STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING _____ B. WING _____	R-C 04/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00349740 that resulted in an unrelated deficiency completed March 23, 2021.

This visit was in conjunction with a PSR to the Investigation of Complaints IN00347986 and IN00348360 completed on March 3, 2021.

This visit was in conjunction with a PSR to the Investigation of Complaint IN00345721 and the COVID-19 Focused Infection Control Survey completed on February 19, 2021.

Complaint IN00347986 - Corrected.
Complaint IN00348360 - Corrected.

Complaint IN00345721 - Corrected.

Survey date: April 21, 2021

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

Census Bed Type:
SNF/NF: 61
Total: 61

Census Payor Type:
Medicare: 8
Medicaid: 46
Other: 7
Total: 61

Homestead Healthcare Center was found to be in compliance with 42 CFR Part 483 Subpart B and

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING _____ B. WING _____	R-C 04/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	Continued From page 1 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00349740 that resulted in an Unrelated Deficiency. Quality Review completed on April 22, 2021.	{F 000}		