STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING 01 B. WING	12/27/2021

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
K 0000 Bldg. 01	A Life Safety Code Preoccupancy survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). The Preoccupancy survey was for the addition of one resident bed to resident sleeping Rooms 101, 103, 105, 107 through 112, 201 through 214, 301, 406, 408, 410, 412, 601 and 602. Each of the aforementioned resident sleeping rooms will now have a capacity of two beds. The facility is adding a total of 30 resident beds to increase the total number of certified resident beds in the facility from 126 certified resident beds to 156 certified resident beds. Survey Date: 12/27/21 Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560 At this Life Safety Code and Preoccupancy survey, Homestead Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities. This one story facility was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated	K 0000	01/06/2022 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life Safety Survey Homestead Health Care Center 7465 S Madison Ave Indianapolis, IN 46227 Dear Ms. Buroker, On December 27, 2021, a life safety survey (Survey ID J1X921) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of Jan 10,2022. Please feel free to call me with any further questions at 1 (317) 788-3000. Respectfully submitted, Manoj Berry (Executive Director) 7465 S Madison Ave	

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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	smoke detectors installed in all resident sleeping rooms except in Room 502 which has a smoke detector hard wired to the facility's fire alarm system. The facility has a capacity of 156 and had a census of 100 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed. Quality Review completed on 12/28/21		Indianapolis, IN 46227	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1			
	Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting systems was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 11:45 a.m. on 12/07/21, the battery operated lighting system installed in the weatherproof shell for the facility's emergency generator located	K 0291	**K291 Emergency Lighting** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	01/10/2022

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	outside the building on the south side of the property failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Director stated he tests the light regularly but agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		*federal and state law.* **1)Immediate actions taken for those residents identified:** · No resident was found to be affected by this alleged deficiency. Battery on the emergency generator located outside the building on the south side of the property was replaced and it illuminated when tested by maintenance director. **2) How the facility identified other residents:** · Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director is re-educated on the Preventative Maintenance Program by the Executive Director/designee. · Maintenance Director will test generator battery emergency light monthly as part of the facilities TELS PM Program for proper operations and compliance. **4)How the corrective actions will be monitored:** · The Executive Director will review the Preventative Maintenance Worksheets monthly. · An Environmental QAPI tool will be utilized monthly to	

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			monitor compliance. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **5) Date of compliance: 01/10/2022.**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling	K 0372	**K372 NFPA 101 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER** **The facility requests paper compliance for this citation.**	01/10/2022

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	assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 30 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 11:45 a.m. on 12/07/21, one inch in diameter holes were noted in the ceiling of resident sleeping rooms 111, 112, 209, 212, 406, 410 and 602. Each of the holes was for the location a former ceiling mounted track to hang privacy curtains in the room. A new ceiling mounted track was relocated in the room to accommodate the bed addition in the rooms to go from single occupancy to dual occupancy. Two layers of 5/8ths inch thick drywall was noted as the ceiling construction for each room as observed from the underside of the holes. Each of the holes was not smoke resistant and did not maintain the fire resistance rating of the ceiling smoke barrier. Based on interview at the time of the observations, the Maintenance Director stated the holes were caused by the relocation of the former ceiling mounted track for privacy curtains in the rooms and agreed the aforementioned openings in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Maintenance		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · No resident was found to be affected by this alleged deficiency. One inch in diameter holes in the ceiling of resident's rooms 111,112,209,212,406,410 and 602 are filled with material capable of resisting the transfer of smoke to maintain fire resistance rating of the ceiling smoke barrier. **2) How the facility identified other residents:** · Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · Maintenance Director was	

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	Director during the exit conference. 3.1-19(b)		educated to ensure holes are filled with material capable of resisting the transfer of smoke to maintain fire resistance rating of the ceiling smoke barrier after completion of any job in the building. · . The Maintenance Director/designee will inspect building once weekly x 4 weeks and then every 2 weeks for 4 weeks and after any job done by any him or outside contractor to ensure compliance prior to job completion. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance with smoke barrier walls. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **5) Date of compliance: 01/10/2022.**	

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K 0373 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Accumulation Subdivision of Building Spaces - Accumulation Space Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2			
	Based on record review and interview, the facility failed to ensure documentation for the accumulation space for the increase in resident capacity was available for review in accordance with LSC 19.3.7.5. LSC 19.3.7.5 states accumulation space shall be provided in accordance with 19.3.7.5.1 and 19.3.7.5.2. LSCC 19.3.7.5.1 stated not less than 30 net ft2 (2.8 net m2) per patient in a hospital or nursing home, or not less than 15 net ft2 (1.4 net m2) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 11:45 a.m. to 12:30 p.m. on 12/27/21, accumulation space documentation for the increase in resident capacity was not available for review. Based on interview at the time of record review, the Maintenance Director stated facility blueprint documentation was not available for review as the blueprints were being copied off-site. In addition, the Maintenance Director stated accumulation space documentation was not part of the application submitted to IDOH Plan	K 0373	**K373 Subdivision of building spaces-Accumulation.** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · No resident was found to be affected by this alleged deficiency. Accumulation space documentation for increase in resident capacity and copy of blue	01/10/2022

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	Review for the increase in resident capacity. At 10:35 a.m. on 12/27/21, the Regional Director of Maintenance relayed to the Maintenance Director via telephone call that the total square footage in the building was 48,770 square feet. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		print is available in building to review. **2) How the facility identified other residents:** · Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director is re-educated on the Preventative Maintenance Program by the Executive Director/designee and documents that need to be in building at all times to ensure compliance. **4) How the corrective actions will be monitored:** · The Executive Director will review the Preventative Maintenance Worksheets monthly. · An Environmental QAPI tool will be utilized monthly to monitor compliance. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **5) Date of compliance: 01/10/2022.**	