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	03/01/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00373526, IN00374106, and IN00374233. Complaint IN00373526 - Substantiated. Federal/State deficiencies related to the allegations are cited at F622. Complaint IN00374106 - Substantiated. Federal/State deficiencies related to the allegations are cited at F691. Complaint IN00374233- Substantiated. Federal/State deficiencies related to the allegations are cited at F691. Survey dates: February 28 and March 1, 2022 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 4 Medicaid: 69 Other: 15 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 4, 2022.	F 0000	The Plan of Correction is the center’s credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk review for this plan of correction.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer			

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	would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for			

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	ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility failed to ensure the correct clinical information was sent to the hospital with a resident to the emergency department for 1 of 3 resident reviewed for facility-initiated transfers. (Resident C) Finding includes: The clinical record of Resident C was reviewed on 2/28/22 at 9:35 a.m. The diagnoses included, but were not limited to, multiple sclerosis and obesity. The Quarterly MDS (Minimum Data Set) assessment, dated 2/21/22, indicated Resident C was not cognitively intact. A Nurse's note, dated 1/8/22 at 11:15 p.m., indicated Resident C had returned from the hospital. A hospital emergency department provider note, dated 1/8/22 at 10:32 a.m., indicated Resident C was initially evaluated by the provider on 1/8/22 at 7:49 a.m... "[Resident C's] facility was called to verify [Resident C's] information. Nursing staff informs that [Resident C] is schizophrenic, and not to believe what [Resident C] says." The clinical record for Resident C lacked documentation of a diagnosis of schizophrenia or schizoaffective disorder. During an interview on 2/28/22 at 9:50 a.m., the	F 0622	1) Resident C was not harmed by the deficient practice. When the hospital notified the facility that they did not have the paperwork they needed to treat resident C the paperwork was immediately sent to the hospital via fax. 2) All residents transferred to the hospital have the potential to be affected by the alleged deficient practice. An audit has been conducted on all residents that have been transferred to the hospital in the last 7 days to review the transfer packet that was sent to the hospital was for the appropriate resident. 3) The DON/Designee has educated all licensed staff on the facility's policy identified as, "Discharge and Transfer Policy" with emphasis on verifying the information in the transfer packet to confirm that the information is for the intended resident going to the hospital and the information is accurate. The licensed nurse will have a second staff member confirm the resident name on the transfer paperwork and both staff will confirm by signature on a	03/25/2022

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	Assistant Director of Nursing indicated the hospital got Resident B and Resident C mixed up and sent this facility the wrong paperwork when Resident C returned from the hospital. The clinical record of Resident B was reviewed on 2/28/22 at 10:00 a.m. The diagnoses included, but were not limited to, diabetes mellitus and schizoaffective disorder. The Quarterly MDS assessment, dated 2/20/22, indicated Resident B was cognitively intact. A Nurse's note, dated 1/9/22 at 5:29 p.m., indicated emergency services had arrived to take Resident B to the hospital. A Hospital After Visit Summary, dated 1/9/22, indicated "reason for visit hypoglycemia..." During an interview on 3/1/22 at 10:15 a.m., the Assistant Director of Nursing indicated she could not remember all the details regarding Resident C being sent to the hospital, but she was able to remember the wrong medication list was sent to the hospital with Resident C. The nurse that worked that day was from an agency. The ADON indicated that Resident C was sent to the hospital with Resident B's clinical information. As soon as the facility was made aware of the incorrect clinical information, the correct information was faxed to the hospital. The correct information should have been sent with Resident C initially. On 3/1/22 at 3:15 p.m. the facility was unable to provide a policy regarding transfer to a hospital prior to exit. This Federal tag relates to Complaint IN00373526. 3.1-12(a)(21)		transfer log. 4) The DON/Designee will audit the transfer log Monday through Friday to ensure compliance, and the weekend manager will review the log on Saturday and Sunday. The DON/Designee will audit transfer packets 3 times weekly for 1 month, then 2 times weekly for 1 month, then 1 time weekly for 1 month. 5) DON/Designee is responsible for the compliance. The results of these audits will be reviewed in Quality Assurance Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.			
	Based on observation, interview, and record review, the facility failed to ensure residents had physician orders for colostomy care and management for 3 of 3 residents reviewed for colostomy care. (Resident D, Resident E, Resident F) Finding includes: 1. During observation on 2/28/22 from 1:12 p.m. to 1:20 p.m., Resident E was resting in bed. She was observed to have a colostomy bag to left lower quadrant with a clean appearance. At that time, Resident E indicated she had a colostomy and the staff had been changing the colostomy bag a few times a week (a bag connected to an opening in the abdominal wall to catch waste) but was unable to remember how often colostomy care should have been provided. The clinical record for Resident E was reviewed on 2/28/22 at 1:35 p.m. The diagnoses included, but were not limited to, colostomy status (an opening in the abdominal wall that diverts part of the colon). The Quarterly MDS (Minimum Data Set) assessment, dated 2/22/22, indicated Resident E was cognitively intact and had an ostomy. The clinical record for Resident E lacked	F 0691	1) Resident C, D, and F were not harmed by the alleged deficient practice. The colostomy orders were immediately obtained from the physician and transcribed to the medical record. The families and physician were notified of the omission of orders for resident C, D, and F. 2) Any resident residing in the facility that has a colostomy has the potential to be affected by the alleged deficient practice. An audit was conducted on all residents and any resident identified with a colostomy had their orders audited to confirm physician orders were transcribed to the medical record for colostomy care. 3) The DON/Designee educated all licensed staff on the facility's policy identified as, "Colostomy Appliance Bag Change" and assessment of a resident with emphasis on obtaining a physician order for colostomy care on any resident that has a colostomy and transcription of that order to the medical record.	03/25/2022

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	physician's orders for colostomy care and management nor documentation that care had been provided. 2. During an observation on 2/28/22 from 1:25 p.m. to 1:30 p.m., Resident F was resting in bed. He was observed to have a colostomy appliance to left side of abdomen with a clean appearance. At that time, Resident F indicated he had a colostomy and the staff had been checking on it daily and changed it when needed but was unable to indicate how often the physician wanted colostomy care provided. The clinical record for Resident F was reviewed on 2/28/22 at 1:50 p.m. The diagnoses included, but were not limited to, colostomy status. The Quarterly MDS assessment, dated 2/2/22, indicated Resident F was cognitively intact and had an ostomy. The clinical record for Resident F lacked physician's orders for colostomy care and management nor documentation that care had been provided. 3. The clinical record of Resident D was reviewed on 2/28/22 at 2:10 p.m. The diagnoses included, but were not limited to, colostomy status. The 5-day MDS assessment, dated 2/3/22, indicated Resident D had an ostomy. The clinical record for Resident D lacked physician's orders for colostomy care and management nor documentation that care had been provided. During an interview on 3/1/22 at 11:52 a.m., the Director of Nursing indicated there should have been Physician's orders in place for colostomy		4) The DON/Designee will audit all new admissions 5 times weekly to ensure the appropriate orders are in place to meet the care needs of the resident. This is an on-going facility practice. The DON/Designee will audit random residents to assess for a colostomy and to ensure physician orders are in place for colostomy care on the following schedule: 5 residents 3 times weekly for 1 month, then 3 residents 2 times weekly for 1 month, then 2 residents 1 time weekly for 1 month. 5) DON/Designee is responsible for the compliance. The results of these audits will be reviewed in Quality Assurance Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	care and management. On 2/28/22 at 2:05 p.m., the Director of Nursing provided a copy of a facility policy, titled "Colostomy Appliance Bag Change," dated 4/8/16, and indicated this was the current policy used by the facility. A review of the policy indicated, "It is the policy of this facility to promote resident centered care by providing care to maintain the proper function of the colostomy and provide a comfortable and hygienic environment." This Federal tag relates to Complaints IN00374106 and IN00374233. 3.1-47(a)(3)			