STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELLENIC SENIOR LIVING OF NEW ALBANY	2632 GRANT LINE ROAD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00423533 and IN00423598. Complaint IN00423533 - No deficiencies related to the allegation are cited. Complaint IN00423598 - State deficiencies related to the allegation are cited at R0093 and R0243. Survey date: January 2 and 3, 2024 Facility number: 014166 Residential Census: 111 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 8, 2024.	R 0000	**Hellenic Senior Living of New Albany** **2632 Grant Line Road** **New Albany, IN 47150** **Facility ID: 014166** *The Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes.* *Survey date: January 2 and 3, 2024.* *This facility alleges substantial compliance with this plan of correction as of January 15, 2024.* Complaint IN00423598-State deficiencies related to the allegation are cited at R0093 and R0243 Rule not met as evidenced by: Based on interview and record review, the facility failed to ensure physician requested laboratory tests were obtained for 3 of 6 residents reviewed for diagnostic services per physician order. (Residents B, F and G) *Problem: Orders were written by NP, but labs were not obtained…. See example below.* NP progress note, dated 11/14/23,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Robinson	Executive Director	01/29/2024

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			indicated laboratory test were reordered as they had not been obtained. The November 2023 medication administration record indicated, on 11/17/23, the labs were obtained. The NP progress note, dated 11/21/23, indicated the labs had not been. obtained. *While all residents have the potential to have been affected in a negative manner, no residents were identified as being negatively affected by labs not being process timely.* **1 Please describe what the facility did to correct the deficient practice.** Director of Nursing, DON Scott Profitt was terminated 12/4/23, wasn't conducting proper practice. 12/8/23 Executive Director, ED and new DON, Chris Shoemaker educated Nurse Practitioner NP with Total Care Family Practice that all lab orders must be inputted by Medical Director, MD and or NP but never by facility staff to assure above issue doesn't re-accrue. Since 12/27/23 NP with Total Care no longer enters facility because she refuses to input/process her orders directly to lab after writing orders. *2.* **Please describe how the facility reviewed all residents**	

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			in the facility that could be affected by the same deficient practice. Facility will maintain current and accurate resident files. An audit was completed by ED and new DON of orders that NP written had previous written to make sure all were property and timely process to lab. **3.Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure.** A. DON, Scott Profitt was terminated 12/4/23, wasn't conducting proper practice. B. 12/8/23 ED and new DON, Chris Shoemaker educated NP, Sunny with Total Family practice that all lab orders must be inputted by MD and or NP but never by facility staff to assure above issue doesn't re-accrue. C. Since 12/27/23 NP, Sunny no longer enters facility because she refuses to input her orders directly to lab after written. D. 12/11/23 New NP educated on facility practice by DON. **4.Please describe how the corrective actions will be monitored to ensure the deficient practice will not**	

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			recure. DON requires a meeting with NP after her rounds on each visit. **5. For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance.** Ongoing-Director of Nursing, DON will meet with NP after each visit and ED will be back up if DON unavailable. *Affective date 1/15/24*	
R 0093 Bldg. 00	410 IAC 16.2-5-1.3(j)(1-4) Administration and Management - Noncompliance (j) If professional or diagnostic services are to be provided to the facility by an outside resource, either individual or institutional, an arrangement shall be developed between the licensee and the outside resource for the provision of the services. If a written agreement is used, it shall specify the following: (1) the responsibilities of both the facility and the outside resource; (2) the qualifications of the outside resource staff; (3) a description of the type of services to be provided, including action taken and reports of findings; and (4) the duration of the agreement. Based on interview and record review, the facility failed to ensure physician requested laboratory	R 0093	**Hellenic Senior Living of New Albany**	01/31/2024

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	tests were obtained for 3 of 6 residents reviewed for diagnostic services per physician order. (Residents B, F and G) Findings include: 1. The clinical record for Resident B was reviewed on 1/2/24 at 11:58 a.m. The diagnoses included, but were not limited to, diabetes and hyperlipidemia. The Nurse Practitioner (NP) progress note, dated 10/17/23, indicated a CBC (complete blood count), CMP (comprehensive metabolic panel), TSH (thyroid-stimulating hormone), A1C (measures average blood sugars over a 3 month period), and Lipid panel was ordered on the visit. The physician's order, dated 10/17/23, indicated to obtain a CBC, CMP, TSH, A1C and Lipid on the next lab (laboratory) day and then every 6 months. Review of the October medication administration record indicated the laboratory tests were to be obtained on 10/25/23, but was not signed off as obtained. The NP progress note, dated 11/14/23, indicated the above laboratory test were reordered as they had not been obtained. The November 2023 medication administration record indicated, on 11/17/23, the labs were obtained. The NP progress note, dated 11/21/23, indicated the labs had not been obtained. During an interview on 1/3/24 at 9:51 a.m., the Director of Nursing indicated she called the lab		**2632 Grant Line Road** **New Albany, IN 47150** **Facility ID: 014166** *The Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes.* *Survey date: January 2 and 3, 2024.* *This facility alleges substantial compliance with this plan of correction as of January 15, 2024.* Complaint IN00423598-State deficiencies related to the allegation are cited at R0093 and R0243 R093 Interventions: All written lab orders or verbal lab orders received from provider will be faxed over to lab of resident's choice on the day they are received from prescribing provider. The community nurse will document in residents electronic record that lab orders were faxed to specific lab. All medical providers seeing residents at Hellenic Senior Living will meet face to face with the DON or ADON at the end of the resident visit and provide any new orders for labs in writing to the DON or ADON at that time. Written orders will not be placed	

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	service and they did not have any record of labs for Resident B for October or November. When the nurse practitioner orders labs, the staff transcribe those orders on to a lab requisite form and place in the lab binder. The lab services came every Wednesday and obtained the labs. At 2:45 p.m., the Director of Nursing indicated there was a meeting on 12/8/23 with herself, the NP (NP 22), and corporate staff, that was when she found out that it was up the the prescriber to have the labs drawn and the results would then go to the NP who ordered the labs. During a telephone interview on 1/3/24 at 3:22 p.m., the Clinical Support indicated the facility was an Assisted Living facility and the NP's are responsible for ordered labs. The staff fax those labs to the NP lab provider of choice and those results would be faxed directly the ordering provider. This was an unwritten policy. The previous Director of Nursing started the lab service back up without anyone's knowledge. They were unaware staff were doing labs and put a stop to it about a month ago. There was a new NP (NP 22) who was unaware of the lab change and the NP upset about it. 2. The clinical record for Resident F was reviewed on 1/3/24 at 10:50 a.m. The diagnoses included, but were not limited to, diabetes, hypertensive heart disease, kidney disease, and hyperlipidemia. The NP note, dated 11/16/23, indicated a CBC, CMP, TSH, A1C and lipid panel were ordered on the visit. The physician's order, dated 11/16/23, indicated to obtain a CBC, CMP, TSH, A1C and lipid panel on the next lab day.		under doors or placed in mailboxes for DON or ADON. If specific lab does not take orders sent by fax and only will take orders that are placed directly into the specific lab site then the prescribing clinician will be responsible for submitting these orders directly to the lab as Hellenic is a residential care setting that will not enter orders for a physician into a site owned and operated by a lab provider. Lab results will be sent from Lab to the prescribing provider and Hellenic will not receive results directly. If lab results are not received in a timely manner the prescribing provider will reach out to the lab for the results as Hellenic is a residential care setting and does not contract with outside providers respecting resident choice. All existing outside providers of resident's choice that visit residents in the Hellenic community will be given this list of instructions to follow and all new providers will be given the list of instructions as listed above with each new provider servicing a resident residing at Hellenic Senior Living. Goal: all residents will receive lab services as ordered beginning 1/30/24 R243 Nurses will be in	

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	The November 2023 medication administration record indicated the labs were not obtained on 11/18/23 and the clinical record lacked documentation of the labs ordered. 3. The clinical record for Resident G was reviewed on 1/3/24 at 11:02 a.m. The diagnoses included, but were not limited to, chronic kidney disease, diabetes, hepatitis C, and hypothyroidism. The NP note, dated 10/31/23, indicated the resident was seen and a CBC, CMP, TSH, A1C and Lipid panel was ordered for the next lab day. The physician's order, dated 10/31/23, indicated to obtain a CBC, CMP, TSH, A1C and lipid panel the next lab day. The clinical record lacked documentation of the ordered lab results. During an interview on 1/3/24 at 2:15 p.m., the Director of Nursing indicated she could not find the labs ordered and that the lab service had no labs on file for the resident. This citation relates to Complaint IN00423598		serviced on 01/31/2024 on orders as listed below following correct process. All written and verbal orders received from licensed medical providers will be sent to pharmacy the day they are received. This includes, discontinue orders, new orders and change in existing orders. The nurse will call the pharmacy to ensure they have received the orders faxed over and document in residents electronic record under order note the name of the order received and that is was faxed over to pharmacy and confirmed with the pharmacy it was received. Nurse will check orders pending confirmation in PointClick Care each nursing shift and confirm all orders sent from pharmacy over to resident's electronic record, PointClick Care. If order does not show up within 24 hours of being send to pharmacy and new order has not arrived at community then nurse will call pharmacy on status and notify physician. Documentation of follow up with pharmacy and physician will be documented in residents' electronic chart, PointClick Care under Order Notes. Medications administered by nurses and/or QMA will be signed off as administered at the time they are administered to the resident. The DON, ADON or designated licensed nurse will run	

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			missed medication report twice weekly for 1 month then once weekly for three months to ensure all medication is available and being given as ordered. If a missed medication shows as being missed the DON, ADON or designated nurse will ensure the missed medication is obtained or discontinued by physician and document in resident record under order notes the outcome. Report will be ran daily beginning 01/30/2024 Affective date 1/31/24	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to ensure medications were administered, as ordered by the physician, for 3 of 4 residents reviewed for medication administration. (Residents B, C and E) Findings include: 1. The clinical record for Resident B was reviewed on 1/2/24 at 11:58 a.m. The diagnoses included, but were not limited to, hypertension (HTN) and restless leg syndrome (RLS).	R 0243	**Hellenic Senior Living of New Albany** **2632 Grant Line Road** **New Albany, IN 47150** **Facility ID: 014166** *The Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes.* *Survey date: January 2 and 3,*	01/31/2024

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	Review of the October, November, and December 2023 medication administration records (MAR) indicated the resident was to receive Furosemide 40 mg (milligrams) daily for HTN; and Ropinirole 1 mg three times a day in the morning, midday and at bedtime. The October 2023 MAR lacked documentation of the administration of the following medications: -Furosemide on 10/26/23 and 10/28/23 -Ropinirole at bedtime on 10/6/23, 10/7/23 and 10/25/23 - 10/31/23 The November 2023 MAR lacked documentation of the administration of the following medications: -Furosemide on 11/2/23, 11/3/23, 11/5/23, 11/13/23, 11/15/23 and 11/18/23 -Ropinirole at bedtime on 11/1/23 - 11/6/23, 11/9/23, 11/10/23, 11/12/23 - 11/18/23 and 11/21/23 The December 2023 MAR lacked documentation of the administration of the following medications: -Ropinirole at bedtime on 12/3/23 - 12/13/23, 11/15/23 - 11/19/23 and 11/21/23 - 11/28/23 During an interview on 1/3/24 at 2:45 p.m., the Director of Nursing indicated when medications were administered, staff were to sign off on the medication administration record to show they were given. On 1/3/24 at 1:00 p.m., the Assistant Director of Nursing provided a current copy of the document titled "Medication Administration" dated 9/30/22. It included, but was not limited to, "The administration of medication shall be as ordered by the resident's		*2024.* *This facility alleges substantial compliance with this plan of correction as of January 15, 2024.* Complaint IN00423598-State deficiencies related to the allegation are cited at R0093 and R0243 R093 Interventions: All written lab orders or verbal lab orders received from provider will be faxed over to lab of resident's choice on the day they are received from prescribing provider. The community nurse will document in residents electronic record that lab orders were faxed to specific lab. All medical providers seeing residents at Hellenic Senior Living will meet face to face with the DON or ADON at the end of the resident visit and provide any new orders for labs in writing to the DON or ADON at that time. Written orders will not be placed under doors or placed in mailboxes for DON or ADON. If specific lab does not take orders sent by fax and only will take orders that are placed directly into the specific lab site then the prescribing clinician will be responsible for submitting these orders directly to the lab as Hellenic is a residential care setting that will not enter orders for	

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	physician...Procedure...Document...administration immediately after administration...." 2. The clinical record for Resident C was reviewed on 1/2/24 at 1:00 p.m. The diagnosis included, but was not limited to, dementia. The progress note, dated 12/21/23 at 11:36 a.m., indicated the resident had a new order for Fluoxetine 10 mg daily for dementia. Review of the December 2023 medication administration record indicated the resident did not receive the medication between 12/22/23 and 12/31/23. 3. The clinical record for Resident E was reviewed on 1/3/24 at 11:29 a.m. The diagnoses included, but were not limited to, hyperlipidemia (HLD) and insomnia. Review of the November and December 2023 medication administration record indicated the resident was to receive Atorvastatin 40 mg at bedtime for HLD and Trazodone 150 mg at bedtime for insomnia. Review of the November 2023 MAR lacked documentation of the administration of the following medications: -Atorvastatin on 11/1/23 - 11/6/23 and 11/9/23 - 11/18/23 -Trazodone on 11/1/23 - 11/6/23 and 11/9/23 - 11/18/23 Review of the December 2023 MAR lacked documentation of the administration of the following medications:		a physician into a site owned and operated by a lab provider. Lab results will be sent from Lab to the prescribing provider and Hellenic will not receive results directly. If lab results are not received in a timely manner the prescribing provider will reach out to the lab for the results as Hellenic is a residential care setting and does not contract with outside providers respecting resident choice. All existing outside providers of resident's choice that visit residents in the Hellenic community will be given this list of instructions to follow and all new providers will be given the list of instructions as listed above with each new provider servicing a resident residing at Hellenic Senior Living. Goal: all residents will receive lab services as ordered beginning 1/30/24 R243 Nurses will be in serviced on 01/31/2024 on orders as listed below following correct process. All written and verbal orders received from licensed medical providers will be sent to pharmacy the day they are received. This includes, discontinue orders, new orders and change in existing orders. The nurse will call the pharmacy to ensure they have received the	

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	-Atorvastatin on 12/3/23 - 12/13/23, 12/15/23 - 12/19/23, and 12/21/23 - 12/31/23 -Trazodone on 12/3/23 - 12/13/23, 12/15/23 - 12/19/23, and 12/21/23 - 12/31/23 This citation relates to Complaint IN00423598		orders faxed over and document in residents electronic record under order note the name of the order received and that is was faxed over to pharmacy and confirmed with the pharmacy it was received. Nurse will check orders pending confirmation in PointClick Care each nursing shift and confirm all orders sent from pharmacy over to resident's electronic record, PointClick Care. If order does not show up within 24 hours of being send to pharmacy and new order has not arrived at community then nurse will call pharmacy on status and notify physician. Documentation of follow up with pharmacy and physician will be documented in residents' electronic chart, PointClick Care under Order Notes. Medications administered by nurses and/or QMA will be signed off as administered at the time they are administered to the resident. The DON, ADON or designated licensed nurse will run missed medication report twice weekly for 1 month then once weekly for three months to ensure all medication is available and being given as ordered. If a missed medication shows as being missed the DON, ADON or designated nurse will ensure the missed medication is obtained or discontinued by physician and	

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			document in resident record under order notes the outcome. Report will be ran daily beginning 01/30/2024 Affective date 1/31/24	