STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155780		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 07/17/2024			ETED			
	ROVIDER OR SUPPLIER		•	7465 M	ADDRESS, CITY, STATE, ZIP COD ADISON AVE IAPOLIS, IN 46227			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0000								
Bldg. 00	IN00438670.	e Investigation of Complaint	F 00	000				
	-	6670 - Federal/State deficiencies are cited at F580, F609, F742,						
	Survey dates: July 1	6 and 17, 2024						
	Facility number: 01 Provider number: 1: AIM number: 2009	55780						
	Census Bed Type: SNF/NF: 64 Total: 64							
	Census Payor Type: Medicare: 3 Medicaid: 52 Other: 9 Total: 64							
	These deficiencies raccordance with 410	reflect State Findings cited in 0 IAC 16.2-3.1.						
	Quality review com	pleted July 23, 2024.						
F 0580 SS=D Bldg. 00	§483.10(g)(14) No (i) A facility must in resident; consult w physician; and not her authority, the r when there is-	(Injury/Decline/Room, etc.) tification of Changes. mmediately inform the						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: POI111 Facility ID: 012225 If continuation sheet Page 1 of 12

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/17/2024
	PROVIDER OR SUPPLIEF		7465 M	ADDRESS, CITY, STATE, ZIP COI ADISON AVE APOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LDBE COMPLETION
	requiring physicia (B) A significant of physical, mental, (that is, a deterior psychosocial static conditions or clinic (C) A need to alte (that is, a need to form of treatment consequences, or of treatment); or (D) A decision to resident from the §483.15(c)(1)(ii). (ii) When making (g)(14)(i) of this seensure that all perin §483.15(c)(2) is upon request to the (iii) The facility more requested and the rany, when there is (A) A change in reassignment as specifically more requested (iv) The facility more requested (iv) The	change in the resident's per psychosocial status ation in health, mental, or us in either life-threatening cal complications); retreatment significantly discontinue an existing due to adverse to commence a new form transfer or discharge the facility as specified in motification under paragraph ection, the facility must retinent information specified available and provided the physician. The proposition of this section. The esident representative, if section or roommate ecified in §483.10(e)(6); or esident rights under Federal gulations as specified in of this section. The proposition of this section and periodically es (mailing and email) and the resident most distinct part. A mposite distinct part (as must disclose in its			

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

Event ID:

POI111

Facility ID: 012225

If continuation sheet Page 2 of 12

08/19/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/17/2024 155780 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVE HOMESTEAD HEALTHCARE CENTER INDIANAPOLIS, IN 46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 F 0580 08/12/2024 Preparation and execution of this review, the facility failed to notify the physician plan of correction does not when staff found a large knife in the drawer of a constitute admission or agreement resident with a history of suicidal ideations and by this provider of the truth of the suicidal attempts for 1 of 3 residents reviewed. facts alleged or conclusions set (Resident B) forth in the Statement of Deficiencies. The plan of Finding includes: correction is prepared and executed solely because it is During an interview 7/17/24 at 8:19 a.m., CNA 1 required by the provisions of indicated, on 7/2/24 at approximately 12:15 a.m., federal and state law. Resident B asked CNA 1 to count some money The facility cordially requests that she kept in a drawer. When CNA 1 opened paper compliance regarding the drawer CNA 1 saw a large "butcher knife". alleged deficient practices. CNA 1 removed the knife and notified LPN 1 and Resident B was not the DON (Director of Nursing). The DON told harmed. Resident no longer CNA 1 to put the knife in the medication room and resides at facility. the DON would take care of it. CNA 1 put the Residents with history of knife in the medication room next to a pink plastic suicidal ideations and suicidal wash basin. attempts are at risk. Behaviors and Careplans to be reviewed to On 7/17/24 at 8:32 a.m., during an observation of assure appropriate and effective the medication room a pink plastic wash basin was interventions are in place and MD sitting in a cabinet above the sink. Under the pink notifications have been made. basin, observed a large metal knife with a dark DON/Designee has handle. The blade on the knife was approximately educated all staff on the Behavior 10 inches long and approximately 2 inches tall. Management for Suicidal Ideations policy. The clinical record for Resident B was reviewed on 7/17/24 at 11:00 a.m. The diagnoses included, DON/Designee will audit but were not limited to, major depressive disorder for new suicidal ideations, with psychotic symptoms, panic disorder, attempts and behaviors have MD assaultive behavior, suicidal ideation, and notification along with intervention post-traumatic stress disorder. and plan of care updated 5xweek x 4 weeks. 3xweek x 4 weeks.

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

A Quarterly MDS (Minimum Data Set)

assessment, dated 5/11/24, indicated Resident B

Event ID:

POI111

Facility ID: 012225

then 1xweek x 4 weeks.

DON/Designee will report on

If continuation sheet

Page 3 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155780	B. Wl	ING		07/17/	/2024
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADISON AVE		
HOMES1	ΓEAD HEALTHCAR	E CENTER		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	was cognitively inta	act with moderate depression.			audits monthly to the		
					interdisciplinary team for 3 mo		
	A History and Physical, dated 12/27/23, indicated				during the QAPI Meeting. The		
	_	ed from an outside hospital			will determine if the audits are		
		hem after an attempted suicide			necessary to continue after 3		
	by overdose at a ho	tel.			months with 100% compliance)	
		21 . 1 . 1 . 100 /04					
		ress Note, dated 1/28/24,					
		B was seen for reevaluation of					
	-	ttempts, suicidal ideation, cal aggression. Resident B					
	overdosed on an antidepressant on 12/22/23. Resident B overdosed on a handful of						
		Resident B's report because					
		and not wake up again after					
	_	t with her daughter. Resident B					
		f four suicide attempts and a					
		psychiatric hospitalizations in					
	the past.	1					
	•						
	A Hospital History	and Physical, dated 2/16/24,					
		B was having thoughts of					
		very impulsive, and Resident B					
	had insomnia.						
	A facility progress	note, dated 2/14/24 at 10:56					
		ident B stated she was not					
		lication regimen for depression					
		ent B wanted an antidepressant					
	-	ducated Resident B that was					
		e. Resident B stated she had					
		and knew how to take it.					
	1	sly had a psychiatric visit for					
		ose on the antidepressant.					
	1 2812 27014	1					
	The clinical record	for Resident B lacked					
	documentation of p	hysician notification when a					
	large knife was four	nd in her drawer on 7/2/24.					
	During an interview	y on 7/17/24 at 12:38 p.m., the					

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

Event ID:

POI111

Facility ID: 012225

If continuation sheet Page 4 of 12

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155780		LDING	nstruction 00	(X3) DATE SURVEY COMPLETED 07/17/2024	
	ROVIDER OR SUPPLIER			7465 MA	DDRESS, CITY, STATE, ZIP COD ADISON AVE APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0609 SS=D Bldg. 00	DON indicated the notified when the known. On 7/16/24 at 11:20 provided a copy of a titled Behavior Marindicated this was the facility. A review of policy of the facility resident who may por others. Contact the unusual behaviors. This citation relates 3.1-5(a)(2) 483.12(b)(5)(i)(A)(Reporting of Alleg §483.12(c) In respending the facility must: §483.12(c)(1) Ensity violations involving exploitation or misinguries of unknown misappropriation or reported immediate hours after the allegation do not in result in serious than 24 hours if the allegation do not in result in serious be administrator of the officials (including Agency and adult	physician should have been nife was found in Resident B's a.m., the Administrator an undated facility policy, nagement General, and he current policy used by the fithe policy indicated it is the vito identify and safely manage resent a danger to themselves the physician for new onset or to Complaint IN00438670. (B)(c)(1)(4) ed Violations conse to allegations of exploitation, or mistreatment, sure that all alleged grabuse, neglect, streatment, including in source and of resident property, are stelly, but not later than 2 the allegation involve abuse is bodily injury, or not later the events that cause the involve abuse and do not		TAG	DEFICIENCY		DATE

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

Event ID:

POI111

Facility ID: 012225

If continuation sheet Page 5 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155780		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/17/2024	
	ROVIDER OR SUPPLIER		7465 N	ADDRESS, CITY, STATE, ZIP COD IADISON AVE IAPOLIS, 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
	through establishe				
	investigations to the her designated reposition of the St 5 working days of alleged violation is corrective action in Based on interview failed to report an a health department of A resident with a hi use made an allegatheroin to the resident Finding includes: During an interview Resident C indicate to the emergency de Resident C was told (cardiopulmonary refinedication used to Resident C snorted controlled substance from someone at the who she got it from Administrator and I During an interview Administrator indice in early July and was department. The facility of the strength of the facility of the strength of the substantial facility of the strength of the s	and record review, the facility llegation of abuse to the state for 1 of 3 allegations reviewed. Story of IV (intravenous) drug ion that a nurse supplied int. (Resident C) If on 7/16/24 at 5:22 a.m., deshe remembered being sent expartment at night on 7/1/24. If she required CPR esuscitation) and Narcan reverse opioid overdose), theroin (an opioid schedule 1 te). Resident C got the heroin e facility but would not say because she already told the DON (Director of Nursing). If on 7/16/24 at 6:27 a.m., the lated Resident C required CPR as sent to the emergency callity believed she had taken ght. Initially, Resident C would where she got the drugs. Then	F 0609	Preparation and execution of plan of correction does not constitute admission or agree by this provider of the truth of facts alleged or conclusions of 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 resident will be interviewed for any allegation of abuse, neglect, of misappropriation. 3) DON/Designee has educated all staff on the policient.	ement ithe set
		t C told him she got the drugs was suspended and the		Abuse & Neglect & Misappropriation of Property	

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

Event ID:

POI111

Facility ID: 012225

If continuation sheet Page 6 of 12

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

PRINTED: 08/19/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155780	B. W	ING		07/17/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER						
HOMEST	EAD HEALTHCAR	E CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227				
TIONILGI	LADTILALTITICAN	L GENTER		INDIAN	AI OLIO, III 40221		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Administrator starte	ed an investigation.					
		for Resident C was reviewed			4) DON/Designee will a	sk	
		a.m. An Admission MDS			a series of questions to 5		
		assessment, dated 5/22/24,			residents a week for any		
		C was moderately cognitively			experienced/witnessed suspec		
	impaired.				abuse, neglect or misappropri		
					for x 4 weeks, then 3 residend		
	_	on 7/17/24 at 12:42 p.m., the			week x 4 weeks, then 1x resid		
		ated he did not think the			a week x 4 weeks. DON/Desig		
	-	Resident C against LPN 1			will report on audits monthly to		
	needed to be reported to the state health				interdisciplinary team for 3 mo		
	-	vestigation into the allegation			during the QAPI Meeting. The	IDT	
	was ongoing.				will determine if the audits are		
					necessary to continue after 3		
		a.m., the Administrator			months with 100% compliance	:	
		an undated facility policy,					
		cident Reporting, and					
		ne current policy used by the					
	-	f the policy indicated a level 2					
		ed more serious or an incident					
		n and should be reported as					
	applicable to state a	uthorities.					
	This citation relates	to Complaint IN00438670.					
	3.1-28(c)						
F 0742	483.40(b)(1)						<u> </u>
SS=D	, , , ,	Mental/Psychoscial					
Bldg. 00	Concerns	vicitai/i Sychosolai					
Biag. 00		on the comprehensive					
	- ', '	esident, the facility must					
	ensure that-	coldent, the identy must					
	§483.40(b)(1)						
	- ',','	splays or is diagnosed with					
		psychosocial adjustment					
		as a history of trauma					
	-	atic stress disorder,					
	•	ate treatment and services					
		ato a confident and 301 vioc3					

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

Event ID:

POI111

Facility ID: 012225

If continuation sheet Page 7 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETED			ETED
		155780	B. W	ING		07/17/2024	
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF				IADISON AVE		
⊔∩ME61	TEAD HEALTHCAD	E CENTED			IAPOLIS, IN 46227		
HOIVIES	TEAD HEALTHCAR	E CENTER					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		essed problem or to attain					
	the highest praction						
	psychosocial well-	•					
		on, interview, and record	F 0'	742	Preparation and execution of	this	08/12/2024
		failed to implement a care plans			plan of correction does not		
	_	ed interventions for a resident			constitute admission or agree		
	~	cidal ideations and a history of			by this provider of the truth of		
		attempts for suicidal ideations			facts alleged or conclusions so	et	
	_	s for 1 of 3 residents reviewed.			forth in the Statement of		
		knife in the resident's drawer			Deficiencies. The plan of		
	during care. (Reside	ent B)			correction is prepared and		
					executed solely because it is		
	Finding included:				required by the provisions of		
					federal and state law.		
	_	7/17/24 at 8:19 a.m., CNA 1			The facility cordially requests		
		at approximately 12:15 a.m.,			paper compliance regarding		
		NA 1 to count some money			alleged deficient practices.		
	_	awer. When CNA 1 opened			1) Resident B was not		
		saw a large "butcher knife".			harmed. Resident no longer		
		e knife and notified LPN 1 and			resides at facility.		
		of Nursing). The DON told			2) Residents with a history	-	
	_	nife in the medication room and			of suicidal ideations and atter	-	
		e care of it. CNA 1 put the			of suicide are at risk, residents		
		tion room next to a pink plastic			identified behaviors and carep	lans	
	wash basin.				to be reviewed to assure		
	O:: 7/17/24 -+ 9:22	1i1			appropriate and effective		
		a.m., during an observation of			interventions are in place and		
		n a pink plastic wash basin was			receiving appropriate		
		above the sink. Under the pink rge metal knife with a dark			treatment/services.		
	1	n the knife was approximately			3) DON/Designee has	vior	
		approximately 2 inches tall.			educated all staff on the Beha		
	10 menes long and	approximatery 2 menes tan.			Management for Suicidal Idea	uOH	
	The clinical record	for Resident B was reviewed			policy.		
		a.m. The diagnoses included,			4) DON/Designee will a	audit	
		d to, major depressive disorder			4) DON/Designee will a for new suicidal ideations,	auuit	
		ptoms, panic disorder,			attempts and behaviors have		
		suicidal ideation, and			1		
	post-traumatic stres				appropriate and effective intervention/treatment/service	s and	
	post-traumane stres	s disorder.			· · · · · · · · · · · · · · · · · · ·		
	l		1		plan of care updated 5xweek 3	x 4	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155780	B. W	ING		07/17/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	R			ADISON AVE		
HOMEST	TEAD HEALTHCAR	E CENTER			APOLIS, IN 46227		
TIONILO	·			II VIDI/ (I V	711 OLIO, 114 40227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Minimum Data Set)			weeks, 3xweek x 4 weeks, the	n	
		/11/24, indicated Resident B			1xweek x 4 weeks.		
	was cognitively intact with moderate depression.				DON/Designee will report on		
					audits monthly to the		
	A History and Physical, dated 12/27/23, indicated				interdisciplinary team for 3 mo		
	_	ed from an outside hospital			during the QAPI Meeting. The		
		hem after an attempted suicide			will determine if the audits are		
	by overdose at a ho	tel.			necessary to continue after 3		
					months with 100% compliance	;	
		ress 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						
		tidepressant on 12/22/23.					
	Resident B overdos						
		Resident B's report because					
	_	and not wake up again after					
		t with her daughter. Resident B					
		f four suicide attempts and a					
		psychiatric hospitalizations in					
	the past.						
	A II '4-1 II' -4	d Di					
		and Physical, dated 2/16/24, B was having thoughts of					
		0 0					
	had insomnia.	very impulsive and Resident B					
	nad insomma.						
	A facility progress	note, dated 2/14/24 at 10:56					
		ident B stated she was not					
		lication regimen for depression					
		ent B wanted an antidepressant					
	1	ducated Resident B that was					
	· ·	e. Resident B stated she had					
		and knew how to take it.					
		sly had a psychiatric visit for					
		ose on the antidepressant.					
	attempting to overd	ose on the antidepressant.					
	The clinical record	for Resident B lacked a care					
		entered interventions for					
	suicidal ideations.	more ventions for					
	suicidal idealions.		1				I

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

Event ID:

POI111

Facility ID: 012225

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If continuation sheet Page 9 of 12

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

PRINTED: 08/19/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155780		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/17/2024	
	ROVIDER OR SUPPLIER		7465 M	ADDRESS, CITY, STATE, ZIP COD ADISON AVE APOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	plan with person-ce suicide attempts. During an interview DON indicated Res plans with person-c suicidal ideations an On 7/17/24 at 11:20 provided a copy of Behavior Managem was the current poli review of the policy plan, update with cl Include specific into	a.m., the Administrator an undated policy, titled ent General, and indicated this cy used by the facility. A indicated complete a care nanges and or new behaviors.			
	3.1-43(a)(1)	to Complaint I 100 150070.			
F 0835 SS=D Bldg. 00	that enables it to use and efficiently to a highest practicable psychosocial well-Based on interview administration faile physical wellbeing reviewed. An allegating against a nurse but the second process of the second pr	administered in a manner use its resources effectively ittain or maintain the e physical, mental, and being of each resident. and record review, the facility d to maintain the mental and of residents for 1 of 3 residents ation of abuse was made was not reported to the state and the nurse was not reported	F 0835	Preparation and execution of the plan of correction does not constitute admission or agreed by this provider of the truth of 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	nent the

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

Event ID:

POI111

Facility ID: 012225

25

If continuation sheet Page 10 of 12

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
		155780	B. W	NG		07/17/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADISON AVE		
HOMES	TEAD HEALTHCAR	RE CENTER		INDIANAPOLIS, IN 46227			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	v, on 7/16/24 at 5:22 a.m.			federal and state law.		
		ed she remembered being sent			The facility cordially requests		
		epartment at night on 7/1/24.			paper compliance regarding		
	Resident C was told	-			alleged deficient practices.		
		resuscitation) and Narcan			1) Resident C was not		
	,	reverse opioid overdose).			harmed. Resident no longer		
		heroin (an opioid schedule 1			resides at facility. SRI was		
		e). Resident C got the heroin			submitted to IDH and police		
		e facility but would not say			notified.		
	_	because she already told the			2) All residents have the		
	Administrator and	DON (Director of Nursing).			potential to be affected by the		
	D	7/16/04 + 6.07 - 4			deficient practice. All resident	.S	
During an interview on 7/16/24 at 6:27 a.m., the				will be interviewed for any			
		cated Resident C required CPR			allegation of abuse, neglect, o	r	
		as sent to the emergency			misappropriation.		
	_	cility believed she had taken			0, 50,45		
		ght. Initially, Resident C would			3) DON/Designee has		
	-	where she got the drugs. Then			educated all staff on the policy	/	
		nt C told him she got the drugs			Abuse & Neglect &		
		sed Practical Nurse). LPN 1 was			Misappropriation of Property		
	suspended, and 1 st	arted an investigation.			4) DON/Designee will a	ISK	
	0 7/17/24 + 11 0	- 1 A 1 * *			a series of questions to 5		
		5 a.m., the Administrator			residents a week for any	-4	
		an Indianapolis Metro Police			experienced/witnessed suspe		
	_	ast District Information Card,			abuse, neglect or misappropri		
		indicated this was the police e allegation made by Resident			for x 4 weeks, then 3 residents		
		•			week x 4 weeks, then 1x residue NON/Desid		
		review of the document			a week x 4 weeks. DON/Design	-	
	indicated incident t	ype: property disposal.			will report on audits monthly to		
	On 7/17/24 at 11:04	5 a.m., the Administrator			interdisciplinary team for 3 mc		
		an undated facility policy,			during the QAPI Meeting. The will determine if the audits are		
		an undated facility policy, acident Reporting, and			necessary to continue after 3		
		he current policy used by the			months with 100% compliance	3	
		of the policy indicated a level 2			months with 100% compliance	7	
		red more serious or an incident					
		n and should be reported as					
	applicable to state a	-					
	applicable to state a	iumoriues.					
	This citation relates	s to Complaint IN00438670					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
		155780	B. WING		07/17/2024		
NAME OF PROVIDER OR SUPPLIER HOMESTEAD HEALTHCARE CENTER				7465 M	ADDRESS, CITY, STATE, ZIP COD ADISON AVE APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-13(q)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: POI111 Facility ID: 012225 If continuation sheet Page 12 of 12