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	11/13/2024

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. This visit included the Investigation of Complaints IN00446493, IN00445723, and IN00443342. Complaint IN00446493 - No deficiencies related to the allegations are cited. Complaint IN00445723 - No deficiencies related to the allegations are cited. Complaint IN00443342 - No deficiencies related to the allegations are cited. Survey dates: November 6, 7, 8, 12, and 13, 2024 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicaid: 49 Other: 3 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 15, 2024.	F 0000		
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jakob Barbour	ED	12/05/2024

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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Bldg. 00	Based on observation, interview, and record review, the facility failed to ensure a comprehensive person-centered care plan was developed for 1 of 2 residents reviewed for catheter care. (Resident 3) Finding includes: On 11/6/24 at 11:20 a.m., Resident 3 was observed resting in bed using his laptop computer. A covered urinary catheter bag was observed hanging on the bed frame. On 11/7/24 at 9:21 a.m., Resident 3 was observed resting in bed using his laptop computer. A covered urinary catheter bag was observed hanging on the bed frame. During an interview at that time, Resident 3 indicated he had the indwelling urinary catheter for about a month. On 11/8/24 at 10:00 a.m., Resident 3's clinical record was reviewed. The diagnosis included, but was not limited to, neuromuscular dysfunction of bladder (a condition that causes bladder control issues due to damage to the nervous system). The Quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated Resident 3 was cognitively intact. Physician's orders included, but were not limited to, indwelling urinary catheter, start date of 10/1/24, and with no end date noted. Resident 3's clinical record lacked a comprehensive person-centered care plan related to the indwelling urinary catheter. During an interview on 11/8/24 at 11:34 a.m., the	F 0656	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** No residents were harmed by the facilities alleged deficient practice. The comprehensive care plan for Resident 3 was updated to reflect the indwelling catheter. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents with Foley catheters have the potential to be affected. The facility reviewed all residents care plans with catheters and no other residents affected by the practice. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility to complete education with all licensed nurses utilizing the Comprehensive Care Plan Policy with emphasis on implementing care plans for catheters. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The Director of Nursing/designee will conduct audits of 5 residents with Foley catheters to ensure they are care planed for 4 weeks, 3 residents	12/13/2024

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	Corporate Clinical Nurse Consultant indicated Resident 3 had an indwelling urinary catheter since 10/1/24. No indwelling urinary catheter care plan had been developed for Resident 3. A care plan should have been developed. On 11/13/24 at 8:25 a.m., the Corporate Clinical Nurse Consultant provided a copy of Plan of Care Overview policy, dated 2017, and indicated it was the current policy in use by the facility. A review of the document indicated, "...written treatment provided for a resident that is resident-focused and provides for optimal personalized care..." 3.1-35(b)(1)		per week for 4weeks, then 3 residents monthly for 4 months to ensure foley catheter care plans are up to date. Any discrepancies will be corrected immediately and education provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner for 3 of 4 kitchen observations. Staff hair was not covered while in the kitchen. (Dietary Cook 2) Findings include: On 11/6/24 from 11:20 a.m. to 11:23 a.m., Dietary Cook 2 was observed walking near the steam table area, located next to the grill and steamer, where the noon foods were being held. Dietary Cook 2 was observed to have facial hair, approximately one-half inch in length, above and below the lips. The facial hair was observed to not be covered. During a follow-up kitchen observation on 11/6/24 from 11:35 a.m. to 11:40 a.m., Dietary Cook 2 was observed at the steam table area taking the noon	F 0812	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** No residents were found to be affected by the alleged deficient practice. The employee was educated and beard guard was donned correctly. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents who eat from the dining room have the potential to be affected. All kitchen, nursing, activity and management staff were educated on wearing proper hair covering while in the	12/13/2024

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	meal starting temperatures and plating the noon meal. Dietary Cook 2 was observed to have facial hair, approximately one-half inch in length, above and below the lips. The facial hair was observed to not be covered. On 11/6/24 from 12:12 p.m. to 12:20 p.m., Dietary Cook 2 was observed at the steam table plating the noon meal. Dietary Cook 2 was then observed taking the noon meal ending temperatures. Dietary Cook 2 was observed to have facial hair, approximately one-half inch in length, above and below the lips. The facial hair was observed to 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 provided a copy of the Staff Attire policy, dated September 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...all staff members will have their hair...confined in a hair net...and facial hair properly restrained..." On 11/6/24 at 3:00 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints such as...hair coverings or nets, beard restraints...that are designed and worn to wear effectively keep their hair from contacting...exposed food..." 3.1-21(i)(2) 3.1-21(i)(3)		kitchen **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with management team, kitchen staff, nursing staff, and activities staff on wearing proper hair and beard covering while in the kitchen. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The Dietary Manager/designee will conduct audits of staff working in and entering the kitchen 5 days a week for 8 weeks, then monthly for 4 months to ensure all staff that enter the kitchen are wearing appropriate hair and beard covering. Any discrepancies will be corrected immediately. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	
F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly			

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	Based on observation, interview, and record review, the facility failed to ensure the ground next to the kitchen's rear door was free from rubbish and failed to ensure the dumpster sliding side panel door was kept closed when not in use for 2 of 3 observations. Findings include: 1. During the initial facility tour with the Dietary Manager on 11/6/24 at 9:35 a.m., the following was observed: - On the ground just outside the kitchen's rear door was a large cardboard box that had unidentifiable debris inside the uncovered box. On the ground near the box, the following was observed: used cups, rags, and other various unidentifiable debris. - The dumpster container area, located approximately 100 yards from the kitchen's rear door was observed. The dumpster area had 2 large dumpster containers. The east dumpster container had 2 sliding side panel doors. The sliding side panel door on the left side of the dumpster container was observed to not be closed. No staff were visible in the area at that time. 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. The east dumpster container had 2 sliding side panel doors. The sliding side panel door on the left side of the dumpster container was observed to not be closed. No staff were visible in the area at that time.	F 0814	**F 814 Dispose Garbage and Refuse Properly** **Corrective actions accomplished for those residents founds to be affected by the alleged practice:** No residents were affected by the alleged deficient practice. The Maintenance Director immediately closed the dumpster lids, searched the grounds for debris and removed any debris located. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** No residents have the potential to be affected. All kitchen, nursing, maintenance, housekeeping, activity and management staff were educated on closing dumpster lids after use and ensuring all fallen materials are placed in appropriate receptacle anytime waste receptacles are used **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with management team, maintenance employees, housekeeping and nursing staff, and activities staff on ensuring outside trash receptacles are closed and clear of free-standing rubbish and waste.	12/13/2024

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	During an interview on 11/8/24 at 2:54 p.m., the Dietary Manager indicated the dumpster container lids and sliding side panel doors were to be kept closed when not in use. All debris should be placed into the dumpster containers. On 11/6/24 at 12:45 p.m., the Administrator provided a copy of the Environment policy, dated September 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...all trash will be properly disposed of in external receptacles (dumpsters) and the surrounding area will be free of debris..." On 11/6/24 at 3:15 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside..." 3.1-21(i)(5)		**How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The Executive Director/designee will conduct audits of outside trash receptacles for 5 days a week for 8 weeks, then monthly for 4 months to ensure all waste is properly disposed and trash receptacles are properly closed and secured. Any discrepancies will be corrected immediately. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	