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	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Healthcare Center	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 31085 Based on interview and record review, the facility failed to ensure a resident had a means of mobility in relationship to their diagnoses of morbid obesity and fracture of the left lower leg for 1 of 2 residents reviewed for accommodation of needs. (Resident H) Finding includes: The clinical record for Resident H was reviewed on 2/7/22 at 2:40 p.m. An Admission MDS (Minimum Data Set) assessment, dated 12/18/21, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, morbid obesity, fracture of left lower leg, and chronic lymphedema with healing. A review of Resident H's MDS assessment, dated 12/24/21, indicated the resident required a wheelchair. There was no mention of the residents need for a bariatric wheelchair due to size and comfort. A review of Resident H's care plan, dated 12/18/22, indicated Resident H's weight was document to be 445 pounds and would require a bariatric wheelchair and/ or a bariatric stretcher for mobilization and the ability to get to appointments. During an interview with the DON, on 2/14/22 at 1:15 p.m., she indicated she had made several attempts to get a bariatric stretcher for Resident H. The DON indicated Resident H was only able to use one type of transportation company. As of January 12, Resident H had been able to attend scheduled appointments with a larger wheelchair and transportation via the facility van. During an interview with Resident H, on 2/15/22 at 2:50 p.m., Resident H indicated her new wheelchair was comfortable and she had been able to make it to her appointments. This Federal tag relates to Complaints IN00372425, IN00373289, and IN00372387. 3.1-3(v)(1)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 44849 Based on interview and record review, the facility failed to notify the physician for a male resident that had been drinking alcohol in the facility which resulted in behavioral symptoms of physical, sexual, and verbal abuse toward female residents for 1 of 3 residents reviewed for notification. (Resident B, Resident D, Resident E) Finding includes: During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. The QMA had overheard other staff discussing this at the nurse's station. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she heard discussing this at the nurse's station. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated when Resident B got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, you f**king b*tch, I'll knock you out of that wheelchair. Resident E told a member of the resident council and he said he would take care of it. The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, and had moderate depression. The clinical record lacked physician notification of Resident B's alcohol use in the facility. During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated the physician should have been notified of Resident B's alcohol consumption and behaviors. On 2/7/22 at 11:00 a.m., the Director of Nursing provided a copy of a facility policy, titled Physician Notification for Change in Condition Reporting, dated 8/1/16, and indicated this was the current policy used by the facility. A review of the policy indicated Unless there are documented extenuating circumstances, the nurse will report immediately .new or worsening behavioral symptoms. This Federal tag relates to Complaint IN00372277. 3.1-5(a)(2)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 A. Based on observation, interview and record review, the facility failed to prevent sexual and physical (death) abuse resulting in a female resident being physically and sexually abused by a male resident for 2 of 4 residents reviewed for abuse. (Residents C, Resident B) B. Based on interview and record review, the facility failed to prevent verbal abuse resulting in 2 female residents being threatened with physical and sexual abuse by a male resident that was not Immediate Jeopardy for 3 of 4 residents reviewed for abuse. (Residents D, Resident B, Resident E) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 2/2/22 at approximately 5:00 a.m., when the facility failed to prevent physical (death) and sexual abuse. The Administrator, Administrator in Training, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 2/7/22 at 5:00 p.m. The Immediate Jeopardy was removed on 2/10/22 at 2:40 p.m., but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: A. During the initial tour of the facility, on 2/2/22 from 11:40 a.m. to 12:15 p.m., Resident C was in her room with Police Officers standing guard at the door. Resident C could not be observed from the hallway. Resident B was in his room, located on a different unit in the facility, with a Police Officer standing guard at the door to the room. Resident B was observed sitting up in his electric wheelchair staring at the hallway with a flat affect (showing no emotion on his face). The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, and had moderate depression. The current physician's order, indicated Resident B could have alcoholic beverages, with a start date of 10/8/21. The clinical record for Resident C was reviewed on 2/2/22 at 12:15 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, morbid obesity, congestive heart failure, and obstructive sleep apnea. An Admission Initial Evaluation, dated 1/28/22 at 3:15 p.m., indicated Resident C was nonverbal, bedfast (confined to bed), and mobility was very limited (she made occasional slight changes in body or extremity position but unable to make frequent or significant changes independently). (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 2/3/22 at 5:10 p.m., QMA (Qualified Medication Aide) 1 indicated she entered Resident C's room and Resident B was lying on top of Resident C, in bed, with his pants down. Resident C's face was covered with Resident B's hand. Resident B jumped off of Resident C and left the room. QMA 1 removed a pillow from Resident C's face. Resident C was without clothing, had a small scratch to her left leg, and her incontinence brief was pulled to the side. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., he was at the nurse's station for the 100 and 200 Hall. QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said, come on, come on. When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. The resident's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry [NAME] on the floor. Resident B was escorted out of Resident C's room and immediately placed on one-on-one supervision with another staff member. Resident C was lying in bed, on her back, with legs spread apart and her face looking at the ceiling. Resident C did not have a pulse, but her body was warm to touch. During an interview on 2/3/22 at 5:24 p.m., CNA (Certified Nursing Assistant) 1 indicated, on 2/2/22, when she entered Resident C's room the resident's brief was pulled to the side. During an interview on 2/7/22 at 8:53 a.m., QMA 2 indicated Resident B seemed depressed over the past few weeks because his roommate moved out. On 2/2/22 at 2:06 p.m., Resident B was observed to be handcuffed and assisted into the back of the police van. He required minimal assistance from the police officer. Resident B stepped up into the back of the van. B.1. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. The QMA had overheard other staff discussing this at the nurse's station. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she heard discussing this at the nurse's station. During an interview on 2/7/22 at 9:20 a.m., Resident D indicated on 2/1/22 at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to eat between my legs and made comments about Resident D's breasts. Resident B laughed and said, just wait until tonight, just wait until tonight. Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on 2/1/22. At that time, QMA 4 indicated to her (Resident D) not to worry because she would watch the hall. The clinical record for Resident D was reviewed on 2/7/22 at 11:00 a.m. The diagnoses included, but were not limited to, debility, morbid obesity, and acquired absence of right and left legs above the knee. The Quarterly MDS assessment, dated 12/11/21, indicated Resident D was cognitively intact. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	B.2. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B told her she was beautiful and offered to buy her jewelry. She said no. When he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, you f**king b*tch, I'll knock you out of that wheelchair. Resident E told a member of the resident council and he said he would take care of it. During an interview on 2/7/22 at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that didn't like him. About a week and a half ago, Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. The clinical record for Resident E was reviewed on 2/7/22 at 11:40 a.m. The diagnoses included, but were not limited to, morbid obesity, reduced mobility, and debility. The Quarterly MDS assessment, dated 11/11/21, indicated Resident E was cognitively intact. On 2/7/22 at 11:00 a.m., the Director of Nursing provided a copy of a facility policy, dated 9/1/17, 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, It is the intent of this facility to prevent the abuse, mistreatment or neglect of residents. The Immediate Jeopardy, that began on 2/2/22, was removed on 2/10/22 when the facility inserviced the facility staff on abuse policies and behaviors, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaints IN00372277 and IN00372425. 3.1-27(a)(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on observation, interview, and record review, the facility failed to report allegations of sexual abuse for 3 of 4 residents reviewed for abuse (Residents B, Resident D, Resident E) this resulted in a female resident being physically (death) and sexually abused by a male resident. (Resident C, Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, [DATE] at approximately 2:00 p.m., when the facility failed to report prior sexual actions of a resident which resulted in a female resident being sexually and physically (death) assaulted. The Administrator, Administrator in Training, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on [DATE] at 5:00 p.m. The Immediate Jeopardy was removed on [DATE] at 2:40 p.m., but noncompliance remained at a lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. During an interview on [DATE] at 9:00 a.m., QMA 3 indicated Resident B threatened to rape Resident D several times on [DATE]. The QMA had overheard other staff discussing this at the nurse's station on [DATE]. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she heard discussing this at the nurse's station. During an interview on [DATE] at 9:20 a.m., Resident D indicated on [DATE] at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to eat between my legs and made comments about Resident D's breasts. Resident B laughed and said, just wait until tonight, just wait until tonight. Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on [DATE]. At that time, QMA 4 had indicated to her (Resident D) not to worry because she would watch the hall. The clinical record for Resident D was reviewed on [DATE] at 11:00 a.m. The diagnoses included, but were not limited to, debility, morbid obesity, and acquired absence of right and left legs above the knee. The Quarterly MDS (Minimum Data Set) assessment, dated [DATE], indicated Resident D was cognitively intact. 2. During an interview on [DATE] at 9:50 a.m., Resident E indicated there was a day, the week before last, Resident B got out of his wheelchair and in her face and said, you f**king b*tch, I'll knock you out of that wheelchair. She didn't think staff saw this happen and had not reported this to staff. Resident E told a member of the resident council about the incident with Resident B, and he said he would take care of it. (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that didn't like him. About a week and a half ago, Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. The clinical record for Resident E was reviewed on [DATE] at 11:40 a.m. The diagnoses included, but were not limited to, morbid obesity, reduced mobility, and debility. The Quarterly MDS assessment, dated [DATE], indicated Resident E was cognitively intact. 3. During the initial tour of the facility, on [DATE] from 11:40 a.m. to 12:15 p.m., Resident C was in her room with Police Officers standing guard at the door. Resident C could not be observed from the hallway. Resident B was in his room, located on a different unit in the facility, with a Police Officer standing guard at the door to the room. During an interview on [DATE] at 5:10 p.m., QMA (Qualified Medication Aide) 1 indicated, on [DATE] at approximately 5:00 a.m., she entered Resident C's room and Resident B was on top of Resident C, in bed, with his pants down. Resident C's face was covered with Resident B's hand. Resident B jumped off of Resident C and left the room. Resident C was naked, had a small scratch to her left leg, and her incontinence brief was pulled to the side. Resident C's pupils were dilated and she was found to be deceased . On [DATE] at 11:00 a.m., the Director of Nursing provided a copy of a facility policy, dated [DATE], 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, Each occurrence . of alleged abuse . will be identified and reported to the supervisor and investigated timely. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately The Immediate Jeopardy, that began on [DATE], was removed on [DATE] when the facility inserviced the staff on reporting abuse, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaints IN00372277 and IN00372425. 3XXX,d+[DATE](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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on interview and record review, the facility failed to investigate allegations of verbal abuse for 2 of 4 residents reviewed for abuse. (Residents D and E). This resulted in a female resident being physically (death) and sexually assaulted. (Resident C, Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, [DATE] at approximately 2:00 p.m., when the facility failed to investigate reported allegations of sexual and verbal abuse. The Administrator, Administrator in Training, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on [DATE] at 5:00 p.m. The Immediate Jeopardy was removed on [DATE] at 2:40 p.m., but noncompliance remained at a lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. During an interview on [DATE] at 9:20 a.m., Resident D indicated on [DATE] at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. She had reported to QMA 4 around 11:00 p.m. on [DATE] that Resident B had made inappropriate sexual comments towards her. The QMA had indicated to her not to worry because she would watch the hall. The clinical record for Resident D was reviewed on [DATE] at 11:00 a.m. The Quarterly MDS (Minimum Data Set) assessment, dated [DATE], indicated Resident D was cognitively intact. During an interview on [DATE] at 9:00 a.m., QMA 3 indicated she had overheard other staff discussing that Resident B threatened to rape Resident D several times on [DATE]. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. QMA 3 was unable to remember which staff members she heard discussing this at the nurse's station. 2. During an interview on [DATE] at 10:00 a.m., the resident council member indicated Resident E came to him and was afraid of Resident B. Resident B had made vulgar comments to her about a week and a half ago. The resident council member indicated he had told Resident B that he could not behave in that manner. He had reported this information to a staff member after Resident E spoke to him. During an interview on [DATE] at 9:50 a.m., Resident E indicated Resident B was making inappropriate comments and was verbally aggressive towards her. The resident reported Resident B's behaviors to a resident council member and he indicated he would take care of it. The clinical record for Resident E was reviewed on [DATE] at 11:40 a.m. The Quarterly MDS assessment, dated [DATE], indicated Resident E was cognitively intact. On [DATE] at 1:30 p.m., the police officer indicated that at approximately 5:00 a.m. on [DATE], police were dispatched to the facility following a sexual assault resulting in Resident C being found deceased . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 2:00 p.m., the Administrator in Training, DON, and Regional Nurse Consultant indicated they were unaware of Residents D's or E's allegations of verbal abuse. On [DATE] at 9:15 a.m., the DON indicated that the allegations should have been reported and investigated. On [DATE] at 11:00 a.m., The Director of Nursing provided a copy of a facility policy, dated [DATE], 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, Each occurrence . of alleged abuse . will be identified and reported to the supervisor and investigated timely. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately. The Immediate Jeopardy, that began on [DATE], was removed on [DATE] when the facility inserviced staff on abuse policies and procedures, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaints IN00372277 and IN00372425. 3XXX,d+[DATE](d)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 31085 Based on interview and record review, the facility failed to provide an accurate MDS (Minimum Data Set) assessment by staff qualified to assess relevant care areas for 1 of 3 residents reviewed for accurate assessment. (Resident G) Findings include: The clinical record for Resident G was reviewed on 2/8/22 at 9:45 a.m. A Quarterly MDS assessment, dated 1/2/22, indicated the resident did not have an indwelling urinary catheter. The diagnoses included, but were not limited to, epilepsy, abnormal posturing, encephalitis, polymer. The resident had an indwelling urinary catheter. The MDS assessment, dated 1/4/22, did not indicate resident G had a Foley catheter. The TAR (Treatment Administration Record), was provided by the DON (Director of Nursing) on 2/8/22 at 12:23 p.m. The TAR dated 12/1/21 thru 12/31/21, did not indicate the resident had a Foley catheter. The resident's catheter was inserted on 12/22/21. The clinical record lacked catheter care from 12/22/21-12/31/21. During an interview on 2/15/22 at 10:15 a.m., LPN 3 indicated she did not do an assessment after she inserted the residents Foley catheter in December 2021. A policy received on 2/9/22, revised 7/26/18, indicated this policy was the one the facility was using, indicated: the facility will: i . provide an assessment of the resident as an on going-periodic review that provides the foundation for a resident focused care and the care planning process . This Federal tag relates to Complaint IN00372387. 3.1-31(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on interview and record review, the facility failed to ensure a person-centered care plan was developed for a resident that had physical, sexual, and verbally aggressive behaviors and diagnosed with alcohol abuse and major depressive disorder for 1 of 3 resident reviewed for behaviors. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m., the diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact and had moderate depression. The hospital discharge summary, dated 9/16/21 at 2:19 a.m., indicated Resident B had been consuming alcohol 3 to 5 times per week, consumed more alcohol than intended, and was homeless because his family member had made him leave home due to alcohol consumption. During an interview on 2/7/22 at 8:53 a.m., QMA 2 indicated Resident B seemed depressed over the past few weeks because his roommate moved out. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B told her she was beautiful and offered to buy her jewelry. She said no. When he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, you f**king b*tch, I'll knock you out of that wheelchair. Resident E told a member of the resident council and he said he would take care of it. During an interview on 2/7/22 at 9:20 a.m., Resident D indicated on 2/1/22 at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to eat between my legs and made comments about Resident D's breasts. Resident B laughed and said, just wait until tonight, just wait until tonight. Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on 2/1/22. At that time, the QMA 4 indicated to her (Resident D) not to worry because she would watch the hall. (continued on next page)

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	155780	A. Building B. Wing	02/16/2022

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., he was at the nurse's station for the 100 and 200 Hall. QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said, come on, come on. When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry [NAME] on the floor. Resident B was escorted out of Resident C's room and immediately placed on one-on-one supervision with another staff member. Resident C was lying in bed, on her back, with legs spread apart and her face looking at the ceiling. Resident C did not have a pulse, but her body was warm to touch. The clinical record for Resident B lacked a care plan for behaviors, major depressive disorder, and alcohol abuse. During an interview on 2/11/22 at 8:30 a.m., the Director of Nursing indicated Resident B's alcohol consumption, major depressive disorder, and behaviors should have been care planned with appropriate interventions. On 2/14/22 at 1:00 p.m., the Director of Nursing provided a copy of a facility policy, titled Plan of Care Overview, dated 7/26/18, and indicated this was the current policy used by the facility. A review of the facility policy indicated it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is the primary concern for our resident, staff and visitors. This Federal tag relates to Complaints IN00372425 and IN00372277. 3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44849 Based on interview and record review, the facility failed to update a care plan within 7 days of an assessment to reflect a resident's appropriate weight bearing status for 1 of 3 residents reviewed for activities of daily living. (Resident B). Finding includes: The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, had moderate depression, and used a manual wheelchair. A hospital discharge summary, dated 9/16/21 at 2:47 a.m., indicated the resident was non weight bearing. A care plan, dated 9/17/21 and current through 3/22/22, indicated Resident B required assistance with ADL (activities of daily living) related to non-weight bearing to RLE (right lower extremity), right ankle fixture, pain in right ankle. A therapy progress note, dated 11/29/21 at 3:45 p.m., indicated weight bearing as tolerated to the right lower extremity. During an interview on 2/15/22 at 3:11 p.m., the Director of Nursing indicated the care plan should have been updated to show Resident B's weight bearing status and improvement. On 2/14/22 at 1:00 p.m. The Administrator provided a copy of a facility policy, titled Plan of Care Overview, dated 7/26/18, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will: review care plans quarterly and/or with significant changes in care. This Federal tag relates to Complaint IN00372277. 3.1-35(d)(2)(B)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44849 Based on interview and record review, the facility failed to ensure a resident with diabetes mellitus type 2 had blood glucose monitoring completed and documented for 2 of 2 residents reviewed for blood glucose monitoring. (Resident B, Resident C) Findings include: 1. The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus type 2, major depressive disorder, and alcohol abuse. A Nurse Practitioner progress note, dated 10/10/21 at 12:06 p.m., indicated the resident was to have his blood glucose levels checked twice a day. The clinical record lacked documentation the residents blood glucose levels were being monitoring. During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated Resident B's blood glucose levels should have been monitored and documented as indicated by the Nurse Practitioner's note. 2. The clinical record for Resident C was reviewed on 2/2/22 at 12:15 p.m. The diagnoses included, but were not limited to, diabetes mellitus type 2 and morbid obesity. The current Physician's orders, dated 1/30/22, indicated staff were to monitor the residents blood glucose levels four times a day. The clinical record lacked documentation of the residents blood glucose levels being monitored. During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated Resident C's blood glucose levels should have been documented. On 2/7/22 at 11:00 a.m. The Director of Nursing provided a copy of a facility policy, titled Medication Administration, dated 12/14/17, and indicated this was the current policy used by the facility. A review of the policy indicated record pertinent information .blood sugars. This Federal tag relates to Complaints IN00372387, IN00372425, and IN00373289. 3.1-37(a)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on observation, interview, and record review, the facility failed to prevent a resident from driving an electric wheelchair while under the influence of alcohol for 1 of 3 resident reviewed for safety. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact and required extensive assistance of one staff member for bed mobility and transfers. During the initial tour of the facility, on 2/2/22 from 11:40 a.m. to 12:15 p.m., Resident B was in his room with a Police Officer standing guard at the door to the room. Resident B was observed sitting up in his electric wheelchair. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated when he (Resident B) got drunk, he would get violent. There was a day, the week before last, he got off of his wheelchair and in her face and said, you f**king b*tch, I'll knock you out of that wheelchair. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., Resident B's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when the resident was trying to speak. There was a large bottle of dry [NAME] on the floor. During an interview on 2/9/22 at 2:15 p.m., the Administrator indicated an evaluation was completed for residents who wish to drive an electric wheelchair for safety. The clinical record lacked an evaluation for Resident B to drive an electric wheelchair. During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated an evaluation should have been completed for Resident B to drive an electric wheelchair. The physician should have been notified when the staff realized Resident B had been drinking alcohol and let the physician make a recommendation regarding the electric wheelchair. She would have stopped Resident B from driving the electric wheelchair after drinking alcohol. On 2/16/22 at 2:00 p.m., the facility was unable to provide a policy regarding electric wheelchairs prior to exit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This Federal tag relates to Complaint IN00372277. 3.1-45(a)(2)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 31085 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for care of a resident with a clinically-justified indwelling catheter for 1 of 5 residents reviewed for catheter care. (Resident G). Finding includes: The clinical record for Resident G was reviewed on 2/8/22 at 9:45 a.m. A Quarterly MDS (Minimum Data Set) assessment, dated 1/2/22, indicated the resident cognition was moderately impaired. The MDS assessment had no indication resident G had a indwelling urinary catheter. The diagnoses included, but were not limited to: epilepsy, abnormal posturing, encephalitis, polyneuropathy. The resident had an indwelling catheter at that time. The physician's order, dated 12/22/21 at 2:34 p.m., indicated to insert a Foley catheter for a diagnosis of overactive bladder. There were no follow up progress notes indicating Resident G's toleration of the insertion of the Foley catheter or if any urine, including color was obtained. The TAR (Treatment Administration Record), was provided by the DON (Director of Nursing) on 2/8/22 at 12:23 p.m. The TAR for 12/22/21-12/31/21 lacked urinary catheter care. The TAR from 1/1/22-1/31/22 lacked urinary catheter care on 14 occurrences. On 2/15/22 at 11:00 a.m., Resident G was observed to not have a urinary catheter. A policy Catheter Care was provided by the Administrator and reviewed on 2/8/22 at 1:50 p.m., and read as follows:catheter care at the beside is performed to promote cleanliness and dignity and by nursing staff II: for a female resident .e. Obtain clean, wet washcloth with warm soap and water .Clean around catheter just above entrance downward approximately 6 inches, repeat until no visible soiling is observed on the catheter . h. Rinse with clean wet wash cloth . This Federal tag relates to Complaint IN00372387. 3.1-41(a)(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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on interview and record review, the facility failed to ensure staff had the skills and competencies to identify and address a male resident that had been drinking alcohol in the facility which resulted in behavioral symptoms of physical (death), sexual, and verbal abuse toward female residents for 4 of 4 residents reviewed for competent nursing staff. (Resident B, Resident C, Resident D, Resident E) Finding includes: The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m., the diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, and had moderate depression. The clinical record lacked documentation of a care plan for his behavior of drinking. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B got violent when he was drunk. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, you f**king b*tch, I'll knock you out of that wheelchair. Resident E told a member of the resident council and he said he would take care of it. During an interview on 2/7/22 at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that didn't like him. About a week and a half ago Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said, come on, come on. When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. The resident's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry [NAME] on the floor. During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated alcohol consumption would not be considered a change of condition, but the physician should have been notified Resident B was drinking alcohol. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/15/22 at 11:56 a.m., the Director of Nursing provided a copy of a facility policy, titled Notification for Change in Condition, dated 11/30/18, and indicated this was the current policy used by the facility. A review of the policy indicated unless there are documented extenuating circumstances, the nurse will report immediately changes in condition based on the following criteria for reporting to the Physician .New or worsening physical or verbal aggression or a danger to self or others. This Federal tag relates to Complaint IN00372277. 3.1-14(a)(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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on observation, interview, and record review, the facility failed to monitor a male resident for verbal and physically aggressive behaviors, towards female residents, and alcohol consumption for 1 of 1 residents reviewed for behaviors. This resulted in resulted in 2 female residents being verbally abused and 1 female resident being physically (death) and sexually abused. (Resident B, Resident C, Resident D, Resident E) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 1/28/22 at approximately 12:00 p.m., when the facility failed to implement behavior monitoring and appropriate interventions to manage the behaviors for a male resident that became aggressive toward female residents and consuming alcohol. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 2/10/22 at 2:40 p.m. The Immediate Jeopardy was removed on 2/11/22 at 1:15 p.m., but noncompliance remained at a lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The clinical record of Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, alcohol abuse and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact. The clinical record for Resident B lacked a person-centered care plan with appropriate interventions to address major depressive disorder, alcohol abuse, and behaviors related to consuming alcohol. The hospital discharge summary, dated 9/16/21 at 2:19 a.m., indicated Resident B had been consuming alcohol 3 to 5 times per week, consumed more alcohol than intended, and was homeless because his family member had made him leave home due to alcohol consumption. During an interview on 2/7/22 at 8:53 a.m., QMA 2 indicated Resident B seemed depressed over the past few weeks because his roommate moved out. During the initial tour of the facility, on 2/2/22 from 11:40 a.m. to 12:15 p.m., Resident C was in her room with Police Officers standing guard at the door. Resident C could not be observed from the hallway. Resident B was in his room, located on a different unit in the facility, with a Police Officer standing guard at the door to the room. Resident B was observed sitting up in his electric wheelchair staring at the hallway with a flat affect (showing no emotion on face). (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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 2/3/22 at 5:10 p.m., QMA (Qualified Medication Aide) 1 indicated, she entered Resident C's room and Resident B was on top of Resident C, in bed, with his pants down. Resident C's face was covered with Resident B's hand. Resident B jumped off of Resident C and left the room. Resident C was naked, had a small scratch to her left leg, and her incontinence brief was pulled to the side. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., he was at the nurse's station for the 100 and 200 Hall. QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said, come on, come on. When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. Resident C's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry [NAME] on the floor. Resident B was escorted out of Resident C's room and immediately placed on one-on-one supervision with another staff member. Resident C was lying in bed, on her back, with legs spread apart and her face looking at the ceiling. Resident C did not have a pulse, but her body was warm to touch. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. Resident B could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. QMA 3 overheard other staff discussing this at the nurse's station Resident D hadn't reported this to QMA 3. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she had heard discussing this at the nurse's station. During an interview on 2/7/22 at 9:20 a.m., Resident D indicated on 2/1/22 at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to eat between my legs and made comments about Resident D's breasts. Resident B laughed and said, just wait until tonight, just wait until tonight. Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on 2/1/22. The QMA had indicated to Resident D not to worry because she would watch the hall. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B told her she was beautiful and offered to buy her jewelry. She said no. When he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, you f**king b*tch, I'll knock you out of that wheelchair. Resident E told a member of the resident council about the incident with Resident B, and he said he would take care of it. During an interview on 2/7/22 at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that he didn't think liked him. About a week and a half ago, Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. (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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 2/10/22 at 1:03 p.m., the Social Service Director indicated she was not aware of Resident B's alcohol use prior to admission but if a resident was admitted with a diagnosis of alcohol abuse and had been consuming alcohol, that would be considered a behavior. If the resident was currently consuming alcohol, first she would have attempted to send the resident to a recovery center. If a recovery center was not available or could not care for that resident, she would have had the resident sign a behavior contract. The contract should have included if the resident consumed alcohol, they would have received a 30-day notice for discharge. If psychiatric services would have recommended behavior monitoring, we would have had it in place. During an interview on 2/10/22 at 1:12 p.m., the Admission Coordinator indicated she could not remember the admission for Resident B but if a resident was referred for admission with a diagnosis of alcohol abuse and had been consuming alcohol, that would have been a concern and should have been reported to the Director of Nursing. During an interview on 2/10/22 at 1:20 p.m., the Director of Nursing indicated she had a concern regarding Resident B's admission because he had left other facilities against medical advice and a criminal background check showed he had previous drug and alcohol problems. Resident B originally was admitted for rehabilitation to home, but when the discharge process was started Resident B indicated to social services he was homeless. During an interview on 2/11/22 at 8:30 a.m., the Director of Nursing indicated the alcohol consumption and behaviors caused by consuming alcohol should have been monitored. There should have been appropriate interventions in place to address Resident B's behaviors. On 2/11/22 at 8:30 a.m., the Director of Nursing provided a copy of a facility policy titled, Behavior Management General, dated 4/8/16, and indicated this was the current policy used by the facility. A review of the policy indicated It is the policy of this facility to identify and safely manage residents who are exhibiting behaviors related to psychotropic diagnoses or who may present a danger to themselves or others. The Immediate Jeopardy, that began on 1/28/22, was removed on 2/11/22 when the facility inserviced staff on reporting behaviors, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaint IN00372277. 3.1-43(a)(1)

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	02/16/2022

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on interview and record review, the facility failed to provide appropriate social service interventions for a male resident who was homeless and abused alcohol at the time of admission and was diagnosed with alcohol abuse for 1 of 1 residents reviewed for social services. (Resident B) Findings include: During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated when he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, you f**king b*tch, I'll knock you out of that wheelchair. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., Resident B's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry [NAME] on the floor. The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, had moderate depression, and used a manual wheelchair. The hospital discharge summary, dated 9/16/21 at 2:19 a.m., indicated Resident B had been consuming alcohol 3 to 5 times per week, consumed more alcohol than intended, and was homeless because his family member had made him leave home due to alcohol consumption. During an interview on 2/10/22 at 1:03 p.m., the Social Service Director indicated she was not aware of Resident B's alcohol use prior to admission but if a resident was admitted with a diagnosis of alcohol abuse and had been consuming alcohol, that would be considered a behavior. If the resident was currently consuming alcohol, first she would have attempted to send the resident to a recovery center. If a recovery center was not available or could not care for that resident, she would have had the resident sign a behavior contract. The contract should have included if the resident consumed alcohol, they would have received a 30-day notice for discharge. If psychiatric services would have recommended behavior monitoring, we would have had it in place. The clinical record lacked documentation of a referral to recovery center, behavior contract nor a 30-day notice for discharge. (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/22 at 11:00 a.m., the Director of Nursing provided a copy of a facility policy, titled Resident Substance Abuse in Facility, dated 8/20/18, and indicated this was the current policy used by the facility. A review of the policy indicated Abused substances may also include alcohol. The facility will safeguard the resident under the influence .this may include up to discharge of the substance abusing resident. This Federal tag relates to Complaint IN00372277. 3.1-34(a)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on observation, interview, and record review, the facility administration failed to maintain the mental and physical wellbeing of residents when a male resident (Resident B) verbally and physically abused 3 of 4 female residents. (Resident C, Resident D, Resident E) Findings include: The clinical record of Resident B was reviewed on [DATE] at 12:30 p.m. The diagnoses included, but were not limited to, alcohol abuse and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident B was cognitively intact. The hospital discharge summary, dated [DATE] at 2:19 a.m., indicated Resident B had been consuming alcohol 3 to 5 times per week, consumed more alcohol than intended, and was homeless because his family member had made him leave home due to alcohol consumption. During an interview on [DATE] at 1:20 p.m., the Director of Nursing indicated she had a concern regarding Resident B's admission because he had left other facilities against medical advice and a criminal background check showed he had previous drug and alcohol problems. Resident B originally was admitted for rehabilitation to home, but when the discharge process was started Resident B indicated to social services he was homeless. 1. During the initial tour of the facility, on [DATE] from 11:40 a.m. to 12:15 p.m., Resident C was in her room with Police Officers standing guard at the door. Resident C was deceased . Resident B was in his room, located on a different unit in the facility, with a Police Officer standing guard at the door to the room. Resident B was observed sitting up in his electric wheelchair staring at the hallway with a flat affect (showing no emotion on face). During an interview on [DATE] at 5:10 p.m., QMA (Qualified Medication Aide) 1 indicated, she entered Resident C's room and Resident B was on top of Resident C, in bed, with his pants down. Resident C's face was covered with Resident B's hand. Resident B jumped off of Resident C and left the room. Resident C was naked, had a small scratch to her left leg, and her incontinence brief was pulled to the side. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on [DATE] at approximately 5:00 a.m., he was at the nurse's station for the 100 and 200 Hall. QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said, come on, come on. When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. The resident's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry [NAME] on the floor. Resident B was escorted out of Resident C's room and immediately placed on one-on-one supervision with another staff member. Resident C was lying in bed, on her back, with legs spread apart and her face looking at the ceiling. Resident C did not have a pulse, but her body was warm to touch. 2. During an interview on [DATE] at 9:00 a.m., QMA 3 indicated on [DATE] Resident B had been drinking out of a cup that smelled like alcohol. Resident B could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on [DATE]. The QMA had overheard other staff discussing this at the nurse's station on [DATE]. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she heard discussing this at the nurse's station. During an interview on [DATE] at 9:20 a.m., Resident D indicated on [DATE] at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to eat between my legs and made comments about Resident D's breasts. Resident B laughed and said, just wait until tonight, just wait until tonight. Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on [DATE]. At that time, QMA 4 had indicated to her (Resident D) not to worry because she would watch the hall. The clinical record for Resident D was reviewed on [DATE] at 11:00 a.m., the diagnoses included, but were not limited to, debility, morbid obesity, and acquired absence of right and left legs above the knee. The Quarterly MDS assessment, dated [DATE], indicated Resident D was cognitively intact. 3. During an interview on [DATE] at 9:50 a.m., Resident E indicated Resident B told her she was beautiful and offered to buy her jewelry. She said no. When he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, you f**king b*tch, I'll knock you out of that wheelchair. She didn't think staff saw this happen and had not reported this to staff. Resident E told a member of the resident council about the incident with Resident B, and he said he would take care of it. During an interview on [DATE] at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that didn't like him. About a week and a half ago, Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. The clinical record for Resident E was reviewed on [DATE] at 11:40 a.m., the diagnoses included, but were not limited to, morbid obesity, reduced mobility, and debility. The Quarterly MDS assessment, dated [DATE], indicated Resident E was cognitively intact. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:00 a.m., The Director of Nursing provided a copy of a facility policy, dated [DATE], 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, Each occurrence . of alleged abuse . will be identified and reported to the supervisor and investigated timely. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately This Federal tag relates to Complaint IN00372277. 3XXX,d+[DATE](r)(2)