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	08/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00433061 and IN00433647 completed on June 17, 2024, which resulted in unrelated deficiencies. This visit was in conjunction with the PSR to the Investigation of Complaints IN00437007 and IN00438015 completed on July 5, 2024, which resulted in unrelated deficiencies. This visit was in conjunction with the Investigation of Complaint IN00439096. Complaint IN00433061 - Federal/State deficiencies related to the allegations are cited at F760. Complaint IN00433647 - Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00437007 - Corrected. Complaint IN00438015 - Corrected. Complaint IN00439096 - Federal/State deficiencies related to the allegations are cited at F625. Unrelated deficiency cited. Survey dates: July 31 and August 1 and 2, 2024 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 59 Total: 59	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Gunter	RN	08/21/2024

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

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	Census Payor Type: Medicare: 2 Medicaid: 50 Other: 7 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 8, 2024.			
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 3 residents reviewed for medication errors. Medications used to prevent and treat seizures were not administered. This deficient practice resulted in Resident M requiring an emergency room visit after experiencing three seizures in thirty minutes. Finding includes: During an interview on 8/1/24 at 1:00 p.m., QMA 8 (Qualified Medication Aide) indicated, on 7/30/24, Resident M was sent to the hospital for seizures. Earlier that day, Resident M looked pale and was drooling. QMA 8 worked with Resident M often and had not seen him drool before that day. The clinical record for Resident B was reviewed on 8/1/24 1:30 p.m. The diagnoses included, but were not limited to, autistic disorder, intellectual disability, and epilepsy.	F 0760	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident M was sent to the hospital and returned with no new orders 2. All residents on anticonvulsants were audited for the last 14 days to ensure that their medications have been given 3. DON/Designee educated all licensed nurses and med techs on	08/27/2024

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	An Admission MDS (Minimum Data Set) assessment, dated 7/13/24, indicated Resident M was severely cognitively impaired. A physician's order, dated 7/8/24, indicated lacosamide (a medication used to control seizures) 200 mg (milligrams), give 1 tablet by mouth two times daily. A physician's order, dated 7/8/24, indicated clobazam (a medication used to treat seizures) 10 mg, give half a tablet by mouth two times daily. The controlled drug administration record, dated from 7/11/24 at 8:00 a.m. through 7/31/24 at 8:00 p.m., indicated Resident M did not receive lacosamide in accordance with the physician's order on 10 of 38 opportunities as follows: - 7/11/24 at 8:00 p.m. - 7/12/24 at 8:00 a.m. and 8:00 p.m. - 7/13/24 at 8:00 p.m. - 7/15/24 at 8:00 p.m. - 7/22/24 at 8:00 a.m. - 7/26/24 at 8:00 p.m. - 7/29/24 at 8:00 p.m. -7/31/24 at 8:00 a.m. and 8:00 p.m. The controlled drug administration record, dated from 7/11/24 at 8:00 a.m. through 7/31/24 at 8:00 p.m., indicated Resident M did not receive clobazam in accordance with the physician's order on 7 of 38 opportunities as follows: - 7/12/24 at 8:00 a.m. and 8:00 p.m. - 7/15/24 at 8:00 p.m. - 7/22/24 at 8:00 a.m. - 7/29/24 at 8:00 p.m. -7/31/24 at 8:00 a.m. and 8:00 p.m. A change in condition progress note, dated 7/30/24 at 5:43 p.m., indicated Resident M had		policy titled “Medication Administration” 4. DON/Designee will audit 5 residents a week on anticonvulsant medications to ensure medication was given times 4 weeks then 3 residents a week times 4 weeks then 1 resident a week times 4 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance.	

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	three seizures in approximately 30 minutes. This change in condition progress note did not contain sufficient documentation to determine the details of the change in condition. An After Visit Summary, dated 7/30/24 at 8:27 p.m., indicated reason for Resident M's visit to the emergency department was for seizures. Resident M was diagnosed with seizure like activity. During an interview on 8/1/24 at 1:38 p.m., QMA 1 indicated Resident M should have received lacosamide 200 mg and clobazam 10 mg two times daily. If the medications were not signed out on the controlled drug administration record then the medication was not administered. During an interview on 8/1/24 at 2:34 p.m., the DON (Director of Nursing) indicated, on 7/30/24, Resident M was sent to the hospital because of seizures. The physician gave a new order for Ativan (controlled substance used for seizures) 0.5 mg intramuscularly (into the muscle) as needed for seizures, but RN 9 was looking in the wrong place. RN 9 looked in the Pixus (electronic machine to dispense emergency medications) on the other side of the facility, but the injectable Ativan was kept in the refrigerator on Resident M's unit. Resident M's seizure medication should have been administered as the physician ordered. RN 9 should have known the injectable Ativan was kept in the refrigerated emergency drug kit on Resident M's unit. During an interview on 8/1/24 at 2:48 p.m., RN 9 (Registered Nurse) indicated she was Resident M's nurse when he had 3 seizures. After the physician gave a new order for Ativan 1 mg intramuscularly as needed for seizures, RN 9 went to the Pixus, located on the other side of the			

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	facility, to get the Ativan. RN 9 did not know the Ativan for intramuscular injection was kept in the refrigerated emergency drug kit in the refrigerator on Resident M's unit. Resident M was sent to the hospital because RN 9 could not locate Ativan for intramuscular injection for Resident M's seizures. On 8/1/24 at 3:00 p.m., the Administrator provided a copy of an undated facility policy, titled Missed Medication/Medication Error, and indicated this was the current policy used by the facility. A review of the policy indicated any physician or provider prescribed medication that is not administered as prescribed is a medication error. This deficiency was cited on 6/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence. This citation relates to Complaint IN00433061. 3.1-48(c)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-			

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	(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must			

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	contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, interview and record review, the facility failed to ensure a resident's record was complete and accurate for 1 of 3 residents reviewed for complete and accurate records. (Resident M) Finding includes: During an interview on 8/1/24 at 1:43 a.m., the Activity Director indicated Resident M looked like he had a broken nose because his nose was swollen, cut, and bruised. The Activity Director couldn't remember the exact date she first saw the injury but was sure it was before Resident M moved to the 600 hall, on 7/24/24. During an interview on 8/1/24 at 2:54 p.m., CNA 10 (Certified Nursing Aide) indicated, on 7/24/24 at approximately 3:00 p.m. Resident M's left eye was black, his nose was swollen, cut, and bruised. Resident M's nose looked crooked like it was broken. CNA 10 reported this to RN 9 but didn't feel like the injury was taken seriously. The clinical record for Resident M was reviewed on 8/1/24 1:30 p.m. The diagnoses included, but were not limited to, autistic disorder, intellectual	F 0842	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Investigation was initiated and any documentation discovered during was added to medical record. 2. All incidents in the last 2 weeks were reviewed to ensure accurate documentation was in the medical record. 3. RDCO educated all licensed nurses and the IDT team on accurate documentation in the medical record 4. RDCO/Designee will	08/27/2024

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	disability, and epilepsy. A quarterly MDS (Minimum Data Set) assessment, dated 7/13/24, indicated Resident M was severely cognitively impaired. A physician's phone order, dated 7/24/24, indicated x-ray of nose. The order was discontinued. A physician's verbal order, dated 7/25/24 at approximately 3:00 a.m., indicated x-ray of nose due to swelling, mass, lump. An x-ray result, dated 7/25/24 at 9:45 a.m., indicated exam of nasal bones for nasal pain. There was no fracture, dislocation, nor bony destructive lesion noted. Paranasal air cells demonstrate no specific abnormality. No acute traumatic osseous abnormality. A progress note, dated 7/25/24 at 1:17 p.m., indicated the DON (Director of Nursing) observed Resident M "bump" into a wall while ambulating. The Nurse Practitioner was notified with a new physician's order for an x-ray. The progress note was entered into the electronic medical record, on 8/1/24 at 1:18 p.m. (7 days after the x-ray was ordered) A weekly skin assessment, dated 7/29/24 at 11:27 a.m., indicated Resident M did not refuse a skin assessment. Resident M did not have any skin alterations noted. The weekly skin assessment was completed by the DON. During an interview, on 8/1/24 at 2:17 p.m., the Administrator indicated, during the morning clinical meeting, on 7/25/24, he was made aware of a scratch and some discoloration on Resident M's		complete an audit of 5 incidents a week times 4 weeks to ensure accurate documentation is recorded in the medical chart than 3 incidents a week times 4 weeks then 1 incident a week times 4 weeks. RDCO/Designee will report audits monthly to the interdisciplinary team for 3 months during the QAPI meeting. The IDT team will determine if the audits are necessary to continue after 3 months with 100% compliance.	

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	nose. The nurse got a physician's order for an x-ray of Resident M's nose to make sure there was no further injury. The Administrator needed to speak with the DON (Director of Nursing) to see if the DON found anyone that knew what happened. During an interview, on 8/1/24 at 2:34 p.m., the DON indicated, on the morning of 7/25/24, she was going outside to take a break when she watched Resident M "bump" into a wall. It was possible that Resident M's nose had swelling, a cut, and bruising before the DON saw Resident M "bump" into the wall. The DON may not have been notified of any injury prior to that. The DON should have documented the injury and entered a progress note the morning she watched Resident M "bump" into the wall, so the medical record was accurate. During an observation, on 8/2/24 at 7:30 a.m., Resident M was sitting in his room. Observed a small scratch and discoloration along the bridge and to the left side of his nose. This deficiency were cited on 6/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence. This citation relates to Complaint IN00433647. 3.1-50(a)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

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	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

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	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control practices were implement for Enhanced Barrier Precautions (EBP) for 4 of 4 residents rooms reviewed for EBP (Room 607, Room 612, Room 705, Room 714, Resident C), failed to ensure sharps biohazard waste was disposed of safely for 4 of 4 rooms observed for disposal of sharps (Room 602, Room 613, Room 611, Room 608) and failed dispense medications in a manner to prevent the possibility of cross-contamination for 1 of 2 residents observed for medication pass. (Resident G) Findings Include:	F 0880	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Sharps containers in room 602, 613, 611 and 608 were	08/27/2024

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	1. During the initial tour on 7/31/24 between 8:50 a.m. and 9:58 a.m., the following was observed: Room 602: The wall mounted sharps container was overflowing with 2 syringes with sheathed needles and 4 lancets (Finger-stick blood samplers device used to obtain blood for testing blood sugar) sitting on the outside of the container at the opening. Room 613: The wall mounted sharps container was overflowing with 1 syringe with a sheathed needle sitting on the outside of the container at the opening. Room 611: The wall mounted sharps container was overflowing with 4 syringes with sheathed needles on the outside of the container at the opening. At the time of the observation the DON and ED were informed and they removed the sharps container. Room 608: The wall mounted sharps container was overflowing with 1 syringe with a sheathed needle and 2 lancets on the outside of the container at the opening. A Policy titled "Biohazardous Waste Management Plan" was provided by the Executive Director on 8/1/24 at 9:11 a.m., and deemed as current. The policy indicated " ...Sharps biohazardous waste (or simply sharps) is any medical device that is sharp enough to puncture skin (not to mention a plastic bag) and that had been in contact with potentially infectious biological material ...All sharps waste must be contained in a sharps containers that are red, rigid and leak proof with the words "sharps waste" or the International Biohazard Symbol and the work "biohazard" on the sharps container ...and come		immediately removed Resident C was assessed and EBP supplies were stocked in room 607,612,705, and 714. Due to the confidentiality of the complaint survey we are unable to identify Resident G Med Tech 1 was educated on policy titled “Administration Procedures for all Medications” 2. All rooms in the facility and all med carts sharp containers were removed and new empty containers were placed. EBP supplies were stocked in all rooms in facilities All residents have the ability to be affected by the alleged deficient practice 3. RDCO/Designee educated all licensed nurses and med techs on policy titled “Biohazardous Waste Management Plan” RDCO/Designee educated all staff on policy titled “Enhanced Barrier Precautions” RDCO/Designee educated all licensed nurses and Med techs on policy titled “Administration Procedures for all Medications” 4. RDCO/Designee will complete an audit of all sharp containers 3 times a week times 3 months to ensure they are not full and over flowing. RDCO/Designee will complete an audit of 5 residents’ rooms a week times 3 months to ensure EBP supplies are stocked. RDCO/Designee will complete an	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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
	marked with a line that indicates when the container should be considered full, which means it's time to dispose of the container ...." 2. During the initial tour on 7/31/24 between 8:50 a.m. and 9:58 a.m., the following was observed: Room 607: An Enhanced Barrier Precautions (EBP) sign was hung on the door but did not have gowns near the door to the room nor inside the room. Room 612: An EBP sign was hung on the door but did not have gowns near the door to the room nor inside the room. Room 705: An EBP sign was hung on the door but did not have gowns near the door to the room nor inside the room. Room 714: An EBP sign was hung on the door but did not have gowns near the door to the room nor inside the room. During an observation on 7/31/24 at 9:44 a.m., a sign was hanging on Resident C's door that indicated EBP. There were no gowns or gloves observed in the area near Resident C's door. Inside Resident C's room, observed gloves but no gowns. Resident C was lying on his bed turned to his left side. CNA 11 was standing on the opposite side of Resident C's bed. Observed Resident C's brief to be unfastened. At that time, CNA 11 indicated she was providing incontinence care. CNA 11 knew she should have been wearing a gown and gloves because Resident C was on EBP, but there were no gowns in Resident C's room. The clinical record for Resident C was reviewed		observation audit of 5 residents 3 times a week on EBP to ensure employees are wearing all PPE than 3 residents 3 times a week times 4 weeks than 1 resident a week times 4 weeks. RDCO/Designee will report audits monthly to the interdisciplinary team for 3 months during the QAPI meeting. The IDT team will determine if the audits are necessary to continue after 3 months with 100% compliance	

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	08/02/2024

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	on 7/31/24 at 10:33 a.m. The diagnoses included, but were not limited to, generalized edema, diabetes, and atrial fibrillation. A quarterly MDS (Minimum Data Set) assessment, dated 7/18/24, indicated Resident C was cognitively intact. The current physician's orders indicated: - Enhanced barrier precautions related to wounds. Use when dressing, bathing, showering, transferring in room or therapy gym, personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting. Started on 7/13/24, with no end date noted. During an interview on 7/31/24 at 1:50 p.m., the ADON/IP (Assistant Director of Nursing/ Infection Preventionist) indicated Resident C was on EBP because he had wounds to his bilateral inner thighs. Staff should have been wearing a gown and gloves in the room whenever they provide care. During an interview on 8/1/24 at 12:11 p.m., Resident C indicated he still had some skin breakdown on his inner bilateral thighs. The staff told Resident C he was on enhanced barrier precautions, for wounds, a few weeks ago but the staff do not wear gowns when they are providing his care. Resident C's lower legs had a blister that opened a few days ago and started draining. At that time, Resident C was in the hallway sitting in his wheelchair. Observed an open ulcer, approximately the size of a quarter, on Resident C's right lower leg. Both of Resident C's legs appeared to be swollen. The ulcer was open with a red wound base and was draining clear fluid that was running down Resident C's leg.			

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	On 8/2/24 at 11:15 a.m., the Corporate Nurse provided a copy of an undated policy, titled Enhanced Barrier Precautions, and indicated the personal protective equipment required for enhanced barrier precautions are a gown and gloves. This was communicated to staff by posting a sign on the resident's door indicating enhanced barrier precautions is required. 3. During a medication pass observation on 8/1/24 at 10:19 a.m., with QMA 1 the QMA dispensed the following medications for Resident G into hands prior to placing them in the medication cup. She placed the medication in the medication cup, and with the same hand she moved the mouse on the computer to adjust the screen. Buspar (anti-anxiety medication) 10 milligram (mg) tab Wellbutrin (anti-depressant medication) 150 mg tab Plavix (anti-platelet medication) 75 mg tab Ferrous Sulfate (iron supplement) 325 mg Amlodipine (blood pressure medication) 5 mg Claritin (allergy medication) 10 mg Aspirin (anti-inflammatory medication) 81 mg Lexapro (anti-depressant medication) 20 mg During an interview on 8/1/24 at 10:25 a.m., the QMA indicated she had dispensed the medications into her hands because she was in a hurry. A policy titled "Administration Procedures for All Medications" was provided by the Director of Nursing on 8/1/24 at 11:43 a.m. and deemed as current. The policy indicated " ...Cleanse hand using antimicrobial soap and water or facility-approved hand sanitizer before beginning a med pass, before handling medication, and			

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	before contact with the resident ...." This deficiency was cited on 6/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(b)(1)			