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	07/05/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00437007 and IN00438015. Complaint IN00437007 - No deficiencies related to the allegations are cited. Complaint IN00438015 - No deficiencies related to the allegations are cited. Unrelated deficiencies cited. Survey dates: July 2, 3, and 5, 2024 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicare: 1 Medicaid: 54 Other: 7 Total: 62 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 9, 2024.	F 0000		
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Lai	Executive Director	07/23/2024

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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	care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to provide behavioral health services to maintain residents highest practicable well-being for 2 of 3 residents reviewed. Residents with a known history of resident to resident altercations lacked interventions to prevent aggressive behaviors and a resident with a history of drinking alcohol in the facility did not have a plan for treatment and prevention for a substance use disorder. (Resident B, Resident C) Finding included: 1. During an interview on 7/3/24 at 11:53 a.m., the Activity Director indicated Resident B was outside in the courtyard on his way to smoke. Resident C walked up behind Resident B and threatened Resident B. Resident C said if Resident B didn't get out of Resident C's way he would... and then Resident B stood up. At that time, Resident C "lunged" at Resident B and they both went down to the ground. Neither resident hit the other. They were separated immediately. The Activity Director was not aware of another time when either resident was aggressive with another resident. During an interview on 7/3/24 at 11:59 a.m., QMA 1 (Qualified Medication Aide) indicated she heard someone yell a resident had fallen outside. QMA 1 looked and saw Resident C on top of Resident B	F 0740	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 B and C were not harmed by the alleged deficient practice. Resident B and C were immediately separated. Resident B was assessed and placed on one on one for safety, room searched for alcohol, none noted. Resident C was assessed and placed on one on one for safety. Care plans for both residents were reviewed and updated. Resident B no longer a resides at facility. 2 All residents with a history of substance abuse disorder will be audited for appropriate interventions and care plan in	07/29/2024

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	on the ground holding on to each other but not hitting each other. The Activity Director was separating Resident B and Resident C and QMA 1 immediately went to assist. During an interview on 7/3/24 at 12:36 p.m., the Administrator indicated he witnessed an incident approximately a year ago when another resident told Resident B to get out of the way and Resident B stood up in a defensive stance and was verbally defensive. During an interview on 7/5/24 at 9:22 a.m., the Social Service Director indicated she went to speak with Resident B almost immediately after the incident with Resident C. Resident B was agitated and upset and said he wasn't going to let anyone push him around. Resident B was not able to recall the details of what happened with Resident C. Then, the Social Service Director went to speak to Resident C. Resident C's hair was disheveled from the "tussle". Resident C told the Social Service Director that Resident B pushed him, Resident C wasn't going to take that, and Resident C would kill Resident B. The Social Service Director went back to speak with Resident B and Resident C a little while later and neither resident could recall the incident. The clinical record for Resident B was reviewed on 7/3/24 at 12:08 p.m. The diagnoses included, but were not limited to, dementia, Wernicke's encephalopathy, and anxiety disorder. A quarterly MDS (Minimum Data Set) assessment, dated 6/18/24, indicated Resident B was moderately cognitively impaired. A progress note, dated 4/13/24 at 1:00 p.m., indicated Resident B had a verbal disagreement		place. All residents involved in resident to resident altercation in the past 30 days plan of care will be reviewed to assure appropriate and effective interventions in place. 3 DON/Designee has educated all staff on behavior management policy and substance abuse policy. 4 DON/Designee will audit all residents with new behaviors or substance abuse incidents 5xweek x 4 weeks, 3xweek x 4 weeks, then 1xweek x 4 weeks to verify new effective interventions put in place and care plan updated. 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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	with another resident. The residents were immediately separated. Law enforcement notified. Guardian gave permission for resident to be moved to another room. A progress note, dated 7/3/24 at 8:30 a.m., indicated Resident B was outside for a smoke break when Resident C said if Resident B didn't move. Then, Resident B stood up and made physical contact with Resident C. Both residents ended up on the ground before supervising staff were able to reach the residents. The residents were immediately separated. Resident B's clinical record lacked interventions for a history of resident to resident aggression. The clinical record for Resident C was reviewed on 7/3/24 at 12:15 p.m. The diagnoses included, but were not limited to, dementia and traumatic brain injury. A quarterly MDS assessment, dated 5/15/24, indicated Resident C was moderately cognitively impaired. A progress note, dated 3/3/24 at 11:40 a.m., indicated Resident C was observed being verbally aggressive in a common area. Resident C was educated on importance of being respectful to peers while in common areas. The DON was notified. Resident C's clinical record lacked interventions for a history of resident to resident aggression. 2. During an interview on 7/5/24 at 9:22 a.m., the Social Service Director indicated she was aware of one time when Resident B was intoxicated. Resident B hid a bottle of alcohol in the toilet			

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	tank. The Activity Director caught him with the alcohol in May. Resident B was also sent out to the hospital and diagnosed with alcohol intoxication in April. During an interview 7/5/24 on 9:42 a.m., the Activity Director indicated she found a glass bottle of liquor in the back of Resident B's toilet. Resident B smelled like alcohol and was trying to wash vomit off of his clothes. Resident B was intoxicated. The Activity Director reported to the Administrator and the Director of Nursing. The clinical record for Resident B was reviewed on 7/3/24 at 12:08 p.m. The diagnoses included, but were not limited to, alcohol dependence with alcohol induced persistent dementia and Wernicke's encephalopathy. A quarterly MDS assessment, dated 6/18/24, indicated Resident B was moderately cognitively impaired. A progress note, dated 4/16/24 at 4:24 p.m., indicated Resident B was sent to the emergency room this morning for a fall. Resident B was brought back to the facility during this shift with a diagnosis of alcohol intoxication. Resident B drank mouthwash overnight to the point of intoxication. A progress note, dated 5/3/24 at 2:51 p.m., indicated on 5/1/24, staff reported to writer there was a smell of smoke coming from Resident B's room. Upon entering the room, Resident B was in the bathroom with the tank lid removed and Resident B had vomited and was trying to wash out his clothes. Staff reported Resident B was intoxicated.			

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	A post fall evaluation, dated 4/14/24, indicated Resident B was drunk. A hospital discharge summary, dated 4/16/24, indicated a diagnosis of acute alcohol intoxication. An alcohol, serum plasma laboratory result, dated 4/16/24 at 10:02 a.m., indicated Resident B's blood alcohol level was 262.0 mg/dl (milligrams per decaliter). The normal range was less than 10.0 mg/dl. The clinical record lacked a plan for prevention and treatment of Resident B's substance use disorder. During an interview on 7/5/24 at 1:27 p.m., the Director of Nursing indicated Resident B should have had a care plan for hiding the liquor in the back of his toilet and smelling like alcohol. On 7/5/24 at 2:32 p.m., the Director of Nursing provided a copy of an undated facility policy, titled Behavior Management, and indicated this was the current policy used by the facility. A review of the policy indicated update the care plan with changes and or new behaviors. Include resident specific interventions. 3.1-37(a)			