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	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELLENIC SENIOR LIVING OF INDIANAPOLIS	8601 SOUTH SHELBY STREET INDIANAPOLIS, IN 46227

(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 Complaint IN00388330. Complaint IN00388330 - Substantiated. State deficiencies related to the allegations are cited at R0091. Survey dates: August 19 and 22, 2022 Facility number: 014062 Residential Census: 116 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed August 25, 2022.	R 0000	**The creation and submission of the Plan of Correction does not constitute an admission by this provider, or a conclusion set forth in the state of deficiencies, or of any violation or regulation. This provider respectfully requests that this Plan of Correction be considered the letter of Credible Allegation and Requests a Desk Review in lieu of a Post Survey Review. 9/22/2022**	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to ensure residents rights were maintained for 8 of 9 residents interviewed. A resident retained a handgun in the facility, a violation of the facility's admission agreement, which resulted in resident's fearful for their safety. (Resident B,	R 0091	**R091** - 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Executive Director had a	09/22/2022

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Resident C, Resident D, Resident E, Resident G, Resident H, Resident J, Resident K) Findings include: During an interview on 8/19/22 at 1:00 p.m., the DON indicated on 8/2/22 Resident B drove his electric wheelchair out of his room backwards hitting Resident H. This caused Resident H to yell out in pain. Resident B indicated he had a gun in the facility. The DON called the local police and the officer indicated to the DON he was not going to arrest a Resident B, nor would the officer take Resident B's "alleged gun". The DON indicated she was concerned about the safety of the residents and spoke with the officer's supervisor. The supervising officer agreed with his subordinate. The DON indicated she then called the state police and asked for an officer to come to the facility to check out the "alleged gun". Resident B allowed the officer in and state police officer reported to the DON the gun was examined and it was inoperable at that time. The DON indicated Resident B had told her it was a new gun and he or a family member would take it back to be fixed. She indicated to Resident B he should not have a gun on the premises and Resident B told her to get out of his room. Resident B would not allow the DON back into his room or speak with the DON. The DON indicated Resident B had no psychological history and the facility attempted to send Resident B to the emergency room and a psychological facility but Resident B refused. On 8/19/22 at 3:50 p.m., Resident B's clinical record was reviewed. An admission agreement, originally dated, 2019, but resigned on 12/30/21, indicated "residents may not store any firearms or firearms supplies in the Unit or on the Premises".		meeting with the resident and his wife on August 30th regarding to have retained a handgun, thus broke the lease agreement. The removal of the firearms was observed by the BOM and the Executive Director. This corrective action was immediately monitored for any negative outcome by the practice, and none occurred. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same deficient practice and to protect all residents, the Executive Director has met with residents to let them know that no firearms are allowed on the premises as this is a part of their lease agreement. The Executive Director informed residents that suspected firearms have been removed from the premises. -3. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur,** Systemic changes include the Move in Coordinator will discuss with potential residents and their POA's that no firearms are allowed on the premises and the Executive Director will also discuss no storing or use of	

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	During interviews with Resident C, Resident D, Resident E, Resident F, Resident G, Resident H, Resident J, Resident K on 8/19/22 from 3:25 p.m. until 5:00 p.m., the residents at the facility indicated the following. They did not feel safe at the facility. The residents indicated they did not leave their rooms unless they were accompanied by either other residents or staff. They were fearful of Resident B. This State Residential Findings relates to Complaint IN00388330.		firearms are allowed on the premises at any time during lease signing. -4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and -By what date the systemic changes will be completed.** Q.A. will include random weekly apartment inspections for four weeks, then monthly random apartment inspections thereafter. These inspections will be completed by the Executive Director and /or assigned Designee. This quality assurance program will be maintained over the next 4 quarters. The inspections will begin September 6, 2022 with first inspections starting on the third floor, then the second floor, and then the first floor. - 5. By what date the Systemic systemic changes will be completed. 9/22/2022	