STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents had a call light that was within their reach for 4 of 10 residents observed for call lights. (Resident L, M, N, and P) Findings include: 1. On 8/10/2020 from 11:15 a.m. to 11:20 a.m., observed Resident L in her room sitting in her chair. She was facing the television. The resident's bed was behind the chair and approximately 3 feet away from the resident. The resident's call light cord was hanging from the wall to the floor on the far side of the bed. Resident L was unable to reach her call light. No staff were observed to be present. Interview, on 8/10/2020 at that time, Licensed Practical Nurse (LPN) 1 indicated all residents should have a call light within reach. Observed LPN 1 instruct Certified Nursing Assistants to check all rooms and ensure all residents have a call light in reach. On 8/11/2020 at 11:30 a.m., the clinical record of Resident L was reviewed. [DIAGNOSES REDACTED]. An annual Minimum Data Set (MDS) assessment, dated 7/13/2020, indicated Resident L had a severely impaired cognitive status, required extensive assist with bed mobility, and was totally dependent for all transfers. 2. On 8/10/2020, at 11:15 a.m. to 11:20 a.m., observed Resident M in her wheel chair facing the television. The resident's bed was behind her wheel chair and approximately 3 feet away from the resident. The resident's call light was hanging from the wall to the floor on the far side of the bed. Resident M was unable to reach her call light. Interview, on 8/10/2020 at 11:20, Licensed Practical Nurse (LPN) 1, indicated all residents should have a call light within reach. Observed LPN instruct Certified Nursing Assistants to check all rooms and ensure all residents have a call light in reach. On 8/11/2020 at 11:44 a.m., the clinical record of Resident M was reviewed. [DIAGNOSES REDACTED]. An annual Minimum Data Set (MDS) assessment, dated 5/2/2020, indicated Resident M had a severely impaired cognitive status, required extensive assist with bed mobility, and was total dependent with all transfers. 3. On 8/10/2020 at 11:19 a.m., observed Resident N in his bed. Resident N's call light was hanging from the wall to the floor and out of the reach of the resident. Resident N was alert and able to communicate. During an interview, at that time, the resident indicated if the staff does not give him his call light, he will yell, and a staff member will come in to assist. Interview, on 8/10/2020 at 11:20 a.m., Licensed Practical Nurse (LPN) 1, indicated all residents should have a call light within reach. Observed LPN instruct Certified Nursing Assistants to check all rooms and ensure all residents have a call light in reach. On 8/11/2020 at 11: 50 a.m., the clinical record of resident N was reviewed. [DIAGNOSES REDACTED]. An annual Minimum Data Set (MDS) assessment, dated 7/10/2020, indicated Resident N required extensive assist with bed mobility and extensive assist with all transfers. 4. On 8/10/2020 at 11:23 a.m., observed Resident P in his room. Resident P was in his bed with his call light hanging from the wall and resting on the floor, out of the reach of the resident. Interview, on 8/10/2020 at 11:20 a.m., Licensed Practical Nurse (LPN) 1, indicated all residents should have a call light within reach. Observed LPN instruct Certified Nursing Assistants to check all rooms and ensure all residents have a call light in reach. On 8/11/2020 at 11:55 a.m., the clinical record or Resident P was reviewed. [DIAGNOSES REDACTED]. A care plan, undated and current, indicated Focus: The resident is at risk for falls. Interventions included, but were not limited to: Be sure the call light is within reach and encourage resident to use it for assistance as needed. An annual Minimum Data Set assessment, dated 5/27/2020, indicated Resident P required extensive assist with bed mobility and extensive assist with all transfers. Interview on 8/10/2020 at 11:00 a.m., the Administrator indicated the facility did not have a specific call light policy. This Federal tag relates to Complaint IN 519. 3.1-19(u)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.