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	07/17/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00438670. Complaint IN00438670 - Federal/State deficiencies related to allegation are cited at F580, F609, F742, and F835 Survey dates: July 16 and 17, 2024 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 3 Medicaid: 52 Other: 9 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 23, 2024.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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

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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, interview, and record review, the facility failed to notify the physician when staff found a large knife in the drawer of a resident with a history of suicidal ideations and suicidal attempts for 1 of 3 residents reviewed. (Resident B) Finding includes: During an interview 7/17/24 at 8:19 a.m., CNA 1 indicated, on 7/2/24 at approximately 12:15 a.m., Resident B asked CNA 1 to count some money that she kept in a drawer. When CNA 1 opened the drawer CNA 1 saw a large "butcher knife". CNA 1 removed the knife and notified LPN 1 and the DON (Director of Nursing). The DON told CNA 1 to put the knife in the medication room and the DON would take care of it. CNA 1 put the knife in the medication room next to a pink plastic wash basin. On 7/17/24 at 8:32 a.m., during an observation of the medication room a pink plastic wash basin was sitting in a cabinet above the sink. Under the pink basin, observed a large metal knife with a dark handle. The blade on the knife was approximately 10 inches long and approximately 2 inches tall. The clinical record for Resident B was reviewed on 7/17/24 at 11:00 a.m. The diagnoses included, but were not limited to, major depressive disorder with psychotic symptoms, panic disorder, assaultive behavior, suicidal ideation, and post-traumatic stress disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 5/11/24, indicated Resident B	F 0580	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1) Resident B was not harmed. Resident no longer resides at facility. 2) Residents with history of suicidal ideations and suicidal attempts are at risk. Behaviors and Careplans to be reviewed to assure appropriate and effective interventions are in place and MD notifications have been made. 3) DON/Designee has educated all staff on the Behavior Management for Suicidal Ideations policy. 4) DON/Designee will audit for new suicidal ideations, attempts and behaviors have MD notification along with intervention and plan of care updated 5xweek x 4 weeks, 3xweek x 4 weeks, then 1xweek x 4 weeks. DON/Designee will report on	08/12/2024

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	was cognitively intact with moderate depression. A History and Physical, dated 12/27/23, indicated Resident B presented from an outside hospital after presenting to them after an attempted suicide by overdose at a hotel. A Psychiatric Progress Note, dated 1/28/24, indicated Resident B was seen for reevaluation of history of suicide attempts, suicidal ideation, agitation, and physical aggression. Resident B overdosed on an antidepressant on 12/22/23. Resident B overdosed on a handful of antidepressant per Resident B's report because she wanted to sleep and not wake up again after having an argument with her daughter. Resident B reported a history of four suicide attempts and a history of multiple psychiatric hospitalizations in the past. A Hospital History and Physical, dated 2/16/24, indicated Resident B was having thoughts of self-harm. She was very impulsive, and Resident B had insomnia. A facility progress note, dated 2/14/24 at 10:56 a.m., indicated Resident B stated she was not happy with the medication regimen for depression and anxiety. Resident B wanted an antidepressant three times daily. Educated Resident B that was not the ordered dose. Resident B stated she had been on it for years and knew how to take it. Resident B previously had a psychiatric visit for attempting to overdose on the antidepressant. The clinical record for Resident B lacked documentation of physician notification when a large knife was found in her drawer on 7/2/24. During an interview on 7/17/24 at 12:38 p.m., the		audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance	

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	DON indicated the physician should have been notified when the knife was found in Resident B's room. On 7/16/24 at 11:20 a.m., the Administrator provided a copy of an undated facility policy, titled Behavior Management General, and indicated this was the current policy used by the facility. A review of the policy indicated it is the policy of the facility to identify and safely manage resident who may present a danger to themselves or others. Contact the physician for new onset or unusual behaviors. This citation relates to Complaint IN00438670. 3.1-5(a)(2)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term			

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	care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report an allegation of abuse to the state health department for 1 of 3 allegations reviewed. A resident with a history of IV (intravenous) drug use made an allegation that a nurse supplied heroin to the resident. (Resident C) Finding includes: During an interview on 7/16/24 at 5:22 a.m., Resident C indicated she remembered being sent to the emergency department at night on 7/1/24. Resident C was told she required CPR (cardiopulmonary resuscitation) and Narcan (medication used to reverse opioid overdose). Resident C snorted heroin (an opioid schedule 1 controlled substance). Resident C got the heroin from someone at the facility but would not say who she got it from because she already told the Administrator and DON (Director of Nursing). During an interview on 7/16/24 at 6:27 a.m., the Administrator indicated Resident C required CPR in early July and was sent to the emergency department. The facility believed she had taken illegal drugs that night. Initially, Resident C would not tell the facility where she got the drugs. Then on 7/15/24 Resident C told him she got the drugs from LPN 1. LPN 1 was suspended and the	F 0609	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1) Resident C was not harmed. Resident no longer resides at facility. SRI was submitted to IDH 2) All residents have the potential to be affected by the deficient practice. All residents will be interviewed for any allegation of abuse, neglect, or misappropriation. 3) DON/Designee has educated all staff on the policy Abuse & Neglect & Misappropriation of Property	08/12/2024

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	Administrator started an investigation. The clinical record for Resident C was reviewed on 7/16/24 at 11:21 a.m. An Admission MDS (Minimum Data Set) assessment, dated 5/22/24, indicated Resident C was moderately cognitively impaired. During an interview on 7/17/24 at 12:42 p.m., the Administrator indicated he did not think the allegation made by Resident C against LPN 1 needed to be reported to the state health department. The investigation into the allegation was ongoing. On 7/17/24 at 11:05 a.m., the Administrator provided a copy of an undated facility policy, titled Occurrence Incident Reporting, and indicated this was the current policy used by the facility. A review of the policy indicated a level 2 incident is considered more serious or an incident that resulted in harm and should be reported as applicable to state authorities. This citation relates to Complaint IN00438670. 3.1-28(c)		4) DON/Designee will ask a series of questions to 5 residents a week for any experienced/witnessed suspected abuse, neglect or misappropriation for x 4 weeks, then 3 residends a week x 4 weeks, then 1x resident a week x 4 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance	
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services			

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	to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview, and record review, the facility failed to implement a care plans with person-centered interventions for a resident diagnosed with suicidal ideations and a history of trauma and suicide attempts for suicidal ideations and suicide attempts for 1 of 3 residents reviewed. Staff found a large knife in the resident's drawer during care. (Resident B) Finding included: During an interview 7/17/24 at 8:19 a.m., CNA 1 indicated on 7/2/24 at approximately 12:15 a.m., Resident B asked CNA 1 to count some money that she kept in a drawer. When CNA 1 opened the drawer CNA 1 saw a large "butcher knife". CNA 1 removed the knife and notified LPN 1 and the DON (Director of Nursing). The DON told CNA 1 to put the knife in the medication room and the DON would take care of it. CNA 1 put the knife in the medication room next to a pink plastic wash basin. On 7/17/24 at 8:32 a.m., during an observation of the medication room a pink plastic wash basin was sitting in a cabinet above the sink. Under the pink basin, observed a large metal knife with a dark handle. The blade on the knife was approximately 10 inches long and approximately 2 inches tall. The clinical record for Resident B was reviewed on 7/17/24 at 11:00 a.m. The diagnoses included, but were not limited to, major depressive disorder with psychotic symptoms, panic disorder, assaultive behavior, suicidal ideation, and post-traumatic stress disorder.	F 0742	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1) Resident B was not harmed. Resident no longer resides at facility. 2) Residents with a history of suicidal ideations and attempts of suicide are at risk, residents identified behaviors and careplans to be reviewed to assure appropriate and effective interventions are in place and receiving appropriate treatment/services. 3) DON/Designee has educated all staff on the Behavior Management for Suicidal Ideation policy. 4) DON/Designee will audit for new suicidal ideations, attempts and behaviors have appropriate and effective intervention/treatment/services and plan of care updated 5xweek x 4	08/12/2024

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	A quarterly MDS (Minimum Data Set) assessment, dated 5/11/24, indicated Resident B was cognitively intact with moderate depression. A History and Physical, dated 12/27/23, indicated Resident B presented from an outside hospital after presenting to them after an attempted suicide by overdose at a hotel. A Psychiatric Progress Note, dated 1/28/24, indicated Resident B was seen for reevaluation of history of suicide attempts, suicidal ideation, agitation, and physical aggression. Resident B overdosed on an antidepressant on 12/22/23. Resident B overdosed on a handful of antidepressant per Resident B's report because she wanted to sleep and not wake up again after having an argument with her daughter. Resident B reported a history of four suicide attempts and a history of multiple psychiatric hospitalizations in the past. A Hospital History and Physical, dated 2/16/24, indicated Resident B was having thoughts of self-harm. She was very impulsive and Resident B had insomnia. A facility progress note, dated 2/14/24 at 10:56 a.m., indicated Resident B stated she was not happy with the medication regimen for depression and anxiety. Resident B wanted an antidepressant three times daily. Educated Resident B that was not the ordered dose. Resident B stated she had been on it for years and knew how to take it. Resident B previously had a psychiatric visit for attempting to overdose on the antidepressant. The clinical record for Resident B lacked a care plan with person-centered interventions for suicidal ideations.		weeks, 3xweek x 4 weeks, then 1xweek x 4 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance	

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	The clinical record for Resident B lacked a care plan with person-centered interventions for suicide attempts. During an interview on 7/17/24 at 12:38 p.m., the DON indicated Resident B should have had care plans with person-centered interventions for suicidal ideations and suicide attempts. On 7/17/24 at 11:20 a.m., the Administrator provided a copy of an undated policy, titled Behavior Management General, and indicated this was the current policy used by the facility. A review of the policy indicated complete a care plan, update with changes and or new behaviors. Include specific interventions. This citation relates to Complaint IN00438670. 3.1-43(a)(1)			
F 0835 SS=D Bldg. 00	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility administration failed to maintain the mental and physical wellbeing of residents for 1 of 3 residents reviewed. An allegation of abuse was made against a nurse but was not reported to the state health department and the nurse was not reported to the police. (Resident C) Finding included:	F 0835	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of	08/12/2024

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	During an interview, on 7/16/24 at 5:22 a.m. Resident C indicated she remembered being sent to the emergency department at night on 7/1/24. Resident C was told she required CPR (cardiopulmonary resuscitation) and Narcan (medication used to reverse opioid overdose). Resident C snorted heroin (an opioid schedule 1 controlled substance). Resident C got the heroin from someone at the facility but would not say who she got it from because she already told the Administrator and DON (Director of Nursing). During an interview on 7/16/24 at 6:27 a.m., the Administrator indicated Resident C required CPR in early July and was sent to the emergency department. The facility believed she had taken illegal drugs that night. Initially, Resident C would not tell the facility where she got the drugs. Then on 7/15/24, Resident C told him she got the drugs from LPN 1 (Licensed Practical Nurse). LPN 1 was suspended, and I started an investigation. On 7/17/24 at 11:05 a.m., the Administrator provided a copy of an Indianapolis Metro Police Department Southeast District Information Card, dated 7/17/24, and indicated this was the police report regarding the allegation made by Resident C against LPN 1. A review of the document indicated incident type: property disposal. On 7/17/24 at 11:05 a.m., the Administrator provided a copy of an undated facility policy, titled Occurrence Incident Reporting, and indicated this was the current policy used by the facility. A review of the policy indicated a level 2 incident is considered more serious or an incident that resulted in harm and should be reported as applicable to state authorities. This citation relates to Complaint IN00438670.		federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1) Resident C was not harmed. Resident no longer resides at facility. SRI was submitted to IDH and police notified. 2) All residents have the potential to be affected by the deficient practice. All residents will be interviewed for any allegation of abuse, neglect, or misappropriation. 3) DON/Designee has educated all staff on the policy Abuse & Neglect & Misappropriation of Property 4) DON/Designee will ask a series of questions to 5 residents a week for any experienced/witnessed suspected abuse, neglect or misappropriation for x 4 weeks, then 3 residents a week x 4 weeks, then 1x resident a week x 4 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance	

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	3.1-13(q)			