STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING _____ B. WING _____	R-C 07/20/2021

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
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00352866 completed on 5/12/21. This visit was in conjunction with a PSR to the Investigation of Complaint IN00353724 completed on 5/26/21. This visit was in conjunction with a PSR to the Investigation of Complaints IN00355303, IN00355560, and IN00356071 completed on 6/23/21. Complaint IN00352866 - Corrected Complaint IN00353724 - Corrected Complaint IN00355303 - Corrected Complaint IN00355560 - Corrected Complaint IN00356071 - Corrected Survey date: July 20, 2021 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicaid: 61 Other: 8 Total: 69 Homestead Healthcare Center was found to be in	{F 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING _____ B. WING _____	R-C 07/20/2021

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
{F 000}	Continued From page 1 compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00352866. Quality Review completed on July 23, 2021.	{F 000}		