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	04/04/2022

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/04/22 Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560 At this Emergency Preparedness survey, Homestead Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 156 certified beds. At the time of the survey, the census was 63. Quality Review completed on 04/06/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/04/22 Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560 At this Life Safety Code survey, Homestead	K 0000		

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

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	Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms except in Room 502 which has a smoke detector hard wired to the facility's fire alarm system. The facility has a capacity of 156 and had a census of 63 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for three detached storage sheds. Quality Review completed on 04/06/22			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____			

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation, and interview; the facility failed to ensure 12 of 12 sprinkler heads in the main kitchen area were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect as many as six staff in the kitchen. Findings include: Based on observation with the Maintenance	K 0353	**The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Homestead Healthcare Center.** The citation identified that the facility failed to ensure 12 of 12 sprinkler heads in the main kitchen area were maintained in accordance with NFPA 25. As an immediate correction, the maintenance director/designee placed a replacement order for all main kitchen sprinkler heads through SafeCare. The maintenance director/designee conducted a sweep of all sprinkler heads in the main kitchen to identify any other sprinkler heads that needed replacement. The Executive Director provided training to maintenance	04/25/2022

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	Director during a tour of the facility at 2:31 p.m. to on 04/04/22, all 12 sprinkler heads located in the main kitchen area were covered with a green corrosion. This could hinder the function and spray patterns of the aforementioned sprinklers. Based on interview at the time of observation, the Maintenance Director acknowledged the sprinkler as being dirty and stated that he would have his vendor cone in and give him quote on getting them replaced as soon as possible. During the exit conference with the facility Maintenance Director, the Divisional Nurse, and the Director of Nursing at at 3:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		director/designee on the importance of proper maintenance of sprinkler heads on the main kitchen. The Maintenance Director/Designee will facilitate quarterly inspections of sprinkler heads using TELS preventative maintenance program and SafeCare contractor to ensure proper maintenance of water-based fire protection systems and to maintain compliance. Executive Director will review quarterly inspection reports to maintain compliance as per NFPA 25.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 1) Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of	K 0374	**The facility recognizes that it must persuade your office that appropriate systems are in**	04/25/2022

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	smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 24 residents, 4 staff and 2 visitors in the two adjoining smoke compartments. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 1:49 p.m. to on 04/04/22, the set of barrier doors nearest to resident rooms #111 and #112 did not fully close or latch into the doorframe. These doors were tested on three separate occasions and there was a two-inch gap between the doors when closed to their fullest. Based on interview during the time of observations, the Maintenance Director acknowledged these barrier doors did not fully close or latch into the doorframe and added that he would make more adjustments as these doors had given him some problems in the past. During the exit conference with the facility Maintenance Director, the Divisional Nurse, and the Director of Nursing at 3:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening		**place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Homestead Healthcare Center.** The citation identified the facility failed to ensure 1 of 6 sets of smoke barrier doors restricted the movement of smoke for 20 minutes. As an immediate correction, Medicine cart was removed from in front of the fire doors, the maintenance director/designee placed a replacement order for door hardware and latches for one set of smoke barrier doors nearest rooms #111 and #112 through local contractor, Underwood Construction. The maintenance director/designee conducted a facility-wide sweep of smoke doors to identify any other smoke doors that did not meet code and/or needed replacement. No others found. The Executive Director provided training to maintenance director/designee on the importance of proper maintenance of smoke doors. The maintenance director/designee will facilitate	

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	leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 24 residents, 4 staff and 2 visitors in the two adjoining smoke compartments. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 3:15 p.m. to on 04/04/22, the set of barrier doors on the 500 Hall nearest to the nurses' station could not fully close or latch into the doorframe. These doors were obstructed by a nursing medicine (Med) cart that was blocking the barrier doors. Based on interview during the time of observations, the Maintenance Director acknowledged these barrier doors were obstructed and could not fully close or latch into the doorframe because of the Med cart blocking them. The Maintenance Director then spoke to on duty staff and removed the Med cart obstruction from the barrier doors taking it to another location. During the exit conference with the facility Maintenance Director, the Divisional Nurse, and the Director of Nursing at 3:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		weekly inspections of smoke barrier doors using TELS preventative maintenance program to ensure doors will restrict movement of smoke for at least 20 minutes and to maintain overall compliance. Executive Director will review quarterly inspection reports to ensure compliance as per LSC 19.3.7.8.	
K 0511 SS=C Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.			

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	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on record review, observation, and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review with the Maintenance Director at 1:20 p.m. on 04/04/22, it was stated that the fuel source for the facility emergency generator was natural gas. During a tour of the	K 0511	**The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Homestead Healthcare Center.** The citation identified the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance to regulations. As an immediate correction, the maintenance director retrieved an updated certificate of Gas Service Reliability for the emergency generator from Citizens Gas Company. The maintenance director/designee completed a facility-wide sweep to identify any other emergency generators that do not have a reliable source of fuel in accordance to NFPA code. No others found. The Executive Director provided training to maintenance director/designee on the importance of maintaining current updated certificate of Gas Service Reliability for the emergency generator.	04/25/2022

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	facility at 1:49 p.m. it was observed and verified that the fuel source for the generator was indeed natural gas. Further review of records determined that a natural gas letter of reliability was eventually located, but it was dated December 2nd, 2014. Based on an interview at the time of record review, the Maintenance Director stated that he would contact the vendor and have another letter sent as soon as he was able to do so. During the exit conference with the facility Maintenance Director, the Divisional Nurse, and the Director of Nursing at 3:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		The maintenance director/designee will facility yearly inspections of Gas Service Reliability to ensure updated certificate and maintain compliance. Executive Director will review yearly inspection reports to ensure compliance as per NFPA regulation.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in			

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	patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, Section 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect any 12 residents, 4 staff, or 2 visitors in the vicinity of the oxygen storage and transfilling room.	K 0923	**The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Homestead Healthcare Center.** The citation identified that the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in	04/25/2022

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	Findings include: Based on observation with the Maintenance Director during a tour of the facility at 2:16 p.m. to on 04/04/22, a 1-inch by 6-inch by 4-inch piece of wood was attached to the wall and had hooks in it for storage of small portable oxygen tanks and was stored within five feet of five stationary liquid oxygen containers in the oxygen storage and transfilling room. Based on interview at the time of observation, the Maintenance Director acknowledged that a combustible material (wood) was stored within five feet of stationary liquid oxygen containers and stated that he would have the wood painted and protected as soon as he could. During the exit conference with the facility Maintenance Director, the Divisional Nurse, and the Director of Nursing at 3:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		1 of 1 oxygen storage areas. As an immediate correction, the maintenance director/designee removed all combustible materials such as wood and base boards from the storage room. The Maintenance Director/Designee completed a facility wide sweep of all oxygen rooms for identification of combustible materials. No others were found. The ED provided training to the maintenance director on the importance of gas equipment-cylinder and container storage as per NFPA 99, section 11.3.2.3. The Maintenance Director/Designee will facilitate weekly inspections of oxygen storage rooms using TELS preventative maintenance program to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment. ED will monitor for weekly TELS preventative maintenance program for continued compliance.	