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	02/02/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00426618 and IN00426929. Complaint IN00426618 - No deficiencies related to the allegations are cited. Complaint IN00426929 - Federal/State deficiencies related to the allegations are cited at F842. Survey dates: January 28, 29, 30, 31 and February 1, and 2, 2024 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicaid:50 Other: 4 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 6, 2024.	F 0000		
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who			

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

Justin Lai | Executive Director | 02/16/2024

Any defiencystatement 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 disclo 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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	require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to provide services for residents who required dialysis for 1 of 2 residents reviewed. Dialysis access sites were not monitored. (Resident 49) Findings include: On 1/30/24 at 2:37 p.m., the clinical record of Resident 49 was reviewed. The diagnoses included, but were not limited to, end stage renal disease (ESRD), chronic kidney disease, and dependence on renal dialysis. The Quarterly Minimum Data Set (MDS) assessment, dated 1/16/24, indicated Resident 49 was cognitively intact and was dependent on dialysis. Resident 49's care plan included, but was not limited to: Resident is currently on dialysis therapy related to ESRD, initiated 11/10/23 and current through 4/15/24. The interventions included, but were not limited to, report abnormal findings, evaluate resident following dialysis treatment, report abnormal findings, listen for bruit (the swishing sound heard over the site using a stethoscope) and thrill (the vibration felt by the flow of blood at dialysis site). Resident 49's clinical record lacked documentation regarding nursing staff having monitored and documented the dialysis site, bruit, and thrill.	F 0698	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 49 was not harmed by the alleged deficient practice. Resident 49 has had an order added to monitor thrill and bruit every shift. The care plan for resident has been reviewed and updated accordingly. 2 All dialysis residents have the potential to be affected by the alleged deficient practice. An audit of all dialysis residents has been completed to determine if thrill and bruit monitoring orders are in place. No concerns noted. 3 DON/Designee has educated the skilled nursing staff on Hemodialysis Care and Monitoring Policy with an emphasis on monitoring for thrill and bruit.	02/26/2024

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	During an interview on 1/31/24 at 11:55 a.m., the Director of Nursing Services (DNS) indicated the nursing staff had not been monitoring Resident 49's dialysis site. During an interview on 1/31/24 at 3:25 p.m., Resident 49 indicated the nursing staff were not monitoring the dialysis site or the bruit and thrill. On 1/31/24 at 11:55 a.m., the DNS provided an undated copy of the Hemodialysis Care and Monitoring policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...signs and symptoms to monitor...lack of bruit heard or thrill palpated at the site...general VAD [vascular access devise] care and precautions: monitor for infection, thrill...bruit...post-dialysis-nurse to complete the post dialysis evaluation from the dialysis center to include but not limited to: thrill absence or presence; bruit absence..." 3.1-37(a)		4 DON/Designee will audit all dialysis residents 5xweek x 4 weeks, 3xweek x 4 weeks, then 1xweek x 4 weeks to verify monitoring of thrill and bruit are being completed. 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 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent			

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	facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 4 of 4 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Dietary Staff 2, Cook 3, and Dietary Staff 4) Findings include: 1. During the initial kitchen tour with Cook 3, on 1/28/24 from 10:15 a.m. to 10:30 a.m., the following was observed: - Dietary Staff 2 was observed walking through out the kitchen area and was washing the breakfast meal dishes. Observed Dietary Staff 2 to have facial hair, approximately 1/2 inch in length, above and below the lip area. The facial hair was observed to not be covered. - Cook 3 was observed walking through out the kitchen area. Observed Cook 3 to have facial hair, approximately 1/2 inch in length, above and below the lip area. Cook 3 also was observed to have hair, approximately 1/4 inch in length, on top of his head. The hair was observed to not be covered.	F 0812	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 No resident was harmed by the alleged deficient practice. Dietary staff immediately educated on company policy and procedure, no other concerns noted. 2 All residents have the potential to be affected by alleged deficient practice. Dietary Manager/Designee audited compliance of staff utilizing hair restraints each shift, no concerns noted.	02/26/2024

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	2. During a follow up kitchen observation, on 1/28/24 from 11:30 a.m. to 11:35 a.m., the following was observed: - Dietary Staff 2 was observed walking through out the kitchen area and was preparing the noon meal drinks for the residents. Dietary Staff 2's facial hair was observed to not be covered. - Cook 3 was observed at the steam table where the noon meal was being held and was observed taking and recording the noon meal starting food temperatures. Cook 3's hair was observed to not be covered. 3. During a follow up kitchen observation, on 1/28/24 from 12:40 p.m. to 12:45 p.m., the following was observed: - Dietary Staff 2 was observed near the steam table where the noon meal was being held. Dietary Staff 2's facial hair was observed to not be covered. - Dietary Staff 4 was observed at the steam table and was plating the resident's noon meal. Dietary Staff 4 was observed to have multiple loose hairs, approximately 4 inches in length, at the neckline and in front of both ears. The hair was observed to not be covered. - Cook 3 was observed at the steam table where the noon meal was being held and was observed taking and recording the noon meal ending food temperatures. Cook 3's hair was observed to not be covered. 4. During a follow up kitchen observation, on 1/29/24 from 3:25 p.m. to 3:30 p.m., the following was observed:		3 Dietary Manager/Designee has educated the dietary department on the Staff attire policy with an emphasis on providing sanitary environment in relationship to hair restraints. 4 Dietary Manager/Designee will observe meal service for required hair restraints 5 x week x 4 weeks, 3 x week x 4 weeks, then 1 x week x 4 weeks. Dietary Manager/Designee will report on audits monthly to interdisciplinary team for 3 months during QAPI meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance.	

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	- Dietary Staff 2 was observed walking through out the kitchen area. Observed Dietary Staff 2 to have facial hair, approximately 1/2 inch in length, above and below the lip area. The facial hair was observed to not be covered. - Dietary Staff 4 was observed walking through out the kitchen area. Dietary Staff 4 was observed to have multiple loose hairs, approximately 4 inches in length, at the neckline and in front of both ears. The hair was observed to not be covered. During an interview on 1/28/24 at 3:40 p.m., the Dietary Manager indicated staff hair was to be covered while in the kitchen. On 1/30/24 at 10:30 a.m., the Director of Nursing Services provided a copy of the Staff Attire policy, dated September 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...all staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained ..." On 1/30/24 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food..." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information.			

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	(i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.			

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	§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to accurately and completely document services provided for 2 of 22 residents reviewed. Catheter care was not documented, medication administration was not documented. Resident B, Resident C Findings include: 1. On 1/29/2024 at 2:50 p.m., the clinical record for Resident B was reviewed. The diagnoses included, but were not limited to, retention of	F 0842	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	02/26/2024

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	urine and obstructive and reflux uropathy (difficulty passing urine). The Quarterly Minimum Data Set (MDS) assessment, dated 1/26/2024, indicated Resident B was cognitively intact and had an indwelling urinary catheter. Resident B's care plan, dated initiated on 4/10/2023 and current through 4/24/2024, indicated "Focus: The resident has indwelling catheter [related to] obstructive uropathy...Interventions/Tasks: provide catheter care every shift and PRN..." Physician orders included, but was not limited to, "foley [urinary] catheter [a medical device that helps drain urine from the bladder] care every shift and PRN [as needed] with soap and water. Secure straps if applicable, document [urine] output every shift...start date 4/7/2023..." No stop date was indicated. The November 2023 Treatment Administration Record (TAR) lacked facility staff's initials that indicated catheter care was provided and urine output amount was recorded for the following dates: - 11/1/2023 - day shift; - 11/8/2023 - day shift; - 11/9/2023 - day shift; - 11/15/2023 - evening shift; - 11/17/2023 - day shift; - 11/20/2023 - day shift; - 11/21/2023 - day shift; - 11/22/2023 - day shift; - 11/22/2023 - evening shift; - 11/23/2023 - evening shift; - 11/24/2023 - day shift;		alleged deficient practices. 1 Resident B and C was not harmed by the alleged deficient practice. DON/Designee notified provider and families of missed documentation and missed medications. Individualized care plans reviewed. 2 All residents have the potential to be affected by alleged deficient practice. DON/Designee conducted 100% audit on all residents in the facility for missing documentation in the MAR and TAR for previous 2 weeks and provider was notified of all missing documentation. 3 DON/Designee has educated all staff on the General Guidelines for Medication Administration policy and catheter care policy with an emphasis on timely and accurate documentation 4)DON/Designee will audit 10 residents MAR and TAR 5xwk x4wks, 3xwk x4wks, 1xwk x 4wks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance.	

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	- 11/26/2023 - day shift - 11/28/2023 - day shift; - 11/29/2023 - day shift; - 11/30/2023 - day shift; and - 11/30/2023 - evening shift. The December 2023 TAR lacked facility staff's initials that indicated catheter care was provided and urine output amount was recorded for the following dates: - 12/1/2023 - day shift; - 12/1/2023 - night shift; - 12/3/2023 - day shift; - 12/4/2023 - day shift; - 12/5/2023 - day shift; - 12/6/2023 - day shift; - 12/7/2023 - day shift; - 12/8/2023 - evening shift; - 12/10/2023 - day shift; - 12/11/2023 - evening shift; - 12/15/2023 - day shift; - 12/16/2023 - day shift; - 12/17/2023 - day shift; - 12/19/2023 - day shift; - 12/20/2023 - day shift; - 12/20/2023 - night shift - 12/21/2023 - day shift; - 12/21/2023 - night shift; - 12/23/2023 - day shift; - 12/25/2023 - evening shift; - 12/26/2023 - day shift; and - 12/28/2023 - day shift. The January 2024 TAR lacked facility staff's initials that indicated catheter care was provided and urine output amount was recorded for the following dates: - 1/3/2024 - day shift;			

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	- 1/3/2024 - evening shift; - 1/3/2024 - night shift; - 1/4/2024 - day shift; - 1/4/2024 - night shift; - 1/7/2024 - day shift; - 1/8/2024 - day shift; - 1/9/2024 - day shift; - 1/9/2024 - evening shift; - 1/10/2024 - day shift; - 1/11/2024 - day shift; - 1/11/2024 - evening shift; - 1/11/2024 - night shift; - 1/12/2024 - night shift; - 1/13/2024 - day shift; - 1/18/2024 - day shift; - 1/18/2024 - night shift; - 1/19/2024 - night shift; and - 1/23/2024 - night shift During an interview on 1/31/2024 at 11:55 a.m., the Director of Nursing Services (DNS) indicated Resident B's November, December, and January MAR documents lacked multiple staff signatures to signify catheter care had been provided to the resident. The DNS indicated Resident B was to have catheter care provided during each shift as indicated by the Physician's orders. On 1/31/2024 at 2:04 p.m., the DNS provided a copy of the Catheter Care policy, dated 4/20/2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place..." 2. On 1/29/2024 at 9:48 a.m., the clinical record for Resident C was reviewed. The diagnoses included, but were not limited to, glaucoma and hypertension.			

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	The Quarterly Minimum Data Set (MDS) assessment, dated 1/3/2024, indicated Resident C was cognitively intact. Resident C's care plan, dated initiated on 5/25/2023 and current through 4/4/2024, indicated "Focus: The resident has hypertension disease process...Interventions/Tasks: administer medications per medical provider's orders..." Physician Orders included, but were not limited to, the following: - Lantanoprost ophthalmic solution 0.005%, install 1 drop in both eyes at bedtime for eye health, start date 8/29/2023, no end date noted; - Clonidine HCl 0.1mg. (milligram), 1 tablet by mouth every morning and at bedtime for HTN (hypertension), start date 8/30/2023, no end date noted; - Ferrous Sulfate tablet, 325 (65 Fe) mg, 1 tablet two times per day for anemia, start date 11/29/2023, no end date noted; - Benzonatate capsule 100 mg. 1 capsule three time a day for cough, start date 11/25/2023, stop date 1/11/2024; - Benzonatate capsule 100 mg. 1 capsule three time a day for cough, start date 1/11/2024, no end date noted; and - Atorvastatin Calcium tablet 40 mg. 1 tablet at bedtime for HLD (hyperlipidemia), start date 8/29/2023, no end date noted. The January 2024 Medication Administration Record (MAR) lacked facility staff's initials that indicated the Physician's prescribed medications were not administered and recorded for the following dates: - Lantanoprost ophthalmic solution 0.005%, install			

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	1 drop in both eyes at bedtime for eye health on 1/6/2024; 1/15/2024; and 1/22/2024; - Clonidine HCl 0.1 mg. (milligram), 1 tablet by mouth every morning and at bedtime for HTN (hypertension) on 1/6/2024; 1/15/2024; and 1/22/2024; - Ferrous Sulfate tablet, 325 (65 Fe) mg, 1 tablet two times per day for anemia on 1/22/2024; - Benzonatate capsule 100 mg. 1 capsule three time a day for cough 1/5/2024 morning dose; 1/6/2024 evening dose; 1/11/2024 morning dose; 1/12/2024 afternoon dose; 1/13/2024 afternoon dose ; 1/21/2024 afternoon dose; and 1/22/2024 evening dose; and - Atorvastatin Calcium tablet 40 mg. 1 tablet at bedtime 1/6/2024; 1/15/2024; 1/22/2024. During an interview on 1/28/2024 at 9:05 a.m., Resident C indicated she had not received all her medications. During an interview on 2/1/2024 at 11:05 a.m., the Director of Nursing Services (DNS) indicated the facility lacked the documentation that would indicate Resident C had received all her medications. All medications were to be administered as ordered by the physician and if it was not administered, then the clinical record should have been updated to reflect the same. On 2/2/2024 at 8:02 a.m., the DNS provided a copy of the General Guidelines for Medication Administration policy, dated September 2018, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...medications are administered as prescribed in			

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	02/02/2024

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

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	accordance with good nursing principles and practices...always employ the MAR [Medication Administration Record] during medication administration..." On 2/2/2024 at 3:00 p.m., a review of Basic Healthcare Documentation Standards indicated "...entries are dated and authenticated by the author. Documentation is made at the time service is provided..." This citation tag relates to Complaint IN00426929. 3.1-50(a)(1)			