This visit was for the Investigation of Complaints IN00359147, IN00357454 and IN00358582.

Complaint IN00359147 - Substantiated. Federal/State deficiencies related to the allegations are cited at F695.

Complaint IN00357454 - Unsubstantiated. No deficiencies related to the allegations are cited.

Complaint IN00358582 - Substantiated. No deficiencies related to the allegations are cited.

Unrelated deficiencies are cited.

Survey dates: July 29, 30 and August 2, 2021

Facility number: 012225
Provider number: 155780
AIM number: 200983560

Census Bed Type:
SNF/NF: 72
Total: 72

Census Payor Type:
Medicare: 1
Medicaid: 62
Other: 9
Total: 72

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality Review completed on August 12, 2021.
**Statement of Deficiencies and Plan of Correction**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Regulatory or LSC Identifying Information</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 0695</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>483.25(i) Respiratory/Tracheostomy Care and Suctioning</td>
<td>F 0695 – CPAP Corrective action for the residents found to have been affected by the deficient practice: Resident E's CPAP mask immediately replaced. Corrective action taken for those residents having the potential to be affected by the same deficient practice: Resident E is the only resident with a CPAP mask at this time. CPAP masks have been preemptively ordered to be kept in stock for Resident E, and future residents that require usage. Measures/systematic changes put into place to ensure the deficient practice does not recur: DON/designee has in-serviced all licensed nursing staff on the facilities policy, identified as &quot;APAP, BIPAP, CPAP and VPAP Cleaning and Maintenance.&quot; Corrective actions to be</td>
<td>09/10/2021</td>
</tr>
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</table>

**Summary Statement of Deficiencies**

- **Respiratory Care and Suctioning**

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

Based on observation, interview, and record review, the facility failed to ensure a resident had clean and maintained equipment (BiPap and C-Pap) to assist resident with assistance with breathing for 1 of 1 resident reviewed for respiratory care. (Resident E)

Findings include:

- On 7/29/21 at 7:15 a.m., during observation of a medication pass, Resident E was observed to have a BiPap/C-pap (device to deliver two levels of pressures - inspiratory/breathing in and expiratory/breathing out) mask which was observed to be dingy in color and had no proper seal. Resident B was observed to be using his accessory muscles with each inspiration.

Interview with Resident E, at that time, indicated he transferred from the hospital and he has had this same mask set since admitting to the nursing facility on 5/6/21.

- Resident E's clinical record was review on 7/30/21 at 10:00 a.m. Diagnosis included, but were not limited to: chronic obstructive pulmonary disease.

- Resident E's CPAP mask immediately replaced.

- Residents having the potential to be affected by the same deficient practice:

  - Resident E is the only resident with a CPAP mask at this time.

  - CPAP masks have been preemptively ordered to be kept in stock for Resident E, and future residents that require usage.

- Measures/systematic changes put into place to ensure the deficient practice does not recur:

  - DON/designee has in-serviced all licensed nursing staff on the facilities policy, identified as "APAP, BIPAP, CPAP and VPAP Cleaning and Maintenance."

- Corrective actions to be...
An admission BIMS (brief interview for mental status), dated 5/13/21, indicated Resident E was 14 of 15, cognitively intact.

A physician's last order dated 7/12/21, with a revision date of 7/30/21 and a start date of 8/1/21, indicated to clean C-pap mask once a week.

A progress note, dated 5/6/21 at 11:40 p.m., indicate, "Resident [Resident E] arrived to facility via stretcher. Resident [Resident E] is AOX3 [alert and oriented times 3/person, place, and time]...Resident has C-PAP already on..."

During interview with the DON (Director of Nursing), on 7/29/21 at 8:30 a.m., indicated she was not aware of the condition of Resident E's C-Pap mask.

On 7/30/21 at 9:40 a.m., the DON provided a policy titled: A-Pap, BiPap, C-pap, V-Pap, cleaning and maintenance, dated 11/24/18, and indicated it was the current policy used by the facility. A review of the policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotion needs and concerns of the residents." Masks should be soft and pliable to fit over face comfortably, should be changed every 6 months or as manufacturer recommends, change if deterioration, cracks or tears are noted final rinse after cleaning with sterile water to prevent contaminants into lungs.

This Federal tag relates to Complaint IN00359147.

3.1-47(a)(6)
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

#### Identification Number:
- **MULTIPLE CONSTRUCTION**
- **00**
- **08/02/2021**

#### Name of Provider or Supplier
- **HOMESTEAD HEALTHCARE CENTER**
- **7465 MADISON AVE**
- **INDIANAPOLIS, IN 46227**

#### Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Regulatory or LSC identifying information</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Corrective Action</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 0761</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>§483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals</td>
<td>F 0761</td>
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<td>F761 – Medication Storage</td>
<td>09/10/2021</td>
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<td>§483.45(g) Labeling of Drugs and Biologicals</td>
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<td>Corrective action for the residents found to have been affected by the deficient practice:</td>
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<td>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</td>
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<td>No residents have been harmed by the alleged deficient practice.</td>
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<td>§483.45(h) Storage of Drugs and Biologicals</td>
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<td>Corrective action taken for those residents having the potential to be affected by the same deficient practice:</td>
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<td>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</td>
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<td>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</td>
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<td>Based on observation and interview, the facility failed to ensure all medication carts were locked and resident medication were properly stored in a locked medication storage room.</td>
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<td>Findings Include:</td>
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<td>On 7/29/21 at 5:20 a.m. to 6:00 a.m., indicated 1 box of Lovenox injectable, 1 blister pack of trazodone tablets, 1 blister pack of Risperdal tablets, and 1 over the counter (probiotic)</td>
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Medication carts audited to ensure proper storage of medications. Nurses inserviced on medication storage, and that medications are to be stored in a medication cart that is to be locked when a nurse is not present.

**Measures/systematic changes put into place to ensure the deficient practice does not recur:**

DON/designee has in-serviced all licensed nursing staff on the facilities policy, identified as, “Storage of Medications”, with emphasis on storage of medication to be kept in the nurses cart which is to be locked when not in use.

**Corrective actions to be monitored to ensure the deficient practice will not recur:**

Director of nursing/ designee will audit the medication cart rooms, and medication carts 5 times a week for x 12 weeks, then monthly for no less than 3 months or until compliance is met. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 0880</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>483.80(a)(1)(2)(4)(e)(f) Infection Prevention &amp; Control</td>
<td>§483.80 Infection Control</td>
<td>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</td>
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<td>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</td>
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<td>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based on the facility assessment conducted according to §483.70(e) and following accepted national standards;</td>
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<td>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</td>
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<td>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</td>
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<td>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</td>
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<td>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</td>
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</tbody>
</table>
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOMESTEAD HEALTHCARE CENTER</td>
<td>7465 MADISON AVE INDIANAPOLIS, IN 46227</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>X(4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X(5)) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td></td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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</tbody>
</table>

- **(iv)** When and how isolation should be used for a resident; including but not limited to:
  - (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
  - (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
- **(v)** The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
- **(vi)** The hand hygiene procedures to be followed by staff involved in direct resident contact.

- **§483.80(a)(4)** A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

- **§483.80(e)** Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

- **§483.80(f)** Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

Based on observation, interview, and record review, the facility failed to ensure glove usage during blood glucose monitoring, and multi use glucometer were properly disinfected between residents for 6 of 6 residents reviewed for blood sugar readings (Resident C, E, F, M, Q) and the facility failed to ensure a facial mask was worn covering the nose and mouth at all times to

F 0880  Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: LPN 1, LPN 2, RN 1 have been educated on proper cleaning of
prevent the spread of COVID-19 for 1 of 1 random observation.

Findings include:

1) Observation, on 7/29/21 at 5:45 a.m., LPN 1 was observed to pick up the glucometer without gloves on, did not sanitize it first, inserted the glucose strip, proceeded to obtain blood sample from Resident C without gloves, and was not observed sanitizing the glucose monitor after use.

Observation on, 7/29/21 at 7:15 a.m., of insulin preparation, administration, and follow-up glucose monitor cleaning, LPN 2 was observed cleaning the glucose meter before and after each resident with alcohol pads. Interview with LPN 1, at that time, indicated only one glucometer was on the cart and was used for residents C, E, F, M and Q.

On 7/29/21 at 11:30 a.m., RN 1 was observed cleaning the glucometer with alcohol pads before and after getting Resident M's blood sugar reading.

Resident C's clinical record was reviewed on 7/30/21 at 1:00 p.m. Diagnoses included, but were not limited to: diabetes.

Resident E's clinical record was reviewed on 7/30/21 at 1:30 p.m. Diagnoses included, but were not limited to: diabetes.

Resident F's clinical record was reviewed on 7/30/21 at 1:50 p.m. Diagnoses included, but were not limited to: diabetes.

Resident M's clinical record was reviewed on

3) IDENTIFICATION NUMBER: 155780
4) ID PREFIX TAG
5) ID PREFIX TAG
6) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
7) COMPLETION DATE
7/30/21 at 2:10 p.m. Diagnoses included, but were not limited to: diabetes.

Resident Q's clinical record was reviewed on 7/30/21 at 2:30 p.m. Diagnoses included, but not limited to: diabetes.

On 8/2/21 at 7:30 a.m., the DON provided a policy titled: Cleaning and Disinfection of Glucose Meter, revised 10/8/2018, and indicated it was the current policy used by the facility. A review of this policy indicated proper PPE (personal protective equipment) are to be used when providing cleaning and disinfecting of glucose devices. Disinfect the glucometer immediately before re-use with an EPA approved wipe that is effective against HIV, hepatitis C, and hepatitis B. Each medication cart should have at least 2 glucose meters that are shared by residents. One meter may be in use while the other meter is going under disinfection with the antimicrobial wipe for wet-contact time per manufactures recommendations.

On 8/2/21 at 7:30 a.m., the DON provided a policy titled: Facility policy Blood Glucose Point of Care Testing, revised 5/23/18, and indicated it was the current policy used by the facility. A review of this policy indicated hand hygiene and donning gloves is to be performed prior to obtaining a blood sugar stick.

2) On 7/30/21 at 5:30 a.m. to 6:00 a.m., observed LPN 1 walking down from dining room to the west wing nurses station without a mask in place that covered their nose and mouth, and proceeded to obtain a blood sugar from a resident (C).

Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:
A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate.

How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:
After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control Practices are maintained, the following monitoring will be implemented.
1. The IP nurse/DON/Designee will monitor each solution and
Review of CDC guidance, dated March 4, 2021, indicated masks are important to keep patients and healthcare personnel (HCP) healthy and safe. CDC's infection prevention and control guidance applies to all settings where healthcare is delivered.

3.1-18(b)