	T OF HEALTH AND HU R MEDICARE & MEDIC					FO	TED: 09/16/2024 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 B. WING			(X3) DATE SURVEY COMPLETED 08/20/2024	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 7465 MADISON AVE INDIANAPOLIS, IN 46227				
(X4) ID PREFIX	ID SUMMARY STATEMENT OF DEFICIENCIE FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CROSS-REFERENCED TO		ON SHOULD BE COMPLETION THE APPROPRIATE	
TAG F 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00		he Investigation of Complaints 441229, and IN00441243.	F 00	000			
	Complaint IN0044 the allegations are	1162 - No deficiencies related to cited.					
		1229 - Federal/State deficiencies ations are cited at F842.					
	_	1243 - Federal/State deficiencies ations are cited at F580 and					
	Survey dates: Augu	ust 19 and 20, 2024					
	Facility number: 02 Provider number: 1 AIM number: 2009	155780					
	Census Bed Type: SNF/NF: 59 Total: 59						
	Census Payor Type Medicaid: 53 Other: 6 Total: 59	e:					
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.					
	Quality review con	npleted August 23, 2024.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Notify of Changes (Injury/Decline/Room, etc.)

Based on interview and record review, the facility

483.10(g)(14)(i)-(iv)(15)

F 0580

SS=D

Bldg. 00

TITLE (X6) DATE

08/28/2024

Preparation and execution of this

Victoria Gunter RN 09/10/2024

F 0580

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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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 08/20/2024 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 failed to notify a resident's guardian prior to a plan of correction does not transfer for 1 of 3 residents reviewed for transfers constitute admission or agreement requirements. (Resident D) by this provider of the truth of the facts alleged or conclusions set Finding includes: forth in the Statement of Deficiencies. The plan of The clinical record for Resident D was reviewed correction is prepared and on 8/19/24 at 1:16 p.m. The diagnoses included, executed solely because it is but were not limited to, epilepsy, alcohol required by the provisions of dependence, and vascular dementia. federal and state law. The facility cordially requests An Order Appointing Guardian Over paper compliance regarding Incapacitated Person, dated 2/22/23, indicated a alleged deficient practices. guardian was appointed on 2/22/23. Resident D was not harmed by the alleged deficient A progress note, dated 7/18/24 at 9:34 a.m., practice. Resident D no longer indicated Resident D discharged to another resides at facility. facility. All Resident D's belongings were sent All residents that have with Resident D. discharged in the last 14 days will be reviewed to assure notification The clinical record lacked documentation the of transfer/discharge is guardian was notified prior to Resident D's documented in the medical record. discharge. DON/Designee will educate the licensed nursing staff During an interview on 8/20/24 at 10:00 a.m., on Admission, Discharge and Corporate Nurse 1 indicated there was no Transfer Policy, emphasizing on additional documentation regarding Resident D's notifying resident representative of discharge. transfer/discharge and documenting. During an interview on 8/20/24 at 10:45 a.m., LPN 1 DON/Designee will audit indicated Resident D's guardian should have been all residents that have discharged notified before he was transferred. 5xweek x 4 weeks, 3xweek x 4 weeks, then 1xweek x 4 weeks to On 8/20/24 at 10:27 a.m., Corporate Nurse 1 verify notification to resident provided a copy of an undated policy, titled representatives is documented. Admission, Discharge, and Transfer, and DON/Designee will report on indicated this was the current policy used by the audits monthly to the facility. A review of the policy indicated notify the interdisciplinary team for 3 months resident and the resident's representative of the during the QAPI Meeting. The IDT transfer or discharge and the reasons for the move will determine if the audits are

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155780		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7465 MADISON AVE INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0623 SS=D Bldg. 00	in writing and in a language and manner they understand. Record the reasons for the transfer or discharge in the medical record. This citation relates to Complaint IN00441243. 3.1-5(a)(4) 483.15(c)(3)-(6)(8) Notice Requirements Before			necessary to continue after 3 months with 100% compliance			
	Based on interview failed to provide a variansfer/Discharge representative prior residents reviewed requirements. (Resilier Finding includes: The clinical record on 8/19/24 at 1:16 put were not limited dependence, and varians appointed to the progress note, daindicated Resident I facility. All Resident with Resident D. The clinical record written Notice of Total record written Notice of Total resident I facility. All record written Notice of Total record resident I facility and the provided record written Notice of Total record resident Notice of Total record record resident Notice of Total record record record resident Notice of Total record rec	and record review, the facility written Notice of to the resident's to a discharge for 1 of 3 for transfer and discharge dent D) for Resident D was reviewed o.m. The diagnoses included, d to, epilepsy, alcohol scular dementia. In Guardian Over n, dated 2/22/23, indicated a	F 0623	Preparation and execution of plan of correction does not constitute admission or agree by this provider of the truth of facts alleged or conclusions s 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 D was not harmed by the alleged deficie practice. Resident D no longe resides at facility. 2) All residents that had discharged in the last 14 days be reviewed to assure notice of transfer/discharge was provid the resident's representative in the medical record. 3) DON/Designee will educate the licensed nursing on Admission, Discharge and Transfer Policy, emphasizing	ment the et nt ve s will of ed to s in		

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During an interview on 8/20/24 at 10:00 a.m.,

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providing notice of

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	· ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LDING	00	COMPLETED		
155780		B. WIN	IG		08/20/	/2024		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
HOMESTEAD HEALTHCARE CENTER					ADISON AVE APOLIS, IN 46227			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	I	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Corporate Nurse 1 indicated there was no				transfer/discharge to the resid			
	additional documentation regarding Resident D's				representative prior to discharge.			
	discharge.				4) DON/Designee will audit			
	Om 8/20/24 at 10:22	7 a m. Campanata Niversa 1			all residents that have dischar	-		
	On 8/20/24 at 10:27 a.m., Corporate Nurse 1 provided a copy of an undated policy, titled				5xweek x 4 weeks, 3xweek x			
		an undated policy, titled rge, and Transfer, and			weeks, then 1xweek x 4 week verify notice of transfer/discha			
		-			was provided to the resident's	-		
	indicated this was the current policy used by the facility. A review of the policy indicated record				representative is documented			
	the reasons for the transfer or discharge in the				DON/Designee will report on	•		
	medical record. This citation relates to Complaint IN00441243.				audits monthly to the			
					interdisciplinary team for 3 mo	onths		
					during the QAPI Meeting. The			
					will determine if the audits are			
	3.1-12(a)(6)(A)(iii)				necessary to continue after 3			
					months with 100% compliance	Э		
F 0842	483.20(f)(5), 483.	70(i)(1)-(5)						
SS=D	Resident Records - Identifiable Information							
Bldg. 00	55.45.11 1 1000146							
	Based on interview and record review, the facility		F 084	F 0842	Preparation and execution of this		08/28/2024	
		ident's records were complete		-	plan of correction does not		00.20.2021	
	and accurate for 2 of 3 residents reviewed.				constitute admission or agree	ment		
	Medications were not documented when				by this provider of the truth of			
	administered. (Resident B, Resident C) Finding includes:				facts alleged or conclusions s			
					forth in the Statement of			
					Deficiencies. The plan of			
					correction is prepared and			
		rd for Resident B was reviewed			executed solely because it is			
		a.m. The diagnoses included,			required by the provisions of			
		d to, gastroesophageal reflux			federal and state law.			
	disease and dystonia. The physician's orders included, but were not				The facility cordially requests			
					paper compliance regarding			
					alleged deficient practices.			
	limited to:	and (modication us - 1 ts turst			1) Due to confidentiality	-		
	-	opa (medication used to treat			the complaint survey Residen and C can't be identified.	ιΒ		
	_	tem disorders) 25/250 mg				iok		
	(milligrams) tablet, give one tablet by mouth every				 All residents are at r to be affected. All MARS to be 			
	three hours, started on 1/19/24.		1		to be allected. All MARS to be	,	1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILI	A. BUILDING <u>00</u>		COMPLETED	
		155780	B. WING	<u></u>		08/20/	/2024
I			S	TREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ADISON AVE		
HOMESTEAD HEALTHCARE CENTER					APOLIS, IN 46227		
TIOMESTE AB TIE AETHO, THE SELVERY			<u> </u>		711 0210, 117 10227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE]	ID	PROVIDER'S PLAN OF CORRECTION	OF CORRECTION (X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	Т	`AG	DEFICIENCY)		DATE
	- Hydrocodone/Acetaminophen (narcotic pain				reviewed for last 14 days to as		
	, ,	tablet, give one tablet by mouth			medications were administered per MD orders, any discrepancies will be addressed.		
		ain, started on 7/22/24.					
		lication used for acid reflux) 20					
		capsule, give one capsule by			DON/Designee will		
	mouth in the morni	ng, started on 1/19/24.			educate the licensed nurses a	nd	
					qualified medication aides on		
	The August 2024 N	•			Medication Administration Poli	•	
		cord), dated from 8/17/24 at			emphasizing on documenting	in	
		n 8/17/24 at 9:00 p.m., indicated			the EMAR.		
		receive the following			4) DON/Designee will a		
		ordance with the physician's			EMAR compliance 5xweek x 4		
	orders:				weeks, 3xweek x 4 weeks, the	n	
					1xweek x 4 weeks to verify		
	_	opa 25/250 mg at 12:00 a.m.,			medications are administered.		
	3:00 a.m., and 6:00				DON/Designee will report on		
		etaminophen 5/325 mg at 12:00			audits monthly to the		
	a.m. and 8:00 a.m.				interdisciplinary team for 3 mo		
	- Omeprazole 20 m	g at 8:00 a.m.			during the QAPI Meeting. The		
		0/00/04			will determine if the audits are		
	_	v on 8/20/24 at 8:35 a.m.,			necessary to continue after 3		
	_	indicated Resident B's			months with 100% compliance	;	
		dministered. The staff should					
		he medication administration					
	when they were add	mmsterea.					
	2 The climical corre	rd for Posidont C was reviews 1					
		ard for Resident C was reviewed a.m. The diagnoses included,					
		d to, diabetes, morbid obesity,					
		d to, diabetes, morbid obesity,					
	and depression. The physician's orders included, but were not limited to:						
	innica to.	minied to:					
	- Furosemide (med	ication used to remove excess					
	- Furosemide (medication used to remove excess fluid) 40 mg tablet, give one tablet by mouth one time a day, started on 8/14/24.						
	•	ication used to lower blood					
		blet, give one tablet by mouth					
		-					
one time a day, started 8/14/24.							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY A. BUILDING 00							
	PROVIDER OR SUPPLIEF		7465 M	STREET ADDRESS, CITY, STATE, ZIP COD 7465 MADISON AVE INDIANAPOLIS, 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE			
	- Doxepin (medicat 100 mg capsule, give bedtime, started on - Clonazepam (medicat mg tablet, give one day, started on 8/14 - Insulin glargine (I diabetes) 100 units/ units subcutaneousl at bedtime, started or - Trulicity (medicat mg/0.5 ml, inject 3 morning every Frid - Insulin lispro (fast diabetes) 100 units/ three times daily pe 8/13/24 Oxycodone/Acetat medication) 5/325 mouth three times of the August 2024 Madministration Recalization., through 8/18/28 Resident C did not medications in accorders: - Furosemide 40 mg - Amlodipine 10 mg - Doxepin 100 mg of 8/17/24 at 8:00 p.m Clonazepam 1 mg - Insulin glargine 10 mg - Insulin glar	ion used to treat depression) we one capsule by mouth at 8/13/24, lication used to treat anxiety) 1 tablet by mouth one time a 6/24. ong acting insulin used to treat fml (units/milliliter), inject 10 by (under the skin into the fat) on 8/13/24. tion used to treat diabetes) 3 mg subcutaneously in the ay, started on 8/16/24. ta acting insulin used to treat fml, inject subcutaneously or sliding scale, started on minophen (narcotic pain mg tablet, give one tablet by laily, started on 8/14/24.							

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2024				
NAME OF PROVIDER OR SUPPLIER HOMESTEAD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 7465 MADISON AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	OULD BE COMPLETION			
	8/15/24 at 8:00 a.m	•							
	During an interview on 8/20/24 at 8:35 a.m., Corporate Nurse 1 indicated Resident C's medications were administered. The staff should have documented the medication administration when they were administered.								
	The Corporate Nurse provided a copy of an undated facility policy, titled Medication Administration, and indicated this was the current policy used by the facility. A review of the policy indicated administer medications as prescribed by the provider and medications will be charted when given.								
	This citation relates to Complaint IN00441229. 3.1-50(a)								

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