

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

PRINTED: 05/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155780</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOMESTEAD HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7465 MADISON AVE</b> <b>INDIANAPOLIS, IN 46227</b>		
(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}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on March 21, 2022.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00373289, IN00372277, IN00372387, and IN00372425 completed on February 16, 2022.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00373526, IN00374106, and IN00374233 completed on March 1, 2022.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00374538 completed on March 21, 2022.</p> <p>Complaint IN00373289 - Corrected.</p> <p>Complaint IN00372277 - Corrected.</p> <p>Complaint IN00372387 - Corrected.</p> <p>Complaint IN00372425 - Corrected.</p> <p>Complaint IN00373526 - Corrected.</p> <p>Complaint IN00374106 - Corrected.</p> <p>Complaint IN00374233 - Corrected.</p> <p>Complaint IN00374538 - Corrected.</p> <p>Survey dates: May 4, 5, and 6, 2022</p> <p>Facility number: 012225</p>	{F 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 14 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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{F 000}	Continued From page 1 Provider number: 155780 AIM number: 200983560  Census Bed Type: SNF/NF: 57 Total: 57  Census Payor Type: Medicare: 1 Medicaid: 51 Other: 5 Total: 57  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 PSR to the Recertification and State Licensure Survey.	{F 000}			
{F9999}	Quality review completed May 10, 2022. FINAL OBSERVATIONS	{F9999}	refer to paper documentation for details		