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	05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 IN00353686 and IN00353724. Complaint IN00353686 - Unsubstantiated due to lack of evidence. Complaint IN00353724 - Substantiated. Federal/State deficiencies related to the allegations are cited at F694 and F760. Survey dates: May 25 and 26, 2021 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 5 Medicaid: 85 Other: 11 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on May 28, 2021.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is 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 annual survey on May 25th-26th 2021. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to request a desk review for this survey.	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to ensure an Intravenous (IV) Peripherally Inserted Central Catheter (PICC) was assessed upon admission and flushed prior to and following intravenous antibiotic administration for 1 of 3 residents reviewed for intravenous therapy. Findings include: During an interview, on 5/25/21 at 3:00 P.M., Resident B indicated she had been transferred to the current nursing home from the facility's sister facility (a company owned by the same parent company and considered a subsidiary of the larger company) on 5/10/21. She had been recovering from an infection following a heart valve surgery. While at the sister facility, she received IV antibiotics. During the admission process to the current nursing home, her PICC had not been assessed. After admission to the current nursing home, for 2 days, her PICC had not been flushed. On 5/25/21 at 3:00 P.M., the resident was observed to have a PICC in place on the inside of her upper right arm. During an interview, on 5/26/21 at 3:20 P.M., the resident indicated she had not had any antibiotic treatment that day, and the PICC line had not been flushed. On 5/26/21 at 3:25 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, endocarditis (inflammation of the inner lining of the heart, usually caused by	F 0694	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B was not harmed by the alleged deficient practice. Resident B has had her IV site assessed and appropriate orders are in place for flushing the IV site. Resident B's physician has been notified of the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** An audit was conducted by the DON/designee on all residents that have intravenous orders to ensure each resident has appropriate assessment orders, flush orders, and appropriate medication orders. Any resident found out of compliance with the facility intravenous management policy has been corrected and their plan of care has been updated to reflect accuracy. Facility audit completed to ensure all intravenous lines have orders for flushes before and after intravenous medication administration, medications correct and followed per physician's orders, and site is observed per protocol.	06/11/2021

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	bacteria) and sepsis (a condition that occurs when the body's response to an infection damages its own tissues). The 5 day Minimum Data Set assessment, dated 5/17/21, indicated the resident had no cognitive impairment. The Clinical Admission Evaluation, dated 5/10/21, 16:59 (4:59 P.M.), indicated no PICC was observed, and the resident was not receiving antibiotics. The Nursing Skilled Evaluation, dated 5/14/21, 19:16 (7:16 P.M.), indicated no PICC was observed. A physician order from the facility's sister facility, start date 4/20/21 and end date 5/26/21, indicated, "ceFAXolin Sodium-Dextrose Solution Reconstituted 2-3GM [gram]-% (50ML[milliliter]) [an antibiotic used to treat certain infections caused by bacteria] Use 2 gram intravenously every 8 hours for endocarditis until 5/26/21 23:59 [11:59 P.M.]." A physician order from the current facility, revision date 5/17/21, indicated, "ceFAXolin Sodium-Dextrose Solution Reconstituted 2-3GM-%(50ML) Use 2 gram intravenously every 8 hours for endocarditis until 5/26/21 23:59 [11:59 P.M.]". Physician's orders from the current facility, revision date 5/19/21, indicated, "PICC-flush each lumen [a hollow channel through which medication may be administered] not in use with 10cc [cubic centimeter] of saline every 8 hours and prn [as needed]...PICC-flush with 10cc of saline post infusion...PICC-flush with 10cc of saline prior to infusion."		**Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/designee has inserviced all licensed nursing staff on the facilities policy identified as, “Physician Orders” with emphasis on intravenous orders. DON/designee has inserviced all licensed nursing staff on the facilities new admission assessment expectations with emphasis on assessing for intravenous lines. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Director of nursing or designee will audit all residents upon admission 5 times per week to ensure medication orders are implemented per physician orders and the appropriate assessments have been completed including assessment for intravenous lines. Director of nursing or designee will audit 5 residents every week for 4 weeks, then 5 residents 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	

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	The Medication Administration Record indicated the resident had not received IV antibiotic administration on the following scheduled dates and times: 5/11/21 0600 (6:00 A.M.), 1400 (2:00 P.M.), 2200 (10:00 P.M.) 5/12/21 0600, 1400, 2200 5/13/21 0600 5/26/21 0600, 1400 The Medication Administration Record, dated 5/1/21 through 5/31/21, lacked documentation the resident's PICC had been flushed every 8 hours, prior to infusion, and post infusion while at the facility. During an interview, on 5/26/21 at 2:00 P.M., the Director of Nursing indicated the clinical record lacked documentation the resident had received IV antibiotics on 5/11/21, 5/12/21, and 5/13/21 6:00 A.M., and there was no documentation to indicate the resident's PICC had been flushed every 8 hours, prior to infusion, and post infusion. The 5/10/21 Admission Evaluation indicated no PICC was observed, and the resident received no antibiotics. The 5/14/21 Nursing Skilled Evaluation indicated no PICC was observed. The continuity of care relative to the resident's IV antibiotic treatment was not maintained upon admission. During an interview, on 5/26/21 at 3:30 P.M., Licensed Practical Nurse 1 indicated she was uncertain if the resident had received her scheduled morning IV antibiotics, and according to the clinical record, she had not. The resident had not received her 2:30 P.M. IV antibiotics, as it appeared to her the IV antibiotic order had been accidentally removed from the order list.		QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	The PICC was to be flushed prior to and following IV antibiotic administrations. This Federal tag relates to Complaint IN00353724. 3.1-47(a)(2)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure intravenous antibiotics were administered as ordered for 1 of 3 residents reviewed for intravenous medication therapy. Findings include: During an interview, on 5/25/21 at 3:00 P.M., Resident B indicated she had been transferred to the current nursing home from the facility's sister facility (a company owned by the same parent company and considered a subsidiary of the larger company) on 5/10/21. She had been recovering from an infection following a heart valve surgery. While at the sister facility, she received IV antibiotics. During the admission process to the current nursing home, her PICC had not been assessed. After admission to the current nursing home she had not received IV antibiotics for 2 days. On 5/25/21 at 3:00 P.M., the resident was observed to have a PICC in place on the inside of her upper right arm. During an interview, on 5/26/21 at 3:20 P.M., the	F 0760	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B was not harmed by the alleged deficient practice. Resident B's medications have been reconciled to reflect the physician's orders and are being administered appropriately. Resident B's physician was notified of the missed doses and orders were obtained to extend the antibiotic dose until the therapy was complete. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** The DON/designee has completed an audit on all residents in the facility. Any resident identified as having IV antibiotics has been reviewed to validate that the medication has been given per the physician order. Any resident	06/11/2021

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	resident indicated she had not had any antibiotic treatment that day, and the PICC line had not been flushed. On 5/26/21 at 3:25 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, endocarditis (inflammation of the inner lining of the heart, usually caused by bacteria) and sepsis (a condition that occurs when the body's response to an infection damages its own tissues). The 5 day Minimum Data Set assessment, dated 5/17/21, indicated the resident had no cognitive impairment. The Clinical Admission Evaluation, dated 5/10/21, 16:59 (4:59 P.M.), indicated no PICC was observed, and the resident was not receiving antibiotics. The Nursing Skilled Evaluation, dated 5/14/21, 19:16 (7:16 P.M.), indicated no PICC was observed. A physician order from the facility's sister facility, start date 4/20/21 and end date 5/26/21, indicated, "ceFAXolin Sodium-Dextrose Solution Reconstituted 2-3GM [gram]-% (50ML[milliliter]) [an antibiotic used to treat certain infections caused by bacteria] Use 2 gram intravenously every 8 hours for endocarditis until 5/26/21 23:59 [11:59 P.M.]". A physician order from the current facility, revision date 5/17/21, indicated, "ceFAXolin Sodium-Dextrose Solution Reconstituted 2-3GM-%(50ML) Use 2 gram intravenously every 8 hours for endocarditis until 5/26/21 23:59 [11:59 P.M.]". Physician's orders from the current facility,		found to have missed doses has had their physician and family notified and new orders obtained to extend the dose of the antibiotic to ensure the antibiotic therapy is complete. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/designee has inserviced all licensed nursing staff on the facilities policy identified as, “Physician Orders” and “Medication Administration” with emphasis on IV antibiotic administration. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Director of nursing or designee will audit all residents on IV antibiotic therapy 5 times per week to ensure medication orders are implemented per physician orders. Director of nursing or designee will audit 5 residents every week for 4 weeks, then 5 residents 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	

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	revision date 5/19/21, indicated, "PICC-flush each lumen [a hollow channel through which medication may be administered] not in use with 10cc [cubic centimeter] of saline every 8 hours and prn [as needed]...PICC-flush with 10cc of saline post infusion...PICC-flush with 10cc of saline prior to infusion". The Medication Administration Record indicated the resident had not received IV antibiotic administration on the following scheduled dates and times: 5/11/21 0600 (6:00 A.M.), 1400 (2:00 P.M.), 2200 (10:00 P.M.) 5/12/21 0600, 1400, 2200 5/13/21 0600 5/26/21 0600, 1400 During an interview, on 5/26/21 at 2:00 P.M., the Director of Nursing indicated the clinical record lacked documentation the resident had received IV antibiotics on 5/11/21, 5/12/21, and 5/13/21 6:00 A.M. The 5/10/21 Admission Evaluation indicated no PICC was observed and the resident received no antibiotics. The 5/14/21 Nursing Skilled Evaluation indicated no PICC was observed. The continuity of care relative to the resident's IV antibiotic treatment was not maintained upon admission. During an interview, on 5/26/21 at 3:30 P.M., Licensed Practical Nurse 1 indicated she was uncertain if the resident had received her scheduled morning IV antibiotics, and according to the clinical record, she had not. The resident had not received her 2:30 P.M. IV antibiotics, as it appeared to her the IV antibiotic order had been accidentally removed from the order list.		QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	The PICC was to be flushed prior to and following IV antibiotic administrations. This Federal tag relates to Complaint IN00353724. 3.1-48(c)(2)			