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	02/29/2024

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/29/24 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 61. Quality Review completed on 03/04/24	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: 02/29/24 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

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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	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 61 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 03/04/24			
K 0291 SS=D Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 3 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition.	K 0291	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by this alleged deficiency. *How other residents having the*	03/15/2024

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	Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 02/29/24 at 1:50 p.m., the battery powered emergency light at the generator transfer switch did not work when tested. Based on interview at the time of the observation, the Maintenance Director stated the light worked when he tested it on 02/12/24 and agreed the battery powered emergency light failed to function when its respective test button was pushed. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		*potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* No residents were affected by this alleged di *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Maintenance director replaced the light bulb as soon as the deficiency was discovered. Maintenance will check the status of this light with monthly inspection. Staff will be monitored by ED/designee once monthly for 6 months to ensure compliance. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* The alleged deficient practice will be reviewed at the building's next Quality Assurance meeting. ED/Designee will audit this once monthly to ensure completion. This will be monitored monthly by ED/designee for 6 months to ensure compliance.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material			

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	capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure all resident room corridor doors would latch into the door frame. This deficient practice could affect 14 residents and staff in the 700 Hall.	K 0363	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* 14 residents on 700 hall had the	03/15/2024

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	Findings include: Based on observation on 02/29/24 during a tour of the facility at 2:15 p.m. with the Maintenance Director, the corridor door to resident room 705 would not latch into the door frame after three attempts. Based on interview at the time of observation, the Maintenance Director confirmed the corridor door to room 705 failed to latch into its door frame when tested. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		potential to be affected by this alleged deficiency. The door was fixed as soon as the problem was discovered. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* ED/designee to complete a building wide inspection of all fire doors to ensure proper maintenance. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Maintenance director shall continue to complete Fire door inspections per TELs. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* Executive director/designee will audit the TELS logbook documentation weekly to ensure compliance for the first two (2) months and then each month thereafter. This will be reviewed by Quality Assurance committee each month for a minimum of six (6) months for further recommendations.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire			

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	alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Tels Fire Drill Reports documentation with the Maintenance Director during record review from 10:20 a.m. to 1:32 p.m. on 02/29/24, second shift (2:00 p.m. to 10:00 p.m.) fire drills conducted on 01/31/24, 04/27/23 and 07/31/23 were conducted at, respectively, 4:45 p.m., 3:32 p.m. and 3:33 p.m. Third shift (10 p.m. to 6:00 a.m.) fire drills conducted on 02/28/23, 05/31/23, 08/31/23 and 11/30/23 were conducted at, respectively, 4:00 a.m., 4:00 a.m., 3:30 a.m. and 3:30 a.m. Based on interview at the time of record review, the Maintenance Director agreed the aforementioned second and third shift fire drills were not conducted at unexpected times under varying conditions. This finding was reviewed with the Exective Director and Maintenance Director at the exit conference.	K 0712	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* This deficient practice could affect all residents, staff and visitors in the facility. Maintenance director was given immediate education. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* This alleged deficient practice could affect all residents. Education completed with Maintenance director on 3.8.24 to ensure that fire drills are completed correctly. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* ED/designee will review fire drills to ensure they are completed in accordance to instructions provided by TELS. *How the corrective action will be monitored to ensure the deficient*	03/15/2024

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	3.1-19(b) 3.1-51(c)		*practice will not recur (i.e. – what QA program will be put into place)?* ED/designee will audit TELS logbook documentation to ensure compliance This will be reviewed by Quality Assurance committee for further recommendations.	
K 0761 SS=F Bldg. 01	Based on records review, and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads	K 0761	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* This deficient practice could affect all residents *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* ED/designee to complete a building wide inspection of all fire doors to ensure proper maintenance. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Maintenance director shall continue to complete Fire door inspections per TELs. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* Executive director/designee will	03/15/2024

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	are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director on 02/29/24, current documentation of an annual inspection for the fire door assemblies was not available for review. Based on interview at the time of records review, the Maintenance Director stated the annual fire door inspection within the last 12 months have not been conducted. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		audit the TELS logbook documentation weekly to ensure compliance for the first two (2) months and then each month thereafter. This will be reviewed by Quality Assurance committee each month for a minimum of six (6) months for further recommendations.	

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K 0927 SS=D Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 02/29/24 at 2:40 p.m., the oxygen storage/transfer room near the employee entrance contained large liquid oxygen tanks and small portable oxygen cylinders. There was a mechanically ventilated exhaust fan installed on the ceiling, however it was not working at the time of observation. A piece of paper was put up against the fan, and it did not stick to the fan grate. Based on interview at the time of observation, the Maintenance Director	K 0927	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* This deficient practice could affect staff *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* The facility identified the fan in one room to be out of service. Exhaust fan was fixed on 3.4.24. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Maintenance director or designee will inspect the fan weekly to ensure no issues for 2 months, and then two months thereafter. *How the corrective action will be monitored to ensure the deficient*	03/15/2024

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	agreed the fan did not appear to working at the time of observation. This finding was reviewed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)		*practice will not recur (i.e. – what QA program will be put into place)?* Executive director/designee will audit documentation weekly to ensure compliance for the first two (2) months and then each month thereafter. This will be reviewed by Quality Assurance committee each month for a minimum of six (6) months for further recommendations.	