin should have been a consumption and b On 2/7/22 at 11:00 provided a copy of "Physician Notific Reporting," dated the current policy the policy indicate documented exten will report immedi behavioral sympto	a.m., the Director of Nursing f a facility policy, titled ation for Change in Condition 8/1/16, and indicated this was used by the facility. A review of d "Unless there are uating circumstances, the nurse iatelynew or worsening	TAG	DEFICIENCY) consequences in accordance the facility's progressive discip policy. 4) How the corrective actions will be monitored: Behaviors and/or change of condition will be reviewed by a Interdisciplinary Team and/or designee in the clinical mornin meeting to ensure each reside change of condition is reporte physician /psych services /fam member/DON. This is an onge facility practice that will contin DON/designee will audit 3 residents' records 3 times a w x 4 weeks, then 3 residents' records 1 time weekly thereaf for 5 months to ensure behavit monitoring orders are in place care plans are updated. DON/Designee will interview & random staff members 5 times week for 4 weeks and then 3 s members for 2 week to ensure compliance and accurate reporting. Audits/observation be conducted randomly, across 3 shifts, and will include weekends. The DON/Designed responsible for compliance. The results of these audits will reviewed in the Quality Assura Committee monthly meetings months or until 100% compliad is achieved x 3 consecutive months. The QA Committee we identify any trends or patterns	DATE       with       pline       s       the       ng       pent's       d to       nily       poing       ue.       reek       ter       ior       and       5       s a       staff       n 1       re       will       ss all       ee is       l be       ance       for 6       nce       will	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0600 SS=K Bldg. 00	Exploitation The resident has abuse, neglect, n property, and exp subpart. This inc freedom from con involuntary seclu chemical restrain resident's medica §483.12(a) The fi §483.12(a)(1) No	n from Abuse, Neglect, and the right to be free from hisappropriation of resident ploitation as defined in this ludes but is not limited to poral punishment, sion and any physical or t not required to treat the al symptoms. acility must- t use verbal, mental, sexual,		make recommendations to revis the plan(s) of correction as indicated.		
	<ul> <li>g405.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</li> <li>A. Based on observation, interview and record review, the facility failed to prevent sexual and physical (death) abuse resulting in a female resident being physically and sexually abused by a male resident for 2 of 4 residents reviewed for abuse. (Residents C, Resident B)</li> <li>B. Based on interview and record review, the facility failed to prevent verbal abuse resulting in 2 female residents being threatened with physical and sexual abuse by a male resident that was not Immediate Jeopardy for 3 of 4 residents reviewed for abuse. (Residents D, Resident B, Resident E)</li> <li>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 2/2/22 at approximately 5:00 a.m., when the facility failed to prevent physical (death) and sexual</li> </ul>	F 0600	<ol> <li>The facility failed to prever sexual, physical (death) and ver abuse for 3 of 4 residents review for abuse. A female resident we found with a male a resident on top of her with his pants off and her legs spread and brief pulled the side. The male resident was holding a pillow over her head. The female resident was deceased. complete head to toe assessme was completed for any other affected residents. Any findings were reported to the physician a family.</li> <li>Immediately separated the residents and the licensed nurse evaluated the residents.</li> </ol>	bal ved as to The A nt nd		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155780		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 7465 MADISON AVE INDIANAPOLIS, IN 46227				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR	DBE	COMPLETIC	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	abuse. The Admin	istrator, Administrator in		• The male resident v	vas		
	-	of Nursing, and the Regional		immediately placed on 1:1			
		g were notified of the Immediate		supervision in his room.			
		2 at 5:00 p.m. The Immediate		• The female resident	twas		
	Jeopardy was rem	oved on 2/10/22 at 2:40 p.m., but		noted to be without pulse	or		
	-	nained at the lower scope and		respirations and DNR adv	anced		
		attern, no actual harm with		directives were validated.			
		than minimal harm that is not		<ul> <li>The DON was notifi</li> </ul>	ed of		
	Immediate Jeopard	ły.		incident and IMPD notified	l.		
				Staff in the building			
	Findings include:			validated that all other res	idents		
				were secure and accounte	ed		
	A. During the initi	al tour of the facility, on 2/2/22		for-noted no other concerr			
	from 11:40 a.m. to	12:15 p.m., Resident C was in her		residents safe and secure			
	room with Police	Officers standing guard at the		· IMPD assumed			
	door. Resident C c	ould not be observed from the		responsibility for the male	resident		
	hallway. Resident	B was in his room, located on a		and continued 1:1 through	out day		
	different unit in th	e facility, with a Police Officer		until departure with detect	ives.		
	standing guard at t	he door to the room. Resident		<ul> <li>Medical Director was</li> </ul>	S		
	B was observed si	tting up in his electric		notified of the event.			
	wheelchair staring	at the hallway with a flat affect		Marion County Core	oner and		
	(showing no emotion	ion on his face).		Detectives are at the facili	ty		
				directing the investigation.			
	The clinical record	l for Resident B was reviewed		· Self-report Incident			
	on 2/2/22 at 12:30	p.m The diagnoses included,		submitted to ISDH gatewa	у.		
	but were not limite	ed to, major depressive disorder		· Call placed to Area			
	and alcohol abuse.	The Quarterly Minimum Data		Supervisor and discussed	event.		
	Set (MDS) assessr	nent, dated 1/12/22, indicated		· The female resident	i's body		
	Resident B was co	gnitively intact, required		was released to the Coror	ier.		
	extensive assistant	e of one staff member for bed		· In-service initiated of	on		
	mobility and trans	fers, and had moderate		existing facility policy for A	buse		
	depression.			prevention, investigation, a	and		
				reporting, behavior monito	ring,		
	The current physic	ian's order, indicated Resident		sexual behavior monitoring	g		
	B could have alcol	nolic beverages, with a start		including reinforcing the			
	date of 10/8/21.			expectation that facility po	licy		
				would be followed and ren			
	The clinical record	l for Resident C was reviewed		staff of the consequences	•		
	on 2/2/22 at 12:15	p.m. The diagnoses included,		to follow this policy.	-		
		ed to, acute and chronic		· Residents educated	l again		
					5		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155780	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/16/2022
	PROVIDER OR SUPPLIE		7465 M	ADDRESS, CITY, STATE, ZIP COD ADISON AVE APOLIS, IN 46227	-
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	respiratory failure, heart failure, and of An Admission Init 3:15 p.m., indicate bedfast (confined t limited (she made body or extremity frequent or signifie During an intervie (Qualified Medica entered Resident C lying on top of Re- down. Resident C' Resident B's hand. Resident C and lef pillow from Resid- without clothing, F leg, and her incont side. During an intervie (Licensed Practica approximately 5:0) station for the 100 to the nurse's static what she saw. QM "come on, come on C's room, he saw F approximately a fo with his pants dow electric wheelchain approximately a fo trying to sit in the and confused when The nurse smelled trying to speak. Th on the floor. Resid	R LSC IDENTIFYING INFORMATION morbid obesity, congestive obstructive sleep apnea. ial Evaluation, dated 1/28/22 at d Resident C was nonverbal, o bed), and mobility was very occasional slight changes in position but unable to make cant changes independently). w on 2/3/22 at 5:10 p.m., QMA tion Aide) 1 indicated she C's room and Resident B was sident C, in bed, with his pants is face was covered with Resident B jumped off of t the room. QMA 1 removed a ent C's face. Resident C was had a small scratch to her left inence brief was pulled to the w on 2/7/22 at 10:20 a.m., LPN 1 Nurse) 2 indicated on 2/2/22 at 0 a.m., he was at the nurse's and 200 Hall. QMA 1 had come on and was unable to verbalize A 1 grabbed his hand and said, n." When he entered Resident Resident B standing bot away from Resident C's bed in to his ankles. The resident's twas inside the room, bot behind him. Resident B was wheelchair but was unsteady in trying to speak to the nurse. alcohol when Resident B was here was a large bottle of dry gin ent B was escorted out of and immediately placed on	TAG	<ul> <li>on reporting abuse to facility s and staff's commitment to act upon any such report.</li> <li>SSD is following up with any affected resident and notifying psychologist, physician, and family for additional support. O plans updated as needed.</li> <li>2. All other residents had t potential to be affected. Abuse interviews were completed with alert and oriented residents to identify any concerns. Reside who could not be interviewed underwent a head to toe skin assessment with no findings.</li> <li>staff were interviewed to deter if they were aware of any allegations that may constitute abuse. Any findings were rep to ISDH and other reporting agencies. Families and physic have been notified. SSD is following up with any affected resident and notifying psychologist, physician, and family for additional support. O plans updated as needed. Behavior monitoring of all residents was reviewed to ide any increased behaviors or behaviors requiring physic notification or nursing interver Through resident and staff interviews behaviors were rev to identify any behavior that constitutes abuse or requires follow-up. Any concerns were immediately addressed to the</li> </ul>	DATE DATE

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155780	B. WING			02/16/2022	
JAME OF	PROVIDER OR SUPPLIE	۲. ۲.			ADDRESS, CITY, STATE, ZIP COD		
					IADISON AVE		
HOMES	TEAD HEALTHCA	RE CENTER		INDIAN	IAPOLIS, IN 46227		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	-	vision with another staff			residents' satisfaction.		
		C was lying in bed, on her back,					
		part and her face looking at the			3. The facility needs to ens		
		C did not have a pulse, but her			abuse does not occur and that		
	body was warm to	touch.			any abuse allegation is reported		
					and investigated in accordanc		
	-	w on 2/3/22 at 5:24 p.m., CNA			with existing facility policy. All		
		Assistant) 1 indicated, on			allegations of abuse or a conc		
		entered Resident C's room the			that may constitute abuse will		
	resident's brief wa	s pulled to the side.			reported to the Executive Dire	ctor	
					immediately. DON/Designee		
	e	w on 2/7/22 at 8:53 a.m., QMA 2			educated all staff on the existi	ng	
		B seemed depressed over the			facility policy identified as,		
	past few weeks be	cause his roommate moved out.			"Indiana Abuse, Neglect, and		
					Misappropriation", with empha	isis	
	On 2/2/22 at 2:06	p.m., Resident B was observed to			on reporting and investigating	and	
	be handcuffed and	assisted into the back of the			reinforcing the expectation this	S	
	police van. He req	uired minimal assistance from			policy will be followed includin	g	
	the police officer.	Resident B stepped up into the			discussion of the consequence	es of	
	back of the van.				not following facility policy for	both	
					the residents and staff. In-serv	/ices	
	B.1. During an int	erview on 2/7/22 at 9:00 a.m.,			on the facility's abuse prevent	ion,	
	QMA 3 indicated	on 1/28/22 Resident B had been			investigation, and reporting po	olicy	
	drinking out of a c	up that smelled like alcohol. The			will be conducted once a quar	ter.	
	resident could be	verbally aggressive when he			Alert and oriented residents v	vere	
	had been drinking	alcohol. Resident B threatened			educated and encouraged to		
	to rape Resident D	several times on $2/1/22$ . The			report any acts of abuse or re	ports	
	QMA had overhea	rd other staff discussing this at			of abuse to facility staff. All ne	w	
	the nurse's station.	The QMA was not sure if this			hires will continue to receive		
	had been reported	but indicated the threats			education during their orientat	ion	
	should have been	reported to the supervisor. The			on the facility's Abuse policy, t	the	
	QMA was unable	to remember which staff			expectation that this policy wil	l be	
	members she hear	d discussing this at the nurse's			followed, and the consequenc	es of	
	station.				not following this policy. All		
					residents are screened prior to	C	
	During an intervie	w on 2/7/22 at 9:20 a.m.,			admission to validate		
	Resident D indicat	ted on 2/1/22 at approximately			appropriateness of placement	,	
		t B began making inappropriate			including but not limited to		
	-	oward her. Resident B indicated			checking the sex offender reg	istry.	
	to Resident D that	he was going to "eat between			Any resident who is not		

Event ID: 26YZ11 Facility ID: 012225

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DAT	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155780	A. BUILDING B. WING	00		COMPLETED 02/16/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP C	OD		
	TEAD HEALTHCA			5 MADISON AVE ANAPOLIS, IN 46227			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	RECTION IOULD BE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE	
		e comments about Resident D's		appropriate will be den	ied		
		B laughed and said, "just wait		admission. Care plans			
		vait until tonight." Resident B		implemented for any as			
		these comments several times		behavior that has the p			
		y. Resident D reported this to		impact other residents			
	-	:00 p.m. on $2/1/22$ . At that time,		An Ad Hoc Resident Co	0,		
		to her (Resident D) not to worry		meeting was held and t			
	because she would	· · · ·		for reporting abuse was	-		
				including but not limited			
	The clinical record	l for Resident D was reviewed		facility's grievance proc			
		a.m. The diagnoses included,		including the ability to r			
		ed to, debility, morbid obesity,		concerns anonymously	-		
		nce of right and left legs above		abuse to the Executive			
	-	rterly MDS assessment, dated		any facility staff member			
		d Resident D was cognitively		education was also pro			
	intact.	6 7		the reporting guidelines			
				investigation, and follow			
	B.2. During an inte	erview on 2/7/22 at 9:50 a.m.,		Monthly Resident Cour			
	-	ed Resident B told her she was		meetings will review an			
		ed to buy her jewelry. She said		related to abuse and/or	•		
		dent B) got drunk, he would get		Those concerns will be			
		s a day, the week before last,		the Executive Director			
		of his wheelchair and in her		immediately and report	ed per		
		ı f**king b*tch, I'll knock you		facility policy. The Resi	•		
	-	nair." Resident E told a member		Council President was			
	of the resident cou	ncil and he said he would take		on the facility's abuse			
	care of it.			policy/process in the ev	/ent abuse		
				is reported directly to F			
	During an intervie	w on 2/7/22 at 10:00 a.m., the		Council President.			
	resident council m	ember indicated Resident B had		All staff have been edu	cated on		
	been vulgar to fem	ale residents that didn't like		the facility's existing po	olicy and		
	him. About a week	and a half ago, Resident E was		the expectation that wh	ien		
	afraid of Resident	B because of vulgar comments		behaviors occur they a	re to be		
	he had made to her	r. The resident council member		reported immediately to	o the		
	had reported this to	o staff. He was unable to		charge nurse/DON/ED/	/SSD.		
	remember which s	taff member he reported this to.		All staff have been edu	cated on		
				the facility's policy on a	issessing		
		l for Resident E was reviewed on		challenging behaviors,	resident		
	2/7/22 at 11:40 a.n	n. The diagnoses included, but		substance abuse, and	residents		
	were not limited to	, morbid obesity, reduced	1	who are unaware of pe	rsonal		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/16/2022 155780 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVE HOMESTEAD HEALTHCARE CENTER INDIANAPOLIS, IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE mobility, and debility. The Quarterly MDS boundaries: this education assessment, dated 11/11/21, indicated Resident E included but was not limited to was cognitively intact. documentation of behaviors in the clinical record, documentation On 2/7/22 at 11:00 a.m., the Director of Nursing from CNA/QMA in POC on daily provided a copy of a facility policy, dated 9/1/17, assigned task identified as "Any titled "Indiana Abuse and Neglect and changes in my resident today", Misappropriation of Property," and indicated this Residents identified with was the current policy used by the facility. A behaviors, substance abuse, or review of the policy indicated, "It is the intent of personal boundary concerns will this facility to prevent the abuse, mistreatment or be referred to SSD, MD, and IDT neglect of residents." to determine if there is a need for additional psychotherapy, The Immediate Jeopardy, that began on 2/2/22, outpatient services, temporary 1:1, was removed on 2/10/22 when the facility substance abuse counseling, or if inserviced the facility staff on abuse policies and relocation is required. behaviors, but the noncompliance remained at the All staff and alert and oriented lower scope and severity of no actual harm with residents have been educated on potential for more than minimal harm that is not the facility's existing policy and Immediate Jeopardy because a systemic plan of process on reporting abuse, correction had not been developed and including but not limited to what implemented to prevent recurrence. constitutes abuse, when to report abuse, to whom to report abuse This Federal tag relates to Complaints IN00372277 to, the Executive Director's phone and IN00372425. number, and the grievance process including where to locate 3.1-27(a)(1)grievance forms. The DON/SSD/Designee will 4 interview 5 random staff members and 5 random residents weekly x 4 weeks, then 10 random staff members and 10 random residents monthly x 2 months, then 5 random staff members and 5 random residents monthly x 3 months to ensure no incidents have occurred and to ensure staff and residents are aware of reporting responsibilities. Interviews will be conducted on 26YZ11

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 012225

If continuation sheet

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/16/2022
NAME OF PROVIDER OR SUPPLIER		7465 N	ADDRESS, CITY, STATE, ZIP COD IADISON AVE		
HOMESTI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	RE CENTER ( STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL () I LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIA DEFICIENCY) random days, including weeke and all shifts. Any findings will investigated and reported per facility policy. Monitoring residents' behavior and potential substance abuse be conducted by the DON/Designee Monday-Frida and the designated clinical manager Saturday and Sunda a review of the 24-hour report priority progress notes, and Einteract alerts for change in condition. This is an on-going facility practice. Non-verbal residents will have skin assessment completed n less than weekly and any chai in skin conditions including bu limited to bruising and discoloration will be reported immediately to the DON. This an on-going facility practice. The DON/ Designee will repor findings of the interviews to th Committee monthly and the O Committee will determine how best to conduct ongoing monitoring so that facility polic implemented and followed and reinforce the facility's commitr to abuse prevention investigat and reporting and to ensure th staff is aware of the potential consequences for both reside and staff for failing to follow th facility's policies.	ends, be rs e will y y y by , high e a o nges t not is t the e QA QA y y is d to ment tion, ne nts

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465	t address, city, state, zip cod MADISON AVE NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E COMPLETION	
F 0609 SS=K Bldg. 00	483.12(c)(1)(4) Reporting of Alley §483.12(c) In res abuse, neglect, et the facility must: §483.12(c)(1) En violations involvir exploitation or mi injuries of unknow misappropriation reported immedia hours after the al events that cause or result in seriout than 24 hours if t allegation do not result in serious that administrator of t officials (including Agency and adul state law provide care facilities) in through establish §483.12(c)(4) Re investigations to her designated re officials in accord including to the S 5 working days o alleged violation corrective action Based on observat review, the facility sexual abuse for 3 abuse (Residents E resulted in a femal	ged Violations ponse to allegations of xploitation, or mistreatment, sure that all alleged ng abuse, neglect, streatment, including wn source and of resident property, are ately, but not later than 2 legation is made, if the e the allegation involve abuse is bodily injury, or not later he events that cause the involve abuse and do not bodily injury, to the he facility and to other g to the State Survey t protective services where s for jurisdiction in long-term accordance with State law ed procedures. port the results of all the administrator or his or epresentative and to other lance with State law, itate Survey Agency, within f the incident, and if the is verified appropriate must be taken. ion, interview, and record failed to report allegations of of 4 residents reviewed for 8, Resident D, Resident E) this e resident being physically ly abused by a male resident.	F 0609	<ol> <li>The facility failed to reallegations of sexual abuse (vocalized sexual actions) by male resident to female resider residing in the facility. Due to freporting of prior sexual a the a female resident was for the second se</li></ol>	eport 03/25/202 y a dents o lack ctions,	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/16/2022	
	155780				02/16/2022	
NAME OF PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP COD MADISON AVE		
HOMES	TEAD HEALTHCA	RE CENTER		ANAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG		Diffe	
				with the male resident on top of	of	
	-	tice resulted in an Immediate		her with his pants off and the		
		nediate Jeopardy began on,		female resident had her legs		
	~ ~	hately 2:00 p.m., when the facility		spread with brief pushed to the	9	
		or sexual actions of a resident		side The male resident was	-1-	
		a female resident being sexually ath) assaulted. The		holding a pillow over the fem residents face and she was	lale	
		ministrator in Training, Director e Regional Director of Nursing		deceased. The Q.M.A. that fail		
	-	e Immediate Jeopardy on 2/7/22		to report an allegation of abuse	eis	
		nmediate Jeopardy was removed		no longer employed with the	le .	
	-	p.m., but noncompliance		company. The facility staff too the following actions:	n l	
		er scope and severity level of		the following actions.		
		narm with potential for more		· Immediately separated t	the	
		that is not Immediate Jeopardy.		residents and the licensed nur		
		i that is not ininicalate scoparay.		evaluated the residents.	30	
	Findings include:			• The male resident was		
	8			immediately placed on 1:1		
	1. During an interv	view on 2/7/22 at 9:00 a.m., QMA		supervision in his room.		
	-	nt B threatened to rape		• The female residents wa	as	
		times on 2/1/22. The QMA had		noted to be without pulse or		
		aff discussing this at the		respirations and DNR advance	ed	
	nurse's station on 2	2/1/22. The QMA was not sure		directives were validated.		
	if this had been rep	ported but indicated the threats		• The DON was notified of	of	
	should have been i	reported to the supervisor. The		incident and IMPD notified.		
	QMA was unable	to remember which staff		· Staff in the building		
	members she heard	d discussing this at the nurse's		validated that all other residen	ts	
	station.			were secure and accounted		
				for-noted no other concerns,		
	-	w on 2/7/22 at 9:20 a.m.,		residents safe and secure.		
		ed on 2/1/22 at approximately		· IMPD assumed		
	· ·	t B began making inappropriate		responsibility for the male resid		
		oward her. Resident B indicated		and continued 1:1 throughout	-	
		he was going to "eat between		until departure with detectives.		
		e comments about Resident D's		Medical Director was		
		B laughed and said, "just wait		notified of the event.	.	
		vait until tonight." Resident B		Marion County Coroner	and	
		these comments several times		Detectives are at the facility		
	-	y. Resident D reported this to $\frac{2}{1}$ $\frac{2}{1}$ $\frac{2}{22}$ At that time		directing the investigation.		
	QIMA 4 around 11	:00 p.m. on 2/1/22. At that time,		<ul> <li>Self-report Incident</li> </ul>		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEN	MEDICARE & MEDIC T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/16/2022
	ROVIDER OR SUPPLIE		7465 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE NAPOLIS, IN 46227	
X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	QMA 4 had indica	ted to her (Resident D) not to		submitted to ISDH gateway.	
	worry because she	would watch the hall.		Call placed to Area	
				Supervisor and discussed ev	ent.
		for Resident D was reviewed		• The female resident's I	body
		a.m. The diagnoses included,		was released to the Coroner.	
		d to, debility, morbid obesity,		<ul> <li>In-service initiated on</li> </ul>	
	•	ce of right and left legs above		existing facility policy for Abu	
		terly MDS (Minimum Data Set)		prevention, investigation, and	
		12/11/21, indicated Resident D		reporting, behavior monitoring	g,
	was cognitively int	act.		sexual behavior monitoring	
				including reinforcing the	
	-	riew on 2/7/22 at 9:50 a.m.,		expectation that facility policy	
		ed there was a day, the week		would be followed and remine	Ŭ I
		nt B got out of his wheelchair		staff of the consequences to	
		said, "you f**king b*tch, I'll		residents and staff of failing to	0
	•	hat wheelchair." She didn't		follow this policy.	
		happen and had not reported		· Residents educated a	-
		ent E told a member of the		on reporting abuse to facility	
		out the incident with Resident		and staff's commitment to ac	t
	B, and he said he v	vould take care of it.		upon any such report.	
				2. All other residents had the	
		w on 2/7/22 at 10:00 a.m., the		potential to be affected. Abus	
		ember indicated Resident B had		interviews were initiated with	
	-	ale residents that didn't like		alert and oriented residents to	
		and a half ago, Resident E was		identify any concerns. Reside	
		B because of vulgar comments		who could not be interviewed	
		The resident council member		a head to toe skin assessme	
	-	staff. He was unable to		completed and there were no	
	remember which s	taff member he reported this to.		findings. SSD is following up	
	The clinical record	for Resident E was reviewed on		any affected resident by notif	ying
		1. The diagnoses included, but		psychologist, physician, and	Cara
		, morbid obesity, reduced		family for additional support. plans have been revised whe	
		ity. The Quarterly MDS			
	-	11/11/21, indicated Resident E		appropriate. All staff have be interviewed to identify any	
	was cognitively int			potential events or incidents t	that
	was cognitively ill	act.		may constitute abuse and an	
	3 During the initia	l tour of the facility, on 2/2/22		events have been reported to	•
		12:15 p.m., Resident C was in her		ISDH and all other reporting	
		Difficers standing guard at the		entities.	
		sincers standing guard at the			

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Event ID: 26YZ11 Facility ID: 012225

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

# PRINTED: 03/31/2022 FORM APPROVED

STATEME! AND PLAN	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/16/2022
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
HOMES	TEAD HEALTHCAF	RE CENTER		IADISON AVE IAPOLIS, IN 46227	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ould not be observed from the			
	-	B was in his room, located on a		<b>3</b> . The facility must ensure all	
		e facility, with a Police Officer		allegations of abuse are report	
	standing guard at the	he door to the room.		and investigated per the facili	-
	<b>D</b> · · · ·			policy to protect the residents.	
		w on 2/3/22 at 5:10 p.m., QMA		DON/Designee educated all st	
		ion Aide) 1 indicated, on 2/2/22		on the facility's existing policy	
		:00 a.m., she entered Resident		identified as, "Indiana Abuse,	
		lent B was on top of Resident		Neglect, and Misappropriation	
		pants down. Resident C's face		with emphasis on reporting to	
		Resident B's hand. Resident B		Executive Director and Directo	or of
		dent C and left the room.		Nursing and reinforcing the	
		ked, had a small scratch to her		expectation this policy will be	<i>c</i>
	-	continence brief was pulled to		followed including a discussion	
	the side.			the consequences of not follow	ving
	Desident Clause ile			facility policy for both the	
	found to be decease	were dilated and she was		residents and staff. In-services	
	found to be decease	ed.		the facility's abuse prevention,	
	$O_{\pi} 2/7/22 = \pm 11.00$	a.m., the Director of Nursing		investigation, and reporting po	-
		a facility policy, dated 9/1/17,		will be conducted once a quar	
		ise and Neglect and		Alert and oriented residents w	ere
		of Property," and indicated this		educated and encouraged to	aarta
		icy used by the facility. A		report any acts of abuse or rep of abuse to facility staff. All ne	
	_	y indicated, "Each occurrence		hires will continue to receive	vv
	_	will be identified and		education on the facility's Abu	so.
	-	ervisor and investigated		policy in orientation, the	56
	· ·	isor or designee will notify the		expectation that this policy will	lhe
		g and Executive Director of the		followed, and the consequence	
	incident or allegati			both residents and staff of not	
	meruent of unegut			following this policy during the	
	The Immediate Jeo	pardy, that began on 2/1/22,		orientation.	
		10/22 when the facility		An Ad Hoc Resident Council	
		on reporting abuse, but the		meeting was held and the syst	tem
		nained at the lower scope and		for reporting abuse was review	
	-	al harm with potential for more		including but was not limited to	
		that is not Immediate Jeopardy		the facility's grievance process	
		plan of correction had not		including the ability to report	
	-	d implemented to prevent		concerns anonymously, report	tina
	recurrence.			abuse to the Executive Directo	-
			1		

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7465 MADISON AVE				
HOMESTEAD HEALTHCARE CENTER			INDIA	NAPOLIS, IN 46227			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETI DATE		
		elates to Complaints IN00372277		<ul> <li>any facility staff member. In addition, education was provid on the reporting guidelines, investigation, and follow-up. At concerns related to abuse or behaviors which made at the monthly Resident Council meetings will be reported to the Executive Director immediately and investigated per facility po The Resident Council Presider has been educated on the facility's abuse policy/process the event abuse is reported directly to the President.</li> <li>4. The DON/SSD/Designee wi interview 5 random staff members and 10 random residents monthly x 2 months, then 5 random staff members 3 random staff members 5 random residents monthly x 2 months to ensure no incidents have occurred and to ensure s and residents are aware of reporting responsibilities. Interviews will be conducted our random days, including weeke and all shifts. Any findings will investigated and reported per facility policy. The DON/ Designee will report findings of the interviews to the Committee will determine how best to conduct ongoing monitoring so that facility policy implemented and followed and</li> </ul>	ed ny e / licy. nt in Il bers y x and 3 taff n nds, be t the e QA A y is		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE			7465 M	ADDRESS, CITY, STATE, ZIP COI IADISON AVE IAPOLIS, IN 46227	)	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY) reinforce the facility's con to abuse prevention, inve and reporting and to ens staff is aware of the pote consequences for both r and staff for failing to foll	DILD BE PROPRIATE mmitment estigation, ure the ential esidents	(X5) COMPLETION DATE
F 0610 SS=K Bldg. 00	§483.12(c) In res abuse, neglect, e the facility must: §483.12(c)(2) Ha violations are tho §483.12(c)(3) Pre neglect, exploitat the investigation §483.12(c)(4) Re investigations to f her designated re officials in accord including to the S 5 working days o alleged violation corrective action Based on interview failed to investigat for 2 of 4 residents D and E). This resu physically (death) (Resident C, Resid This deficient prac Jeopardy. The Imm	port the results of all the administrator or his or epresentative and to other ance with State law, tate Survey Agency, within f the incident, and if the s verified appropriate must be taken. and record review, the facility e allegations of verbal abuse reviewed for abuse. (Residents alted in a female resident being and sexually assaulted.	F 06	510	1. The facility failed to investigate an allegation abuse. The male resider threatened at least two for residents with sexual vio The allegations of sexual were reported to facility so were not investigated. The resident was found to be a female resident with hi	of sexual at had emale lence. I abuse staff and his same on top of	03/25/2022

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			SURVEY LETED
155780		B. WING	G		02/16/2022		
NAME OF PROVIDER OR SUPPLIER		CR .			ADDRESS, CITY, STATE, ZIP COD		
HOMESTEAD HEALTHCARE CENTER					ADISON AVE IAPOLIS, IN 46227		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	e reported allegations of sexual			down and her brief pulled to t		
		The Administrator,			side with legs spread. The ma	ale	
		raining, Director of Nursing,			resident was holding a pillow	over	
	-	Director of Nursing were notified			the resident's face. The fema	le	
		leopardy on 2/7/22 at 5:00 p.m.			resident was deceased. The		
		opardy was removed on 2/10/22			female residents who were		
	· ·	oncompliance remained at a			allegedly threatened have ha	d their	
	-	everity level of pattern, no			family, physician, SSD, and		
	-	otential for more than minimal			psychologist notified.		
	harm that is not Im	nmediate Jeopardy.			Psychosocial well-being is be	eing	
					monitored by SSD and		
	Findings include:				psychologist. Care plans will	be	
					updated accordingly as need	ed.	
	-	view on 2/7/22 at 9:20 a.m.,			2. All other residents had	the	
		ted on 2/1/22 at approximately			potential to be affected. Abus	e	
	2:00 p.m., Residen			interviews were conducted w	ith all		
		toward her. She had reported to			alert and oriented residents to	C	
		:00 p.m. on 2/1/22 that Resident			identify any concerns. Reside	ents	
		ropriate sexual comments			who could not be interviewed		
		QMA had indicated to her not to			a head to toe skin assessme	nt	
	worry because she	would watch the hall.			completed and there were no		
					findings. SSD is following up		
		l for Resident D was reviewed			any affected resident by notif	ying	
		a.m. The Quarterly MDS			psychologist, physician, and		
		et) assessment, dated 12/11/21,			family for additional support.	Care	
	indicated Resident	D was cognitively intact.			plans have been revised whe		
					appropriate to do so. All staff		
	-	w on 2/7/22 at 9:00 a.m., QMA 3			interviewed to determine if th	-	
		overheard other staff			were aware of or to identify a	-	
	-	sident B threatened to rape			potential allegations of abuse		
		l times on 2/1/22. The QMA was			events that require investigat		
		been reported but indicated			Any identified events or alleg		
		have been reported to the			were reported to ISDH and al	II	
		3 was unable to remember			other reporting entities.		
		ers she heard discussing this at			3. The facility must ensure	e all	
	the nurse's station.				allegations of abuse are		
					investigated per the existing		
	-	view on 2/7/22 at 10:00 a.m., the			facility policy to protect the		
		ember indicated Resident E			residents. The Regional Direct		
	came to him and w	vas afraid of Resident B.			Clinical Operations (RDCO)	vill	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES				O	MB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	r í	JILDING	DNSTRUCTION 00	COMP	e survey deted 5/2022
	PROVIDER OR SUPPLIE			7465 M	ADDRESS, CITY, STATE, ZIP COD IADISON AVE IAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Resident B had ma about a week and a member indicated could not behave it this information to spoke to him. During an intervier Resident E indicate inappropriate comma aggressive towards Resident B's behave member and he ind The clinical record 2/7/22 at 11:40 a.m assessment, dated was cognitively int On 2/3/22 at 1:30 p that at approximate were dispatched to assault resulting in deceased. On 2/7/22 at 2:00 p Training, DON, an indicated they wer E's allegations of v a.m., the DON ind should have been n On 2/7/22 at 11:00 provided a copy of titled "Indiana Abu Misappropriation of was the current point curve of the polic of alleged abuse	Ide vulgar comments to her a half ago. The resident council he had told Resident B that he n that manner. He had reported a staff member after Resident E w on 2/7/22 at 9:50 a.m., ed Resident B was making ments and was verbally s her. The resident reported viors to a resident council dicated he would take care of it. I for Resident E was reviewed on n. The Quarterly MDS 11/11/21, indicated Resident E			ensure all investigations a conducted timely and thor In the event the RDCO is unavailable the Regional of Operations (RDO) will b responsible to ensure all investigations are conduct timely and thoroughly in accordance with facility po allegations of abuse or a d that may constitute abuse reported to the Executive immediately. DON/Design educated all staff on the fa existing policy identified a "Indiana Abuse, Neglect, a Misappropriation", with en on reporting and investiga reinforcing the expectation policy will be followed incl discussion of the consequ not following facility policy the residents and staff. In- on the facility's existing ab prevention, investigating a reporting policy will be con once a quarter. Alert and residents were educated a encouraged to report any abuse or reports of abuse facility staff. All new hires continue to receive educa the facility's Abuse policy their orientation including expectation that this policy. All staff have been educated the facility's policy and expectation that when beh	roughly. Director be ted blicy. All concern will be Director hee acility's s, and nphasis ating and n this uding a hences of for both services buse and nducted oriented and acts of to will tion on during the y will be uences of	

Event ID:

26YZ11

Facility ID: 012225

If continuation sheet Page 22 of 56

PRINTED: 03/31/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155780 NAME OF PROVIDER OR SUPPLIER HOMESTEAD HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	DRRECTION (X5)	
		7465 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE NAPOLIS, IN 46227 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
	timely. The superv Director of Nursin incident or allegat The Immediate Jee was removed on 2 inserviced staff on but the noncompli scope and severity potential for more Immediate Jeopard correction had not implemented to pr	risor or designee will notify the g and Executive Director of the ion immediately". oppardy, that began on 2/1/22, /10/22 when the facility abuse policies and procedures, ance remained at the lower of no actual harm with than minimal harm that is not dy because a systemic plan of been developed and	TAG	<ul> <li>occur they are to be reported immediately to the charge nurse /DON/ED/SSD.</li> <li>All staff have been educated of the facility's policy on assessing challenging behaviors, resident substance abuse, and resident who are unaware of personal boundaries; this education included but was not limited to Identify, Preventing, and Mana Aggressive Behaviors, documentation of behaviors in clinical record, and documenta from CNA/QMA in POC on dail assigned task identified as "An changes in my resident today", Residents with behaviors, substance abuse, or personal boundary concerns will be refet to SSD, MD, and IDT to determ if there is a need for additional psychotherapy, outpatient services, temporary 1:1, substance abuse counseling, or relocation is required.</li> <li>The RDCO will validate a abuse allegations are reported investigated per the facility polit x 6 months. The DON/SSD/Designee will intervit 5 random staff members and 10 random residents monthly x 2 months, then 5 random staff members and 10 random residents monthly x 2 months, then 5 random residents monthly x 2 months, then 5 random residents monthly x 3 months to ensure no incidents</li> </ul>	se n g g t t ts g g ing t ton ly y ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SUF COMPLETH 02/16/20	ED
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	_	
HOMESTEAD HEALTHCARE CENTER			/ADISON AVE NAPOLIS, IN 46227			
	IOMESTEAD HEALTHCARE CENTER					
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) OMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	have occurred that were not reported or investigated, and ensure staff and residents are aware of reporting responsibil Interviews will be conducted random days, including week and all shifts. Any findings wi investigated and reported per facility policy. Monitoring of residents' beha and potential substance abus be conducted by the DON/Designee Monday-Frida and the designated clinical manager Saturday and Sund a review of the 24-hour repor priority progress notes, and Einteract alerts for change in condition. This is an on-going facility practice. Non-verbal residents will hav skin assessment completed r less than weekly and any cha in skin condition including but limited to bruising and discoloration will be reported immediately to the DON. This an on-going facility practice. The grievances will be review Monday-Friday in the clinical morning meeting to ensure appropriate actions and resol are provided. This is an ongo facility practice. The DON/ Designee will rep the findings of the interviews monthly QA Committee meet and the QA Committee meet and the QA Committee will determine how best to condu going monitoring so that facili	e ano anges t not s is ved ution ing ort to the ing ct on characteristication ing ct on characte	DATE

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING <u>00</u>			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		155780	B. W		00		5/2022
NAME OF 1	PROVIDER OR SUPPLIE	R		7465 N	ADDRESS, CITY, STATE, ZIP COE IADISON AVE	)	
HOMES	FEAD HEALTHCAP	RECENTER		INDIAN	IAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETION DATE
					policy is implemented an followed and to reinforce facility's commitment to a prevention, investigation, reporting and to ensure t aware of the potential consequences for failing the facility's policies.	the abuse , and he staff is	
<sup>-</sup> 0641 SS=D Bidg. 00	The assessment resident's status. Based on interview failed to provide an Set) assessment by relevant care areas for accurate assess Findings include: The clinical record on 2/8/22 at 9:45 a assessment, dated did not have an included epilepsy, abnormal polymer. The resid catheter. The MDS assessm indicate resident G The TAR (Treatme provided by the D0 2/8/22 at 12:23 p.n 12/31/21, did not in	essments acy of Assessments. must accurately reflect the a and record review, the facility a accurate MDS (Minimum Data staff qualified to assess for 1 of 3 residents reviewed ment. (Resident G) for Resident G was reviewed .m. A Quarterly MDS 1/2/22, indicated the resident welling urinary catheter. The but were not limited to, posturing, encephalitis, lent had an indwelling urinary ent, dated 1/4/22, did not had a Foley catheter. ent Administration Record), was DN (Director of Nursing) on h. The TAR dated 12/1/21 thru ndicate the resident had a Foley lent's catheter was inserted on	F 04	541	<ol> <li>Immediate actions tail those residents identifie Resident G was not harm the alleged deficient prace Resident G's assessmen 01/02/2022 and 01/04/20 modified by MDS to refle accurate status. Resident G was reassess nursing staff and the cath removed as per MD orde 02/09/2021.</li> <li>How the facility ident other residents: Any resident who has an indwelling catheter has th potential to be affected b alleged deficient practice was conducted on all res with indwelling catheters confirm their most recent reflects accurate coding o indwelling catheter, that of care orders are in place,</li> </ol>	ed: ned by ctice. its on 22 were ct sed by neter was er on ified ne y the An audit idents to : MDS of an catheter	03/25/202

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155780	(X2) MULTIPLE CONSTRUCTION X A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE	
	12/22/21. The clinical record 12/22/21-12/31/21	l lacked catheter care from		the plan of care is updated accordingly. Any findings were immediately corrected and the family and physician were not	9	
	indicated she did r inserted the reside 2021. A policy received indicated this polic	w on 2/15/22 at 10:15 a.m., LPN 3 not do an assessment after she nts Foley catheter in December on 2/9/22, revised 7/26/18, ey was the one the facility was the facility will: i provide an resident as an on		3) Measures put into place/System changes: The Regional Resident Care Coordinator has educated the MDS coordinator reinforcing the need for accurately completing MDS per the guidelines of the manual.	ne g an	
	foundation for a re care planning proc	iew that provides the sident focused care and the ess" elates to Complaint IN00372387.		4) How the corrective actions will be monitored: The Regional Resident Care Coordinator will audit 3 reside		
	3.1-31(d)			MDS's weekly x 4 weeks, ther resident MDS's monthly x 5 months to ensure the accurace the resident MDS assessment MDS coordinator is responsib the compliance. The results of these audits will be reviewed in Quality Assurance Committee monthly meetings for 6 month until 100% compliance is achi x 3 consecutive months. The Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated	y of t. le for f n the s or eved QA ends	
<sup>-</sup> 0656 SS=D Bldg. 00	§483.21(b) Com §483.21(b)(1) Th	ent Comprehensive Care Plan prehensive Care Plans e facility must develop and prehensive person-centered				

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP. AND PLAN OF CORRECTION IDENTIFICATION NU 155780		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/16/2022	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COL	)	
HOMES	TEAD HEALTHCA	RE CENTER		IADISON AVE IAPOLIS, IN 46227		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETIO
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	the resident right and §483.10(c)(3 objectives and the resident's medical psychosocial new comprehensive a comprehensive a comprehensive a following - (i) The services the attain or maintain practicable physic psychosocial we §483.24, §483.2 (ii) Any services required under § but are not provi- exercise of rights the right to refuse (6). (iii) Any specializ rehabilitative ser provide as a resu- recommendation the findings of the its rationale in the (iv)In consultation resident's repress (A) The resident desired outcome (B) The resident future discharge whether the resident future discharge whether the resident (C) Discharge pli- care plan, as app	care plan must describe the that are to be furnished to in the resident's highest ical, mental, and II-being as required under 5 or §483.40; and that would otherwise be 483.24, §483.25 or §483.40 ded due to the resident's is under §483.10, including the treatment under §483.10(c) red services or specialized vices the nursing facility will ult of PASARR is. If a facility disagrees with the PASARR, it must indicate the resident's medical record. in with the resident and the treattive(s)- is goals for admission and				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION (X: 00	3) DATE SURVEY COMPLETED	
		155780	B. WING		02/16/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
HOMES	TEAD HEALTHCA	RE CENTER		/ADISON AVE NAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		v and record review, the facility	F 0656	1) Immediate actions taken for	03/25/2022	
	-	person-centered care plan was		those residents identified:		
	-	sident that had physical, sexual,		Resident B no longer resides in		
		ssive behaviors and diagnosed and major depressive disorder		the facility.2) How the facility identified other residents:All		
		reviewed for behaviors.		residents have the potential to be		
	(Resident B)	reviewed for behaviors.		affected by the alleged deficient	5	
	(Resident B)			practice. An audit was conducted	4	
	Findings include:			on all residents to ensure that		
	T munigs menuae.			those residents with behaviors,		
	The clinical record	l for Resident B was reviewed		major depressive disorders, and		
		p.m., the diagnoses included,		alcohol abuse have a care plan		
		ed to, major depressive disorder		that accurately reflects their		
	and alcohol abuse.			physical and mental health need	s	
				and assures their needs are		
	The Quarterly Mir	nimum Data Set (MDS)		addressed and met. Care plans		
	assessment, dated	1/12/22, indicated Resident B		were immediately updated to		
	was cognitively in	tact and had moderate		reflect an accurate,		
	depression.			person-centered plan of care for		
				the resident based upon the		
	-	arge summary, dated 9/16/21 at		resident's assessed condition an	d	
		d Resident B had been		needs, if required. 3) Measures		
	-	1 3 to 5 times per week,		put into place/ System		
		cohol than intended, and was		changes:The DON/MDS		
		his family member had made		Coordinator educated the nursing	g	
	him leave home du	ue to alcohol consumption.		staff and IDT on the facility's		
	During on intern	$N_{\rm con}$ $2/7/22$ of $9.52$ or $0.000$		existing policy identified as, "Plan		
		w on 2/7/22 at 8:53 a.m., QMA 2 B seemed depressed over the		of Care Overview" with emphasis	5	
		cause his roommate moved out.		on development of a person-centered care plan for		
	past ICW WEEKS DE	cause ins roominate moved out.		those residents exhibiting		
	During an intervie	w on 2/7/22 at 9:00 a.m., QMA 3		behaviors and a diagnosis		
	-	22 Resident B had been drinking		including alcohol abuse and majo	or	
		nelled like alcohol. The resident		depressive disorder. Staff was		
		aggressive when he had been		reminded of the potential		
		Resident B threatened to rape		consequences to both the		
	Resident D several			residents and staff if the policy is not followed. <b>4) How the</b>		
	During an intervie	w on 2/7/22 at 9:50 a.m.,		corrective actions will be		
		ed Resident B told her she was		monitored:The Social Service		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
HOMES	TEAD HEALTHCA	RE CENTER		NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETIO DATE
	beautiful and offer no. When he (Resi violent. There wa Resident B got out face and said, "you out of that wheeled of the resident cour care of it. During an intervie Resident D indicat 2:00 p.m., Resider sexual comments to to Resident D that my legs" and made breasts. Resident I until tonight, just y continued to make throughout that da QMA 4 around 11 the QMA 4 indica worry because she During an intervie (Licensed Practica approximately 5:0 station for the 100 to the nurse's static what she saw. QM "come on, come o C's room, he saw I approximately a fo with his pants dow smelled alcohol w speak. There was a floor. Resident B w room and immedia supervision with a was lying in bed, o	red to buy her jewelry. She said ident B) got drunk, he would get s a day, the week before last, t of his wheelchair and in her u f**king b*tch, I'll knock you hair." Resident E told a member mcil and he said he would take wo n 2/7/22 at 9:20 a.m., ted on 2/1/22 at approximately nt B began making inappropriate toward her. Resident B indicated he was going to "eat between e comments about Resident D's B laughed and said, "just wait wait until tonight." Resident B e these comments several times y. Resident D reported this to :00 p.m. on 2/1/22. At that time, ted to her (Resident D) not to e would watch the hall. wo on 2/7/22 at 10:20 a.m., LPN dl Nurse) 2 indicated on 2/2/22 at 0 a.m., he was at the nurse's and 200 Hall. QMA 1 had come on and was unable to verbalize IA 1 grabbed his hand and said, n." When he entered Resident Resident B standing bot away from Resident C's bed vn to his ankles. The nurse hen Resident B was trying to a large bottle of dry gin on the was escorted out of Resident C's ately placed on one-on-one nother staff member. Resident C on her back, with legs spread looking at the ceiling. Resident		Director will audit 5 residen plans x 4 weeks, then 3 re care plans x 4 weeks, ther resident care plans month months to ensure develop a person-centered care pla those residents exhibiting behaviors and a diagnosis including alcohol abuse ar depressive disorder are in accurate, and implemente Social Service Director is responsible for the complia Audit findings will be prese the QA Committee monthl meetings x 6 months. The of these audits will be revit the monthly QA Committee monthly meetings for 6 mo until 100% compliance is a x3 consecutive months. T Committee will identify any or patterns and make recommendations to revise plan of correction as indica	nt care sident 5 by x 4 ment of an for d major place, d. The ance. ented to y results ewed in e onths or achieved he QA y trends e the	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	A (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
	OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 7465 MADISON AVE EAD HEALTHCARE CENTER INDIANAPOLIS, IN 46227				DD	
	1					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE CO	(X5) OMPLETION DATE
ino		ulse, but her body was warm to				DITTE
		l for Resident B lacked a care , major depressive disorder, and				
	Director of Nursin consumption, majo	w on 2/11/22 at 8:30 a.m., the g indicated Resident B's alcohol or depressive disorder, and have been care planned with entions.				
	provided a copy of Care Overview," d was the current po review of the facil policy of this facil care that meets the emotional needs an	) p.m., the Director of Nursing f a facility policy, titled "Plan of lated 7/26/18, and indicated this licy used by the facility. A ity policy indicated "it is the ity to provide resident centered psychosocial, physical and nd concerns of the residents. ary concern for our resident,				
	This Federal tag read and IN00372277.	elates to Complaints IN00372425				
	3.1-35(a)					
F 0657 SS=D Bldg. 00	§483.21(b)(2) A of must be- (i) Developed wit of the comprehen (ii) Prepared by a includes but is no (A) The attending	g and Revision prehensive Care Plans comprehensive care plan hin 7 days after completion nsive assessment. an interdisciplinary team, that ot limited to				

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155780		IA (X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
NAME OF PROVIDER OR SUPPLIER HOMESTEAD HEALTHCARE CENTER		7465	ET ADDRESS, CITY, STATE, ZIP C MADISON AVE ANAPOLIS, IN 46227	OD		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
	resident. (D) A member of staff. (E) To the extent participation of th representative(s) included in a resi- participation of th representative is for the developm plan. (F) Other approp- disciplines as def- needs or as requi- (iii)Reviewed and interdisciplinary tri- including both the quarterly review and Based on interview failed to update a co- assessment to reflecing sta- for activities of da Finding includes: The clinical record on 2/2/22 at 12:30 but were not limited and alcohol abuse. The Quarterly Min- assistance of one si- sistance of one si- sistance of one si- tanta and and and and and and and and and an	An explanation must be dent's medical record if the re resident and their resident determined not practicable ent of the resident's care riate staff or professionals in termined by the resident's ested by the resident. drevised by the eam after each assessment, e comprehensive and assessments. v and record review, the facility care plan within 7 days of an ext a resident's appropriate tus for 1 of 3 residents reviewed ily living. (Resident B). d for Resident B was reviewed p.m. The diagnoses included, ed to, major depressive disorder minum Data Set (MDS) 1/12/22, indicated Resident B tact, required extensive taff member for bed mobility moderate depression, and used	F 0657	<ol> <li>Immediate actions those residents identified to the service of the s</li></ol>	ified: esides in B was not deficient ntified ange in as identified essment, ers, or itential to be deficient conducted ad a change	03/25/20

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155780 B. WING 02/16/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVE HOMESTEAD HEALTHCARE CENTER INDIANAPOLIS, IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE A hospital discharge summary, dated 9/16/21 at their plan of care reflected 2:47 a.m., indicated the resident was non weight accurately their weight bearing bearing. status and to meet their daily mobility needs. A care plan, dated 9/17/21 and current through 3/22/22, indicated Resident B required assistance 3) Measures put into place/ with ADL (activities of daily living) related to System changes: non-weight bearing to RLE (right lower extremity), right ankle fixture, pain in right ankle. The DON/MDS coordinator educated the IDT and nursing staff A therapy progress note, dated 11/29/21 at 3:45 on the existing facility policy p.m., indicated weight bearing as tolerated to the identified as, "Plan of Care right lower extremity. Overview" with emphasis on timely revision of resident care plans During an interview on 2/15/22 at 3:11 p.m., the upon as assessed of observed Director of Nursing indicated the care plan should condition change and the have been updated to show Resident B's weight consequences for not following the bearing status and improvement. existing policy for both the residents and staff. On 2/14/22 at 1:00 p.m. The Administrator provided a copy of a facility policy, titled "Plan of Care Overview," dated 7/26/18, and indicated this 4) How the corrective actions was the current policy used by the facility. A will be monitored: review of the policy indicated "the facility will: The DON/Designee will audit 5 review care plans quarterly and/or with significant resident care plans x 4 weeks, changes in care." then 3 resident care plans x 4 weeks, then 5 resident care plans This Federal tag relates to Complaint IN00372277. monthly x 4 months to ensure timely revision of care plans. 3.1-35(d)(2)(B) The Director of Nursing is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meeting for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Event ID: 26YZ11 Facility ID: 012225 Page 32 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465	T ADDRESS, CITY, STATE, ZIP COD MADISON AVE ANAPOLIS, IN 46227		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	ION D BE OPRIATE	(X5) COMPLETION
F 0684 SS=D Bldg. 00	<ul> <li>483.25</li> <li>Quality of Care</li> <li>§ 483.25 Quality</li> <li>Quality of care is</li> <li>applies to all treat</li> <li>facility residents.</li> <li>comprehensive at</li> <li>facility must ensult reatment and ca</li> <li>professional stant</li> <li>comprehensive pand the residents</li> <li>Based on interview</li> <li>failed to ensure a result type 2 had blood g</li> <li>and documented for</li> <li>blood glucose more</li> <li>C)</li> <li>Findings include:</li> <li>1. The clinical record on 2/2/22 at 12:30</li> <li>but were not limited</li> </ul>	a fundamental principle that tment and care provided to Based on the ssessment of a resident, the tre that residents receive re in accordance with dards of practice, the erson-centered care plan,	F 0684	<ul> <li>Committee will identify an or patterns and make recommendations to revisi plan of correction as indice</li> <li>1) Immediate actions tak those residents identified. Resident B no longer residents facility and was not har alleged deficient practice. Resident C no longer residents identified the facility</li> <li>2) How the facility identified to ther residents: Any resident who requires sugar monitoring has the to be affected by the alleged deficient practice. All resident practice. Predicted practice. Practice. Practice. Pra</li></ul>	e the ated. en for d: des in rmed by des in <b>ied</b> blood potential ed dents	03/25/2022
	10/10/21 at 12:06 j to have his blood g day.	er progress note, dated p.m., indicated the resident was flucose levels checked twice a		were reviewed to ensure to sugar monitoring and documentation occurred of last 14 days. Physician at family were notified imme- and new orders were obta meet the needs of the res	ver the nd diately ined to	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155780 B. WING 02/16/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVE HOMESTEAD HEALTHCARE CENTER INDIANAPOLIS, IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE monitoring. any resident's whose blood sugar was not monitored in accordance During an interview on 2/9/22 at 2:35 p.m., the with physician orders. Director of Nursing indicated Resident B's blood glucose levels should have been monitored and 3) Measures put into place/ documented as indicated by the Nurse System changes: Practitioner's note. The Director of Nursing/designee in-serviced nursing staff on the 2. The clinical record for Resident C was reviewed existing facility's policies identified on 2/2/22 at 12:15 p.m. The diagnoses included, as, "Medication Administration" but were not limited to, diabetes mellitus type 2 and "Physician Orders" with and morbid obesity. emphasis on following physician orders, completion, documentation The current Physician's orders, dated 1/30/22, and the consequences for not indicated staff were to monitor the residents blood following these existing policies glucose levels four times a day. and procedures for both residents and staff. The clinical record lacked documentation of the 4) How the corrective actions residents blood glucose levels being monitored. will be monitored: Director of Nursing/designee will During an interview on 2/9/22 at 2:35 p.m., the audit 5 resident records with blood Director of Nursing indicated Resident C's blood sugar monitoring weekly x4 weeks glucose levels should have been documented. and then 3 resident records x 4 weeks then 1 resident record On 2/7/22 at 11:00 a.m. The Director of Nursing weekly for 4 months to ensure provided a copy of a facility policy, titled compliance with blood sugar "Medication Administration," dated 12/14/17, and monitoring orders and the blood indicated this was the current policy used by the sugar readings are documented. facility. A review of the policy indicated "record Care Plans will be updated to pertinent information ... blood sugars." reflect the resident's current status and any changes in a This Federal tag relates to Complaints IN00372387, resident's condition. IN00372425, and IN00373289. Audits/observation will be conducted randomly, across all 3 3.1-37(a) shifts, and will include weekends. DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meeting x 6 months. The results of these FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 26YZ11 Facility ID: 012225 If continuation sheet Page 34 of 56

03/31/2022

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	R MEDICARE & MEDI				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465 M	ADDRESS, CITY, STATE, ZIP COD MADISON AVE NAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
				audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x consecutive months. The QA Committee will identify any tren or patterns and make recommendations to revise the plan of correction as indicated.	ds	
= 0689 SS=D Bldg. 00	• • • • • •	ents.				
		ch resident receives sion and assistance devices nts.				
	review, the facility from driving an ele influence of alcoho for safety. (Reside Finding includes: The clinical record on 2/2/22 at 12:30	for Resident B was reviewed p.m. The diagnoses included, d to, major depressive disorder	F 0689	1) Immediate corrective action(s) for those residents affected by the deficient practice: Resident B no longer resides within facility. No residents were injured by this alleged deficient practice. 2) Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be		
	assessment, dated was cognitively in	imum Data Set (MDS) 1/12/22, indicated Resident B act and required extensive taff member for bed mobility		taken:Any resident who utilizes an electric wheelchair and has history of alcohol use has the potential to be affected by the alleged deficient practice. An au	a	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/16/2022	
	NAME OF PROVIDER OR SUPPLIER		7465 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE		
HOMES	IEAD HEALTHCAI	RECENTER	INDIA	NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETIC DATE
1/10	and transfers.		1110	was conducted on all residen		DATE
	During the initial t from 11:40 a.m. to room with a Police door to the room. I up in his electric w During an intervie indicated on 1/28/2 out of a cup that su could be verbally a drinking alcohol. During an intervie Resident E indicat drunk, he would g week before last, h	w on 2/7/22 at 9:00 a.m., QMA 3 22 Resident B had been drinking nelled like alcohol. The resident aggressive when he had been w on 2/7/22 at 9:50 a.m., ed when he (Resident B) got et violent. There was a day, the ne got off of his wheelchair and d, "you f**king b*tch, I'll knock		utilize an electric wheelchair a have a history of alcohol use ensure they were educated o proper use of the electric wheelchair and had a current assessment identified as "Powered Personal Mobility E Skills Evaluation" completed a that facility policy prohibits the use of an electric wheelchair any resident who has consun alcohol. <b>3)Facility measures</b> <b>and systemic changes to</b> <b>ensure the deficient practice</b> <b>does not recur</b> :The DON/Designee completed in-servicing with all staff on th existing facility policy of continuously monitoring resid ability to safely operate a	and to n Device and e by ned <b>s</b> e	
	<ul> <li>(Licensed Practical approximately 5:0)</li> <li>wheelchair was inst foot behind him. Rethe wheelchair but when trying to spe smelled alcohol was speak. There was a floor.</li> <li>During an intervie Administrator indicompleted for resident electric wheelchain</li> <li>The clinical record</li> </ul>	w on 2/7/22 at 10:20 a.m., LPN l Nurse) 2 indicated on 2/2/22 at 0 a.m., Resident B's electric side the room, approximately a tesident B was trying to sit in twas unsteady and confused ak to the nurse. The nurse hen the resident was trying to a large bottle of dry gin on the w on 2/9/22 at 2:15 p.m., the cated an evaluation was dents who wish to drive an r for safety. H lacked an evaluation for e an electric wheelchair.		motorized wheelchair and to a MD/DON/ED/family immediat any concerns or discrepancie with operation of the motorize wheelchair. <b>4)Facility plan to</b> <b>monitor corrective actions &amp;</b> <b>sustain compliance; Integra</b> <b>QA Process:</b> The DON/Desig will audit new admission /readmission and residents w express the desire to use a motorized wheelchair in the building for safety and ensure "Powered Personal Mobility E Skills Evaluation" is complete timely, this is ongoing facility practice. The DON/Designee audit via observation 3 reside weekly x 4 weeks, then 1 residents of the state interval and the set of the state weekly x 4 weeks, then 1 residents	ely of es ed o <b>b</b> <b>te</b> nee tho e a Device d will ents	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465 N	ADDRESS, CITY, STATE, ZIP C IADISON AVE IAPOLIS, IN 46227	COD	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C During an intervie Director of Nursin should have been of drive an electric w have been notified Resident B had be physician make an electric wheelchain Resident B from d after drinking alco On 2/16/22 at 2:00 provide a policy re prior to exit.	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION w on 2/9/22 at 2:35 p.m., the g indicated an evaluation completed for Resident B to heelchair. The physician should when the staff realized en drinking alcohol and let the recommendation regarding the r. She would have stopped riving the electric wheelchair	ID PREFIX TAG	PROVIDERS, IN 40227 PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) Weekly x 4 weeks, ther residents monthly to er operation of the electri- is safe. The facility will its practice of assessin resident's ability to safe a motorized wheelchai year and more frequent resident demonstrates operation of a motorized wheelchair. Audits/obs will be conducted rand across all 3 shifts, and weekends. DON/Desig responsible for the cond Audit findings will be pi the QA Committee mon meetings x 6 months. To of these audits will be a the monthly QA month for 6 months or until 10 compliance is achieved consecutive months. To Committee will identify or patterns and make recommendations to re plan of correction as in	HOULD BE APPROPRIATE n 3 insure c wheelchair continue ag a ely operate ir twice a ntly if the any unsafe ed servation fomly, will include gnee is npliance. resented to nthly The results reviewed in ly meetings 00% d x3 The QA r any trends evise the	(X5) COMPLETION DATE
<sup>=</sup> 0690 SS=D Bldg. 00	§483.25(e) Incom §483.25(e)(1) Th resident who is c bowel on admiss assistance to ma or her clinical con	icontinence, Catheter, UTI tinence. e facility must ensure that ontinent of bladder and ion receives services and intain continence unless his ndition is or becomes such s not possible to maintain.				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP COD MADISON AVE		
HOMES	TEAD HEALTHCAI	RE CENTER		ANAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROUTDEDIC DI AN OF CORRECTIO	NT.	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	incontinence, bas comprehensive a ensure that- (i) A resident who an indwelling cat unless the reside demonstrates that necessary; (ii) A resident wh indwelling cathet one is assessed as soon as possi clinical condition catheterization is (iii) A resident wh receives appropr to prevent urinary restore continence, bas comprehensive a ensure that a resi bowel receives a services to restor function as possi Based on observat review, the facility treatment and serv clinically-justified residents reviewed Finding includes: The clinical record on 2/8/22 at 9:45 a Data Set) assessme	no is incontinent of bladder iate treatment and services y tract infections and to be to the extent possible. It a resident with fecal sed on the resident's assessment, the facility must ident who is incontinent of ppropriate treatment and re as much normal bowel	F 0690	<ol> <li>Immediate actions take those residents identified: Resident G was not harmed the alleged deficient practic Resident G was reassessed nursing staff and the cathet discontinued per MD order 02/09/2021.</li> <li>How the facility identifion other residents: Any reside who has an order for an ind Foley catheter has the pote</li> </ol>	l by e. d by er was on <b>fied</b> ent welling	03/25/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		00	(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE			7465 M	ADDRESS, CITY, STATE, ZIP COD IADISON AVE IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	AIE	DATE
	had a indwelling u	rinary catheter. The diagnoses			deficient practice. An audit wa	as	
	included, but were	not limited to: epilepsy,			conducted to identify those		
	abnormal posturin			residents who currently utilize	an		
	polyneuropathy. 7	The resident had an indwelling			indwelling Foley catheter to		
	catheter at that tim	e.			ensure catheter care orders a	ind a	
					plan of care were in place and	d	
		der, dated 12/22/21 at 2:34 p.m.,			implemented accurately and		
		a Foley catheter for a diagnosis			timely. 3.) Measures put into	)	
		der. There were no follow up			place/ System changes:The		
		icating Resident G's toleration			DON/Designee educated the		
		the Foley catheter or if any			nursing staff and IDT on the		
	urine, including co	lor was obtained.			existing facility policy identifie		
					as, "Catheter Care" with empl	nasis	
		ent Administration Record), was			on ensuring orders were		
		ON (Director of Nursing) on			documented, followed, and th		
	2/8/22 at 12:23 p.r				catheter care was provided in		
		lacked urinary catheter care.			accordance with nursing prac	tice	
		/22-1/31/22 lacked urinary			and physician's orders. The		
	catheter care on 14	occurrences.			expectation this policy is follow	wea	
	$O_{\rm m} 2/15/22$ at 11.0	0 a.m., Resident G was observed			was reinforced and staff was	a ta	
	to not have a urina	·			reminded of the consequence the residents and staff if phys		
	to not have a urma	ry cameter.			orders or facility policy are no		
	A policy "Catheter	Care" was provided by the			followed. The Director of Nur		
		l reviewed on 2/8/22 at 1:50 p.m.,			Designee will ensure this plar	•	
		s:"catheter care at the beside is			correction is implemented. A		
		note cleanliness and dignity and			will be conducted 3 times wee		
		II: for a female residente.			x 4 weeks, then 2 times week	-	
		washcloth with warm soap and			for 4 weeks and once a week		
		nd catheter just above entrance			thereafter to include all shifts		
		imately 6 inches, repeat until no			documentation of ordered cat		
		bserved on the catheterh.			care, that bowel and bladder		
	Rinse with clean w				assessments completed, and	the	
					correct placement of catheter		
	This Federal tag re	elates to Complaint IN00372387.			tubing. 4.) How the correct		
					actions will be monitored:Th		
	3.1-41(a)(1)				DON/Designee will audit 5		
					residents weekly x 4 weeks, t	hen	
					3 residents weekly x 4 weeks		
					then 3 residents monthly x 4		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 26YZ11 Facility ID: 012225

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		FIPLE CONS		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155780	A. BUILDING <u>00</u> B. WING		00	COMPLETED 02/16/2022	
NAME OF 1	PROVIDER OR SUPPLIE	R			DRESS, CITY, STATE, ZIP CO	OD	
HOMES	FEAD HEALTHCAI	RE CENTER			DISON AVE POLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE PPROPRIATE	COMPLETION DATE
					nonths to ensure cathe		
					eing completed and de ppropriately in the clin		
					All admissions will be re		
					he clinical morning me he use of an indwelling	•	
					atheter and audited to		
				c	atheter care orders an are is in place, this is a	-	
					acility practice. Audits/observ	vation will	
					e conducted randomly		I
					shifts, and will include		
					veekends. DON/Desig		
					esponsible for the com Audit findings will be pr		
					ne QA Committee mor		
					neeting x 6 months. T	-	
					f these audits will be r		
					he monthly QA Commi nonthly meetings for 6		
					Intil 100% compliance		
					3 consecutive months		
				C	Committee will identify	any trends	
					r patterns and make		
					ecommendations to re lan of correction as inc		
				۲ ۲		ulcaleu.	
0700		,					
0726 SS=E	483.35(a)(3)(4)(c Competent Nursi						
Bldg. 00	§483.35 Nursing	•					
J 74		have sufficient nursing staff					
	with the appropri	ate competencies and skills					
		ursing and related services					
		it safety and attain or est practicable physical,					
	-	hosocial well-being of each					
		rmined by resident					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE			7465 N	ADDRESS, CITY, STATE, ZIP COD IADISON AVE JAPOLIS, IN 46227		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETIO DATE
	considering the r diagnoses of the in accordance wi required at §483 §483.35(a)(3) Th licensed nurses I competencies ar care for residents through resident described in the §483.35(a)(4) Pr not limited to ass and implementin responding to res §483.35(c) Profit The facility must able to demonstr techniques neces needs, as identifi assessments, an care. Based on interview failed to ensure sta competencies to id resident that had b facility which resu physical (death), s female residents for competent nursing Resident D, Resid Finding includes: The clinical record on 2/2/22 at 12:30	e facility must ensure that have the specific d skill sets necessary to s' needs, as identified assessments, and plan of care. oviding care includes but is essing, evaluating, planning g resident care plans and sident's needs. ensure that nurse aides are ate competency in skills and sary to care for residents' ed through resident d described in the plan of w and record review, the facility aff had the skills and lentify and address a male een drinking alcohol in the lted in behavioral symptoms of exual, and verbal abuse toward or 4 of 4 resident B, Resident C,	F 0'	726	<ol> <li>Immediate actions takes for those residents identified Resident B no longer resides i the building. Residents affected were provid psychosocial support by social services and psychology servid and all residents were satisfied with the services provided.</li> <li>How the facility identified other residents: All residents with exhibited behaviors and change of cond have the potential to be affected</li> </ol>	: n ded l ces d	03/25/202

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD IADISON AVE		
IOMESTEAD HEALTHCARE CENTER		INDIAN	NAPOLIS, IN 46227			
X4) ID	SUMMARY	MARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CO.		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	and alcohol abuse.	The Quarterly Minimum Data		by the alleged deficient practice		
	Set (MDS) assessm	nent, dated 1/12/22, indicated		The clinical record of all residen	ts	
	Resident B was co	gnitively intact, required		with the potential for alcohol use	e	
	extensive assistance	e of one staff member for bed		or who have exhibited behaviors	S	
	mobility and transf	fers, and had moderate		will be audited to ensure that an	ıy	
	depression.			exhibited behavior has been		
				reported to the physician and		
	The clinical record	lacked documentation of a care		family, that behavior monitoring		
	plan for his behavi	or of drinking.		orders are documented and		
		-		implemented and that appropria	ite	
	During an intervie	w on 2/7/22 at 9:00 a.m., QMA 3		interventions are in place.		
	-	22 Resident B had been drinking		Interventions will be reviewed		
		nelled like alcohol. The resident		periodically for effectiveness an	d	
	-	aggressive when he had been		the physician notified if any	-	
	-	Resident B threatened to rape		intervention is ineffective. All ca	re	
	Resident D several			plans will be updated according		
				3) Measures put into	·y.	
	During an intervie	w on 2/7/22 at 9:50 a.m.,		place/System changes:		
	-	ed Resident B got violent when		All staff have been educated on		
		re was a day, the week before		existing facility policy and nursir		
		ot out of his wheelchair and in		practice to report behaviors	9	
	-	'you f**king b*tch, I'll knock		immediately to the charge		
		eelchair." Resident E told a		nurse/DON/ED/SSD. All staff		
	-	dent council and he said he		have been educated on assessi	ina	
	would take care of			challenging behaviors, resident	•	
		1		substance abuse and residents		
	During an intervie	w on 2/7/22 at 10:00 a.m., the		who are unaware of personal		
	-	ember indicated Resident B had		boundaries; this education		
		ale residents that didn't like		included but was not limited		
	•	and a half ago Resident E was		identifying, preventing, best		
		B because of vulgar comments		practices for managing aggress	ive	
		r. The resident council member		behaviors, documentation of		
		o staff. He was unable to		behaviors in the clinical record,		
	-	taff member he reported this to.		documentation from CNA/QMA	in	
	i internet which s	and memoer he reported this to.		POC on daily assigned task		
	During an interview	w on 2/7/22 at 10:20 a.m., LPN		identified as "Any changes in my		
	-	l Nurse) 2 indicated on 2/2/22 at		resident today". Residents	у	
		0 a.m., QMA 1 had come to the		identified with behaviors,		
	•••	was unable to verbalize what				
				substance abuse, or personal	rad	
	she saw. QMA I g	rabbed his hand and said,		boundary concerns will be refer	reu	

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465 N	ADDRESS, CITY, STATE, ZIP COD IADISON AVE IAPOLIS, IN 46227		
		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	"come on, come or	n." When he entered Resident		to SSD, MD, and IDT to determ	nine	
	C's room, he saw I	Resident B standing		if a need for additional		
	approximately a fo	oot away from Resident C's bed		psychotherapy, outpatient		
	with his pants dow	n to his ankles. The resident's		services, temporary 1:1, or		
	electric wheelchain	r was inside the room,		substance abuse counseling, c	or if	
	approximately a fo	oot behind him. Resident B was		relocation is required		
	trying to sit in the	wheelchair but was unsteady		4) How the corrective		
		n trying to speak to the nurse.		actions will be monitored:		
	The nurse smelled	alcohol when Resident B was		Monitoring of residents' behavi	ors	
	trying to speak. Th	here was a large bottle of dry gin		and substance abuse will be		
	on the floor.			conducted by the DON/Design	ee	
				Monday-Friday and the designation	ated	
	During an intervie	w on 2/9/22 at 2:35 p.m., the		clinical manager on Saturday a	nd	
	Director of Nursin	g indicated alcohol		Sunday by reviewing the 24-ho	ur	
	consumption woul	d not be considered a change		report, high priority progress		
	of condition, but th	ne physician should have been		notes, and Einteract alerts for		
	notified Resident I	3 was drinking alcohol.		change in condition. This is an		
				on-going facility practice.		
	On 2/15/22 at 11:5	6 a.m., the Director of Nursing		Residents will be monitored for		
	provided a copy of	f a facility policy, titled		behaviors 7 days weekly on all		
	"Notification for C	Change in Condition," dated		shifts via observation and verba	al	
	11/30/18, and indi	cated this was the current policy		interactions with the residents,		
	used by the facility	A review of the policy		including but is not limited to		
	indicated "unless t	here are documented		administrative rounding, Angel		
	extenuating circun	nstances, the nurse will report		care rounds, and nursing		
		ges in condition based on the		assessments and interactions.		
	following criteria			Non-verbal residents will have	a	
	-	r worsening physical or verbal		skin assessment completed no		
	aggression or a dat	nger to self or others."		less than weekly and any chan	•	
				in skin conditions including but	not	
	This Federal tag re	elates to Complaint IN00372277.		limited to bruising and		
				discoloration will be reported		
	3.1-14(a)(1)			immediately to the DON. This is		
				an on-going facility practice. Ar	ıy	
				grievances will be reviewed		
				Monday-Friday in the clinical		
				morning meeting to ensure		
				appropriate action and resolution	on	
				are provided. This is an ongoin	g	
			1	facility practice. The DON/		

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155780	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465 1	ADDRESS, CITY, STATE, ZIP COD MADISON AVE NAPOLIS, IN 46227	-	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
= 0742 SS=K Bldg. 00	483.40(b)(1) Treatment/Srvcs Concerns §483.40(b) Base assessment of a ensure that- §483.40(b)(1) A resident who d mental disorder of difficulty, or who and/or post-traur receives appropr to correct the ass the highest pract psychosocial wel Based on observat review, the facility resident for verbal behaviors, towards consumption for 1	Mental/Psychoscial d on the comprehensive resident, the facility must isplays or is diagnosed with or psychosocial adjustment has a history of trauma natic stress disorder, iate treatment and services sessed problem or to attain icable mental and	F 0742	<ul> <li>Designee will report the finding the interviews to the QA Committee monthly meetings the QA Committee will determ ongoing monitoring.</li> <li>DON/Designee is responsible compliance. The results of the audits will be reviewed in the monthly QA Committee month meeting for 6 months or until 100% compliance is achieved consecutive months. The QA Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.</li> <li>1. The facility failed to more a male resident for violent behaviors related to alcohol consumption which resulted i female residents being verbal abused and 1 female resident</li> </ul>	ngs of and nine of for ese hly d x 3 a ends ne d.	

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 02/16/2022	
NAME OF	NAME OF PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COD		
HOMES	TEAD HEALTHCAI	RE CENTER		5 MADISON AVE ANAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX		COMPLETI	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	resident being phy	sically (death) and sexually		sexually assaulted for 1 of 1		
		B, Resident C, Resident D,		resident reviewed for behavio	ors.	
	Resident E)			When a male resident was fo	ound	
	,			on top of a female resident w	ithout	
	This deficient prac	tice resulted in an Immediate		his pants on and a pillow ove		
	-	nediate Jeopardy began on,		head, which resulted in death		
		mately 12:00 p.m., when the		the female resident. Staff obs		
		plement behavior monitoring		an odor of alcohol on his brea		
		terventions to manage the		and a bottle of liquor on the f		
		le resident that became		Staff were aware of prior		
		female residents and		allegations of verbal threats a	and	
		I. The Administrator and		behaviors to female residents		
	Director of Nursing were notified of the Immediate			the male residents alcohol us		
		22 at 2:40 p.m. The Immediate		2. All residents and staff w		
		oved on 2/11/22 at 1:15 p.m., but		interviewed to identify any		
		nained at a lower scope and		residents with challenging		
	-	attern, no actual harm with		behaviors, behaviors related	to	
		than minimal harm that is not		substance abuse, and reside		
	Immediate Jeopard			who lack respect for persona		
	miniculate scopare			boundaries. Any resident		
	Findings include:			identified with a behavior had		
	i manigs metade.			behavior monitoring plan	i a	
	The clinical record	l of Resident B was reviewed on		implemented. Residents ider	atified	
		n. The diagnoses included, but		with a substance abuse histo		
	-	b, alcohol abuse and major		active use have agreed to	iy Oi	
	depressive disorde			participate in a behavior		
	depressive disorde	1.		plan/contract outlining guideli	inos	
	The Quarterly Mir	iimum Data Set (MDS)		to comply with the facility's		
	· ·	1/12/22, indicated Resident B		substance abuse policy. A		
	was cognitively in				o/bor	
	was cognitivery in	iaci.		resident's compliance with hi		
	The clinical record	l for Resident B lacked a		plan of care to include the be		
		re plan with appropriate		plan/contract and cooperation staff during their stay in the fa		
	<u>^</u>	dress major depressive			-	
		buse, and behaviors related to		is encouraged. The intent of Behavior Guidelines is to		
	consuming alcoho					
	consuming alcoho	1.		address the potential volition		
	The hear 14-1 4: 1	area summary data $\frac{1}{2}0/16/21$ -		behaviors of those individuals		
	-	arge summary, dated 9/16/21 at		have the capacity to understa	ano	
		d Resident B had been		the consequences of their		
	consuming alcoho	1 3 to 5 times per week,		behaviors. All residents with		

	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIEF		7465	ADDRESS, CITY, STATE, ZIP COD MADISON AVE NAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ohol than intended, and was		behaviors a have monitoring p	lan	
		is family member had made		in place, appropriate intervent	ions	
	him leave home due	e to alcohol consumption.		are implemented and current	with	
				the plan of care specific to any	/	
	During an interview	on 2/7/22 at 8:53 a.m., QMA 2		behaviors.		
	indicated Resident B seemed depressed over the			3. All staff have been educ	ated	
	past few weeks bec	ause his roommate moved out.		on the existing facility policy		
				requiring that behaviors are		
	-	ur of the facility, on 2/2/22		reported immediately to the		
	from 11:40 a.m. to 12:15 p.m., Resident C was in her room with Police Officers standing guard at the door. Resident C could not be observed from the			charge nurse/DON/ED/SSD.	All	
				staff have been educated on t	he	
				existing facility policy of		
hallway. Resident B was in his i different unit in the facility, with				assessing challenging behavior	ors,	
		-		residents' potential substance		
	standing guard at the door to the room. Resident B was observed sitting up in his electric			abuse, and residents who are		
				unaware of personal boundari		
	-	at the hallway with a flat affect		This education included but w	as	
	(showing no emotio	on on face).		not limited to identifying,		
				preventing, and managing		
	-	y on 2/3/22 at 5:10 p.m., QMA		aggressive behaviors,		
		on Aide) 1 indicated, she		documentation of behaviors in		
		s room and Resident B was on		clinical record, documentation		
		n bed, with his pants down.		from CNA/QMA in POC on da	-	
		as covered with Resident B's		assigned task identified as "Ar	•	
	-	mped off of Resident C and		changes in my resident today"		
		ent C was naked, had a small		Residents identified with		
		g, and her incontinence brief		behaviors, potential substance	;	
	was pulled to the si	ae.		abuse, or personal boundary		
	During our interm	x = 2/7/22 of 10.20 I DNI		concerns will be referred to SS	, טמ	
	-	y on 2/7/22 at 10:20 a.m., LPN		MD, and IDT to determine if a		
		Nurse) 2 indicated on $2/2/22$ at		need for additional psychother		
		a.m., he was at the nurse's		outpatient services, temporary		
		and 200 Hall. QMA 1 had come		substance abuse counseling,		
		n and was unable to verbalize		relocation is required.		
		A 1 grabbed his hand and said,		4. Monitoring of residents'		
		"When he entered Resident		behaviors and potential substa		
	C's room, he saw R	-		abuse will be conducted by the		
		ot away from Resident C's bed		DON/Designee Monday-Friday	y	
	-	to his ankles. Resident C's was inside the room,		and the designated clinical	y by	
	electric wheelchair	was inside the room,		manager Saturday and Sunda	y by	

TATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	DING	00	COMPLETED	
		155780	B. WING			02/16	/2022
JAME OF I	PROVIDER OR SUPPLIE	P	S	TREET A	DDRESS, CITY, STATE, ZIP COD		
IOMES	FEAD HEALTHCAF	RECENTER			APOLIS, IN 46227		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	П	D	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
		ot behind him. Resident B was			a review of the 24-hour report,	, high	
		wheelchair but was unsteady			priority progress notes, and		
	and confused when	n trying to speak to the nurse.			Einteract alerts for change in		
		alcohol when Resident B was			condition. This is an on-going		
	trying to speak. Th			facility practice. Residents will	be		
	on the floor. Resid			monitored for behaviors 7 day	s		
		and immediately placed on			weekly on all shifts including		
		ision with another staff			weekends via observation and	1	
		C was lying in bed, on her back,			verbal interactions with the		
	• · ·	part and her face looking at the			residents, this includes but is r	not	
	ceiling. Resident C	did not have a pulse, but her			limited to administrative round	ing,	
	body was warm to	touch.			Angel care rounds, and nursin	g	
					assessments and interactions.		
	During an interview	w on 2/7/22 at 9:00 a.m., QMA 3			Non-verbal residents will have	а	
	indicated on 1/28/2	22 Resident B had been drinking			skin assessment completed no	0	
	out of a cup that sn	nelled like alcohol. Resident B			less than weekly and any char	nges	
	could be verbally a	ggressive when he had been			in skin condition including but	not	
	drinking alcohol. R	Resident B threatened to rape			limited to bruising and		
	Resident D several	times on 2/1/22. QMA 3			discoloration will be reported		
	overheard other sta	iff discussing this at the			immediately to the DON. This	is	
	nurse's station Res	ident D hadn't reported this to			an on-going facility practice. A	ny	
	QMA 3. The QMA	was not sure if this had been			grievances will be reviewed		
	reported but indica	ted the threats should have			Monday-Friday in the clinical		
		e supervisor. The QMA was			morning meeting to ensure		
		er which staff members she had			appropriate actions and resolu	ition	
	heard discussing th	is at the nurse's station.			are provided. This is an ongoin	ng	
					facility practice.		
	-	w on 2/7/22 at 9:20 a.m.,			The The DON/ Designee will r	-	
		ed on 2/1/22 at approximately			the findings of the interviews to		
		t B began making inappropriate			monthly QA Committee meeting	ng	
		oward her. Resident B indicated			and the QA Committee will		
		he was going to "eat between			determine ongoing monitoring		
		e comments about Resident D's			that facility policy is implement		
		laughed and said, "just wait			and followed and to reinforce t		
		vait until tonight." Resident B			facility's commitment to abuse	•	
		these comments several times			prevention, investigation, and		
		y. Resident D reported this to			reporting and to ensure the sta	aff is	
		00 p.m. on 2/1/22. The QMA			aware of the potential		
	had indicated to Re	esident D not to worry because			consequences to both staff an	d	
	she would watch th	ne hall.			residents for failing to follow th	ne	

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	construction 00	COMPLETED	
		155780	B. WING	<u></u>	02/16/2022	
JAME OF	PROVIDER OR SUPPLIEF	<b></b>	STREE	T ADDRESS, CITY, STATE, ZIP C	COD	
				MADISON AVE NAPOLIS, IN 46227		
10IVIES		E CENTER		INAPOLIS, IN 40227		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COF	RRECTION (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				facility's policies.		
	-	v on 2/7/22 at 9:50 a.m.,				
		d Resident B told her she was				
		d to buy her jewelry. She said				
		lent B) got drunk, he would get				
		a day, the week before last,				
		of his wheelchair and in her				
	-	f**king b*tch, I'll knock you				
		air." Resident E told a member				
		cil about the incident with				
	Resident B, and he	said he would take care of it.				
	During an interviev	v on 2/7/22 at 10:00 a.m., the				
	resident council me	mber indicated Resident B had				
	been vulgar to fema	ale residents that he didn't				
	think liked him. Ab	out a week and a half ago,				
	Resident E was afra	nid of Resident B because of				
	vulgar comments h	e had made to her. The resident				
		d reported this to staff. He was				
		r which staff member he				
	reported this to.					
	During an interview	v on 2/10/22 at 1:03 p.m., the				
	Social Service Dire	ctor indicated she was not				
	aware of Resident I	B's alcohol use prior to				
	admission but if a r	esident was admitted with a				
		l abuse and had been				
	-	that would be considered a				
		dent was currently consuming				
		ould have attempted to send				
		overy center. If a recovery				
		lable or could not care for that				
		have had the resident sign a				
		The contract should have				
		lent consumed alcohol, they				
		d a 30-day notice for				
		atric services would have				
		vior monitoring, we would				
	have had it in place					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/16/2022 155780 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVE HOMESTEAD HEALTHCARE CENTER INDIANAPOLIS, IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE During an interview on 2/10/22 at 1:12 p.m., the Admission Coordinator indicated she could not remember the admission for Resident B but if a resident was referred for admission with a diagnosis of alcohol abuse and had been consuming alcohol, that would have been a concern and should have been reported to the Director of Nursing. During an interview on 2/10/22 at 1:20 p.m., the Director of Nursing indicated she had a concern regarding Resident B's admission because he had left other facilities against medical advice and a criminal background check showed he had previous drug and alcohol problems. Resident B originally was admitted for rehabilitation to home, but when the discharge process was started Resident B indicated to social services he was homeless. During an interview on 2/11/22 at 8:30 a.m., the Director of Nursing indicated the alcohol consumption and behaviors caused by consuming alcohol should have been monitored. There should have been appropriate interventions in place to address Resident B's behaviors. On 2/11/22 at 8:30 a.m., the Director of Nursing provided a copy of a facility policy titled, "Behavior Management General," dated 4/8/16, and indicated this was the current policy used by the facility. A review of the policy indicated "It is the policy of this facility to identify and safely manage residents who are exhibiting behaviors related to psychotropic diagnoses or who may present a danger to themselves or others." The Immediate Jeopardy, that began on 1/28/22, was removed on 2/11/22 when the facility inserviced staff on reporting behaviors, but the 26YZ11 Facility ID: 012225 Page 49 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

03/31/2022

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155780 B. WING 02/16/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVE HOMESTEAD HEALTHCARE CENTER INDIANAPOLIS, IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaint IN00372277. 3.1-43(a)(1) F 0745 483.40(d) SS=D Provision of Medically Related Social Service Bldg. 00 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on interview and record review, the facility Immediate actions taken F 0745 1) 03/25/2022 failed to provide appropriate social service for those residents identified: interventions for a male resident who was Resident B no longer resides in homeless and abused alcohol at the time of the facility. admission and was diagnosed with alcohol abuse for 1 of 1 residents reviewed for social services. 2) How the facility identified other residents: (Resident B) All residents who have a history of Findings include: alcohol abuse have the potential to be affected by the alleged deficient During an interview on 2/7/22 at 9:00 a.m., QMA 3 practice. All residents and staff indicated on 1/28/22 Resident B had been drinking were interviewed and asked to out of a cup that smelled like alcohol. The resident identify any residents with could be verbally aggressive when he had been challenging behaviors, behaviors drinking alcohol. related to substance abuse, and lack of respect for personal During an interview on 2/7/22 at 9:50 a.m., boundaries. Any resident Resident E indicated when he (Resident B) got identified with a behavior had drunk, he would get violent. There was a day, the behavior monitoring plan week before last, Resident B got out of his implemented. Residents' wheelchair and in her face and said, "you f\*\*king identified with a substance abuse b\*tch, I'll knock you out of that wheelchair." history and active use have agreed 26YZ11

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	R MEDICARE & MEDIC NT OF DEFICIENCIES	XAID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OM (X3) DATE	IB NO. 0938-0
AND PLAN OF CORRECTION				<u>00</u>	COMPLETED 02/16/2022	
	PROVIDER OR SUPPLIE		7465 N	ADDRESS, CITY, STATE, ZIP COD IADISON AVE NAPOLIS, IN 46227	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE OPRIATE	(X5) COMPLET DATE
	<ul> <li>(Licensed Practical approximately 5:00)</li> <li>wheelchair was ins foot behind him. R the wheelchair but when trying to speas smelled alcohol wh speak. There was a floor.</li> <li>The clinical record on 2/2/22 at 12:30 but were not limite and alcohol abuse.</li> <li>The Quarterly Min assessment, dated 1 was cognitively int assistance of one st and transfers, had r a manual wheelcha</li> <li>The hospital discha 2:19 a.m., indicated consuming alcohol consumed more alchomeless because I him leave home du</li> <li>During an interview Social Service Dire aware of Resident 1 admission but if a resident 1 admission but if a resident 2 alcohol, first she w</li> </ul>	v on 2/7/22 at 10:20 a.m., LPN Nurse) 2 indicated on 2/2/22 at 0 a.m., Resident B's electric ide the room, approximately a esident B was trying to sit in was unsteady and confused ak to the nurse. The nurse ten Resident B was trying to large bottle of dry gin on the for Resident B was reviewed p.m. The diagnoses included, d to, major depressive disorder imum Data Set (MDS) 1/12/22, indicated Resident B act, required extensive aff member for bed mobility noderate depression, and used ir. trge summary, dated 9/16/21 at d Resident B had been 3 to 5 times per week, cohol than intended, and was his family member had made e to alcohol consumption. v on 2/10/22 at 1:03 p.m., the tector indicated she was not B's alcohol use prior to resident was admitted with a of abuse and had been , that would be considered a ident was currently consuming ould have attempted to send covery center. If a recovery		to participate in a behavior contract outlining guideline comply with the facility's substance abuse policy. A resident's compliance with plan of care including the contract and cooperation of during the stay in the facility encouraged. The intent of <b>Behavior Guidelines</b> is to address the volitional beh those individuals who hav capacity to understand the consequences of their bel All residents with behavior behavior monitoring planss a current plan of care, with appropriate interventions implemented and the impli- interventions are monitore effectiveness. Ineffective interventions are removed care plan and the resident reassessed for more appr and effective interventions <b>3) Measures put into place/System changes:</b> The Regional Director of C Operations has educated Social Service Director, D and IDT on the need to ar implementation of approp- interventions for residents identified with alcohol/sub abuse. The DON/SSD have educated the staff on the expectation and policy on monitoring with an empha- alcohol/substance abuse a	es to A h his/her behavior with staff ity is of the o aviors of re the e haviors. rs have a in place, h has been lemented ed for d from the t is ropriate s. Clinical the ON, ED, hd proper riate stance d facility's behavior usis on	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE ( A. BUILDING B. WING	COMPLE	(X3) DATE SURVEY COMPLETED 02/16/2022	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD MADISON AVE		
HOMES	TEAD HEALTHCAI	RE CENTER		NAPOLIS, IN 46227		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E RIATE	(X5) COMPLETION
TAG	center was not ava resident, she would behavior contract. included if the resi would have receiv discharge. If psych recommended beh have had it in plac The clinical record referral to recover 30-day notice for of On 2/7/22 at 11:00 provided a copy of "Resident Substan 8/20/18, and indicaused by the facility indicated "Abused alcohol. The facili under the influence discharge of the su	l lacked documentation of a y center, behavior contract nor a	TAG	appropriate and timely implementation of intervention designed to keep the resident fellow residents safe. 4) How the corrective action will be monitored: DON/designee/Social Service audit 3 resident records 3 tim week x 4 weeks, then 3 resident records 1 time weekly thereas for 5 months to ensure appro- interventions are implemented in place for residents identifit with alcohol/substance abus DON will monitor the SSD to ensure compliance with aud compliance. DON/Designee/Social service Director is responsible for compliance. The results of the audits will be reviewed in the Committee monthly meeting months or until 100% compli is achieved x 3 consecutive months. The QA Committee identify any trends or pattern make recommendations to n the plan of correction as indi-	nt and ns e will nes a dent after opriate ed and ed e. The o its and e e e QA s for 6 iance e will nes a e will e will e will e will e will e mode e will e will e mode e mode e mode e will e mode e mode e mode e will e mode e mode	DATE
F 0835 SS=E Bldg. 00	483.70 Administration §483.70 Adminis A facility must be	tration. • administered in a manner				
	that enables it to and efficiently to highest practicab psychosocial wel Based on observat review, the facility	use its resources effectively attain or maintain the le physical, mental, and l-being of each resident. ion, interview, and record administration failed to al and physical wellbeing of	F 0835	1)Immediate actions taken those residents identified: Resident B no longer reside		03/25/202

STATEME	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CO A. BUILDING B. WING	00	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 02/16/2022
	PROVIDER OR SUPPLIE		7465 N	ADDRESS, CITY, STATE, ZIP COD IADISON AVE IAPOLIS, IN 46227	
X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		PR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
IAG	residents when a n verbally and physi residents. (Resider Findings include: The clinical record 2/2/22 at 12:30 p.r were not limited to depressive disorde The Quarterly Mir assessment, dated was cognitively in The hospital disch 2:19 a.m., indicate consuming alcoho consumed more al homeless because him leave home du During an intervie Director of Nursin regarding Residen left other facilities criminal backgrou previous drug and originally was adn but when the disch Resident B indicat homeless. 1. During the initi from 11:40 a.m. to	hale resident (Resident B) cally abused 3 of 4 female at C, Resident D, Resident E) d of Resident B was reviewed on n. The diagnoses included, but o, alcohol abuse and major r. himum Data Set (MDS) 1/12/22, indicated Resident B tact. arge summary, dated 9/16/21 at d Resident B had been 13 to 5 times per week, cohol than intended, and was his family member had made ue to alcohol consumption. w on 2/10/22 at 1:20 p.m., the g indicated she had a concern t B's admission because he had against medical advice and a nd check showed he had alcohol problems. Resident B hitted for rehabilitation to home, harge process was started ed to social services he was al tour of the facility, on 2/2/22 o 12:15 p.m., Resident C was in her		the facility. Residents C no longer resides the facility. Resident D and E were offere if accepted were provided psychosocial therapy by psych services and additionally had follow-up for psychosocial well-being from SSD with continuing monitoring and inq <b>2) How the facility identified</b> <b>other residents:</b> All residents had the potential be affected by the alleged def practice. Abuse interviews we completed with all alert and oriented residents to identify a concerns. Residents who cou not be interviewed had a head toe skin assessment complete and any findings were reported the physician. All staff were interviewed for any allegations incidents that may constitute abuse that were potentially no reported or investigated in accordance with existing facilit policy. Any findings have beer reported to ISDH and other reporting agencies. Families a physicians have been notified SSD is following up with any affected resident and notifying psychologist, physician, and	s in d and h uiry. to icient re any ld d to ed d to s of ot ty en and
	door. Resident C v his room, located o with a Police Offic	Officers standing guard at the vas deceased. Resident B was in on a different unit in the facility, cer standing guard at the door to t B was observed sitting up in		family for additional support. O plan have been updated as needed. All residents' behavior monito was reviewed to identify any	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE C A. BUILDING B. WING	005TRUCTION	X3) DATE SURVEY COMPLETED 02/16/2022
	PROVIDER OR SUPPLIE		7465 N	ADDRESS, CITY, STATE, ZIP COD 1ADISON AVE 1APOLIS, IN 46227	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	his electric wheele	hair staring at the hallway with		increased behaviors.	
	a flat affect (show)	ng no emotion on face).		Through resident and staff	
				interviews were conducted to	
	During an intervie	w on 2/3/22 at 5:10 p.m., QMA		identify any behavior that	
	(Qualified Medica	tion Aide) 1 indicated, she		constitutes abuse and/or requir	e
	entered Resident C	"s room and Resident B was on		follow-up. Any concerns were	
		in bed, with his pants down.		immediately addressed.	
		vas covered with Resident B's			
	hand. Resident B j	umped off of Resident C and			
	left the room. Resi	dent C was naked, had a small		3)Measures put into	
		eg, and her incontinence brief		place/System changes:	
	was pulled to the s	ide.		The Regional Director of Clinica	al
				Operations has educated the E	D,
	-	w on 2/7/22 at 10:20 a.m., LPN		DON, and IDT on existing facility	y
	(Licensed Practica	l Nurse) 2 indicated on 2/2/22 at		policy and requirement for	
		0 a.m., he was at the nurse's		maintaining the mental and	
		and 200 Hall. QMA 1 had come		physical well-being of residents	by
		on and was unable to verbalize		ensuring behaviors are monitor	ed
		A 1 grabbed his hand and said,		and incidents are reported,	
		n." When he entered Resident		investigated, and managed	
		Resident B standing		appropriately. The DON has	
		ot away from Resident C's bed		in-serviced all staff and residen	ts
	-	n to his ankles. The resident's		on the existing facility policy	
		was inside the room,		regarding reporting abuse direct	
		oot behind him. Resident B was		to Administrator. Nursing staff v	
		wheelchair but was unsteady		educated on existing facility pol	icy
		n trying to speak to the nurse.		and expectation that alleged	
		alcohol when Resident B was		abuse will be reported immedia	tely
		ere was a large bottle of dry gin		to the ED for investigation and	
		ent B was escorted out of		follow-up and the facility's exist	ng
		and immediately placed on		policy and expectation that	
	-	ision with another staff		physician and family will be	
		C was lying in bed, on her back,		notified of any condition change	<b>;</b> ,
	<b>.</b> .	bart and her face looking at the		behavior, or injury. Behaviors	
	e	did not have a pulse, but her		and/or change of condition will	
	body was warm to	touch.		reviewed by the Interdisciplinar	
	2 Dania i c			Team and/or designee to ensur	
	-	view on 2/7/22 at 9:00 a.m., QMA		resident's change of condition i	6
	3 indicated on 1/28/22 Resident B had been			reported to physician /psych	
	drinking out of a c	up that smelled like alcohol.		services /family member/DON a	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

HOMESTEAD HEALTHCARE CENTER

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

JMAN SERVICES			FOF	RM APPROVED	
CAID SERVICES			OMB NO. 0938-039		
X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPL 02/16/	ETED	
R RE CENTER	7465 M	ADDRESS, CITY, STATE, ZIP COD ADISON AVE IAPOLIS, IN 46227			
' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
be verbally aggressive when he alcohol. Resident B threatened several times on 2/1/22. The rd other staff discussing this at		in accordance with existing fac policy and regulatory requirements. The Regional Director of Clinical Operations			

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)
	Resident B could be verbally aggressive when he		in accordance with existing facility
	had been drinking alcohol. Resident B threatened		policy and regulatory
	to rape Resident D several times on 2/1/22. The		requirements. The Regional
	QMA had overheard other staff discussing this at		Director of Clinical Operations will
	the nurse's station on $2/1/22$ . The QMA was not		be responsible for compliance of
	sure if this had been reported but indicated the		completing staff education.
	threats should have been reported to the		1 5
	supervisor. The QMA was unable to remember		4)How the corrective actions
	which staff members she heard discussing this at		will be monitored:
	the nurse's station.		SSD will interview 5 residents
			weekly x 4 weeks, then 3
	During an interview on 2/7/22 at 9:20 a.m.,		residents weekly x 4 weeks, then
	Resident D indicated on $2/1/22$ at approximately		5 residents monthly to ensure
	2:00 p.m., Resident B began making inappropriate		their mental and physical
	sexual comments toward her. Resident B indicated		well-being is being maintained by
	to Resident D that he was going to "eat between		the facility and staff and that any
	my legs" and made comments about Resident D's		behaviors or condition changes are
	breasts. Resident B laughed and said, "just wait		reported and followed up upon in
	until tonight, just wait until tonight." Resident B		accordance with facility policy and
	continued to make these comments several times		regulatory requirements.
	throughout that day. Resident D reported this to		Audits/observation will be
	QMA 4 around 11:00 p.m. on 2/1/22. At that time,		conducted randomly, across all 3
	QMA 4 had indicated to her (Resident D) not to		shifts, and will include weekends.
	worry because she would watch the hall.		DON/Designee/Social Service
	won'y because she would watch the han.		Director is responsible for the
	The clinical record for Resident D was reviewed		compliance. The results of these
	on $2/7/22$ at 11:00 a.m., the diagnoses included,		audits will be reviewed in the
	but were not limited to, debility, morbid obesity,		
	and acquired absence of right and left legs above		monthly QA Committee monthly
			meetings for 6 months or until
	the knee. The Quarterly MDS assessment, dated 12/11/21, indicated Resident D was cognitively		100% compliance is achieved x 3
			consecutive months. The QA
	intact.		Committee will identify any trends
	2. During an interview on $2/7/22$ at 0.50 a re-		or patterns and make
	3. During an interview on 2/7/22 at 9:50 a.m.,		recommendations to revise the
	Resident E indicated Resident B told her she was		plan of correction as indicated.
	beautiful and offered to buy her jewelry. She said		
	no. When he (Resident B) got drunk, he would get		
	violent. There was a day, the week before last,		
	Resident B got out of his wheelchair and in her		
	face and said, "you f**king b*tch, I'll knock you		

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STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155780         NAME OF PROVIDER OR SUPPLIER         HOMESTEAD HEALTHCARE CENTER		(X2) MULTIPLE CO A. BUILDING B. WING	COMI	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 02/16/2022		
		STREET A 7465 M INDIAN				
HOMES (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE) REGULATORY O out of that wheeled this happen and ha Resident E told a r about the incident would take care of During an intervie: resident council m been vulgar to fem him. About a week afraid of Resident he had made to her had reported this to remember which s The clinical record 2/7/22 at 11:40 a.m were not limited to mobility, and debil assessment, dated was cognitively im On 2/7/22 at 11:00 provided a copy of titled "Indiana Abu Misappropriation of was the current point ceview of the polic of alleged abuse	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION hair." She didn't think staff saw d not reported this to staff. nember of the resident council with Resident B, and he said he "it. w on 2/7/22 at 10:00 a.m., the ember indicated Resident B had ale residents that didn't like t and a half ago, Resident E was B because of vulgar comments the resident council member to staff. He was unable to taff member he reported this to. f for Resident E was reviewed on h., the diagnoses included, but o, morbid obesity, reduced lity. The Quarterly MDS 11/11/21, indicated Resident E	ID PREFIX TAG	APOLIS, IN 46227  PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Director of Nursin incident or allegati	isor or designee will notify the g and Executive Director of the on immediately" lates to Complaint IN00372277.				

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