

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Homestead Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7465 Madison Ave Indianapolis, IN 46227	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>44849</p> <p>Based on observation, interview, and record review, the facility failed to notify the physician when staff found a large knife in the drawer of a resident with a history of suicidal ideations and suicidal attempts for 1 of 3 residents reviewed. (Resident B)</p> <p>Finding includes:</p> <p>During an interview 7/17/24 at 8:19 a.m., CNA 1 indicated, on 7/2/24 at approximately 12:15 a.m., Resident B asked CNA 1 to count some money that she kept in a drawer. When CNA 1 opened the drawer CNA 1 saw a large butcher knife. CNA 1 removed the knife and notified LPN 1 and the DON (Director of Nursing). The DON told CNA 1 to put the knife in the medication room and the DON would take care of it. CNA 1 put the knife in the medication room next to a pink plastic wash basin.</p> <p>On 7/17/24 at 8:32 a.m., during an observation of the medication room a pink plastic wash basin was sitting in a cabinet above the sink. Under the pink basin, observed a large metal knife with a dark handle. The blade on the knife was approximately 10 inches long and approximately 2 inches tall.</p> <p>The clinical record for Resident B was reviewed on 7/17/24 at 11:00 a.m. The diagnoses included, but were not limited to, major depressive disorder with psychotic symptoms, panic disorder, assaultive behavior, suicidal ideation, and post-traumatic stress disorder.</p> <p>A Quarterly MDS (Minimum Data Set) assessment, dated 5/11/24, indicated Resident B was cognitively intact with moderate depression.</p> <p>A History and Physical, dated 12/27/23, indicated Resident B presented from an outside hospital after presenting to them after an attempted suicide by overdose at a hotel.</p> <p>A Psychiatric Progress Note, dated 1/28/24, indicated Resident B was seen for reevaluation of history of suicide attempts, suicidal ideation, agitation, and physical aggression. Resident B overdosed on an antidepressant on 12/22/23. Resident B overdosed on a handful of antidepressant per Resident B's report because she wanted to sleep and not wake up again after having an argument with her daughter. Resident B reported a history of four suicide attempts and a history of multiple psychiatric hospitalizations in the past.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Hospital History and Physical, dated 2/16/24, indicated Resident B was having thoughts of self-harm. She was very impulsive, and Resident B had insomnia.</p> <p>A facility progress note, dated 2/14/24 at 10:56 a.m., indicated Resident B stated she was not happy with the medication regimen for depression and anxiety. Resident B wanted an antidepressant three times daily. Educated Resident B that was not the ordered dose. Resident B stated she had been on it for years and knew how to take it. Resident B previously had a psychiatric visit for attempting to overdose on the antidepressant.</p> <p>The clinical record for Resident B lacked documentation of physician notification when a large knife was found in her drawer on 7/2/24.</p> <p>During an interview on 7/17/24 at 12:38 p.m., the DON indicated the physician should have been notified when the knife was found in Resident B's room.</p> <p>On 7/16/24 at 11:20 a.m., the Administrator provided a copy of an undated facility policy, titled Behavior Management General, and indicated this was the current policy used by the facility. A review of the policy indicated it is the policy of the facility to identify and safely manage resident who may present a danger to themselves or others. Contact the physician for new onset or unusual behaviors.</p> <p>This citation relates to Complaint IN00438670.</p> <p>3.1-5(a)(2)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse to the state health department for 1 of 3 allegations reviewed. A resident with a history of IV (intravenous) drug use made an allegation that a nurse supplied heroin to the resident. (Resident C)</p> <p>Finding includes:</p> <p>During an interview on [DATE] at 5:22 a.m., Resident C indicated she remembered being sent to the emergency department at night on [DATE]. Resident C was told she required CPR (cardiopulmonary resuscitation) and Narcan (medication used to reverse opioid overdose). Resident C snorted heroin (an opioid schedule 1 controlled substance). Resident C got the heroin from someone at the facility but would not say who she got it from because she already told the Administrator and DON (Director of Nursing).</p> <p>During an interview on [DATE] at 6:27 a.m., the Administrator indicated Resident C required CPR in early July and was sent to the emergency department. The facility believed she had taken illegal drugs that night. Initially, Resident C would not tell the facility where she got the drugs. Then on [DATE] Resident C told him she got the drugs from LPN 1. LPN 1 was suspended and the Administrator started an investigation.</p> <p>The clinical record for Resident C was reviewed on [DATE] at 11:21 a.m. An Admission MDS (Minimum Data Set) assessment, dated [DATE], indicated Resident C was moderately cognitively impaired.</p> <p>During an interview on [DATE] at 12:42 p.m., the Administrator indicated he did not think the allegation made by Resident C against LPN 1 needed to be reported to the state health department. The investigation into the allegation was ongoing.</p> <p>On [DATE] at 11:05 a.m., the Administrator provided a copy of an undated facility policy, titled Occurrence Incident Reporting, and indicated this was the current policy used by the facility. A review of the policy indicated a level 2 incident is considered more serious or an incident that resulted in harm and should be reported as applicable to state authorities.</p> <p>This citation relates to Complaint IN00438670.</p> <p>3XXX,d+[DATE](c)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>44849</p> <p>Based on observation, interview, and record review, the facility failed to implement a care plans with person-centered interventions for a resident diagnosed with suicidal ideations and a history of trauma and suicide attempts for suicidal ideations and suicide attempts for 1 of 3 residents reviewed. Staff found a large knife in the resident's drawer during care. (Resident B)</p> <p>Finding included:</p> <p>During an interview 7/17/24 at 8:19 a.m., CNA 1 indicated on 7/2/24 at approximately 12:15 a.m., Resident B asked CNA 1 to count some money that she kept in a drawer. When CNA 1 opened the drawer CNA 1 saw a large butcher knife. CNA 1 removed the knife and notified LPN 1 and the DON (Director of Nursing). The DON told CNA 1 to put the knife in the medication room and the DON would take care of it. CNA 1 put the knife in the medication room next to a pink plastic wash basin.</p> <p>On 7/17/24 at 8:32 a.m., during an observation of the medication room a pink plastic wash basin was sitting in a cabinet above the sink. Under the pink basin, observed a large metal knife with a dark handle. The blade on the knife was approximately 10 inches long and approximately 2 inches tall.</p> <p>The clinical record for Resident B was reviewed on 7/17/24 at 11:00 a.m. The diagnoses included, but were not limited to, major depressive disorder with psychotic symptoms, panic disorder, assaultive behavior, suicidal ideation, and post-traumatic stress disorder.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 5/11/24, indicated Resident B was cognitively intact with moderate depression.</p> <p>A History and Physical, dated 12/27/23, indicated Resident B presented from an outside hospital after presenting to them after an attempted suicide by overdose at a hotel.</p> <p>A Psychiatric Progress Note, dated 1/28/24, indicated Resident B was seen for reevaluation of history of suicide attempts, suicidal ideation, agitation, and physical aggression. Resident B overdosed on an antidepressant on 12/22/23. Resident B overdosed on a handful of antidepressant per Resident B's report because she wanted to sleep and not wake up again after having an argument with her daughter. Resident B reported a history of four suicide attempts and a history of multiple psychiatric hospitalizations in the past.</p> <p>A Hospital History and Physical, dated 2/16/24, indicated Resident B was having thoughts of self-harm. She was very impulsive and Resident B had insomnia.</p> <p>A facility progress note, dated 2/14/24 at 10:56 a.m., indicated Resident B stated she was not happy with the medication regimen for depression and anxiety. Resident B wanted an antidepressant three times daily. Educated Resident B that was not the ordered dose. Resident B stated she had been on it for years and knew how to take it. Resident B previously had a psychiatric visit for attempting to overdose on the antidepressant.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The clinical record for Resident B lacked a care plan with person-centered interventions for suicidal ideations.</p> <p>The clinical record for Resident B lacked a care plan with person-centered interventions for suicide attempts.</p> <p>During an interview on 7/17/24 at 12:38 p.m., the DON indicated Resident B should have had care plans with person-centered interventions for suicidal ideations and suicide attempts.</p> <p>On 7/17/24 at 11:20 a.m., the Administrator provided a copy of an undated policy, titled Behavior Management General, and indicated this was the current policy used by the facility. A review of the policy indicated complete a care plan, update with changes and or new behaviors. Include specific interventions.</p> <p>This citation relates to Complaint IN00438670.</p> <p>3.1-43(a)(1)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849</p> <p>Based on interview and record review, the facility administration failed to maintain the mental and physical wellbeing of residents for 1 of 3 residents reviewed. An allegation of abuse was made against a nurse but was not reported to the state health department and the nurse was not reported to the police. (Resident C)</p> <p>Finding included:</p> <p>During an interview, on [DATE] at 5:22 a.m. Resident C indicated she remembered being sent to the emergency department at night on [DATE]. Resident C was told she required CPR (cardiopulmonary resuscitation) and Narcan (medication used to reverse opioid overdose). Resident C snorted heroin (an opioid schedule 1 controlled substance). Resident C got the heroin from someone at the facility but would not say who she got it from because she already told the Administrator and DON (Director of Nursing).</p> <p>During an interview on [DATE] at 6:27 a.m., the Administrator indicated Resident C required CPR in early July and was sent to the emergency department. The facility believed she had taken illegal drugs that night. Initially, Resident C would not tell the facility where she got the drugs. Then on [DATE], Resident C told him she got the drugs from LPN 1 (Licensed Practical Nurse). LPN 1 was suspended, and I started an investigation.</p> <p>On [DATE] at 11:05 a.m., the Administrator provided a copy of an Indianapolis Metro Police Department Southeast District Information Card, dated [DATE], and indicated this was the police report regarding the allegation made by Resident C against LPN 1. A review of the document indicated incident type: property disposal.</p> <p>On [DATE] at 11:05 a.m., the Administrator provided a copy of an undated facility policy, titled Occurrence Incident Reporting, and indicated this was the current policy used by the facility. A review of the policy indicated a level 2 incident is considered more serious or an incident that resulted in harm and should be reported as applicable to state authorities.</p> <p>This citation relates to Complaint IN00438670.</p> <p>3XXX,d+[DATE](q)</p>		