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	06/23/2021

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 the Investigation of Complaints IN00354585, IN00355548, IN00355303, IN00355560, and IN00356071. Complaint IN00354585 - Unsubstantiated due to lack of evidence. Complaint IN00355548 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00355303 - Substantiated. Federal/State deficiencies related to the allegations are cited at F761. Complaint IN00355560 - Substantiated. Federal/State deficiencies related to the allegations are cited at F661 and F760. Complaint IN00356071 - Substantiated. Federal/State deficiencies related to the allegations are cited at F755 and F760. Survey dates: June 21, 22, and 23, 2021 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 2 Medicaid: 71 Other: 16	F 0000	Preparation execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The plan of correction is submitted in order to respond to the allegation of non-compliance cited during survey on June 21st- 23rd 2021. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to request a desk review for this survey.	

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 00 B. WING	06/23/2021

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
	Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on June 28, 2021.			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.			

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	06/23/2021

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
	Based on record review and interview, the facility failed to ensure a drug reconciliation was completed on a discharged resident as indicated by facility policy for 1 of 3 residents reviewed for discharge summary. (Resident B) Findings include: On 6/22/21 at 9:30 a.m., Resident B's closed record was reviewed. Resident was admitted on 5/7/2021 from a hospital and discharged to home on 6/3/2021. The recapitulation of Physicians orders, dated May 2021, included, but were not limited to, ceftriaxone sodium solution every 24 hours until 5/20/2021 then discontinue, hydroxyzine, oxycodone, gabapentin, morphine, buspirone, metoprolol, aspirin, folic acid, furosemide, mirtazapine, multivite, naloxegol, thiamine, vitamin D2, and docusate sodium. The clinical record lacked documentation of Resident B's drug disposition/reconciliation of prescribed medications at the time of discharge from the facility. During an interview, on 6/22/2021 at 2:00 p.m., the Director of Nursing indicated the drug disposition for Resident B was not available. On 6/22/21 at 2:22 p.m., the Director of nursing provided a policy titled Transfer and Discharge Policy, dated 3/10/17, and indicated it was the current policy being used by the facility. A review of the policy indicated "...3. i. Reconciliation of all pre-discharge medications with the resident's post-discharge medications will include: 1. Prescribed/Prescription Medication. 2. Over the counter Medication."	F 0661	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B no longer resides in the facility. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Other residents that plan to discharge from the facility or have discharged from the facility have the potential to be affected by the alleged deficient practice. An audit was conducted of discharges in the past 30 days to ensure a disposition/reconciliation of medications was completed. **Measures/systematic changes put into place to ensure the deficient practice does not recur:** DON/designee has in-serviced all licensed nursing staff on the facilities policy identified as, "Transfer and Discharge Policy", with emphasis on medication disposition/reconciliation upon discharge. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Director of nursing or designee will audit all discharged residents daily to ensure discharging resident have a Discharge summary with drug disposition/reconciliation upon discharge x4 weeks, then 3	07/15/2021

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	06/23/2021

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
	This Federal tag relates to Complaint IN00355560. 3.1-25(s)		discharging residents x 4 weeks, then monthly for no less than 3 months or until compliance is met. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			

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	06/23/2021

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
	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to establish and provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of narcotic medications to meet the needs of each resident for 6 of 6 residents reviewed for receipt and disposition of controlled drugs, of 34 residents prescribed controlled drugs, of 89 residents residing in the facility. (Resident P, Q, R, S, T, U) Findings include: a. On 6/22/21 at 11:00 a.m., the clinical record of Resident P was reviewed. Diagnosis included, but were not limited to, chronic pain syndrome. The June 2021 Physician orders, indicated Resident P was prescribed oxycodone ER (opioid analgesic controlled substance schedule II) 40 mg (milligram) tablet, give 1 tablet by mouth every 12 hours for pain, with the start date of 5/18/21. On 6/22/21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of Resident P's Controlled	F 0755	**Corrective action for the residents found to have been affected by the deficient practice:** Residents P, Q, R, S, T, and U were not harmed by the alleged deficient practice. Residents P, Q, R, S, T, and U narcotic count was completed with review of the Controlled Drug Administration Record Tablet Documentation to ensure that there was no discrepancies. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** DNS/NURSE ADMINSTRATION has completed a 100% narcotic count and re-view of the Controlled Drug Administration Record Tablet Documentation to ensure all residents had accurate documentation and there was no discrepancies in the narcotic	07/15/2021

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	06/23/2021

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
	Drug Administration Record Tablet document. A review of the document indicated Resident P was prescribed and the pharmacy provided to the facility, "oxycodone ER 40 mg tablet, give 1 tablet by mouth every 12 hours for pain, quantity 60 tablets." The facility received 30 tablets of the medication on 5/22/21, as indicated by the staff signature on the document. The document had columns titled: -AMT (to track the number of tablets delivered by the pharmacy starting at 60 (in descending order) to indicate one pill per line that is available to be administered; -Date/Time (date and time when medication was administered); -Dose/Amt (dose and amount of medication administered); -AMT Wasted/Witnessed (amount of medication wasted or destroyed); -ADMIN by (staff signature for who administered the medication); and -AMT Rem (amount of medication remaining). As indicated by the document, the facility received 30 tablets as noted by the nurse's signature. The document indicated 15 tablets were administered to Resident P between 5/24/21 and 6/10/21. The staff members utilized the AMT line number 30 down to AMT line number 12 to reflect the number of tablets administered to the resident for a total of 15 tablets administered to Resident P. The Controlled Drug Administration Record Tablet document was not reconciled regarding the number of tablets received to the number of tablets dispensed for Resident P. On 6/21/21 at 10:30 a.m., the Director of Nursing		count. **Measures/systematic changes put into place to ensure the deficient practice does not recur:** DON/designee has in-serviced all licensed nursing staff on the facilities policy, identified as, "Chain of custody for Controlled Substance" with emphasis regarding accurate documentation upon receiving the narcotic from pharmacy and proper documentation of narcotics given on the Controlled Drug Administration Record Tablet Document. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Director of nursing/ designee will audit all narcotic sheets daily to ensure the Controlled Drug Administration Record Tablet Document is completed properly x 4 weeks, then 3 weekly x 4 weeks, then monthly for no less than 3 months or until compliance is met. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring	

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	06/23/2021

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
	provided a copy of the facility MATRIX document, dated 6/21/21, and indicated it was the current list of residents with identified needs. A review of the document indicated 34 residents were prescribed an opioid (a narcotic drug medication). During an interview at that time, the Director of Nursing indicated the facility census was 89. During an interview, on 6/23/21 at 9:00 a.m., the Director of Nursing indicated the Controlled Drug Administration Record Tablet document, which was provided by the pharmacy, was used to track and monitor the administration of narcotics for each resident. The staff was supposed to accurately and consistently complete the form; however, facility staff were inconsistent in how they filled out the form. b. On 6/22/21 at 11:05 a.m., the clinical record of Resident Q was reviewed. Diagnosis included, but were not limited to, multiple fractures. The June 2021 Physician orders indicated Resident Q was prescribed oxycodone APAP (opioid analgesic controlled substance schedule II) 5-325 mg (milligrams) tablet, give 1-2 tablet orally every 4 hours prn (as needed) for pain, with the start date of 5/18/21. On 6/22/21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of Resident Q's Controlled Drug Administration Record Tablet document. A review of the document indicated Resident Q was prescribed and the pharmacy provided to the facility, "oxycodone APAP 5-325 mg tablet, give 1-2 tablet orally every 4 hours prn (as needed) for pain, quantity 12 tablets." The amount of medication received, date received, and the staff member signature lines were blank on the		is required.	

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	06/23/2021

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
	document. The document had columns titled: -AMT (to track the number of tablets delivered by the pharmacy starting at 60 (in descending order) to indicate one pill per line that is available to be administered; -Date/Time (date and time when medication was administered); -Dose/Amt (dose and amount of medication administered); -AMT Wasted/Witnessed (amount of medication wasted or destroyed); -ADMIN by (staff signature for who administered the medication); and -AMT Rem (amount of medication remaining). The pharmacy indicated, on the document, they provided the facility with 12 tablets of medication. The document indicated 12 tablets were administered to Resident Q between 6/3/21 and 6/6/21. The staff members utilized the AMT line number 11 down to AMT line number 2 to reflect the number of tablets administered to the resident for a total of 12 tablets administered to Resident Q. The Controlled Drug Administration Record Tablet document was not reconciled regarding the number of tablets received to the number of tablets dispensed and lacked a staff signature that verified the date and the amount of medications received for Resident Q. On 6/21/21 at 10:30 a.m., the Director of Nursing provided a copy of the facility MATRIX document, dated 6/21/21, and indicated it was the current list of residents with identified needs. A review of the document indicated 34 residents were prescribed an opioid (a narcotic drug medication). During an interview at that time, the			

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	06/23/2021

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
	Director of Nursing indicated the facility census was 89. During an interview, on 6/23/21 at 9:00 a.m., the Director of Nursing indicated the Controlled Drug Administration Record Tablet document, which was provided by the pharmacy, was used to track and monitor the administration of narcotics for each resident. The staff was supposed to accurately and consistently complete the form; however, facility staff were inconsistent in how they filled out the form. c. On 6/22/21 at 11:10 a.m., the clinical record of Resident R was reviewed. Diagnosis included, but were not limited to, fractured right foot. The June 2021 Physician orders indicated Resident R was prescribed hydrocodone APAP (opioid analgesic controlled substance schedule II) 10-325 mg (milligrams) tablet, take one tablet by mouth every six hours as needed for pain, with the start date of 5/14/21. On 6/22/21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of Resident R's Controlled Drug Administration Record Tablet document. A review of the document indicated Resident R was prescribed and the pharmacy provided to the facility, "hydrocodone APAP 10-325 mg tablet, take 1 tablet by mouth every six hours as needed for pain, quantity 24 tablets." The amount of medication received, date received, and the staff member signature lines were blank on the document. The document had columns titled: -AMT (to track the number of tablets delivered by the pharmacy starting at 60 (in descending order) to indicate one pill per line that is available to be administered;			

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	06/23/2021

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
	-Date/Time (date and time when medication was administered); -Dose/Amt (dose and amount of medication administered); -AMT Wasted/Witnessed (amount of medication wasted or destroyed); -ADMIN by (staff signature for who administered the medication); and -AMT Rem (amount of medication remaining). The pharmacy indicated, on the document, they provided the facility with 24 tablets of medication. The document indicated 24 tablets were administered to Resident R between 5/29/21 and 6/6/21. The staff members utilized the AMT line number 24 down to AMT line number 5 to reflect the number of tablets administered to the resident for a total of 24 tablets administered to Resident R. The Controlled Drug Administration Record Tablet document was not reconciled regarding the number of tablets received to the number of tablets dispensed and lacked a staff signature that verified the date and the amount of medications received for Resident R. On 6/21/21 at 10:30 a.m., the Director of Nursing provided a copy of the facility MATRIX document, dated 6/21/21, and indicated it was the current list of residents with identified needs. A review of the document indicated 34 residents were prescribed an opioid (a narcotic drug medication). During an interview at that time, the Director of Nursing indicated the facility census was 89. During an interview, on 6/23/21 at 9:00 a.m., the Director of Nursing indicated the Controlled Drug Administration Record Tablet document, which was provided by the pharmacy, was used to track			

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	06/23/2021

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
	and monitor the administration of narcotics for each resident. The staff was supposed to accurately and consistently complete the form; however, facility staff were inconsistent in how they filled out the form. d. On 6/22/21 at 11:15 a.m., the clinical record of Resident S was reviewed. Diagnosis included, but were not limited to, restless legs syndrome and type 2 diabetes mellitus with diabetic neuropathy. The June 2021 Physician orders indicated Resident S was prescribed oxycodone APAP (opioid analgesic controlled substance schedule II) 10-325 mg (milligrams) tablet, take one tablet by mouth three times a day, with a start date of 4/30/21. On 6/22/21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of Resident S's Controlled Drug Administration Record Tablet document. A review of the document indicated Resident R was prescribed and the pharmacy provided to the facility, "oxycodone APAP 10-325 mg tab, take 1 tablet by mouth three times a day, quantity 4 tablets." The facility received 4 tablets of the medication, as indicated by the staff signature on the document. The date received line on the document was blank. The document had columns titled: -AMT (to track the number of tablets delivered by the pharmacy starting at 60 (in descending order) to indicate one pill per line that is available to be administered; -Date/Time (date and time when medication was administered); -Dose/Amt (dose and amount of medication administered); -AMT Wasted/Witnessed (amount of medication			

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	06/23/2021

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
	wasted or destroyed); -ADMIN by (staff signature for who administered the medication); and -AMT Rem (amount of medication remaining). As indicated on the document, the pharmacy provided the facility with 4 tablets of medication. The document indicated 4 tablets were administered to Resident S between 5/29/21 and 5/30/21. The staff members utilized the AMT line number 34 down to AMT line number 31 to reflect the number of tablets administered to the resident for a total of 4 tablets administered to Resident S. The Controlled Drug Administration Record Tablet document was not reconciled regarding the number of tablets received to the number of tablets dispensed and lacked the date for when the medication was received for Resident S. On 6/21/21 at 10:30 a.m., the Director of Nursing provided a copy of the facility MATRIX document, dated 6/21/21, and indicated it was the current list of residents with identified needs. A review of the document indicated 34 residents were prescribed an opioid (a narcotic drug medication). During an interview at that time, the Director of Nursing indicated the facility census was 89. During an interview, on 6/23/21 at 9:00 a.m., the Director of Nursing indicated the Controlled Drug Administration Record Tablet document, which was provided by the pharmacy, was used to track and monitor the administration of narcotics for each resident. The staff was supposed to accurately and consistently complete the form; however, facility staff were inconsistent in how they filled out the form.			

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	06/23/2021

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
	e. On 6/22/21 at 11:20 a.m., the clinical record of Resident T was reviewed. Diagnosis included, but were not limited to, acute post procedural pain. The June 2021 Physician orders indicated Resident T was prescribed oxycodone IR (opioid analgesic controlled substance schedule II) 5 mg (milligrams) tablet, take 2 tablets orally every 4 hours for 7 days as needed for pain, with a start date of 6/9/21. On 6/22/21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of Resident T's Controlled Drug Administration Record Tablet document. A review of the document indicated Resident T was prescribed and the pharmacy provided to the facility, "oxycodone IR 5 mg tablets, take 2 tablets every 4 hours for 7 days as needed for pain, quantity 12 tablets." The amount of medication received, date received, and the staff member signature lines were blank on the document. The document had columns titled: -AMT (to track the number of tablets delivered by the pharmacy starting at 60 (in descending order) to indicate one pill per line that is available to be administered; -Date/Time (date and time when medication was administered); -Dose/Amt (dose and amount of medication administered); -AMT Wasted/Witnessed (amount of medication wasted or destroyed); -ADMIN by (staff signature for who administered the medication); and -AMT Rem (amount of medication remaining). The pharmacy indicated, on the document, they provided the facility with 12 tablets of medication.			

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	06/23/2021

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
	The document indicated 12 tablets were administered to Resident T between 6/10/21 and 6/11/21. The staff members utilized the AMT line number 12 down to AMT line number 5 to reflect the number of tablets administered to the resident for a total of 12 tablets administered to Resident T. The Controlled Drug Administration Record Tablet document was not reconciled regarding the number of tablets received to the number of tablets dispensed and lacked a staff signature that verified the date and the amount of medications received for Resident T. On 6/21/21 at 10:30 a.m., the Director of Nursing provided a copy of the facility MATRIX document, dated 6/21/21, and indicated it was the current list of residents with identified needs. A review of the document indicated 34 residents were prescribed an opioid (a narcotic drug medication). During an interview at that time, the Director of Nursing indicated the facility census was 89. During an interview, on 6/23/21 at 9:00 a.m., the Director of Nursing indicated the Controlled Drug Administration Record Tablet document, which was provided by the pharmacy, was used to track and monitor the administration of narcotics for each resident. The staff was supposed to accurately and consistently complete the form; however, facility staff were inconsistent in how they filled out the form. f. On 6/22/21 at 11:20 a.m., the clinical record of Resident U was reviewed. Diagnosis included, but were not limited to, cellulitis of the right and left lower limbs. The June 2021 Physician orders indicated			

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	06/23/2021

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
	Resident U was prescribed oxycodone APAP (opioid analgesic controlled substance schedule II) 5-325 mg (milligrams) tablet, take 1-2 tablets by mouth every four hours as needed for pain, with a start date of 5/20/21. On 6/22/21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of Resident T's Controlled Drug Administration Record Tablet document. A review of the document indicated Resident T was prescribed and the pharmacy provided to the facility, "oxycodone APAP 5-325 mg (milligrams) tablet, take 1-2 tablets by mouth every four hours as needed for pain, quantity 30 tablets." The amount of medication received, date received, and the staff member signature lines were blank on the document. The document had columns titled: -AMT (to track the number of tablets delivered by the pharmacy starting at 60 (in descending order) to indicate one pill per line that is available to be administered; -Date/Time (date and time when medication was administered); -Dose/Amt (dose and amount of medication administered); -AMT Wasted/Witnessed (amount of medication wasted or destroyed); -ADMIN by (staff signature for who administered the medication); and -AMT Rem (amount of medication remaining). The pharmacy indicated, on the document, they provided the facility with 30 tablets of medication. The document indicated 30 tablets were administered to Resident U between 5/21/21 and 5/25/21. The staff members utilized the AMT line number 30 down to AMT line number 14 to reflect the number of tablets administered to the resident for a total of 30 tablets administered to Resident			

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	06/23/2021

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
	U. The Controlled Drug Administration Record Tablet document was not reconciled regarding the number of tablets received to the number of tablets dispensed and lacked a staff signature that verified the date and the amount of medications received for Resident U. On 6/21/21 at 10:30 a.m., the Director of Nursing provided a copy of the facility MATRIX document, dated 6/21/21, and indicated it was the current list of residents with identified needs. A review of the document indicated 34 residents were prescribed an opioid (a narcotic drug medication). During an interview at that time, the Director of Nursing indicated the facility census was 89. During an interview, on 6/23/21 at 9:00 a.m., the Director of Nursing indicated the Controlled Drug Administration Record Tablet document, which was provided by the pharmacy, was used to track and monitor the administration of narcotics for each resident. The staff was supposed to accurately and consistently complete the form; however, facility staff were inconsistent in how they filled out the form. On 6/22/21 at 1:50 p.m., the DON provided a copy of the Chain of Custody for Controlled Substance policy, dated 8/1/17, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...to provide a consistent and traceable method to maintain the chain of custody of controlled substances from delivery from the pharmacy to administering to the resident or to disposal..." On 6/22/21 at 1:50 p.m., the DON provided a copy			

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	06/23/2021

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
	of the Medication Controlled Drugs and Security policy, dated 7/25/18, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...the inventory of the controlled drugs, count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count..." This Federal tag relates to Complaint IN00356071. 3.1-25(e)(2)			
F 0760 SS=D 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 provide 4 doses of an Intravenous (IV) Antibiotic therapy for a resident with the diagnosis of Strep viridans bacteremia (VBS) for 1 of 3 residents reviewed for IV medication administration (Resident B) and the facility failed to ensure residents had a Physician order for an antianxiety medication for 2 of 30 residents reviewed for medication administration (Resident W and V). Findings included: 1. On 6/22/21 at 10:30 a.m., the clinical record for Resident B was reviewed. Diagnosis included, but were not limited to, endocarditis of tricuspid valve, bacteremia due to streptococcus, and septic pulmonary embolism. A discharge summary from the a hospital report, dated 4/13/21, indicated reason for visit, "...known tricuspid valve infectious endocarditis. Repeat blood cultures showed no growth and the patient	F 0760	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B is discharged from the facility. Resident V and W were not harmed by the alleged deficient practice. Residents V and W medications have been reconciled to reflect the physician's orders and that their medications are being given appropriately. Residents V and W liquid Ativan was destroyed due to order stating tablet form. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** DNS/NURSE ADMINSTRATION has completed a 100% in- house review of narcotics and order type to ensure medication is in right	07/15/2021

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	06/23/2021

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
	was ultimately taken to the operating room (OR) on 4/19/21 and underwent Tricuspid valve replacement..." Resident B was admitted to the facility from the hospital on 5/7/2021. A Medication Administration Record (MAR), dated May 2021, indicated a Physicians order, with the start date of 5/7/2021, Resident B was to receive ceftriaxone sodium solution 2 GM IV piggyback every 24 hours for infection (Strep Viridans bacteremia), until 5/30/2021. During a confidential interview, on 6/21/21 at 12:05 p.m., a statement was received, Resident B did not receive his IV antibiotic therapy on 4 different days in May. The MAR lacked documentation of ceftriaxone sodium solution having been administered on the following days: May 11, 18, 21, and 22, 2021. During an interview, on 6/22/21 at 11:33 a.m., the Director of Nursing indicated the record lacked documentation of Resident B receiving ceftriaxone sodium solution. She unsure why the clinical record for May 11, 18, 21, and 22 was blank. On 6/23/21 at 10:14 a.m., the Director of Nursing provided a policy titled, Physician Orders, dated 5/30/19, and indicated it was the current policy being used by the facility. A review of the policy indicated "...Definitions: Medication Administration Record-the legal medical record for recording medications and treatments."2.a. Resident V's clinical record was reviewed on 6/22/21 at 11:45 a.m. Resident V was admitted to the facility on 5/10/21.		form for administration. 100% in-house audit has been completed on any residents that are receiving IV therapy to ensure IV ABT therapy is completed per physician order. **Measures/systematic changes put into place to ensure the deficient practice does not recur:** DON/designee has in-serviced all licensed nursing staff on the facilities policy, identified as, "Medication Administration" with over-view of five rights of medication administration, medication administration documentation. DON/designee will perform skills check with all licensed nurse on medication administration. DON/designee has in-serviced all licensed nursing staff on the facilities policy identified as, "Physicians Orders", with emphasis on following physician orders regarding IV medication administration. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Director of nursing/ designee will audit 5 residents daily to ensure medications have been given following the Physicians order x 4 weeks, then 3 residents weekly x 4 weeks, then 5 residents monthly for no less than 3 months or until compliance is met.	

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	06/23/2021

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
	Resident V's May 2021 medication administration record (MAR) indicated, Resident V received 0.25ml of lorazepam 2 mg/ml concentrate (a prescription narcotic medication used to reduce anxiety) on 5/10/21 at 6:00 p.m., 5/14/21 at 3:00 a.m., 5/14/21 at 12:00 p.m., and 5/14/21 at 7:00 p.m. The clinical record lacked a physician's order for lorazepam 2mg/ml concentrate. b. Resident W's clinical record was reviewed on 6/22/21 at 12:00 p.m., Resident W was admitted to the facility on 5/4/21. Resident W's May 2021 medication administration record (MAR) indicated, Resident W received 0.25ml of lorazepam 2mg/ml concentrate (a prescription narcotic medication used to reduce anxiety) on 5/18/21 at 9:00 p.m., 5/19/21 at 9:00 p.m. and 5/20/21 at 9:00 p.m. The clinical record lacked a physician's order for lorazepam 2mg/ml concentrate. During an interview, on 6/23/21 at 11:45 p.m., the Director of Nursing (DON) indicated, the clinical records of Resident V and W lacked a physician's order for lorazepam concentrate, so lorazepam concentrate should not have been given to Residents V and W. An order for lorazepam concentrate had not been provided for Residents V or W. On 6/21/21 at 12:00 p.m., the DON provided a copy of a facility policy, dated 4/2017, titled "Medication Administration, and indicated it was the current policy used by the facility. A review of the policy indicated, " ...Medication ...Read label multiple times comparing to MAR ...Review original Physician's order if discrepancy ...do not		The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	06/23/2021

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
	provide if discrepancies continue." This federal tag relates to Complaint IN00356071 and Complaint IN00355560. 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure that residents' medications, that had been stored in the medication room refrigerator, were properly stored	F 0761	**Corrective action for the residents found to have been affected by the deficient practice:**	07/15/2021

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	06/23/2021

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
	and labeled as indicated by facility policy; and the facility failed to monitor the refrigerator temperature in the medication storage room as indicated by facility policy, for 1 of 2 medication rooms observed. Findings include: 1. During the initial tour of the facility on 6/21/21 at 10:00 a.m., observed the medication storage refrigerator located in the medication room on the west unit. Inside the refrigerator observed 2 pink plastic containers filled with residents' medications. Inside the container observed approximately 2 inches of a cloudy liquid substance that had particles floating. Observed submerged in the liquid were: a. 2 unopened Tresiba insulin pens that lacked a label to identify the resident the pen belonged to. The pens were not in a leak proof package. b. An unopened Trulicity 1.5mg/0.5ml pen that lacked a label to identify the resident the pen belonged to. The pen was not in a leak proof package. c. An unopened Ozempic pen 2mg/1.5ml. The pen was not in a leak proof package. d. An unopened Lantus SoloStar pen. The pen was not in a leak proof package. Observed in the narcotic lock box inside the medication storage refrigerator were 2 opened bottles of Lorazepam 2mg/ml concentrate that lacked a date to indicate the date the bottles had		No residents have been harmed by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All medications rooms were audited for proper medication storage. West side medication room refrigerator was replaced with a new refrigerator. All medication room refrigerators were checked to ensure proper storage of medication. All medication refrigerators have a thermometer and temp log in place to track the refrigerators temperature. **Measures/systematic changes put into place to ensure the deficient practice does not recur:** DON/designee has in-serviced all licensed nursing staff on the facilities policy, identified as, "Storage of Medications", with emphasis on storage of medication within the medication rooms, and monitoring of medication refrigerator temperature. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Director of nursing/ designee will the audit medications rooms/ medication room refrigerators 5 times a week for x 12 weeks, then monthly for no less than 3 months or until compliance is met.	

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	06/23/2021

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
	been opened. During an interview, on 6/21/21 at 10:30 a.m., the Director of Nursing (DON) indicated, the medications should not have been submerged in liquid. During an interview, on 6/23/21 at 9:00 a.m., Pharmscript Pharmacist indicated, the pens should not have been submerged in liquid and could have been contaminated with the liquid getting into the pen's cartridge. During an interview, on 6/23/21 at 11:30 a.m., Licensed Practical Nurse (LPN) 2 indicated, the opened medications should have been dated to identify the date the package was opened. On 6/22/21 at 1:50 p.m., the DON provided a copy of a facility policy, dated 8/20, titled, "Storage of Medication," and indicated it was the current policy used by the facility. A review of the policy indicated, "Outdated, contaminated, or deteriorated medications ...are immediately removed from inventory ...When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated." 2. During medication storage review, on 6/22/11 at 11:33 a.m., observed the medication storage refrigerator to have a temperature storage log taped on the door. The log was dated, April 2021, no temperatures were documented on the form. During an interview, on 6/22/21 at 11:45 a.m., the Director of Nursing indicated the temperature of the refrigerator should be obtained and documented daily. During an interview, on 6/22/21 at 1:22 p.m., the Director of Nursing indicated there were no other		The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	06/23/2021

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
	documented refrigerator temperature logs from the medication storage room were available. On 6/21/21 at 12:56 p.m., the Director of Nursing provided a policy titled, Refrigerator Maintenance and Temperature, dated 10/25/13 and revised on 3/5/19, and indicated it was the current policy being used by the facility. A review of the policy indicated, "1. Daily refrigerator temperature checks must be performed...d. Record and Log temperatures daily on a log kept at the refrigerator. i. Monthly, collect the previous month's log sheet and replace with new." This Federal tag relates to Complaint IN00355303. 3.1-25(j) 3.1-25(m)			