	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/23/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
HOMES	TEAD HEALTHCA	RE CENTER		NAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	DN	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE PRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
= 0000						
Bldg. 00	IN00354585, IN00	the Investigation of Complaints)355548, IN00355303, IN00355560,	Ŭ		titute	
	and IN00356071.			provider of the truth of the f	acts or	
				alleged or conclusions set		
	-	4585 - Unsubstantiated due to		the State of Deficiencies. T	•	
	lack of evidence.			of Correction is prepared a		
	Commission IN10025	5540 Salatantistad Na		executed solely because it		
	•	5548 - Substantiated. No		required by the position of		
	deficiencies related	d to the allegations were cited.		and State Law. The plan of correction is submitted in o		
	Complaint IN0035	5303 - Substantiated		respond to the allegation of		
	Complaint IN00355303 - Substantiated. Federal/State deficiencies related to the allegations are cited at F761.			non-compliance cited durin		
				survey on June 21st- 23rd	-	
	unegations are ente	a at 1701.		Please accept this plan of	2021.	
	Complaint IN0035	5560 - Substantiated.		correction as the provider's		
	· ·	tiencies related to the		credible allegation of comp		
		ed at F661 and F760.		The facility would like to red desk review for this survey.	quest a	
	Complaint IN0035	6071 - Substantiated.		,		
	·	eiencies related to the				
	allegations are cite	ed at F755 and F760.				
	Survey dates: Jun	e 21, 22, and 23, 2021				
	Facility number: ()12225				
	Provider number:					
	AIM number: 200					
	Census Bed Type:					
	SNF/NF: 89					
	Total: 89					
	Census Payor Typ	e:				
	Medicare: 2					
	Medicaid: 71					
	Other: 16					

PRINTED: 07/16/2021

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155780 B. WING 06/23/2021 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG 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 483.21(c)(2)(i)-(iv) SS=D **Discharge Summary** Bldg. 00 §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. H47911

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID: 012225

Page 2 of 23 If continuation sheet

07/16/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB	NO.	0938-039	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	A. BUILDING <u>00</u> B. WING		onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/23/2021	
	PROVIDER OR SUPPLIE			7465 N	ADDRESS, CITY, STATE, ZIP COD IADISON AVE IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		view and interview, the facility	F 06	61	Corrective action for the		07/15/202
		rug reconciliation was			residents found to have bee	n	
		charged resident as indicated			affected by the deficient		
		or 1 of 3 residents reviewed for			practice:		
	discharge summary	v. (Resident B)			Resident B no longer resides	in	
					the facility.		
	Findings include:				Corrective action taken for		
					those residents having the		
		a.m., Resident B's closed record			potential to be affected by the	e	
		ident was admitted on 5/7/2021			same deficient practice:		
	_	l discharged to home on			Other residents that plan to		
	6/3/2021.				discharge from the facility or h		
					discharged from the facility ha		
	*	of Physicians orders, dated			the potential to be affected by		
		d, but were not limited to,			alleged deficient practice. An	audit	
		solution every 24 hours until			was conducted of discharges	in	
		continue, hydroxyzine,			the past 30 days to ensure a		
		entin, morphine, buspirone,			disposition/reconciliation of		
		, folic acid, furosemide,			medications was completed.		
	-	vite, naloxegol, thiamine, vitamin			Measures/systematic chang	es	
	D2, and docusate s	odium.			put into place to ensure the		
					deficient practice does not		
		lacked documentation of			recur:		
		lisposition/reconciliation of			DON/designee has in-service	d all	
		ions at the time of discharge			licensed nursing staff on the		
	from the facility.				facilities policy identified as,		
					"Transfer and Discharge Po	licy",	
	U U	w, on 6/22/2021 at 2:00 p.m., the			with emphasis on medication		
		g indicated the drug disposition			disposition/reconciliation upor	ı	
	for Resident B was	not available.			discharge.		
					Corrective actions to be		
		p.m., the Director of nursing			monitored to ensure the		
		itled Transfer and Discharge			deficient practice will not		
		17, and indicated it was the			recur:		
		g used by the facility. A			Director of nursing or designe		
	review of the polic				audit all discharged residents	•	
	Reconciliation of all pre-discharge medications with the resident's post-discharge medications will				to ensure discharging residen		
					have a Discharge summary w		
		ibed/Prescription Medication.			drug disposition/reconciliation		
	2. Over the counter	r Medication."			upon discharge x4 weeks, the	n 3	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155780	B. WING		06/23	3/2021
NAME OF I	PROVIDER OR SUPPLIE	۲. C	STREET	ADDRESS, CITY, STATE, ZIP COD		
	FEAD HEALTHCA			IAPOLIS, IN 46227		-
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG			DATE
	This Failenslife a	later to Compleint Di002555(0		discharging residents x 4 v		
	This Federal lag re	elates to Complaint IN00355560.		then monthly for no less th		
	2 + 25(a)			months or until compliance		
	3.1-25(s)			The Director of Nursing wi present the results of these		
				monthly to the QAPI com		
				for no less than 3 months.		
				patterns that are identified	•	
				have an Action Plan initiate		
				QAPI committee will deter		
				when 100% compliance is		
				achieved or if ongoing mor	nitoring	
				is required.		
0755	183 15(a)(b)(1) (3)				
SS=E	483.45(a)(b)(1)-(Pharmacy	3)				
Bldg. 00	-	s/Pharmacist/Records				
Blug. 00	§483.45 Pharma					
	-	provide routine and				
		s and biologicals to its				
		ain them under an agreement				
		3.70(g). The facility may				
	-	d personnel to administer				
		v permits, but only under the				
	general supervis	ion of a licensed nurse.				
	8/83 /5(a) Proc	edures. A facility must				
		eutical services (including				
		assure the accurate				
		ing, dispensing, and				
		all drugs and biologicals) to				
	meet the needs of	c c <i>i</i>				
	8182 15(h) Sami	co Consultation The facility				
		ce Consultation. The facility obtain the services of a				
	licensed pharma					
	ncenseu pharma	USL WIIU-				

PRINTED: 07/16/2021 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		<u>00</u>	(X3) DATE SURVEY COMPLETED 06/23/2021	
	PROVIDER OR SUPPLIE			7465 N	ADDRESS, CITY, STATE, ZIP COD IADISON AVE IAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ξ.	(X5) COMPLETIO DATE
	aspects of the pro- in the facility. §483.45(b)(2) Est records of receipt controlled drugs i an accurate record §483.45(b)(3) De are in order and t controlled drugs i periodically record Based on interview failed to establish a services, including accurate acquiring, administering of na needs of each resid reviewed for receipt drugs, of 34 reside of 89 residents resi P, Q, R, S, T, U) Findings include: a. On 6/22/21 at 11 Resident P was rev were not limited to The June 2021 Phy Resident P was pre- analgesic controlle (milligram) tablet, hours for pain, with On 6/22/21 at 1:50	termines that drug records hat an account of all s maintained and	F0	755	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, R, S, T, and U narcotic count w completed with review of the Controlled Drug Administration Record Tablet Documentation t 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 Contro Drug Administration Record Tab Documentation to ensure all residents had accurate documentation and there was no discrepancies in the narcotic	Q, as o N c bled blet	07/15/202

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155780	A. BUILDING <u>00</u> B. WING		COMP1 06/23	
		100100		TADDRESS, CITY, STATE, ZIP C	_	/2021
NAME OF	NAME OF PROVIDER OR SUPPLIER			MADISON AVE		
HOMES	TEAD HEALTHCA	RECENTER	INDIA	NAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	-	on Record Tablet document. A		count.		
		ment indicated Resident P was				
	-	pharmacy provided to the		Measures/systematic	-	
		he ER 40 mg tablet, give 1 tablet		put into place to ensu		
		hours for pain, quantity 60		deficient practice doe	es not	
		ity received 30 tablets of the		recur:		
		2/21, as indicated by the staff		DON/designee has in-		
	-	ocument. The document had		licensed nursing staff		
	columns titled:			facilities policy, identifi		
				"Chain of custody for		
		e number of tablets delivered by		Substance" with emph		
		ing at 60 (in descending order)		regarding accurate do		
		per line that is available to be		upon receiving the nar		
	administered;			pharmacy and proper		
		nd time when medication was		documentation of narc	-	
	administered);			on the Controlled Drug	•	
		nd amount of medication		Administration Record	Tablet	
	administered);			Document.		
		tnessed (amount of medication		Corrective actions to		
	wasted or destroye			monitored to ensure		
		signature for who administered		deficient practice will	not	
	the medication); an			recur:		
	-AMT Rem (amou	nt of medication remaining).		Director of nursing/ de	•	
				audit all narcotic sheet	•	
	-	e document, the facility		ensure the Controlled	0	
		as noted by the nurse's		Administration Record		
	-	to Resident P between 5/24/21		Document is complete		
				4 weeks, then 3 weekl	•	
		staff members utilized the AMT		weeks, then monthly for		
		wn to AMT line number 12 to		than 3 months or until	compliance	
		of tablets administered to the		is met.	a	
	Resident P.	of 15 tablets administered to		The Director of Nursin	•	
	Resident P.			present the results of t		
	The Controlled Dr	va Administration Decend		monthly to the QAPI c		
		ug Administration Record vas not reconciled regarding the		for no less than 3 mon	-	
		received to the number of		patterns that are identi have an Action Plan in		
	tablets dispensed f			QAPI committee will d		
	On 6/21/21 + 10.2	0 a.m., the Director of Nursing		when 100% compliance		
	On 0/21/21 at 10:3	0 a.m., the Director of Nursing		achieved or if ongoing	monitoring	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/23/2021	
NAME OF	NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COI	D	
HOMES	TEAD HEALTHCA	RE CENTER		NAPOLIS, IN 46227		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF	ULD BE COMPLETIO	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	document, dated 6 current list of resid review of the doc were prescribed an medication). Duri	f the facility MATRIX //21/21, and indicated it was the dents with identified needs. A ument indicated 34 residents n opioid (a narcotic drug ing an interview at that time, the ng indicated the facility census		is required.		
	Director of Nursin Administration Re was provided by t and monitor the ac each resident. The accurately and cor	w, on 6/23/21 at 9:00 a.m., the og indicated the Controlled Drug ecord Tablet document, which the pharmacy, was used to track dministration of narcotics for e staff was supposed to asistently complete the form; staff were inconsistent in how form.				
	Resident Q was re	1:05 a.m., the clinical record of viewed. Diagnosis included, ed to, multiple fractures.				
	Resident Q was pr (opioid analgesic o II) 5-325 mg (mill	ysician orders indicated rescribed oxycodone APAP controlled substance schedule igrams) tablet, give 1-2 tablet rs prn (as needed) for pain, with 18/21.				
	(DON) provided a Drug Administrati review of the docu prescribed and the facility, "oxycodo 1-2 tablet orally ev pain, quantity 12 t medication received) p.m., the Director of Nursing copy of Resident Q's Controlled fon Record Tablet document. A ument indicated Resident Q was pharmacy provided to the ne APAP 5-325 mg tablet, give very 4 hours prn (as needed) for ablets." The amount of ed, date received, and the staff lines were blank on the				

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/23/2021		
NAME OF	PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZIP COD 7465 MADISON AVE				
HOMES	TEAD HEALTHCA	RE CENTER	INDIAN	IAPOLIS, IN 46227			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETIO	
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	document. The do	ocument had columns titled:					
	AMT (to track th	e number of tablets delivered by					
		ting at 60 (in descending order)					
		l per line that is available to be					
	administered;	i per fine that is available to be					
	· · · · ·	and time when medication was					
	administered);						
		and amount of medication					
	administered);						
		itnessed (amount of medication					
	wasted or destroy						
		f signature for who administered					
	the medication); a						
	-AMT Kem (amo	unt of medication remaining).					
	The pharmacy ind	licated, on the document, they					
	provided the facili	ity with 12 tablets of medication.					
		icated 12 tablets were					
		esident Q between 6/3/21 and					
		members utilized the AMT line					
		to AMT line number 2 to reflect					
		lets administered to the resident					
		blets administered to Resident					
	Q.						
	The Controlled Dr	rug Administration Record					
		was not reconciled regarding the					
	number of tablets	received to the number of					
	-	and lacked a staff signature that					
		nd the amount of medications					
	received for Resid	lent Q.					
	On 6/21/21 at 10.	30 a.m., the Director of Nursing					
		f the facility MATRIX					
		5/21/21, and indicated it was the					
		dents with identified needs. A					
		ument indicated 34 residents					
		n opioid (a narcotic drug					
	-	ing an interview at that time, the					

		IEDICARE & MEDICAID SERVICES OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION						
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í			č - 1	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00	_	MPLETED	
		155780	В. W	/ING		06/23/2021		
NAME OF	PROVIDER OR SUPPLIE			STREET A	COD			
					ADISON AVE			
HOMES	TEAD HEALTHCAR	E CENTER		INDIAN	APOLIS, IN 46227			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COF	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	indicated the facility census						
	was 89.							
	During on interview	v, on 6/23/21 at 9:00 a.m., the						
	-	; indicated the Controlled Drug						
	-	ord Tablet document, which						
		e pharmacy, was used to track						
		ninistration of narcotics for						
	each resident. The	staff was supposed to						
	accurately and cons	sistently complete the form;						
	however, facility st	aff were inconsistent in how						
	they filled out the f	orm.						
	c. On 6/22/21 at 11	:10 a.m., the clinical record of						
	Resident R was rev	iewed. Diagnosis included,						
	but were not limited	d to, fractured right foot.						
	The June 2021 Phy	sician orders indicated						
	Resident R was pre	scribed hydrocodone APAP						
		ontrolled substance schedule						
		igrams) tablet, take one tablet by						
		urs as needed for pain, with the						
	start date of 5/14/2	l.						
	On 6/22/21 at 1:50	p.m., the Director of Nursing						
		copy of Resident R's Controlled						
	-	n Record Tablet document. A						
		nent indicated Resident R was						
	-	pharmacy provided to the						
		one APAP 10-325 mg tablet, uth every six hours as needed						
		4 tablets." The amount of						
		d, date received, and the staff						
		ines were blank on the						
		cument had columns titled:						
	-AMT (to track the	number of tablets delivered by						
		ng at 60 (in descending order)						
		per line that is available to be						
	administered;							

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/23/2021		
	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7465 MADISON AVE				
HOMES	TEAD HEALTHCA	RE CENTER	INDIAN	IAPOLIS, IN 46227			
(X4) ID PREFIX	PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	T BE PRECEDED BY FULL PREFIX		TION LD BE ROPRIATE	(X5) COMPLETIO	
	 -Date/Time (date a administered); -Dose/Amt (dose a administered); -AMT Wasted/Wi wasted or destroye -ADMIN by (staff the medication); a: -AMT Rem (amou The pharmacy ind provided the facili The document ind administered to Ref 6/6/21. The staff in number 24 down the number of table for a total of 24 tal The Controlled Dr Tablet document with a dispensed a verified the date are received for Reside On 6/21/21 at 10:3 provided a copy of document, dated 6 current list of resider review of the doce was 89. During an interviee Director of Nursin was 89. 	and time when medication was and amount of medication tnessed (amount of medication ed); Signature for who administered and ant of medication remaining). icated, on the document, they ty with 24 tablets of medication. icated 24 tablets were esident R between 5/29/21 and nembers utilized the AMT line to AMT line number 5 to reflect ets administered to the resident blets administered to Resident R. ug Administration Record vas not reconciled regarding the received to the number of and lacked a staff signature that and the amount of medications		DEFICIENCY)		DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/23/2021 155780 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 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 H47911 Facility ID: 012225 Page 11 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

07/16/2021

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/23/2021	
	NAME OF PROVIDER OR SUPPLIER HOMESTEAD HEALTHCARE CENTER		7465 M	address, city, state, zip co IADISON AVE IAPOLIS, IN 46227	D	
HOIVIES		RECENTER	INDIAN	AFULIS, IN 40227		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	PROPRIATE COMPLETIC	
TAG		DR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	the medication); an	signature for who administered				
	provided the facili The document ind administered to Re 5/30/21. The staff number 34 down t the number of tabl for a total of 4 tabl The Controlled Dr Tablet document v number of tablets tablets dispensed a the medication wa On 6/21/21 at 10:3 provided a copy of	e document, the pharmacy ty with 4 tablets of medication. icated 4 tablets were esident S between 5/29/21 and 5 members utilized the AMT line o AMT line number 31 to reflect ets administered to the resident lets administered to Resident S. ug Administration Record was not reconciled regarding the received to the number of and lacked the date for when s received for Resident S. 80 a.m., the Director of Nursing f the facility MATRIX /21/21, and indicated it was the				
	review of the doct were prescribed ar medication). Duri Director of Nursin was 89. During an intervie	dents with identified needs. A ument indicated 34 residents a opioid (a narcotic drug ng an interview at that time, the g indicated the facility census w, on 6/23/21 at 9:00 a.m., the				
	Administration Re was provided by t and monitor the ac each resident. The accurately and com	g indicated the Controlled Drug ecord Tablet document, which the pharmacy, was used to track diministration of narcotics for e staff was supposed to asistently complete the form; staff were inconsistent in how form.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/23/2021 155780 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 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. Event ID: H47911 Facility ID: 012225 Page 13 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/23/2021 155780 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 Event ID: H47911 Facility ID: 012225 Page 14 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFI		x1) provider/supplier/clia identification number 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 06/23/2021	
NAME OF PROVIDER	OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP (COD	
					ADISON AVE		
HOMESTEAD HE	ALTHCAP	RECENTER		INDIAN	APOLIS, IN 46227		
(X4) ID SUMMAR		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO		(X5)
		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE	(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE	
		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
(opioid II) 5-32 mouth o start da On 6/22 (DON) Drug A review prescrib facility, tablet, t as need amount the staft	analgesic c 5 mg (milli every four h te of 5/20/2 2/21 at 1:50 provided a dministration of the docu bed and the "oxycodor ake 1-2 tab ed for pain, of medicat f member s	p.m., the Director of Nursing copy of Resident T's Controlled on Record Tablet document. A ment indicated Resident T was pharmacy provided to the the APAP 5-325 mg (milligrams) lets by mouth every four hours quantity 30 tablets." The ion received, date received, and ignature lines were blank on the					
-AMT (the pha to indic adminis -Date/T adminis -Dose/A adminis -AMT V wasted -ADMI the med -AMT I The pha provide The dod adminis 5/25/21	 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 						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/23/2021 155780 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 Event ID: H47911 Facility ID: 012225 Page 16 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 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 06/23/2021 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 DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG 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 483.45(f)(2) SS=D Residents are Free of Significant Med Errors Bldg. 00 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 F 0760 Corrective action for the 07/15/2021 failed to provide 4 doses of an Intravenous (IV) residents found to have been Antibiotic therapy for a resident with the affected by the deficient diagnosis of Strep viridans bacteremia (VBS) for 1 practice: of 3 residents reviewed for IV medication Resident B is discharged from the administration (Resident B) and the facility failed facility. Resident V and W were to ensure residents had a Physician order for an not harmed by the alleged antianxiety medication for 2 of 30 residents deficient practice. Residents V reviewed for medication administration (Resident and W medications have been W and V). reconciled to reflect the physician's orders and that their Findings included: medications are being given appropriately. Residents V and W 1. On 6/22/21 at 10:30 a.m., the clinical record for liquid Ativan was destroyed due to Resident B was reviewed. Diagnosis included, order stating tablet form. but were not limited to, endocarditis of tricuspid Corrective action taken for valve, bacteremia due to streptococcus, and those residents having the septic pulmonary embolism. potential to be affected by the same deficient practice: A discharge summary from the a hospital report, DNS/NURSE ADMINSTRATION dated 4/13/21, indicated reason for visit, "...known has completed a 100% in-house tricuspid valve infectious endocarditis. Repeat review of narcotics and order type blood cultures showed no growth and the patient to ensure medication is in right H47911

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

TERS FO	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S	SURVEY
		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED	
		155780	B. WING	00	06/23/2021	
			STRFFT	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	R		ADISON AVE		
HOMES	TEAD HEALTHCAR	E CENTER	INDIAN	NAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	was ultimately take	n to the operating room (OR)		form for administration. 100%	, 0	
	on 4/19/21 and und	erwent Tricuspid valve		in-house audit has been		
	replacement"			completed on any residents	hat	
				are receiving IV therapy to e	nsure	
	Resident B was adr	nitted to the facility from the		IV ABT therapy is completed	per	
	hospital on 5/7/202	1.		physician order.		
	-			Measures/systematic change	jes 🛛	
	A Medication Adm	inistration Record (MAR),		put into place to ensure the	-	
		dicated a Physicians order,		deficient practice does not		
		of 5/7/2021, Resident B was to		recur:		
	receive ceftriaxone	sodium solution 2 GM IV		DON/designee has in-service	ed all	
	piggyback every 24	hours for infection (Strep		licensed nursing staff on the		
	Viridans bacteremia	· -		facilities policy, identified as,		
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		"Medication Administration	" with	
	During a confidenti	al interview, on 6/21/21 at 12:05		over-view of five rights of	WICH	
	-	as received, Resident B did not		medication administration,		
	-	iotic therapy on 4 different		medication administration,		
	days in May.	ione merupy on runnerent		documentation. DON/design	aa will	
	days in May.			perform skills check with all		
	The MAR lacked d	ocumentation of ceftriaxone		licensed nurse on medication	,	
		ving been administered on the		administration.	1	
		ay 11, 18, 21, and 22, 2021.				
	ionowing days. Wi	ay 11, 10, 21, and 22, 2021.		DON/designee has in-service	eu all	
	During on interview	v, on 6/22/21 at 11:33 a.m., the		licensed nursing staff on the		
	e e	indicated the record lacked		facilities policy identified as,		
	-			"Physicians Orders", with	vien	
		Lesident B receiving ceftriaxone		emphasis on following physic		
		he unsure why the clinical		orders regarding IV medication		
	record for May 11,	18, 21, and 22 was blank.		administration.		
	$O_{m} (22/21 \rightarrow 10.1)$	1 a martha Dimantar - CN		Corrective actions to be		
		a.m., the Director of Nursing		monitored to ensure the		
		tled, Physician Orders, dated		deficient practice will not		
		ted it was the current policy		recur:		
		acility. A review of the policy		Director of nursing/ designee		
	indicated "Definit			audit 5 residents daily to ens		
		ord-the legal medical record for		medications have been giver		
		ons and treatments."2.a.		following the Physicians orde		
		al record was reviewed on		weeks, then 3 residents wee	-	
		n. Resident V was admitted to		4 weeks, then 5 residents me	-	
	the facility on 5/10/	21.		for no less than 3 months or	until	
	1			compliance is met.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 155780	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/23/2021	
	PROVIDER OR SUPPLIE		7465 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE NAPOLIS, IN 46227		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRC	DBE COMPLETION	
TAG	REGULATORY O provide if discrepa	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		lates to Complaint IN00356071				
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2 Label/Store Drug §483.45(g) Label Drugs and biolog must be labeled i accepted profess the appropriate a					
	§483.45(h)(1) In Federal laws, the and biologicals in under proper tem	ge of Drugs and Biologicals accordance with State and a facility must store all drugs a locked compartments aperature controls, and brized personnel to have /s.				
	separately locked compartments fo listed in Schedule Drug Abuse Prev 1976 and other d except when the package drug dis	e facility must provide d, permanently affixed r storage of controlled drugs e II of the Comprehensive vention and Control Act of lrugs subject to abuse, facility uses single unit stribution systems in which ed is minimal and a missing dily detected.				
	Based on observation review, the facility medications, that here are a second s	ion, interview, and record failed to ensure that residents' had been stored in the efrigerator, were properly stored	F 0761	Corrective action for the residents found to have b affected by the deficient practice:	07/15/202	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 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 06/23/2021 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 and labeled as indicated by facility policy; and the No residents have been harmed by facility failed to monitor the refrigerator the alleged deficient practice. temperature in the medication storage room as Corrective action taken for indicated by facility policy, for 1 of 2 medication those residents having the rooms observed. potential to be affected by the same deficient practice: Findings include: All medications rooms were audited for proper medication 1. During the initial tour of the facility on 6/21/21storage. West side medication at 10:00 a.m., observed the medication storage room refrigerator was replaced refrigerator located in the medication room on the with a new refrigerator. All west unit. medication room refrigerators were checked to ensure proper storage Inside the refrigerator observed 2 pink plastic of medication. All medication containers filled with residents' medications. refrigerators have a thermometer Inside the container observed approximately 2 and temp log in place to track the inches of a cloudy liquid substance that had refrigerators temperature. particles floating. Measures/systematic changes put into place to ensure the Observed submerged in the liquid were: deficient practice does not recur: a. 2 unopened Tresiba insulin pens that lacked a DON/designee has in-serviced all label to identify the resident the pen belonged to. licensed nursing staff on the The pens were not in a leak proof package. facilities policy, identified as, "Storage of Medications", with b. An unopened Trulicity 1.5mg/0.5ml pen that emphasis on storage of lacked a label to identify the resident the pen medication within the medication belonged to. The pen was not in a leak proof rooms, and monitoring of package. medication refrigerator temperature. c. An unopened Ozempic pen 2mg/1.5ml. The pen Corrective actions to be was not in a leak proof package. monitored to ensure the deficient practice will not d. An unopened Lantus SoloStar pen. The pen recur: was not in a leak proof package. Director of nursing/ designee will the audit medications rooms/ Observed in the narcotic lock box inside the medication room refrigerators 5 medication storage refrigerator were 2 opened times a week for x 12 weeks. then bottles of Lorazepam 2mg/ml concentrate that monthly for no less than 3 months lacked a date to indicate the date the bottles had or until compliance is met.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H47911 Facility II

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/23/2021	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COI)	
HOMES	FEAD HEALTHCA	RECENTER		NAPOLIS, IN 46227		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE PROPRIATE	(X5) COMPLETIC
TAG	been opened. During an intervie Director of Nursin medications should liquid. During an intervie Pharmscript Pharm not have been subh have been contami into the pen's cartr During an intervie Licensed Practical opened medicatior identify the date th On 6/22/21 at 1:50 of a facility policy Medication," and i policy used by the indicated, "Outdat deteriorated medic removed from invo of a manufacturer's broken, the contain 2. During medicat 11:33 a.m., observ refrigerator to have taped on the door. no temperatures w During an intervie Director of Nursin the refrigerator should documented daily. During an intervie	w, on 6/23/21 at 11:30 a.m., Nurse (LPN) 2 indicated, the is should have been dated to e package was opened. p.m., the DON provided a copy dated 8/20, titled, "Storage of ndicated it was the current facility. A review of the policy ed, contaminated, or ationsare immediately entoryWhen the original seal is container or vial is initially her or vial will be dated." ion storage review, on 6/22/11 at ed the medication storage e a temperature storage log The log was dated, April 2021, ere documented on the form. w, on 6/22/21 at 11:45 a.m., the g indicated the temperature of buld be obtained and	TAG	The Director of Nursing N present the results of the monthly to the QAPI con for no less than 3 month patterns that are identifie have an Action Plan initia QAPI committee will dete when 100% compliance achieved or if ongoing m is required.	ese audits nmittee s. Any ed will ated. The ermine is	DATE

NTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155780		(X2) MULTIPLE CC A. BUILDING B. WING	COM	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 06/23/2021		
	PROVIDER OR SUPPLIEI		7465 M	ADDRESS, CITY, STATE, ZIP COD ADISON AVE IAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF documented refrige medication storage On 6/21/21 at 12:50 provided a policy th	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION rator temperature logs from the room were available. 6 p.m., the Director of Nursing tled, Refrigerator Maintenance ated 10/25/13 and revised on	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETIO DATE
	being used by the findicated, "1. Daily checks must be per temperatures daily	ed it was the current policy acility. A review of the policy y refrigerator temperature formedd. Record and Log on a log kept at the refrigerator. the previous month's log sheet w."				
	This Federal tag rel 3.1-25(j) 3.1-25(m)	ates to Complaint IN00355303.				

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If continuation sheet

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