DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	04/18/2023

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/18/23 Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560 At this Emergency Preparedness survey, Homestead Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 156 certified beds. At the time of the survey, the census was 55. Quality Review completed on 04/19/23	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during a Life Safety Recertification and State Licensure survey on April 18th,2023. Please accept this plan of correction as the provider's credible allegation of compliance.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Lai	Executive Director	05/15/2023

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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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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	the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Maintenance on 04/18/23 from 10:30 a.m. to 1:10 p.m, documentation for monthly generator load testing for the last 12 months was not available for review. Based on an interview at the time of record review, the Director of Maintenance confirmed that load testing documentation for the last 12 months was not available for review. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference.	E 0041	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* All residents have the potential to be affected by the alleged deficient practice. The facility will ensure that generator load inspections are completed in accordance with TELS. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* ED will in service maintenance director on 5.1.23 on requirement of life safety code E0041. Maintenance Director will conduct monthly load tests and include documentation of this testing in facility TELS logbook. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* Executive Director/designee will conduct an audit of the TELS logbook documentation to ensure	05/01/2023

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			compliance with required generator load test, monthly for three (3) months then quarterly thereafter. Results of the audit will be reported, reviewed, and trended for compliance throughout the facility Quality Assurance Committee for a minimum of six (6) months for further recommendations.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/18/23 Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560 At this Life Safety Code 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 410 IAC 16.2. 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 smoke detectors installed in all resident sleeping	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during a Life Safety Recertification and State Licensure survey on April 18th,2023. Please accept this plan of correction as the provider's credible allegation of compliance.	

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	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 55 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for three detached storage sheds. Quality Review completed on 04/19/23			
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure the cook tops in 1 of 1 activities rooms was shut off at the switch when not in use.	K 0324	*What corrective action will be accomplished for those residents found to have been affected by*	04/18/2023

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	LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect 3 residents and staff while in the Activities Room. Findings include: Based on observation on 04/18/23 at 2:10 p.m. during a tour of the facility with the Director of Maintenance, there was a cooktop stove in the Activities Room. When checked, and not in use, the stove top appliance was not deactivated from the individual cooktop power sources. Additonally, there was a cardboard box stored on the cooktop. Based on interview at the time of observation, the Director of Maintenance confirmed the cooktop stove was not deactivated when not in use, and deactivated the cooktop from the power source upon observation. This finding was reviewed with the Administrator and Director of Maintenance at the exit		*the deficient practice?* No residents were affected by the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* The alleged deficient practice could affect 3 residents and staff while in the activity room. Maintenance director shut off power to the device immediately. Lock has been placed on power source of device. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Maintenance director shut off power to the device as soon as the deficient practice was discovered. The power source has since been locked. Activity director was educated on safe handling of stove. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* The alleged deficient practice will be reviewed at the building's next Quality Assurance meeting. The ED/designee will ensure that activities department staff is inserviced on stove procedures upon hire.	

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	conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 3 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 04/18/23 between 10:30 a.m. and 1:10 p.m. with the Director of Maintenance present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period: a. Second shift (evening) and Third shift (overnight) of the second quarter (April, May, and June) of 2022/2023 b. Third shift (overnight) of the third quarter (July, August, and September) of 2022 c. Second shift (evening) of the fourth quarter (October, November, December) 2022	K 0712	**K 712** *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by the alleged deficiency. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* All residents had the potential to be affected by the alleged deficiency. The fire drills that were unavailable have been located. Facility will continue to complete fire drills monthly per state regulations. *What measures will be put into place and what systemic changes*	04/24/2023

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	Based on interview at the time of record review, the Director of Maintenance confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Administrator and Director of Maintenance during the exit conference. 3.1-19(b) 3.1-51(c)		*will be made to ensure that the deficient practice does not recur?* Maintenance director shall continue to complete monthly fire drills in accordance to instructions provided by TELS. This will be recorded on TELS logbook for documentation of completion. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* Executive director/designee will audit the TELS logbook documentation weekly to ensure compliance for the first two (2) months and then each month thereafter. This will be reviewed by Quality Assurance committee each month for a minimum of six (6) months for further recommendations.	
K 0761 SS=F Bldg. 01	Based on records review, and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices,	K 0761	**K 761** *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* This alleged deficient practice	04/24/2023

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	anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents.		could affect all residents. Fire door inspection was completed on 4.24.2023 to ensure compliance. Fire door inspections will be completed annually to ensure compliance per state regulations. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* The facility's maintenance director will be reeducated to include complete fire door inspections annually in accordance to instructions provided by TELS. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* ED/designee will audit TELS logbook documentation to ensure compliance This will be reviewed by Quality Assurance committee for further recommendations.	

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	Findings include: Based on record review with the Director of Maintenance on 04/18/23, current documentation of an annual inspection for the fire door assemblies was not available for review. The last record of fire door inspection available for review was completed March 30, 2020. Based on interview at the time of records review, the Director of Maintenance stated the annual fire door inspection within the last 12 months was not available for review. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES			

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	loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 12 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Maintenance on 04/18/23 from 10:30 a.m. to 1:10 p.m, documentation for monthly generator load	K 0918	**K 918** *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* All residents have the potential to be affected by the alleged deficient practice. The facility will ensure that generator load inspections are completed in accordance with TELS. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* ED will in service maintenance	05/01/2023

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	04/18/2023

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

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	testing for the last 12 months was not available for review. Based on an interview at the time of record review, the Director of Maintenance confirmed that load testing documentation for the last 12 months was not available for review. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)		director on 5.1.23 on requirement of life safety code K918. Maintenance Director will conduct monthly load tests and include documentation of this testing in facility TELS logbook. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* Executive Director/designee will conduct an audit of the TELS logbook documentation to ensure compliance with required generator load test, monthly for three (3) months then quarterly thereafter. Results of the audit will be reported, reviewed, and trended for compliance throughout the facility Quality Assurance Committee for a minimum of six (6) months for further recommendations.	