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	03/20/2023

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 a Recertification and State Licensure Survey. Survey dates: March 14, 15, 16, 17, and 20, 2023 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicaid: 45 Other: 4 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 24, 2023.	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.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self administration medication assessment was completed for 1 of 1 residents observed with medications at bedside. (Resident 30) Finding includes:	F 0554	**Corrective action for the residents found to have been affected by the deficient practice:** Resident 30 was not harmed by alleged deficient practice. Resident has self-administration assessment complete, and	04/12/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Lai	Executive Director	04/07/2023

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	During an interview on 3/17/23 at 11:11 a.m., in Resident 30's room, a medical basin was observed under the residents bed. The basin contained the following medical items: 1. 1 thirty five ounce tube of iodosorb iodine gel (anti-infective) 2. 1 open bottle containing 20 tablets of ibuprofen 200 mg (nonsteroidal anti-inflammatory drug) 3. 1 tube of silva kollagen 1.5 grams (anti-microbial) 4. 1 tube of medihoney gel 1.5 grams (wound and burn dressing) On 3/17/23 at 12:22 p.m., the clinical record of Resident 30 was reviewed. The diagnosis included but was not limited to, acute kidney failure. A Brief Interview for Mental Status assessment, dated 1/3/23, indicated Resident 30 was cognitively intact. Resident 30's clinical record lacked a self administration assessment. Physician's orders, dated March 2023, indicated Resident 30 did not have an order for any of the medications observed under the bed in a basin. During an interview on 3/17/23 at 11:15 a.m., Resident 30 indicated he self administered the ibuprofen if he had a migraine. During an interview on 3/17/23 at 11:30 a.m., RN 2 indicated the medication should not have been left at bedside. RN 2 also indicated Resident 30 does not have a physicians order for ibuprofen or the treatment supplies. RN 2 was not sure where the treatment supplies came from.		education provided related to keeping medications at bedside. Resident consented to allowing staff to remove medications at bedside. MD and RP was notified and no new orders obtained per notification. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who are able to self-administer medications have the potential to be affected by this alleged deficient practice. An audit was conducted to identify those residents with potential to self-administer medications to ensure a self-administration assessment was complete and care plan updated to reflect resident's ability to safely self-administer medications. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated Licensed Nursing Staff and QMA's on facilities policy "Storage of Medications" with emphasis on ensuring that residents identified as able to self-administer medication have self-administer medication assessment complete. **Corrective actions to be monitored to ensure the**	

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	During an interview on 3/17/23 at 11:45 a.m., the Director of Nursing indicated the medication should not have been left in the residents room. On 3/17/23 at 1:22 p.m., the Director of Nursing provided a policy titled, Storage of Medications, dated September 2018, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...2...Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access." 3.1-11(a)		**deficient practice will not recur:** The DON and/or Designee will audit 5 resident's daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure with any noted medications at bedside that resident has self-administration assessment complete. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for 1 of 1 residents reviewed for wandering and exit-seeking behaviors. (Resident 29) Finding includes: The clinical record for Resident 29 was reviewed on 3/15/23 at 11:05 a.m. The diagnoses included, but were not limited to, unspecified anxiety disorder and psychotic disorder with delusions	F 0641	**Corrective action for the residents found to have been affected by the deficient practice:** Resident 29 was not harm by alleged deficient practice. Resident's 29 MDS was completed to ensure it reflected resident's history of behaviors for wandering and exit seeking. **Corrective action taken for those residents having the**	04/12/2023

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	due to known psychological condition. A Quarterly MDS assessment, dated for 3/1/23, indicated Resident 29 had not exhibited any wandering behaviors. A review of Resident 29's progress notes indicated the following: - A behavior note, dated 2/27/23 at 1:54 p.m., indicated resident exhibiting exit seeking behaviors. Verbal redirection and diversional activities ineffective. Provider and Psych NP (Nurse Practitioner) notified. Order received to place resident on 1:1 observation for safety. - A nurses note, dated 2/28/23 at 2:45 p.m., indicated a message was left for Psych NP related to resident's increased behaviors, continued exit seeking, and insomnia. Resident remains 1:1 at this time. A review of Resident 29's Wandering Observation Tool assessments, which include questions assessing risk factors for wandering and elopement, indicated the following: - A Wandering Observation Tool with an effective date of 2/27/23 at 1:00 p.m., indicated the resident was a high risk for elopement and unsafe wandering. During an interview on 3/20/23 at 11:09 a.m., the DON (Director of Nursing) and the Corporate Nurse both indicated that the Quarterly MDS assessment for 3/1/23 was inaccurate and should have indicated that Resident 29 had wandering and exit seeking behaviors during the assessment period.		**potential to be affected by the same deficient practice:** All residents who have behaviors noted of wandering and exit seeking have the potential to be affected by this alleged deficient practice. An audit was conducted to identify those residents with noted behaviors of exit seeking and wandering to ensure their MDS assessment was accurate. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated MDS coordinator to their job description "Resident Assessment Coordinator" with emphasis on accurate completion of MDS assessments. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident's daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure MDS assessments are completed accurately based on noted behaviors. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will	

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	On 3/20/23 at 11:20 a.m., the Corporate Nurse indicated a specific MDS policy was not available. At that time, the Corporate Nurse provided an untitled position description for the Resident Assessment Coordinator staff with a date of June 2019. The resident assessment coordinator position description included the statement that this individual " ...is responsible for accurate and timely completion of MDS assessments ...". 3.1-31(d)		have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure a treatment cart containing medication, was locked and secure for 1 of 4 treatment carts observed. (400 Hall Treatment Cart) Findings include: During a random observation on 3/17/23 from 11:30 a.m. until 11:45 a.m., the treatment cart next to Room 401, was observed to be unlocked. No staff were visible near the unlocked cart. The treatment cart was observed to contain, but was not limited to, the following items: 1. 1 full box of alcohol swabs 2. 1/2 box of betadine swab sticks 3. 1 tube of nystatin (antifungal medication) cream 30 grams 4. 30 gram tube of clobetasol propionate (an ointment used to treat dry, red skin) 0.05% 5. 1 bottle of nystatin powder 6. 80 gram tube of triamciplone acetonide (an ointment used to treat dry, red skin) cream 0.1% During an interview at that time, the Regional Nurse indicated the treatment cart should have been locked. During an interview on 3/17/23 at 11:45 a.m., Registered Nurse 2 indicated she should have locked the treatment cart before entering a resident's room. During an interview on 3/17/23 at 11:55 a.m., the Director of Nursing indicated the treatment cart should have been locked.	F 0761	**Corrective action for the residents found to have been affected by the deficient practice:** No residents we harmed by this alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Cart was locked immediately and staff member was provided education immediately regarding facilities policy “Storage of Medications”. An audit was conducted to ensure all carts in facility used for medication storage were locked per facility policy. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated Licensed Nursing Staff and QMA’s on facilities policy “Storage of Medications” with emphasis on keeping carts locked at all times per facility protocol. **Corrective actions to be monitored to ensure the deficient practice will not recur:**	04/12/2023

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	On 3/17/23 at 1:22 p.m., the Director of Nursing provided a policy titled, Storage of Medications, dated September 2018, and indicated it was the current policy being used by the facility. A review of the policy indicated "...2...Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access." 3.1-25(m)		The DON and/or Designee will audit through observation daily x's 4 weeks, then weekly x's 4 weeks, then monthly x's 4 months to ensure all carts used for medication storage are locked at all times. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review, the facility failed to ensure that a new physician prescribed blood draw was obtained, as indicated by the laboratory services directive and by the facility policy, for 1 of 5 residents reviewed for laboratory services. (Resident 7)	F 0773	**Corrective action for the residents found to have been affected by the deficient practice:** Resident 7 was not harmed by alleged deficient practice. MD and residents responsible party was	04/12/2023

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	Findings include: Resident 7's clinical record was reviewed on 3/17/23 at 1:05 p.m. The diagnoses, included but were not limited to, seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain), Wernicke's Encephalopathy (degenerative brain disorder caused by the vitamin B1, may result from alcohol abuse, and caused by altered mental status), bipolar disorder, altered mental status, chronic kidney disease, major depression, alcohol dependence with alcohol induced dementia, and encephalopathy (any brain disease that alters brain function or structure). Physician Orders included, but were not limited to: -"ammonia level q [every] 6 months one time a day every 6 month(s) starting on the 8th for 1 day for Depakote use...order date 7/7/2022...start date 7/8/2022...[no end date]..." -"divalproex sodium tablet (Depakote) delayed release...250 mg [milligrams]...give 1 tablet by mouth two times a day for bipolar disorder...order date 2/22/2021...start date 2/22/202 ...[no end date]..." -"topamax (topiramate) oral tablet 25 mg...give 1 tablet by mouth at bedtime for migraines...order date 7/13/2022...start date 7/13/2022...[no end date]..." On 7/8/22 at 4:15 a.m., Resident 7's ammonia blood level was drawn. On 7/11/22 at 1:30 p.m., Resident 7's ammonia blood level report was received by the facility. A review of the report indicated, "...test name problem...Ammonia specimen hemolyzed [red blood cells in the sample burst...preventing a test result]...order for		notified of failure to obtain new lab draw. As a result of notification no new orders were implemented for resident and resident remained at baseline with no concerns noted. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have labs ordered per the MD have the potential to be affected by this alleged deficient practice. The facility conducted a 30-day look back audit to ensure all labs ordered by the MD had been obtained and for any redraws requested per lab, that specimens have be obtain. For any deficiencies noted MD and RP was notified and new orders carried out per MD order. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated Licensed Nursing Staff on facilities policy “Physician Orders” with emphasis on ensuring physician ordered labs are obtained. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident’s daily x’s 4	

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	ammonia to be redrawn on the next laboratory day...any questions contact the laboratory..." The clinical record lacked the required subsequent ammonia blood level test, as indicated by the 7/11/22 laboratory instructions. On 1/13/23 at 4:20 a.m., Resident 7's ammonia blood level was drawn. On 1/13/23 at 2:30 p.m., Resident 7's ammonia blood level report was received. A review of the report indicated Resident 7's ammonia blood level was out of normal range with a score of 88. The normal ammonia blood level range was from 18 to 75. During an interview on 3/20/23 at 12:24 p.m., the Corporate Nurse indicated a follow-up ammonia blood level test should have been drawn immediately as indicated by the laboratory instructions received on 7/11/22. On 3/20/23 at 4:00 p.m., a review of the GoodRx health report indicated, "...Depakote can cause high ammonia levels in your blood. Ammonia is a waste product your body makes when you digest protein. If your body can't get rid of ammonia, it can build up in the blood and cause serious health problems. This includes brain damage, coma, and even death in serious cases. The risk of high ammonia levels with Depakote is higher if you're also taking a medication called topiramate (Topamax)..." On 3/20/23 at 11:45 a.m., the Corporate Nurse provided a copy of the Policies and Standard Procedures for Physician Orders, dated 3/2/2022, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Execution of Order and Notifications...the nurse that takes the physician order will be responsible		weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure any labs ordered per the MD were obtained per MD order. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required	

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	for executing the order or provide for the safe hand-off to the next nurse...contact laboratory services...as required to executive the medical order...the MAR/TAR [Medication Administration Record / Treatment Administration Record] should automatically be updated with the new orders if a schedule has been assigned...notify internal staff of changes/updates as appropriate...notify attending or other providers as appropriate...document contacts in the medical record..." 3.1-49(f)(2)			