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	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Healthcare Center	7465 Madison Ave Indianapolis, IN 46227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 21662 Based on record review and interview, the facility failed to ensure resident rights were maintained related to being able to go outside in the facility courtyard unsupervised during non-smoking times for 5 of 5 residents reviewed for resident rights. (Residents F, Resident G, Resident H, Resident J, Resident K) Findings Include: 1. During an interview with Resident K on 8/1/24 at 1:00 p.m., he indicated could only go outside in the courtyard during smoking times. He indicated this changed after there was a fight in the gazebo and the Executive Director would not let anyone go out without supervision. Those residents who got in the fight aren't here anymore so residents should be able to go outside. He stated I don't want to be inside all the time with TV. He wanted to go outside and enjoy the beautiful weather. He indicated if you signed out you could go off the property to smoke. 2. During an interview with Resident F on 8/1/24 at 1:14 p.m., he indicated he had been informed by facility staff he was not allowed to go outside to the courtyard to get fresh air at any time unless he was supervised. He stated the heat helps my arthritis pain. The record for Resident F was reviewed on 8/1/24 at 1:43 p.m. A Quarterly Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated the resident was cognitively intact and felt it was very important to go outside and get fresh air when the weather was good. A care plan, dated 7/23/24, indicated the resident had a concern of psychosocial well-being with a goal that the resident would report decreased feelings of social isolation by next review. Interventions included, but not limited to, observe resident for signs and symptoms of new onset of psychosocial issues and initiate resident specific interventions. 3. During an interview on 8/1/24 at 1:08 p.m., Resident G indicated she could not go outside except during smoking times without supervision. Facility staff had informed her of this a few weeks ago. She stated it's just not right. The record for Resident G was reviewed on 8/1/24 at 1:49 p.m. A Quarterly MDS assessment, dated 5/10/24, indicated the resident was cognitively intact. An MDS assessment, dated 4/10/24, indicated the resident felt it was very important to go outside to get fresh air when the weather was good. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, dated 7/30/24, indicated the resident had a problem of at risk for impaired psychosocial well-being related to negative interactions with peers with a goal the resident will report maintained/improved psychosocial well-being. 4. During an interview with Resident H on 8/1/24 at 1:15 p.m., he indicated he was not allowed to go outside unless it was smoking time or his wife was with him. He was newly admitted and was informed this on admission. The record for Resident H was reviewed on 8/1/24 at 1:52 p.m. An Admission MDS assessment, dated 7/24/24, indicated the resident was cognitively intact and it was very important to go outside to get fresh air when the weather was good. A care plan, dated 7/22/24, indicated at risk for psychosocial well being with a goal the resident would report decreased feelings of social isolation. 5. During an interview with Resident J on 8/1/24 at 1:33 p.m., he indicated he cannot go outside in the courtyard unless it is supervised smoking times. The rules had changed so often it was hard to keep up. The record for Resident J was reviewed on 8/1/24 at 1:58 p.m. An MDS assessment, dated 7/24/24, indicated the resident was cognitively intact and felt it was very important to go outside to get fresh air when the weather was nice. During an interview with CNA 6 on 8/1/24 at 1:33 p.m., she indicated residents cannot go outside in the courtyard at any time unless they are supervised. During an interview with the Executive Director on 8/1/24 at 2:25 p.m., he indicated the residents had designated smoking times and could be outside during those times. Residents were not allowed in the courtyard unless they were supervised, even if they were cognitively intact. There had been a resident to resident altercation out there so their could not be large groups outside without supervision. 3.1-3(u)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44849 Based on observation, interview, and record review, the facility failed to notify the state health department of an injury of unknown origin for 1 of 3 residents reviewed for abuse. Staff observed a scrape with swelling and bruising to the nose and left eye but did not know how the injury occurred. (Resident M) Finding included: The clinical record for Resident M was reviewed on 8/1/24 at 1:30 p.m. The diagnoses included, but were not limited to, autistic disorder, intellectual disability, and epilepsy. A Quarterly MDS (Minimum Data Set) assessment, dated 7/13/24, indicated Resident M was severely cognitively impaired. A physician's telephone order, dated 7/24/24, indicated x-ray of nose. The order was discontinued. A physician's verbal order, dated 7/25/24 at approximately 3:00 a.m., indicated x-ray of nose due to swelling, mass, lump. An x-ray result, dated 7/25/24 at 9:45 a.m., indicated exam of nasal bones for nasal pain. There was no fracture, dislocation, nor bony destructive lesion noted. Paranasal air cells demonstrate no specific abnormality. No acute traumatic osseous abnormality. A progress note, dated 7/25/24 at 1:17 p.m., indicated the DON observed Resident M bump into a wall while ambulating. The Nurse Practitioner was notified and gave a new physician's order for an x-ray. The progress note was entered into the electronic medical record on 8/1/24 at 1:18 p.m. (7 days after the x-ray was ordered) A weekly skin assessment, dated 7/29/24 at 11:27 a.m., indicated Resident M did not refuse a skin assessment. Resident M did not have any skin alterations noted. The weekly skin assessment was completed by the DON. During an interview on 8/1/24 at 1:43 p.m., the Activity Director indicated Resident M looked like he had a broken nose because his nose was swollen, cut, and bruised. The Activity Director couldn't remember the exact date she first saw the injury but was sure it was before Resident M moved to the 600 hall on 7/24/24. During an interview on 8/1/24 at 2:17 p.m., the Administrator indicated, during the morning clinical meeting, on 7/25/24, he was made aware of a scratch and some discoloration on Resident M's nose. The nurse got a physician's order for an x-ray of Resident M's nose to make sure there was no further injury. The Administrator needed to speak with the DON to find out if the DON found anyone that knew what happened. This would have been considered an injury of unknown origin. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 2:34 p.m., the DON indicated on the morning of 7/25/24, she was going outside to take a break when she watched Resident M bump into a wall. It was possible that Resident M's nose had swelling, a cut, and bruising before the DON saw Resident M bump into the wall. The DON may not have been notified of any injury prior to that. The DON should have documented the injury and entered a progress note the morning she watched Resident M bump into the wall, so the medical record was accurate. During an interview on 8/1/24 at 2:54 p.m., CNA 10 indicated on 7/24/24 at approximately 3:00 p.m., Resident M's left eye was black, his nose was swollen, cut, and bruised. Resident M's nose looked crooked like it was broken. CNA 10 reported this to RN 9 but didn't feel like the injury was taken seriously. During an observation on 8/2/24 at 7:30 a.m., Resident M was sitting in his room. Observed a small scratch and discoloration along the bridge and to the left side of Resident M's nose. On 8/2/24 at 11:15 a.m., the Corporate Nurse provided a copy of an undated facility policy, titled Indiana Abuse and Neglect and Misappropriation of Property, and indicated this was the current policy used by the facility. A review of the policy indicated all allegations involving injuries of unknown injury will be reported to the state. 3.1-28(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 44849 Based on observation, interview, and record review, the facility failed to investigate an injury of unknown origin when a resident was observed to have a scrape on his nose with swelling and bruising on his nose and left eye for 1 of 3 residents reviewed for abuse. (Resident M) Finding includes: The clinical record for Resident M was reviewed, on 8/1/24 1:30 p.m. The diagnoses included, but were not limited to, autistic disorder, intellectual disability, and epilepsy. A quarterly MDS (Minimum Data Set) assessment, dated 7/13/24, indicated Resident M was rarely/never understood. A physician's phone order, dated 7/24/24, indicated x-ray of the nose. A physician's verbal order, dated 7/25/24, indicated x-ray of nose due to swelling, mass, lump. An x-ray result, dated 7/25/24 at 9:45 a.m., indicated exam of nasal bones for nasal pain. There was no fracture, dislocation, nor bony destructive lesion noted. Paranasal air cells demonstrate no specific abnormality. No acute traumatic osseous abnormality. A progress note, dated 7/25/24 at 1:17 p.m., indicated the DON (Director of Nursing) observed Resident M bump into a wall while ambulating. The Nurse Practitioner was notified and gave a new physician's order for an x-ray. This progress note was entered into the electronic medical record on 8/1/24 at 1:18 p.m. (7 days after the x-ray was ordered) During an interview on 8/1/24 at 2:17 p.m., the Administrator indicated, during the morning clinical meeting, on 7/25/24, he was made aware of a scratch and some discoloration on Resident M's nose. The nurse got a physician's order for an x-ray of Resident M's nose to make sure there was no further injury. The Administrator needed to speak with the DON (Director of Nursing) to find out if the DON found anyone that knew how the scrape, swelling, and bruising to Resident M's nose happened. This would have been considered an injury of unknown origin. During an interview on 8/1/24 at 2:34 p.m., the DON indicated, on the morning of 7/25/24, she was going outside to take a break when she watched Resident M bump into a wall. The DON may not have been made aware of the scrape with swelling and bruising to Resident M's nose and eye prior to Resident M bumping the wall. The DON should have documented the injury and entered a progress note the morning she watched Resident M bump into the wall, so the medical record was accurate. During an interview on 8/1/24 at 2:54 p.m. CNA 10 (Certified Nursing Aide) indicated, on 7/24/24 at approximately 3:00 p.m. Resident M's left eye was black, his nose was swollen, cut, and bruised. Resident M's nose looked crooked like it was broken. CNA 10 reported this to RN 9 but didn't feel like the injury was taken seriously. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/2/24 at 7:30 a.m., Resident M was sitting in his room. Observed a small scratch and discoloration along the bridge and to the left side of Resident M's nose. On 8/2/24 at 11:15 a.m., the Corporate Nurse provided a copy of an undated facility policy, titled Indiana Abuse and Neglect and Misappropriation of Property, and indicated this was the current policy used by the facility. A review of the policy indicated all allegations involving injuries of unknown origin will be investigated. On 8/2/24 at 11:35 a.m., the facility had not identified the source of the cut, swelling, and bruising to Resident M's nose and left eye by survey exit. 3.1-28(d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 44849 Based on interview and record review, the facility failed to provide the written bed hold policy prior to leaving the facility or at any time after for 2 of 3 residents reviewed for transfers and discharges. (Resident D, Resident E) Finding included: 1. The clinical record for Resident D was reviewed on 7/31/24 at 11:40 a.m. The diagnoses included, but were not limited to, end stage renal disease, fistula of intestine, and dysphagia. A quarterly MDS (Minimum Data Set) assessment, dated 4/24/24, indicated Resident D was moderately cognitively impaired. A progress note, dated 7/27/24 at 9:40 p.m., indicated Resident D called 911 and asked to be sent to the hospital. Resident D complained of nausea and vomiting and pain at his port site. The clinical record lacked documentation that the written bed hold policy was provided to the resident at the time of transfer or anytime after. During an interview on 7/31/24 at 3:24 p.m., the DON (Director of Nursing) indicated when Resident D called 911 so he could go to the hospital, the staff should have provided a bed hold policy to Resident D before he left the facility. If the nurse sent the bed hold policy, the nurse should have documented a progress note that indicated the document was sent. 21662 2. The record for Resident E was reviewed on 7/31/24 at 2:02 p.m. The diagnosis included, but was not limited to, wounds on bilateral thumbs. A progress note, dated 7/27/24 at 7:20 p.m., indicated Resident E was to sent to the hospital per his request. He complained of bilateral hand pain, inflammation, and redness at the site. The record lacked documentation the resident was given the written bed-hold policy information at time of transfer or at any time after. The resident was his own responsible party. On 7/31/24 at 2:20 p.m., the Administrator provided a copy of an undated facility policy, titled Transfer and Discharge Policy, and indicated this was the current policy used by the facility. A review of the policy indicated when an acute transfer occurs, present the acute transfer letter to the resident prior to the transfer. Discuss the transfer and transfer letter with the resident or responsible party if the resident is incapable of understanding or the transfer is an emergency. The resident's bed will be held while the facility representative contacts the resident or responsible party to discuss bed hold. This Federal tag relates to Complaint IN00439096. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-12(a)(25) 3.1-12(a)(26)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44849 Based on observation, interview, and record review, the facility failed to ensure medications were secured and labeled for 1 of 1 medication rooms and 1 of 1 random observations. Controlled substances were not double locked and TPN was not labeled and dated. (Resident P, Resident D) Finding included: 1. During an observation on 8/1/24 at 1:38 p.m., an unlocked medication refrigerator was inside the South Medication Room. Inside the refrigerator, observed a clear plastic bag sitting in a pink bin with other medications. The label on the bag, dated 7/30/24, indicated Resident P with a prescription number, Ativan (a controlled anti-anxiety/anti-seizure medication) 2 mg/ml (milligrams/milliliter), inject 0.5 ml (1 mg) intramuscularly (into the muscle) as needed for seizures. The bag contained 5 capped 1 ml vials of liquid. At that time, QMA 1 indicated the Ativan injections should be locked in the lock box in the refrigerator not laying in the pink bin with the other medications. On 8/1/24 at 9:11 a.m., the Administrator provided a copy of a policy, dated 9/2018, titled Storage of Medications, and indicated this was the current policy used by the facility. A review of the policy indicated controlled substances that require refrigeration are stored within a locked box attached to the inside of the refrigerator. 2. During an observation on 7/31/24 at 9:09 a.m., a clear plastic bag that contained 1400 ml of yellowish liquid was hanging on a pole in Resident D's room. The bag was labeled Resident D with a prescription number, TPN (total parental nutrition) 2:1, total bag volume 1660 ml, volume to be infused 1560 ml, and instructions to infuse 1560 ml over 24 hours. The bag of TPN was not labeled with any initials nor the date it was hung. During an interview on 7/31/24 at 9:25 a.m., the DON (Director of Nursing) indicated Resident D's TPN should have been labeled with the nurses initials and dated for the date it was administered. The TPN should have been taken down when Resident D went out to the hospital, on 7/27/24. (4 days before the observation and interview) On 8/2/24 at 11:35 a.m., the facility was unable to provide a policy regarding labeling medications. 3.1-25(j) 3.1-25(m) 3.1-25(n)