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 _____	C 09/29/2021

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 the Investigation of Complaint IN00363501. This visit included the Covid -19 Focused Infection Control Survey. Complaint IN00363501 - Unsubstantiated due to lack of evidence. Survey date: September 29, 2021 Facility number: 012225 Provider number: 155780 AIM number: 200983570 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 2 Medicaid: 59 Other: 14 Total: 75 Homestead Healthcare Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00363501 and the Covid -19 Focused Infection Control Survey. Quality review completed on September 30, 2021.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE