This visit was for the Investigation of Complaints IN00348963, IN00349740 and IN00349237.

Complaint IN00348963 - Unsubstantiated due to lack of evidence.
Complaint IN00349740 - Unsubstantiated due to lack of evidence.
Complaint IN00349237 - Unsubstantiated due to lack of evidence.

Unrelated deficiency is cited.

Survey dates: March 22 and 23, 2021

Facility number: 012225
Provider number: 155780
AIM number: 200983560

Census Bed Type:
SNF/NF: 62
Total: 62

Census Payor Type:
Medicare: 9
Medicaid: 50
Other: 3
Total: 62

This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on March 25, 2021.

The Plan of Correction is the center's credible allegation of compliance. Preparation and 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.

This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk review for this plan of correction.

### Summary Statement of Deficiencies

483.25(d)(1)(2)
Free of Accident Hazards/Supervision/Devices
§483.25(d) Accidents.
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<tbody>
<tr>
<td>F0689</td>
<td>1.</td>
<td>Resident B has been placed on 1:1 since 3/24/2021 for supervision and safety. A 30 day discharge letter has been initiated and the local Ombudsman was notified. Resident G is unknown as part of the confidential survey.</td>
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<td>2.</td>
<td>All other residents had a potential to be affected. Indiana Police department completed a search of resident and his room for any weapons. Any items found have been secured. All residents have been interviewed for any safety concerns. Any concerns have been investigated.</td>
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<td>3.</td>
<td>Education has been provided to all staff on Resident rights and resident /employee safety.</td>
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<td>4.</td>
<td>The DON/Designee will review the 24 hour progress notes daily to identify any with resident or employee safety. Any concerns with resident /employee safety from the E.H.R. and/or a concerned or grievance will be investigated by the ED and DON. All findings will be reported to the regulatory agencies as appropriate. The ED/Designee</td>
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The facility must ensure that -

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Based on observation, record review, and interview, the facility failed ensure a resident (Resident B) did not maintain a personal knife in a manor that interfered with the safety of others for 1 of 3 residents reviewed for safe environment from behaviors. (Resident G)

Findings include:

During an interview, on 3/22/21 at 10:48 a.m., Resident G indicated she was scared of Resident B, "he had a knife about this long," holding her hands away from each other, approximately 7 inches. She also indicated Resident B had threatened a Certified Nursing Assistant [CNA 1] with the knife. "[Resident B] liked to show it [knife] off to the other residents."

On 3/22/21 at 11:00 a.m., Resident G's clinical record was reviewed. An annual Minimum Data Set (MDS) assessment, dated 12/23/20, indicated Resident G's cognitive status was intact.

On 3/22/21 at 11:15 a.m., Resident B's clinical record was reviewed. Diagnosis included, but were not limited to, personality and behavioral disorder.

A signed Receipt of information, dated 1/15/2021, indicated Resident B received a copy of Resident Rights.
An admission Minimum Data Set (MDS) assessment, dated 12/28/20, indicated Resident B was cognitively intact. The resident was independent with activities of daily living and was independent using a wheelchair for mobility.

A Care Plan, dated 1/20/21, (no through date) indicated Resident B "has a behavior problem. Resident yells at staff and becomes belligerent at times." The Care Plan lacked goals. An intervention indicated, "To praise any indication of progress in behaviors." No other interventions were documented on the care plan.

A Care Plan, dated 2/11/21 and current through 6/28/21, indicated "Resident [B] has made negative statements towards staff. Goal: Resident [B] will be without injury to himself/herself, or to others, through the review date." Interventions included, but were not limited to," monitor behavioral episodes, and attempt to determine underlying causes."

A Care Plan, dated 3/15/2021 and current through 6/28/2021, indicated "Resident [B] has exhibited a behavior of homicidal threats towards staff. Goals: Un desirable behavior(s) will be monitored/managed. Resident B will experience less behaviors of homicidal threats toward staff."

The Medication Administration Record and the Treatment Administration Record, dated for March 1 through March 31, 2021, lacked any behavior monitoring.

A Progress Note, dated 1/29/21 at 11:11 a.m., indicated "Resident [B] came to the nurses station calling the nurses w....., and the ED [Executive Director] a dweeb. Resident will report the results of these audit to the QAPI monthly committee meeting and this practice of monitoring will never stop because we will continually work on the safety of our residents and staff."
threatened to hurt one of the nurses. When the nurse asked the resident what was wrong, he said ("f... you") and rolled away."

A Progress Note, dated 2/10/2021 at 8:37 a.m., indicated "if you ever decide to kill yourself [writer], let me know because I want to be there so I can help" Resident B educated on inappropriateness of statement".

A Progress Note, dated 2/12/21 at 2:53 a.m., indicated "Resident [B] was sitting at the nurses desk for about an hour, staring directly at a fellow nurse in an attempt to intimidate her."

A Progress note, dated 3/15/2021 at 4:34 p.m., indicated "Resident [B] is currently experiencing unwanted behavior(s). Behavior potentially causing harm to self or others: chronic delusions. Resident [B] with a history of physical and verbal outbursts towards staff and other residents."

A Progress note, dated 3/22/2021 at 1:18 p.m., indicated Resident B "sent himself to the hospital he said he was having SOB [shortness of breath]."

During an interview, on 3/23/2021 at 10:30 a.m., the Social Services Director indicated Resident B "returned from the hospital with no new orders. I guess the knife is still on him, not sure."

On 3/23/2021 at 11:00 a.m., Resident B was observed in his room in his wheelchair with an unlit cigarette and lighter in his hand. The resident was calm and friendly and wanted to go out "to smoke." No knife was observed on the resident.

An incident, dated 3/14/20 at 10:00 p.m.,
indicated "Description: Resident [B] attempted to act as if he was going to cut the CNA [Certified Nursing Assistant 1] with a knife. As she sat in the dinning room area on break, Resident [B] came up on her in his wheelchair behind her back with a knife in his hand. He stated, "I know what you did, you think you [are] slick.' She had no idea what he was talking about he became angered continuing to intimated [sic] the young girl. Resident kept the knife in his hand the entire time never trying to hide it from view. CNA [1] reported this incident to writer and another staff [member] Qualified Medication Assistant on duty at the time of the incident. Social Worker to call the police and report previous entry incident. The police arrived at 10:30 p.m., spoke with myself and another resident that resides across the hall from said resident [Resident B]. Resident B was removed from the property by IMPD [Indianapolis Metropolitan Police Department] and taken for a psycha [psychological evaluation]. Type of incident: Resident [B] acted as if he was going to cut CNA [1] with a knife, while the CNA [1] was sitting in the dining room. Other essential information: Resident is currently on psych services, and will refuse treatment from psych provider. Resident will also refuse medication form staff, and only take certain medications. Resident is adamant someone is spraying something into his room, but complaint has been investigated with no findings."

Emergency Department Provider Notes, dated 3/14/2021 indicated, "Resident [B] presents to the Emergency Department (ED) for agitation and hypertension. He [Resident B] states he lost his cool, he would never hit a woman. Police and EMS [ambulance] were called and he was transported to the ED for evaluation. Crisis
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 155780

**MULTIPLE CONSTRUCTION**

**A. BUILDING**

**B. WING**

**DATE SURVEY COMPLETED:** 03/23/2021

**NAME OF PROVIDER OR SUPPLIER**

**HOMESTEAD HEALTHCARE CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

7465 MADISON AVE

INDIANAPOLIS, IN 46227

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<tr>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tr>
<td>DQFT11</td>
<td>012225</td>
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<td>evaluated the patient [Resident B] and cleared him to return to an ECF [Extended Care Facility].... &quot;</td>
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During an Interview, on 3/22/21 3:33 p.m., CNA 1 indicated on 3/14/2021 she was sitting in the dining room on break. Resident B approached her from behind. He had his knife in his hand and stated "'I know what you did. That was sly.' " CNA 1 indicated she had no idea why he would say that to her or why he would threaten her with a knife. CNA 1 then reported the incident to the nurse.

During an interview, on 3/22/21 at 1:20 p.m., the Social Services Director indicated she was not sure if Resident B was still in possession of the knife. Observed the Social Services Director do a brief search of the resident's room, and was unable to locate the knife.

During an interview, 3/22/21 at 1:35 p.m., the Maintenance Director indicated when the resident was sent out for threatening the CNA with the knife on 3/14/2021, the knife was removed from his room with all of his other belongings. The knife was wrapped with a cloth and put in a box with all of his [Resident B's] other belongings. The belongings were removed from the resident's room and put in an unlocked empty room. The facility did not anticipate the resident would be returning because of his threats against the staff. When the resident returned to the facility, at some point, he ended up with the knife back in his possession. The knife was about 4" long when the blade was not exposed. When the knife was open, and the blade was exposed, it was approximately 7" long. We have tried to get the knife before. The resident refuses to give it up, it is his personal item.
A Progress Note, dated 3/21/21 at 1:32 a.m., indicated "one of the other residents told me [writer] that Mr. (name) [Resident B] was out back smoking and was showing off the knife that he had previously threatened a staff member with."

During an interview, on 3/23/21 at 10:09 a.m., Resident G indicated Resident B "was flashing his knife last night after he returned from the hospital".

A Progress note, dated 3/22/21 at 1:18 p.m., indicated Resident B "sent himself to the hospital he said he is having SOB [shortness of breath]."

During an interview, on 3/23/2021 at 10:30 a.m., the Social Services Director indicated Resident B again "returned from the hospital with no new orders. I guess the knife is still on him, not sure."

On 3/23/2021 at 9:30 a.m., a weapons policy was requested from the Corporate Nurse.

On 3/23/21 at 1:33 p.m., the Corporate Nurse indicated the facility only had a weapons policy for employees and not for the residents.

During an interview, on 3/22/21 at 2:00 p.m., the Administrator indicated he was not aware Resident B had his knife back from the incident that occurred on 3/14/2020.

On 3/23/2021 at 12:38 p.m., the Corporate Nurse proved a policy titled Resident Rights, dated 4/20/17, and indicated it was the current policy being used by the facility. A review of the policy, indicated "...Definitions: a state worthy
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**IDENTIFICATION NUMBER:** 155780

**DATE SURVEY COMPLETED:** 03/23/2021

**NAME OF PROVIDER OR SUPPLIER:** HOMESTEAD HEALTHCARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 7465 MADISON AVE, INDIANAPOLIS, IN 46227

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|    | of honor or respect; includes but not limited to speaking respectfully to resident, providing privacy for care and treatment, providing safe and secure housing...6. Privacy concerning their Privacy, Property, and Living Arrangements including but not limited to: 1. Keep and use personal belongings and property as long as they don't interfere with the rights, health and safety of others."
|    | 3.1-45(a)(1) |   |
|    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  
|    |  |   |
|    | COMPLETION DATE |  |