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 _____	R **01/18/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Preoccupancy survey conducted on 12/27/21 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: 01/18/22 Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560 At this PSR survey to the Life Safety Code and Preoccupancy survey, Homestead Healthcare Center was found 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	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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{K 000}	Continued From page 1 detection in the corridors and in all areas open to the corridor. The facility has battery operated 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 102 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 01/19/22	{K 000}		