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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING 00 B. WING	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HEALTHCARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00374452 and IN00374538. This visit resulted in a Partially Extended Survey- Substandard Quality of Care- Immediate Jeopardy. This visit was in conjunction with the Recertification and State Licensure Survey. Complaint IN00374452 - Unsubstantiated due to lack of evidence. Complaint IN00374538 - Substantiated. Federal/State deficiencies related to the allegations are cited at F641, F684, F690, F711, and F725. Survey dates: March 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 21, 2022 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 4 Medicaid: 61 Other: 10 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed March 29, 2022.			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for for 1 of 21 residents reviewed. An indwelling urinary catheter was not coded on the MDS assessment. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS assessment, dated 1/1/22, indicated Resident B was cognitively intact and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley (urinary) catheter that was draining clear urine. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 P.M., indicated ...Resident B had an indwelling Foley catheter and the catheter had been removed three days prior due to irritation. During an interview on 3/14/22 at 8:47 A.M. The MDS Coordinator indicated she was not aware Resident B had an indwelling urinary catheter because there were no orders entered into the electronic medical record. The indwelling	F 0641	**F 641** **1) Resident B no longer resides in the facility. 2) Any resident who has an indwelling catheter has the potential to be affected by the alleged deficient practice. An audit was conducted on all residents with indwelling catheters to confirm their most recent MDS reflects accurate coding of an indwelling catheter, that catheter care orders are in place, and that the plan of care is updated accordingly. Any findings were immediately corrected and the family and physician were notified. 3) The Regional Resident Care Coordinator has educated the MDS coordinator reinforcing the need for accurately completing an MDS per the guidelines of the RAI manual. 4) The Regional Resident Care Coordinator will audit 3 resident MDS's weekly x 4 weeks, then 5 resident MDS's monthly x 5 months to ensure the accuracy of the resident MDS assessment.MDS coordinator is responsible for the compliance. The results of**	04/27/2022

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	urinary catheter should have been documented on the Admission MDS assessment. On 3/21/22 at 3:20 P.M., the facility was unable to provide a policy regarding MDS assessment accuracy by survey exit. This Federal tag relates to Complaint IN00374538. 3.1-31(d)		**these audits will be reviewed in the Quality Assurance Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0684 SS=J Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. A. Based on interview and record review, the facility failed to ensure a physician order was followed for transferring a resident to the hospital. Two days later the resident was found unresponsive for 1 of 3 residents reviewed for hospital transfers. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 1/11/22 at approximately 2:32 p.m., when the facility failed to follow a physician's order to send a resident to the hospital. Two days later the resident was found unresponsive. The Administrator, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 3/11/22 at 5:00 p.m.	F 0684	The facility respectfully request an IDR to lessen the scope and severity for this alleged deficient practice related to the documentation in the citation was not obtained by the treating NP and Glucagon is not indicated for administration for a blood sugar of 62. ***1.*** The facility allegedly failed to ensure physician's orders for transfer to the hospital were followed. Two days later the resident was found unresponsive. (Resident B) Resident B was seen	04/27/2022

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	The Immediate Jeopardy was removed on 3/16/22 at 4:05 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on interview and record review, the facility failed to ensure medication for reversal of low blood sugar was available and given per nursing measures to treat an acute episode of hypoglycemia resulting in hospitalization for 1 of 3 residents reviewed for diabetic care. (Resident C) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 2/22/22 at approximately 8:50 a.m., when the facility failed to provided glucagon as a nursing measure to treat a hypoglycemic episode. The resident was sent emergently to the emergency room. The Administrator, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 3/11/22 at 5:00 p.m. The Immediate Jeopardy was removed on 3/16/22 at 4:05 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. C. Based on observation, interview, and record review, the facility failed to ensure care was provided to maintain the highest practicable well being for 4 of 21 residents reviewed. Physician's orders were not in place for a resident admitted with surgical wounds and dressings on open wounds were not dated, (Resident J, Resident D, Resident E, Resident F)		by the Nurse Practitioner (NP) on 1/11/22 for a regular visit. The resident asked to be sent to the hospital and the N P ordered the resident be sent to the hospital. On l /13/22 the resident was found unresponsive at the facility and was sent to the hospital with sepsis, respiratory failure, and acute urinary tract infection. At the hospital the resident was placed on palliative care on 1/14/22. B. The facility allegedly failed to ensure medication to reverse low blood sugar was available and administered in accordance with nursing measures to treat an acute episode of hypoglycemia which ultimately resulted in the resident being hospitalized. (Resident C). Resident C was experiencing seizure activity and hypoglycemia with a blood glucose of 64 on 2/22/22. The resident could not drink and the staff could not find Glucagon to administer to increase the blood glucose. The nurse obtained an order from the physician to transfer Resident C to the hospital. C. Resident J, D, E, and F were part of a confidential complaint survey and could not be identified. ***2.*** A facility-wide audit will be completed to ensure all physician's orders for transfer to the hospital for residents who	

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	Findings include: A. The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and respiratory failure. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact. A Nurse Practitioner Note, dated 1/11/22 at 2:32 p.m., indicated Resident B was seen for increased confusion and fever. The Physical Therapist reported Resident B had increased confusion and agitation. The resident requested to go to the hospital. An order to send the resident to the emergency room for evaluation was written. A Nurse's progress note, dated 1/13/22 at 3:49 p.m., indicated Resident B was found unresponsive. Resident B's blood pressure was 80/39 mm/Hg (millimeters/Mercury), temperature 101.2 degrees Fahrenheit, pulse 139 beats per minutes, and the blood sugar was 154. Emergency services were called to transport the resident to the emergency room for evaluation. During an interview on 3/9/22 at 3:13 p.m., the Director of Nursing indicated there was no order written to send Resident B to the hospital nor was an order entered into the electronic medical record. The Nurse Practitioner note, dated 1/11/22 at 2:32 p.m., was not actually signed until 1/14/22 at 10:22 a.m., so the staff wouldn't have been aware Resident B needed to be sent to the hospital. During an interview on 3/11/22 at 11:01 a.m., the Nurse Practitioner indicated she had written an		experience a change in condition are followed and the resident is or was transferred to the hospital. This audit will review any residents who experienced a change in condition in the past 3 days to ensure that the resident was transferred to the hospital if the resident's physician ordered the resident be transfer to the hospital. Any findings indicating a transfer order was not followed will be reported to the family and physician and any follow-up orders are implemented. The DON validated on 03/11/2022 the facility has 3 glucagon injection kits in the Emergency Drug Kit (EDK). All licensed nurses will be educated on the existing facility policy and procedure for hypoglycemia and know the location of medications needed in an emergency situation. This education will be completed by the DON/Designee with all nurses at the beginning of each shift until all licensed nurses have been educated. All licensed nurses will be educated in orientation on the location of glucagon. This education will reinforce the expectation that physician's orders for transfer to the hospital are implemented immediately and that residents requiring emergency medication from the EDK receive those medications as well as the potential consequences to the	

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	order to send Resident B to the Emergency Department and had not reported that to a nurse because it wasn't emergent at that time. The Nurse Practitioner put the order in a mailbox outside the Assistant Director of Nursing's (ADNS) office which was the standard practice used when the Nurse Practitioner wrote new orders for any residents. When the Nurse Practitioner saw him on 1/13/22, she was going to follow up on labs because he was never sent to the hospital as per the 1/11/22 written order. She does not remember Resident B reporting he had refused to go to the Emergency Department nor the staff reporting that Resident B refused to go to the Emergency Department. Resident B should have been sent to the Emergency Department on 1/11/22. During an interview on 3/11/22 at 2:47 p.m., RN (Registered Nurse) 1 indicated she had been working at the facility for several weeks. The Assistant Director of Nursing (ADNS) had been entering the new orders into the electronic medical record and would give a verbal report to the staff to notify them of the new orders. The Nurse Practitioners sometimes entered the orders for themselves, but most of the time it had been the ADNS. During an interview on 3/11/22 at 3:07 p.m., the ADNS indicated she had been entering the new orders for the Nurse Practitioners during the month of January. The Nurse Practitioner's would put the new orders in a mailbox outside her office and then she, the DON, or the Infection Preventionist would enter them into the electronic medical record. They did this because the Nurse Practitioner was not able to sign into the electronic medical record to enter the new orders. She was not aware of an order to send		residents and staff if physician's orders are not followed or residents are not promptly administered medications from the EDK. A facility-wide audit was conducted on all residents requiring wound care to ensure that all physician's orders were documented and implemented. *3.* The DON/Designee will educate all licensed nurses on the facility's existing policy of following physician's orders for transfer to the hospital, and ensure all staff and physician service staff are aware of how to communicate new orders from physicians to staff. All licensed nurses will be educated on the existing facility policy and procedure for treating hypoglycemia and know the location of medications needed in an emergency. This education will be completed by the DON/Designee with all nurses at the beginning of each shift until all licensed nurses have been educated. The DON/Designee has educated all licensed nurses on the existing facility policy identified as, "Skin Care and Wound Management Overview" with emphasis on transcribing and completing wound care and dating the dressing. This education will reinforce the expectation that	

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	Resident B to the hospital. On 3/11/22 at 2:30 P.M., a Hospital Progress Note, dated 1/13/22, indicated Resident B was admitted with sepsis, respiratory failure, an acute urinary tract infection. On 3/11/22 at 2:30 P.M., a Hospital Discharge Summary, dated 2/8/22, indicated on 1/28/22 Resident B was comfort measures only. Resident B's respirations had ceased. On 3/11/22 at 4:21 p.m., the Administrator provided a copy of a facility policy, titled "Physician Orders," dated 8/2010, and indicated this was the current policy used by the facility. A review of the policy indicated "...The provider may write the order in the medical record... place orders in electronic medical record... print copy for Physician to sign and place in paper chart unless they are being signed electronically... the nurse that takes the Physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse... contact...outside venders as required to execute the medical order... notify internal staff of changes/updates as appropriate. document contacts in the medical record." B. The clinical record for Resident C was reviewed on 3/11/22 at 12:50 p.m. The diagnoses included, but were not limited to, diabetes mellitus and schizophrenia. The Annual MDS (Minimum Data Set) assessment, dated 12/24/21, indicated Resident C was cognitively intact and had received insulin every day. A Nurse's progress note, dated 2/22/22 at 1:52 p.m. indicated "I was informed by the QMA (Qualified Medication Aide) on 700-hallway that		facility policies and nursing measures be followed and the potential consequences to both residents and staff if facility policies and nursing measures are not followed. ***4.*** The DON/Designee will complete an exit conference with any provider who treats residents to confirm that orders to transfer a resident to the hospital are implemented, that there is a progress note indicating an order to transfer a resident to the hospital has been obtained, and that the transfer order has been communicated to the licensed nurse. This will remain an ongoing practice of the facility. The DON/Designee will audit all residents' progress notes daily to confirm any order to transfer a resident to the hospital has been timely implemented . This will remain an ongoing practice of this facility. The DON/Designee will audit the EDK five times a week for 4 weeks to confirm that glucagon kits are available, then three times a week for 4 weeks, then weekly for 4 weeks. The DON/Designee will interview 5 licensed nurses a week to confirm they know the location of glucagon kits in the facility for 4 weeks, then 5 nurses a month for 2 months. Any findings from the audits will be addressed with staff immediately.	

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	[Resident C] was having seizure activities at 0850. I immediately rushed to the room knowing that a QMA was on that hallway. When I got to the room [Resident C] was sitting up in the wheelchair dressed. Both QMA and CNA (Certified Nursing Aide) were in the room. [Resident C] was lethargic but could respond to voices... While observing [Resident C] for seizure activity, I did not see any activity going on. Then I asked the QMA what [Resident C's] blood sugar was. QMA reported that [Resident C's] blood sugar was 70 this morning... when she rechecked the blood sugar, it reads 64. [Resident C's] unresponsiveness continues to worsen. The QMA brought orange juice but [Resident C] was not able to drink. Then I rushed to get glucagon [a prescription medication to treat hypoglycemia] to administer and there is none on the cart or EDK [Emergency Drug Kit] on both sides. Then I called 911. When the ambulance arrived, I reported to them what the situation was and asked for glucagon. During their assessment, [Resident C's] blood sugar went down to 36. [Resident C] was transported to the hospital." The February 2022 MAR (Medication Administration Record) indicated Resident C's blood sugar reading, on 2/22/22 at 7:30 a.m., was 70. During an interview on 3/11/22 at 3:15 p.m., RN (Registered Nurse) 1 indicated she was unable to locate the glucagon for when a resident becomes hypoglycemic. She was unsure where to find the EDK. During an interview on 3/11/22 at 3:30 p.m., LPN (Licensed Practical Nurse) 1 indicated nurses ask each other where to find the glucagon for when a resident's blood sugar declines. LPN		The DON/Designee will review and observe random residents' wound care dressings to ensure the dressings indicate the date applied on the following schedule: 10 residents weekly x 4, then 5 residents weekly x 4, then 10 residents monthly x 4 months. The DON/Designee will reconcile all new admission orders to ensure accuracy in transcription including ensuring that treatment orders are entered in the resident's clinical record. This will remain an ongoing facility practice. It will be a documented audit for 6 months and remain a regular practice thereafter. The DON/Designee is responsible for 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 meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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1 was observed to search through the east and west wing medication room refrigerators and was unable to find the glucagon in either refrigerator.

During an interview on 3/12/22 at 10:25 a.m., the Director of Nursing indicated the facility did not have standing orders for an emergency reversal medication for hypoglycemia (low blood sugar). A physician's order would be required before the nurse could administer the medication.

During an interview on 3/13/22 at 10:00 a.m., UM 1 indicated that if a resident was admitted with insulin orders she would call the physician to see if they would like to add an order for glucagon because a resident's blood sugar could drop with insulin.

During an interview on 3/13/22 at 1:54 p.m., the Medical Director indicated that if a nurse would have called and asked for an order for glucagon, he would have given it.

On 3/11/22 at 3:00 p.m., the Director of Nursing provided a copy of a facility policy, titled "Blood Glucose Point of Care Testing," dated 12/2014, 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 provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...Extremely low blood glucose levels (hypoglycemia) may result in confusion, unusual behaviors, coma, and even death if left untreated."

C1. During an interview on 3/14/22 at 10:08 A.M., Resident J indicated his surgical wound treatment to his left ankle had not been completed as ordered by the physician when he

initially admitted to the facility.

The clinical record for Resident J was reviewed on 3/10/22 at 9:40 A.M. The diagnoses included, but were not limited to, stress fracture of left ankle and fracture of lower left tibia. The Admission MDS (Minimum Data Set) assessment, dated 10/30/21, indicated Resident J was cognitively intact, did have surgical wounds, but did not require surgical wound care.

An Initial Admission Evaluation, dated 10/23/21, indicated "Skilled services/reason for admission: wound care... skin intact, resident will remain free of skin breakdown...nurse completing this section [the wound nurse]."

A hospital discharge summary, dated 10/23/21, indicated collagenase ointment (a prescription ointment used to debride wounds) apply 1 application topically 2 times a day.

A Wound Nurse Practitioner Note, dated 10/25/21 at 9:06 A.M., indicated "location - left medial ankle...follow surgeon's orders and scheduled follow up appointments-wet to dry dressings daily."

A Physician's orders, dated 11/16/21, indicated cleanse left medial foot and lateral ankle with normal saline, apply wet to dry dressing, cover with pad and secure every day shift for wound care with a start date of 11/17/21.

The November 2021 TAR (treatment administration record) indicated on 11/17/21 Resident J started receiving the wet to dry dressing to the left foot and ankle that was ordered on 10/25/21.

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On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled "Resident Council Minutes," dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document.

During an interview on 3/21/22 at 9:25 A.M., the Wound Nurse indicated she could not explain why the treatment order from 10/25/21 was not entered into the electronic medical record until 11/17/21 because she didn't work for the facility at that time. However, the Initial Admission Evaluation, dated 10/23/21, indicated she completed the skin section of the evaluation. She was able to recall Resident J admitted with an infection in his wounds.

On 3/11/22 at 4:21 P.M. The Administrator provided a copy of a facility policy, titled "Physician Orders," dated 8/3/2010, and indicated this was the current policy used by the facility. A review of the policy indicated "Medical Orders Transcription...the provider may write the order in the medical record...a provider may give a medical order over the phone...verbal orders are accepted but will be input into [the electronic medical record] by the nurse as soon as practicable. The practitioner will need to sign off on these orders..."

C2. During a random observation on 3/13/22 at 10:00 a.m., Resident D was observed in his room. The resident was lying in his bed. A soiled, undated dressing was noted on his mid-abdomen. The resident was observed to expose the wound. The wound had a moderate

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HEALTHCARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

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amount of thick, dark red, and whitish drainage. During an interview the resident indicated his dressing did not get changed every day.

On 3/14/22 at 9:30 a.m., Resident D was observed in his room. An undated dressing was noted on his mid-abdomen.

During a wound care observation on 3/15/22 at 10:00 a.m., the Wound Nurse was observed at the resident's bedside. The Wound Nurse removed an undated dressing. During an interview, at that time the Wound Nurse indicated the dressing should be dated at the time the dressing was changed.

On 3/15/22 at 10:30 a.m., the clinical record of Resident D was reviewed. The diagnosis included but were not limited to, open wound of abdominal wall.

A Quarterly MDS (Minimum Data Set) assessment, dated 2/21/22, indicated Resident D was cognitively intact.

A Physician's Order Summary Report, dated March 17, 2022, indicated "Cleanse surgical site to mid abdomen with NS [normal saline], pat dry, apply xeroform in wound bed and lastly cover with a bordered gauze Q [every] night shift for surgical wound."

A Care Plan, dated 4/30/21 and current through 3/28/22, indicated Resident D was at risk for altered skin integrity related to impaired mobility. The resident had a surgical wound. The interventions included but were not limited to administer treatments as ordered by a medical provider.

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A Nurse Practitioner note, dated 3/7/22, indicated to encourage nursing staff to change dressings as ordered.

A wound evaluation, dated 3/14/22, indicated to change the dressing daily.

C3. During an interview on 3/18/22 at 2:30 p.m., Resident E indicated his dressings did not get changed every day as ordered by the physician.

On 3/21/22 at 8:30 a.m., the clinical record of Resident E was reviewed. The diagnoses included but were not limited to, acquired absence of right toe and dependence of renal dialysis.

The Annual MDS assessment, dated 12/17/21, indicated Resident E was cognitively intact.

The physician orders, dated 3/17/22, indicated Right plantar/heel eschar: Cleanse area with wound cleanser or normal saline. Paint the areas with Betadine daily, secure with dry gauze/kerlix daily.

During a wound care observation on 3/17/22 at 2:33 p.m., the Wound Nurse was observed completing Resident E's dressing change. The dressing on Resident E's right foot was undated. During an interview at that time, the Wound Nurse indicated the dressing should have been dated.

On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled "Resident Council Minutes," dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J,

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Resident C and Resident F as indicated by the document.

C4. During an interview on 3/13/22 at 11:30 a.m., Resident F indicated the areas on his legs were getting worse and sometimes the dressings on this legs do not get changed for days.

On 3/15/22 at 2:33 p.m., the clinical record of Resident F was reviewed. The diagnosis included but were not limited to, Type 2 diabetes mellitus with diabetic neuropathy.

The Annual MDS assessment, dated 3/12/22, indicated Resident F was cognitively intact.

A Physicians Order, with a start date of 12/27/21, indicated to wrap the bilateral lower extremities with kerlix and ace wraps from toes to knees every day for lymphedema.

A care plan, undated, indicated Resident F was at risk for further skin breakdown. The interventions included, but were not limited to: evaluate existing wound daily.

During a wound care observation on 3/18/22 at 2:00 p.m., the ADON was observed providing wound care. The ADON removed the undated dressing. During an interview at that time, the ADON indicated the dressing should have been dated indicating the date of the previous dressing change.

A wound evaluation, dated 3/14/22, indicated to change the dressing daily.

On 3/18/22 at 2:15 p.m., a policy/procedure was requested from the ADON for dating the dressing at the time it was changed.

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	On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled "Resident Council Minutes," dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. On 3/21/22 at 4:00 p.m., a policy/procedure for dating dressings was not provided from the facility by the end of the exit date. The Immediate Jeopardy, that began on 1/11/22 and 2/22/22, was removed on 3/16/22 when the facility inserviced the facility staff on following physician's orders and emergency diabetic medications, but the 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 is related to Complaint IN00374538. 3.1-37(a)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure urinary catheter care was provided for 1 of 2 residents reviewed for catheter care. This resulted in a resident being diagnosed with sepsis and a urinary tract infection. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive	F 0690	**F 690** **1.) Resident B no longer resides in the facility.** **2.) Any resident who has an order for an indwelling Foley catheter has the potential to be affected by the alleged deficient practice. An facility-wide audit was conducted to identify those residents currently using an indwelling Foley catheter to**	04/27/2022

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	pulmonary disorder and neurogenic bladder. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley catheter that was draining clear urine. A Nurse Practitioner Progress Note, dated 1/11/22 at 2:32 p.m., indicated Resident B was seen for increased confusion and fever. The Physical Therapist reported Resident B had increased confusion and agitation. The resident requested to go to the hospital. An order to send the resident to the emergency room for evaluation was written. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 P.M., indicated ...Resident B had an indwelling Foley catheter and the catheter had been removed three days prior due to irritation. A Nurse's progress note, dated 1/13/22 at 3:49 p.m., indicated Resident B was found unresponsive. Resident B's blood pressure was 80/39 mm/Hg (millimeters/Mercury), temperature 101.2 degrees Fahrenheit, pulse 139 beats per minutes, and the blood sugar was 154. Emergency services were called to transport the resident to the emergency room for evaluation. The clinical record lacked physician's orders for the care and management of the indwelling urinary catheter. The clinical record lacked a care plan for the		**ensure catheter care orders and a plan of care were in place and implemented accurately and timely.** **3.) The DON/Designee educated the nursing staff and IDT on the existing facility policy identified as, "Catheter Care" with emphasis on ensuring orders were documented, followed, and that catheter care was provided in accordance with nursing practice and physician's orders. The expectation this policy is followed was reinforced and staff was reminded of the consequences to the residents and staff if physicians' orders or facility policy are not followed.** **4.) The DON/Designee will audit 5 residents with indwelling Foley catheters weekly x 4 weeks, then 3 residents weekly x 4 weeks, then 3 residents monthly x 4 months to ensure catheter care is being completed, is being documented appropriately in the clinical record, and the residents' care plans reflect the use of an indwelling Foley catheter with appropriate interventions. All admissions will be reviewed in the clinical morning meeting for the use of an indwelling Foley catheter and audited to ensure catheter care orders and a plan of care**	

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	indwelling urinary catheter. The clinical record lacked documentation that urinary catheter care had been provided. During an interview on 3/11/22 at 9:45 a.m., the DON indicated Resident B should have had physician's orders and a care plan for the urinary catheter. On 3/11/22 at 2:30 p.m., a Hospital Progress Note, dated 1/13/22, indicated Resident B was admitted with sepsis, respiratory failure, an acute urinary tract infection. On 3/11/22 at 2:30 p.m., a Hospital Discharge Summary, dated 2/8/22, indicated on 1/28/22 Resident B was comfort measures only. Resident B's respirations had ceased. On 3/14/22 at 10:00 a.m., a urinalysis result, dated 1/17/22, indicated the urinalysis that had been collected on 1/13/22 had greater than 100,000 CFU/ML (colony-forming unit per milliliter) of Proteus vulgaris (bacteria) in the urine. On 3/14/22 at 10:30 a.m., the DON provided a copy of a facility policy, titled "Catheter Care," dated 10/13/13, and indicated this was the current policy used by the facility. A review of the policy indicated "catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place...the risk of bacteremia (bacteria in the blood) is 3 to 36 times more likely than residents without an indwelling catheter." This Federal tag relates to Complaint IN00374538.		**is in place, this is an ongoing facility practice. Audits/observation will be conducted randomly, across all 3 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 audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	3.1-41(a)(2)			
F 0711 SS=D Bldg. 00	483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.			
	Based on interview and record review, the facility failed to ensure a physicians orders were obtained for 1 of 21 residents reviewed. Indwelling urinary catheter and oxygen therapy orders were not obtained. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact, was receiving oxygen therapy, and did not have an indwelling urinary catheter.	F 0711	**F 711** **1) Resident B no longer resides in the facility.** **2) All residents with indwelling catheters and mechanical oxygen have the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted on all residents with indwelling catheters and mechanical oxygen to ensure a physician's order was in place, appropriate, and implemented. The physician(s) for any resident identified with an indwelling catheter or mechanical oxygen for which there is no physician's order**	04/27/2022

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	An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley catheter that was draining clear urine and was receiving 5 liters per minute of oxygen through a nasal cannula. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 p.m., indicated Resident B had an indwelling urinary catheter that had been removed three days prior. The clinical record lacked Physician's orders for the care and management of the urinary catheter and oxygen therapy. During an interview on 3/11/22 at 9:45 A.M., the Director of Nursing indicated Resident B should have had physician's orders for the urinary catheter and oxygen therapy. On 3/11/22 at 4:21 P.M., the Administrator provided a copy of a facility policy, titled "Physician Orders," dated 8/3/10, and indicated this was the current policy used by the facility. A review of the policy indicated "Medical Orders Transcription...the provider may write the order in the medical record...a provider may give a medical order over the phone...verbal orders are accepted but will be input into [the electronic medical record] by the nurse as soon as practicable. The practitioner will need to sign off on these orders..." This Federal tag relates to Complaint IN00374538. 3.1-22(c)(1)		**and new orders were obtained and implemented. The resident's family or responsible party and plan of care were updated accordingly.** **3) The DON/Designee has educated the licensed nursing staff on the existing facility policy identified as, "Physician Orders" with emphasis on ensuring there are physician's orders for indwelling catheters and oxygen therapy. The expectation this policy is followed was reinforced and staff was reminded of the consequences to residents and staff if physicians' orders or facility policy are not followed and implemented.** **4) The DON/Designee will audit the residents' orders to ensure there are physician orders in place for either indwelling catheters and oxygen or both on the following schedule: 10 residents' orders x 4 weeks, 5 residents' orders x 4 weeks, and 10 residents' orders monthly x 4 months. The DON/Designee will review all new admissions during the clinical morning meeting to ensure the physician's orders are in place to meet the needs of the resident. Reviewing all new admissions in the clinical morning meeting to ensure orders are received and implemented will remain an**	

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			ongoing facility practice. The DON/Designee 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 meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0725 SS=H Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:			

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	(i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to ensure sufficient and competent nursing staff was provided. Treatment orders were not in place, appropriate care for a gtube was not provided, dressings were not dated, PICC line dressings were not changed, catheter care was not provided, medications were left in resident rooms, and antibiotics were given longer than prescribed. (Resident B, Resident Y, Resident E, Resident X, Resident M, Resident F, Resident D, Resident K, Resident J, Resident N) Finding includes: 1. During the survey dates of 3/9/22 through 3/21/22 the following interviews were completed. a. The facility does not have enough staff on evenings and weekends. b. The facility does not have enough staff. It takes an hour for call lights to be answered. 2. During an interview on 3/14/22 at 9:10 a.m. the Director of Nursing indicated the facility does not use competencies, instead the facility uses staff in-services for education. 3. On 3/18/21 at 2:00 P.M., the Activity Director provided a documents, titled "Resident Council	F 0725	1) Resident B no longer resides in the facility. Residents Y, E, M, F, D, K, J, and N were part of a confidential complaint survey and could not be identified. Resident X was part of a confidential complaint survey. 2) All residents have the potential to be affected by the alleged deficient practice. 3) The facility will continue to staff at or above the minimum staffing requirements for its daily census to ensure sufficient staff to meet residents needs as determined by the updated facility assessment. The scheduler was educated on the existing policy for staffing requirements to ensure sufficient staff to meet assessed residents' needs. 4) The staffing schedule will be reviewed daily with the Executive Director, DON, Human Resource manager, and staffing coordinator to confirm appropriate staffing levels and identify the distribution of staff based on residents' needs. This remains an ongoing facility practice Monday through	04/27/2022

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Minutes". A review of the documents indicated long call light times were discussed at the Resident Council Meetings on 1/31/22 and 2/28/22.

During Resident Council Meeting on 3/18/22 at 2:15 p.m., the residents indicated the facility does not have enough staff on third shift.

4. The Facility Assessment Tool, dated 10/1/21, indicated: "...average daily census 72... staffing needs...for direct care needs: 3 or 4 Licensed Practical Nurses (LPN) or Registered Nurses (RN) on day shift, 3 or 4 LPN or RN on evening shift, and 2 LPN or RN on night shift."

5. The as worked nursing schedule, dated 2/23/22 to 3/9/22, indicated:

a. On 2/23/22, the facility had 1 Licensed Practical Nurse (LPN) that worked day shift, 1 LPN that worked evening shift, and 1 Registered Nurse (RN) that worked night shift.

b. On 2/24/22, the facility had 1 LPN that worked day shift, 2 LPN's that worked evening shift, and 1 LPN that worked night shift.

c. On 2/25/22, the facility had 1 LPN that worked day shift, 1 RN that worked evening shift, and 1 RN that worked night shift.

d. On 2/26/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift.

e. On 2/27/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift.

Friday and the weekend scheduled is reviewed in the Friday staffing meeting.
="" span="">

The ED/Designee is responsible for 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 meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.

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	f. On 2/28/22, the facility had 1 LPN that worked day shift, 2 LPN's that worked evening shift, and 1 RN that worked night shift. g. On 3/1/22, the facility had 2 LPN's that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. h. On 3/2/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. i. On 3/3/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening shift, and 1 RN that worked night shift. j. On 3/4/22, the facility had 2 LPN's that worked day shift, 2 LPN's that worked evening shift, and 1 LPN that worked night shift. k. On 3/5/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening and night shift. l. On 3/6/22, the facility had 2 LPN's that worked day shift, 1 LPN and 1 RN that worked evening and night shift. m. On 3/7/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening shift, and 1 RN that worked night shift. n. On 3/8/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. o. On 3/9/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING 00 B. WING	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HEALTHCARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

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	6. The lack of sufficient nursing staff resulted surgical dressing changes not being completed. Cross reference F684. 7. The lack of sufficient nursing staff resulted care not being provided for a feeding tube. Cross reference F693. 8. The lack of sufficient nursing staff resulted PICC line dressings not being changed. Cross reference F694. 9. The lack of sufficient nursing staff resulted nutritional supplements not being provided. Cross reference F692. 10. The lack of sufficient nursing staff resulted medications being left in a resident room. Cross reference F689. 11. The lack of sufficient nursing staff resulted a resident receiving unnecessary medications. Cross reference F757. 12. The lack of sufficient nursing staff resulted a lack of urinary catheter care. Cross reference F690. This Federal tag relates to Complaint IN00374538. 3.1-17(a)			