STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDI		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155780	B. WING	·	11/13/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		IADISON AVE		
HOMEST	TEAD HEALTHCAF	RE CENTER		IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	I	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	-	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
			F 0000			
	This visit was for a	Recertification and State				
	Licensure Survey.	This visit included the				
		omplaints IN00446493,				
	IN00445723, and I	N00443342.				
		(400) 1 (6)				
		6493 - No deficiencies related to				
	the allegations are	cited.				
	Complaint IN0044	5723 - No deficiencies related to				
	the allegations are					
	the unegations are	oned.				
	Complaint IN00443342 - No deficiencies related to the allegations are cited.					
	Survey dates: Nov	rember 6, 7, 8, 12, and 13, 2024				
	Facility number: 012225					
	Provider number:					
	AIM number: 200	983560				
	Common Dod Town					
	Census Bed Type: SNF/NF: 52					
	Total: 52					
	10tal. 32					
	Census Payor Type	e:				
	Medicaid: 49					
	Other: 3					
	Total: 52					
		reflect State Findings cited in				
	accordance with 41	10 IAC 16.2-3.1.				
	Quality review con	npleted November 15, 2024.				
F 0656	493 21/h\/1\/2\					
SS=D	483.21(b)(1)(3)	ent Comprehensive Care Plan				
	Develop/impleme	an Complehensive Cale Fiall				
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	GNATURE	TITLE	(X6) DATE	
Jakob Barl	DOUL		ED		12/05/2024	

Any defiency statement 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 disclosable 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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 CO			COMPL	COMPLETED	
		155780	B. WING		11/13/2024			
<u> </u>				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD			
HOMEST	EAD HEALTHCAR	F CENTER			IAPOLIS, IN 46227			
	LADTILALITIOAN	L CLIVILIX	_		T		<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
Bldg. 00								
			F 06	556	Corrective actions		12/13/2024	
	review, the facility failed to ensure a				accomplished for those			
		son-centered care plan was			residents founds to be affect	ted		
	-	2 residents reviewed for			by the alleged practice: No			
	catheter care. (Resid	dent 3)			residents were harmed by the			
	E. 1				facilities alleged deficient prac			
	Finding includes:				The comprehensive care plan			
	O: 11/6/24 + 11 26) Did42 - 1 1			Resident 3 was updated to ref	iect		
		a.m., Resident 3 was observed			the indwelling catheter.			
		his laptop computer. A			Idontification of otherwise 11	4-		
	covered urinary catheter bag was observed				Identification of other reside	nts		
	hanging on the bed frame.				having the potential to be	Ī		
	On 11/7/24 at 9:21 a.m., Resident 3 was observed				affected by the same alleged			
	resting in bed using his laptop computer. A				practice and corrective actio			
		heter bag was observed			taken: All residents with Fole catheters have the potential to	-		
		frame. During an interview at			affected. The facility reviewed			
	that time, Resident 3 indicated he had the				residents care plans with	all		
	indwelling urinary catheter for about a month.				catheters and no other resider	nte		
	mawening armary	cutificial for about a month.			affected by the practice.	113		
	On 11/8/24 at 10:00 a.m., Resident 3's clinical				ancolou by the prudice.			
	record was reviewed. The diagnosis included, but				Measures put in place and			
		neuromuscular dysfunction of			systemic changes made to			
		that causes bladder control			ensure the alleged deficit			
	,	ge to the nervous system).			practice does not recur: Fac	ility		
					to complete education with all	•		
	The Quarterly Mini	mum Data Set (MDS)			licensed nurses utilizing the			
		/27/24, indicated Resident 3			Comprehensive Care Plan Po	licy		
	was cognitively inta	act.			with emphasis on implementir	-		
					care plans for catheters.			
	Physician's orders in	ncluded, but were not limited						
	to, indwelling urina	ry catheter, start date of			How the corrective measures	S		
	10/1/24, and with n	o end date noted.			will be monitored to ensure t	the		
					alleged deficit practice does			
	Resident 3's clinical				not recur: The Director of			
		son-centered care plan related			Nursing/designee will conduct			
	to the indwelling ur	inary catheter.			audits of 5 residents with Fole	У		
					catheters to ensure they are c	are		
During an interview on 11/8/24 at 11:34 a m the		1		planed for 1 weeks 3 resident	to	I		

· '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/13/2024	
	PROVIDER OR SUPPLIER		7465 M	ADDRESS, CITY, STATE, ZIP COD NADISON AVE NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 0812 SS=E Bldg. 00	Resident 3 had an ir since 10/1/24. No ir plan had been devel plan should have be On 11/13/24 at 8:25 Nurse Consultant provided for a residuand provided for a residuand provided for a residuand provides for opt 3.1-35(b)(1) 483.60(i)(1)(2) Food Procurement, Store Based on observation review, the facility is served in a sanitary observations. Staff the kitchen. (Dietar Findings include: On 11/6/24 from 11 Cook 2 was observed area, located next to the noon foods were was observed to have one-half inch in length of the facial hair was During a follow-up from 11:35 a.m. to its plant of the plant of	a.m., the Corporate Clinical rovided a copy of Plan of Care ated 2017, and indicated it was a use by the facility. A review licated, "written treatment ent that is resident-focused timal personalized care" De/Prepare/Serve-Sanitary on, interview, and record failed to ensure food was manner for 3 of 4 kitchen hair was not covered while in	F 0812	per week for 4weeks, then 3 residents monthly for 4 month ensure foley catheter care pla are up to date. Any discrepant will be corrected immediately education provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facilit Quality Assurance Committed a minimum of six months and randomly thereafter for further recommendation. Corrective actions accomplished for those residents founds to be affected by the alleged deficie practice. The employee was educated and beard guard was donned correctly. Identification of other reside having the potential to be affected by the same alleged practice and corrective action taken: All residents who eat the dining room have the potential to be affected. All kitchen, nursing, activity and manager staff were educated on wearing proper hair covering while in the same alleger of the potential covering while in the proper hair covering while in the same alleger of the potential covering while in the proper hair covering	y e for then r 12/13/2024 eted as ents et on from ential ment ng	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OECS11 Facility ID: 012225

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. building <u>00</u>		COMPLETED		
	155780		B. WING		11/13/2024	
			OTREE	TADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD		
HOMESTEAD HEALTHCARE CENTER				MADISON AVE		
HOMES	I EAD HEALTHCAR	RECENTER	INDIA	NAPOLIS, IN 46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	meal starting temp	eratures and plating the noon		kitchen		
	meal. Dietary Coo	ok 2 was observed to have facial				
	hair, approximately	y one-half inch in length, above		Measures put in place and		
	and below the lips.	The facial hair was observed		systemic changes made to		
	to not be covered.			ensure the alleged deficit		
				practice does not recur: Fac	cility	
	On 11/6/24 from 1	2:12 p.m. to 12:20 p.m., Dietary		completed education with		
		ved at the steam table plating		management team, kitchen si	taff,	
		etary Cook 2 was then observed		nursing staff, and activities sta		
		eal ending temperatures.		wearing proper hair and bear		
	-	is observed to have facial hair,		covering while in the kitchen.		
	approximately one	-half inch in length, above and				
	below the lips. Th	e facial hair was observed to		How the corrective measure	s	
	not be covered. During an interview at that time, the Regional Dietary Consultant indicated that staff hair, including facial hair, was to be kept covered while in the kitchen. On 11/6/24 at 12:45 p.m., the Administrator			will be monitored to ensure		
				alleged deficit practice does		
				not recur: The Dietary		
				Manager/designee will condu	ct	
				audits of staff working in and		
				entering the kitchen 5 days a		
		the Staff Attire policy, dated		week for 8 weeks, then month	nly	
		nd indicated it was the current		for 4 months to ensure all sta	•	
	_	e facility. A review of the		that enter the kitchen are wea		
	policy indicated, ".	all staff members will have		appropriate hair and beard		
	their hairconfine	d in a hair netand facial hair		covering. Any discrepancies v	vill	
	properly restrained	"		be corrected immediately. The		
				results of the audit observation		
	On 11/6/24 at 3:00	p.m., a review of the Retail Food		will be reported, reviewed, an	d	
		itation Requirements Title 410		trended for compliance through		
		e November 13, 2004, indicated,		facility Quality Assurance	,	
		shall wear hair restraints such		Committee for a minimum of	six	
		or nets, beard restraintsthat		months and then randomly		
	_	orn to wear effectively keep		thereafter for further		
	_	tactingexposed food"		recommendation.		
		<i>5</i> 1				
	3.1-21(i)(2)					
	3.1-21(i)(3)					
F 0814	483.60(i)(4)					
SS=C	, , , ,	e and Refuse Properly				
Bldg. 00						
J. 3.	I		1	I	ı	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
		155780	B. W	NG		11/13/	/2024
l l				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIE	К			IADISON AVE		
HOMESTEAD HEALTHCARE CENTER					IAPOLIS, IN 46227		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	Da1 , .	an interview 1 1	F 08	314	F 814 Dispose Garbage and		12/13/2024
		on, interview, and record			Refuse Properly		
		failed to ensure the ground			Compositive		
		s rear door was free from			Corrective actions		
		to ensure the dumpster sliding			accomplished for those	.to.al	
	for 2 of 3 observati	s kept closed when not in use			residents founds to be affect	iea	
	101 2 01 3 00servati	ions.			by the alleged practice: No	•	
	Findings include:				residents were affected by the alleged deficient practice. The		
	i manigs meiade:				Maintenance Director immedi		
	1 During the initio	l facility tour with the Dietary			closed the dumpster lids,	ıaı c ıy	
	_	4 at 9:35 a.m., the following was			searched the grounds for deb	rie	
	observed:				and removed any debris loca		
	observed.				and removed any depths loca	.ou.	
		st outside the kitchen's rear			Identification of other reside	ents	
	door was a large cardboard box that had				having the potential to be		
	unidentifiable debris inside the uncovered box.				affected by the same alleged	d	
	On the ground near the box, the following was				practice and corrective action	on	
	observed: used cups, rags, and other various unidentifiable debris.				taken: No residents have the	e	
					potential to be affected. All		
					kitchen, nursing, maintenance	e,	
	_	ntainer area, located			housekeeping, activity and		
		yards from the kitchen's rear			management staff were educ		
		. The dumpster area had 2			on closing dumpster lids after		
		tainers. The east dumpster			and ensuring all fallen materi	als	
		ding side panel doors. The			are placed in appropriate		
	sliding side panel door on the left side of the				receptacle anytime waste		
	dumpster container was observed to not be				receptacles are used		
		ere visible in the area at that			Management in the second		
	time.				Measures put in place and		
	2 During a fallare	un observation on 11/7/24 et			systemic changes made to		
	2. During a follow up observation on 11/7/24 at 4:50 p.m., the dumpster area was observed. The dumpster area had 2 large dumpster containers.				ensure the alleged deficit	oility	
					practice does not recur: Fa completed education with	onity	
		container had 2 sliding side			management team, maintena	nce	
	1	liding side panel door on the			employees, housekeeping an		
	_	npster container was observed			nursing staff, and activities st		
		o staff were visible in the area			ensuring outside trash recept		
	at that time.	o starr were visione in the area			are closed and clear of		
	at that tille.				free-standing rubbish and wa	ste	
		1		I 1100-startuing rubbish and wa	JiC.	I	

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

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00		COMPLETED	
155780		B. WI	NG		11/13	/2024		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	ROVIDER OR SUPPLIER			7465 M	ADISON AVE			
HOMESTEAD HEALTHCARE CENTER				INDIAN	IAPOLIS, IN 46227			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
	_	v on 11/8/24 at 2:54 p.m., the						
	, ,	dicated the dumpster container			How the corrective measure	es		
		e panel doors were to be kept			will be monitored to ensure	the		
	closed when not in use. All debris should be				alleged deficit practice does	3		
	placed into the dumpster containers.			not recur: The Execu				
				Director/designee will conduct		ct		
	On 11/6/24 at 12:45 p.m., the Administrator		audits of outside trash receptacles		acles			
	provided a copy of the Environment policy, dated				for 5 days a week for 8 week	s,		
	September 2017, and indicated it was the current				then monthly for 4 months to			
	policy in use by the facility. A review of the				ensure all waste is properly			
	policy indicated, "all trash will be properly			disposed and trash receptacles				
	disposed of in external receptacles (dumpsters)			are properly closed and secured.				
	and the surrounding	g area will be free of debris"			Any discrepancies will be			
					corrected immediately. The re	esults		
		p.m., a review of the Retail Food			of the audit observations will	be		
	Establishment Sani	tation Requirements Title 410			reported, reviewed, and trend	ded for		
	IAC 7-24, effective November 13, 2004, indicated,				compliance through the facilit	ty		
	"receptacles and waste handling units for		Quality Assurance Committee fo		e for			
	refuse, recyclables and returnables shall be kept				a minimum of six months and	then		
covered with tight-fitting lids or doors if kept				randomly thereafter for furthe	er			
	outside"				recommendation.			
	3.1-21(i)(5)							
	3.1-21(1)(3)							

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