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	03/15/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00429727 and IN00429962. Complaint IN00429727 - Federal/State deficiencies related to the allegations are cited at F609. Complaint IN00429962 - No deficiencies related to allegations are cited. Survey dates: March 14 and 15, 2024 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 4 Medicaid: 50 Other: 6 Total: 60 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 18, 2024.	F 0000		
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the Administrator for 1 of 3 allegations of abuse reviewed. (Resident B, Resident C)	F 0609	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the	04/05/2024

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

Justin Lai | Executive Director | 03/29/2024

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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	Finding included: During an interview on 3/14/24 at 1:52 p.m., LPN 1 indicated she did not notice anything out of the ordinary with Resident B during LPN 1's shift, on 3/3/24. LPN 1 did not witness the incident between Resident B and Resident C, but Resident B was being rude and pushing his way through other residents near the door that leads out to the smoking area. LPN 1 did not hear Resident B threaten to kill Resident C, but Resident B had threatened to kill other residents in the past. Multiple people reported this to the DON. During an interview on 3/14/24 at 2:58 p.m., QMA 1 indicated on 3/3/24, Resident C was trying to go outside to smoke and Resident B didn't think Resident C was going fast enough and Resident B bumped into Resident C which started an argument. Resident B told Resident C that Resident B was going to kill Resident C. QMA 1 ran to Resident B and Resident C. LPN 1 told Resident B it was not okay to talk to other residents that way. Resident B looked at QMA 1 and appeared mad. QMA 1 told Resident B not to hit QMA 1 and Resident B told QMA 1 he wouldn't hit QMA 1, Resident B would kill QMA 1 too. Resident B was placed on 1-on-1 for a few hours. A few hours later, QMA 1 noticed Resident B was alone in his room. Resident B and Resident C had another incident several months ago which was very similar to this incident. During an interview on 3/15/24 at 9:21 a.m., QMA 2 indicated on 3/3/24, Resident B threatened Resident C that Resident B was going to kill Resident C. When QMA 1 intervened, Resident B told QMA 1 that Resident B would kill QMA 1, too.		facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during a survey on March 15th, 2024. Please accept this plan of correction as the provider's credible allegation of compliance. F609 – Reporting of alleged violations What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents B and C were not harmed by the alleged deficient practice. Residents were monitored for psychosocial distress x3 with no findings. Skin and pain assessments completed on both residents with no findings. Family and NP notifications made. Careplans reviewed and updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the deficient practice. All residents were interviewed for any allegation of abuse, neglect, or	

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	During an interview on 3/15/24 at 9:35 a.m., the DON indicated on 3/3/24 at approximately 11:06 a.m., the DON was notified that Resident B became aggravated and shoved his way through other residents to get to the door that leads out to the smoking area. When Resident B was shoving his way through the other residents, Resident B made contact with Resident C's arm. The DON was not notified that Resident B threatened to kill Resident C. The clinical record for Resident B was reviewed on 3/14/24 at 10:42 a.m. The diagnoses included, but were not limited to, dementia, depression, and bipolar disorder. An Annual MDS (Minimum Data Set) assessment, dated 1/26/24, indicated Resident B was moderately cognitively impaired. A care plan, dated 2/16/21 and current through 5/5/24, indicated Resident B had homicidal ideations. Resident B threatened and physically assaulted a staff member. The interventions included, but were not limited to, provide 1-on-1 observation per physician's order, and monitor behavioral episodes and attempt to determine underlying causes. A Nurse Practitioner Progress note, dated 3/4/24 at 4:32 p.m., indicated spoke with Resident B via video visit regarding incident that occurred yesterday with Resident C. Resident B reported Resident C got on Resident B's nerves. A Psychiatric progress note, dated 3/11/24 at 11:22 p.m., indicated continued to apply supportive approach and active listening to help Resident B feel validated while addressing		misappropriation. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Education completed with all staff in each department on abuse reporting. 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)? ED/designee will complete interviews of 5 staff members to ensure facility nursing staff are identifying/assessing for problematic/dangerous behaviors. These audits will be completed 3x weekly for two (2) weeks; once weekly for two (2) weeks and then monthly for four (4) months. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee for a minimum of 6 months and then randomly thereafter.	

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	incident with another resident. Suggested that Resident B avoid being in the same proximity with the other resident to avoid future conflict. The clinical record for Resident C was reviewed on 3/15/24 at 1:16 p.m. The diagnoses included, but were not limited to, anorexia, alcohol abuse, and cirrhosis of the liver. A Quarterly MDS assessment, dated 2/12/24, indicated Resident C was not cognitively impaired. A progress note, dated 3/3/24 at 11:40 a.m., indicated Resident C was observed being verbally aggressive in a common area. Resident C was educated on importance of being respectful to peers while in common areas. The DON was notified. During an interview on 3/15/24 at 10:07 a.m., the Administrator indicated he was never made aware that Resident B threatened to kill Resident C nor that Resident B made contact with Resident C's arm. The staff chose to place Resident B on 1-on-1 observation on their own. The staff should have reported that Resident B threatened to kill Resident C and that Resident B made contact with Resident C's arm. On 3/14/24 at 10:00 a.m., the DON provided a copy of an undated facility policy, titled Abuse and Neglect and Misappropriation of Property, and indicated this was the current policy used by the facility. A review of the policy indicated each allegation of abuse will be identified and reported to the supervisor and investigated timely. The supervisor or designee will notify the DON and the Administrator of the allegation immediately. The Administrator will direct the investigation.			

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	This citation relates to Complaint IN00429727. 3.1-28(c)			