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	07/10/2024

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 a State Residential Licensure Survey. Survey date: July 10, 2024 Facility number: 014166 Residential Census: 122 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 16, 2024.	R 0000	**Facility ID: 014166** **Hellenic Senior Living of New Albany** **2632 Grant Line Road** **New Albany, IN 47150** The Plan of Corrections is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance with this plan of correction as of July 24,2024 **(R 092) 41AC 14.2-5-1.3(i)(1-2) Administration and Management-Noncompliance** While no residents were negatively affected, an investigation was conducted, and “Tel’s” system reviewed that alerts when any drill is past due and a walk -through facility was conducted to make sure all fire and disaster preparedness plans were visible to staff and residents. *Facility has a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency and written preparedness is located at every nurse station, front lobby and will be reviewed with residents throughout the year during resident council by Maintenance Director.* **1 Please describe what the facility did to correct the**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy S. Robinson	Executive Director	07/24/2024

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.

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	07/10/2024

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
			deficient practice. 2 **What measures will be put into place or what systemic change will be made to ensure that the deficient proactive does not recure?** A new position was added allowing an Maintenance Assistant to be hired on 7/24/24. This individual will oversee that all drills get completed timely and a log obtained in “Tels” system (name of fire drill monitoring system) and separate binder in office with documentation and signatures. Quarterly fire drills with transmission of a fire alarm signal and simulation of emergency fire conditions will be held on every shift, at least twelve (12) drills will be held every year along with educational In-services as needed by Executive Director and or Maintenance Director July quarterly fire drill and disaster drill is scheduled 7/26/27. Will be conducted by Maintenance Director and local Fire department. *Note: At least every six (6) months, facility will attempt to hold the fire and disaster drill in conjunction with local fire department and signatures/documentation kept in log located within Maintenance Director’s office and updated in Tel’s system*	

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	07/10/2024

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
			Note: Drills conducted between 9 p.m. and 6 a.m., a coded announcement will be used instead of audible alarms. **3 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents are at potential risk for the mentioned deficient practice; however Executive Director copied the fire drill and disaster preparation/plan and put in each resident mailbox along with the update of next drill with maintenance and fire department has been posted. **4 How will corrective actions be monitored to ensure the deficient practice will not recure? Please explain the criteria or threshold and Quality Assurance Program will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.** Executive Director will be updated on all scheduled fire and disaster drills prior to them occurring along with copies of all drills with signatures and documentation will be given to Executive Director by maintenance. “Tels” system will be utilized by maintenance which Executive Director will now get updates weekly on her computer	

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	07/10/2024

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
			to monitor and will alert when these are due or past due. 5 **For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance.** Ongoing-Director of Maintenance and Assist Maintenance will update Executive Director with every drill. Tels system will update weekly Executive Director of due and past due drills. All systemic changes noted in this deficiency will be completed by 7/26/24	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility			

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	07/10/2024

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
	shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted as required for 4 of 4 quarters reviewed for fire drills. This had the potential to affect 122 residents whom reside in the facility. Findings include: The review of the facility's fire drill work history report, on 7/20/24 at 10:20 a.m., was completed for the last 12 months (4 quarters) time frame, The due date, task description, and task completion form indicated the following: - On 9/30/23 the fire drills were documented as skipped for all shifts. - On 12/21/23 no action was recorded for all shifts. - On 2/2024 an in-service was given but no fire drill was conducted, and no action was recorded. - On 3/31/24 no action was recorded for all shifts. The facility was unable to produce documentation indicating fire drills had been completed since the last survey on 5/2023. During an interview on 7/10/24 at 9:30 a.m., the ED (Executive Director) indicated she was unable to provide the fire drill documentation because the fire drills had not been done. The facility had an in-service on 2/2024 but there had not been one since then. The Maintenance Director had been out and the fire drills did not get done.	R 0092	**Facility ID: 014166** **Hellenic Senior Living of New Albany** **2632 Grant Line Road** **New Albany, IN 47150** The Plan of Corrections is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance with this plan of correction as of July 24,2024 **(R 092) 41AC 14.2-5-1.3(i)(1-2) Administration and Management-Noncompliance** While no residents were negatively affected, an investigation was conducted, and “Tel’s” system reviewed that alerts when any drill is past due and a walk -through facility was conducted to make sure all fire and disaster preparedness plans were visible to staff and residents. *Facility has a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency and written preparedness is located at every nurse station, front lobby and will be reviewed with residents throughout the year during resident council by Maintenance Director.*	07/26/2024

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	07/10/2024

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
	During an interview on 7/10/24 at 1:30 p.m., the Maintenance Director indicated the fire drills should be conducted monthly on all shifts and he would come in at least 1 weekend a month to do the fire drills. He had no paperwork on conducting the fire drills monthly. They did have an inservice and fire drill in February but had not had one since. During an interview on 7/10/24 at 2:45 p.m., the ED indicated the February fire drill was just an in-service. She used the TELS (name of fire drill monitoring system) when the fire drills were due. She would document in the TELS system who attended the fire drill, where the fire drill was and what shift the drill took place. She thought a fire drill was conducted in December and March on all three shifts. The Maintenance Man skipped the fire drills for September. She thought she had documentation for the fire drills completed and she would look for it. During an interview on 7/10/24 at 3:05 p.m., the ED indicated she could not find documentation indicating the fire drills had been done. During an interview on 7/10/24 at 3:00 p.m., the ED indicated the facility did not have a policy on fire drills. The facility followed the State regulations which included, but was not limited to, "drills must be conducted quarterly on each shift to familiarize with signals and emergency actions required under varied conditions. At least 12 drills shall be held every year."		**1 Please describe what the facility did to correct the deficient practice.** 2 **What measures will be put into place or what systemic change will be made to ensure that the deficient proactive does not recure?** A new position was added allowing an Maintenance Assistant to be hired on 7/24/24. This individual will oversee that all drills get completed timely and a log obtained in “Tels” system (name of fire drill monitoring system) and separate binder in office with documentation and signatures. Quarterly fire drills with transmission of a fire alarm signal and simulation of emergency fire conditions will be held on every shift, at least twelve (12) drills will be held every year along with educational In-services as needed by Executive Director and or Maintenance Director July quarterly fire drill and disaster drill is scheduled 7/26/27. Will be conducted by Maintenance Director and local Fire department. *Note: At least every six (6) months, facility will attempt to hold the fire and disaster drill in conjunction with local fire department and signatures/documentation kept in log located within Maintenance*	

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	07/10/2024

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
			Director's office and updated in Tel's system *Note: Drills conducted between 9 p.m. and 6 a.m., a coded announcement will be used instead of audible alarms.* **3 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents are at potential risk for the mentioned deficient practice; however Executive Director copied the fire drill and disaster preparation/plan and put in each resident mailbox along with the update of next drill with maintenance and fire department has been posted. **4 How will corrective actions be monitored to ensure the deficient practice will not recure? Please explain the criteria or threshold and Quality Assurance Program will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.** Executive Director will be updated on all scheduled fire and disaster drills prior to them occurring along with copies of all drills with signatures and documentation will be given to Executive Director by maintenance. "Tels" system will be utilized by maintenance which	

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	07/10/2024

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
			Executive Director will now get updates weekly on her computer to monitor and will alert when these are due or past due. 5 **For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance.** Ongoing-Director of Maintenance and Assist Maintenance will update Executive Director with every drill. Tels system will update weekly Executive Director of due and past due drills. All systemic changes noted in this deficiency will be completed by 7/26/24	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or			

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	07/10/2024

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
	administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure that staff were First Aid certified on each shift for 8 of 11 day and night shifts reviewed. This had the potential to affect 122 residents whom reside in the facility. Findings include: The review of the staff schedule between 6/30/24 and 7/10/24, indicated the following: - On July 1, 2024, during the night shift (CNA 9 and CNA 10), no staff were certified with First Aid. - On July 2, 2024, during the night shift (CNA 9 and CNA 10)t, no staff were certified with First Aid. - On July 5, 2024, during the day shift (LPN 12), no staff were certified with First Aid. - On July 6, 2024, during the day shift (LPN 11 and LPN 8), no staff were certified with First Aid. - On July 6, 2024, during the night shift (CNA 9 and CNA 10), no staff were certified with First Aid. - On July 7, 2024, during the day shift (LPN 11 and LPN 8), no staff were certified with First Aid. - On July 7, 2024, during the night shift (CNA 10 and CNA 9), no staff were certified with First Aid. - On July 9, 2024, during the day shift (LPN 11 and LPN 8), no staff were certified with First Aid. During an interview on 7/10/24 at 3:17 p.m., the ED (Executive Director) indicated she felt the day	R 0117	**(R 117) 410 LAC 16.2-5-1.4b) Personal-Deficiency** **1 Please describe what the facility did to correct the deficient practice.** (All) employees missing First Aid training will be obtain and be placed in binder with updated CPR training by 9/1/24 and kept in Executive Directors office. 2 **What measures will be put into place or what systemic change will be made to ensure that the deficient proactive does not recure?** Executive Director will review First Aid/CPR binder monthly and inform staff when updates are needed. Facility will take care of the cost of staff keeping these updated. **3.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents are at potential risk for the mentioned deficient practice; however, no resident had any issues on any shift where	09/01/2024

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	07/10/2024

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
	shift staff had taken the First Aid/CPR course but would have to take time to contact the fire department for proof of classroom instruction. The staff had not received CPR/First Aid certification cards. She felt the night shift staff had accidentally clicked on the wrong class for CPR/First Aid and had clicked on the CPR class only. No additional First Aid class information was provided. During an interview on 7/10/24 at 3:24 p.m., the ED indicated she did not have a policy for CPR/First Aid certification.		First Aid wasn't updated along with staffs CPR and Executive will keep records secure in binder and review monthly to make sure all are updated. **4.How will corrective actions be monitored to ensure the deficient practice will not recure? Please explain the criteria or threshold and Quality Assurance Program will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.** Executive will keep records secure in binder and review monthly to make sure (all) staff are updated with both First Aid and CPR **5 For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance.** Ongoing monitoring by Executive Director *All systemic changes noted in this deficiency will be completed on or before 9/1/24*	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and	R 0273	**(R 273) 410 IAC 16.2-5-5.1(f)**	07/24/2024

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	07/10/2024

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
	interview, the facility failed to ensure the kitchen equipment was clean and free from grease and food particles for 2 of 2 kitchen observation. This deficient practice had the potential to affect 122 residents currently residing in the facility. Finding includes: 1. During the initial kitchen tour on 7/10/24 between 9:20 and 9:45 a.m. while accompanied by Cook 6, the following concerns were observed: - There was a heavy coating of gray dust on the vents in the overhead stove hood. - The left side of the wall between the refrigerator and the fryer had a heavy coating of grease and yellow food particles. - The right side of the refrigerator had a heavy coating of grease and yellow food particles. - The fryer had a moderate amount of yellow food crumbs on the shelf inside the fryer and surrounding area. An interview with Cook 6 at that time indicated the fryer was last used yesterday. - The steam box on the back of the fryer had a heavy accumulation of grease and yellow food crumbs. - The shelf in front of the flat top griddle had 5 french fries in it with a heavy accumulation of brown/black grease and yellow food crumbs. - The panel in front of the knobs and the shelf under the flat top had a heavy accumulation of brown grease and yellow food particles.		**Food and Nutritional Services-Deficiency** **1 Please describe what the facility did to correct the deficient practice.** Cleaning was conducted by dietary staff and Culinary Director along with outside professional company (Jani King) All items observed in survey has been corrected by this. 2 **What measures will be put into place or what systemic change will be made to ensure that the deficient proactive does not recure?** Cleaning scheduled will be completed by Culinary Director and copies kept in a binder so Executive Director may view monthly. In-service schedule with Culinary Director to review the importance of the log/cleaning schedule and facilities expectations of all items being cleaned regularly. Executive Director will schedule every six-month cleanings from outside source for floors, and heavy equipment. **3 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents are at potential risk for the mentioned deficient	

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	07/10/2024

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
	- The front 2 burners on the stove had a heavy accumulation of dried brown food particles and black grease. - The shelf under the convection oven and the left side of the convection oven had a moderate amount of brown grease and food particles. - The drain under the sink by the spice rack had red and brown food particles on the drain strainer. The inside white area where the water flows into the drain had a brown coating around the drain. - The inside white area and water pipes going into the drain under the dishwasher had a coating of a brown substance. - There were white spills running down the front bottom grate and the door of the refrigerator. - The top of the dishwasher had a moderate amount of yellow food crumbs. A white spot was on the top of the dishwasher which measured 1 foot in width and 6 inches in length.` 2. During a second observation of the kitchen at 1:40 p.m.. the following concerns were observed: - the same issues identified at 9:20 a.m. remained an issue. - There was a black substance is the drain area under the garbage disposal. - The right side of the dishwasher door and front had multiple white streaks and food particles. - The grape juice machine had several purple spills dripping down the backsplash which were sticky to the touch. The drain was almost full of grape juice.		practice; however, a review/inspect of (all) residents by DON and Executive Director reviewing any illness systems reported over the last six months shows no resident was affected. **4 How will corrective actions be monitored to ensure the deficient practice will not recure? Please explain the criteria or threshold and Quality Assurance Program will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.** Ongoing reviews of cleaning schedule by Culinary Director, In-service/education and walkthroughs by Executive Director of kitchen. **5 For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance.** Ongoing by Culinary Director and Executive Director. *All systemic changes noted will be completed on or before 7/26/24*	

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	07/10/2024

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
	- The shelf above the stove had a heavy coating of grease, dust and food particles. During an interview with the Dietary Manager at 2:20 p.m.. she indicated she just got approval today to hire a cleaning company to work on the floors and clean the equipment. She was aware there were issues with the cleaning schedules and not completing them. Review of the as-completed cleaning schedule for July 2024 indicated the following: - The juice machine was cleaned during the first and second weeks of July. - The stove and burners were last cleaned the first week of July. - The hood vent filters were last cleaned the first week of July. - The walls by the dish machine and the oven were last cleaned the first week of July. The cleaning schedule indicated the cleaning schedules were to be done daily if needed. - The deep fryer was to be cleaned weekly if needed and was last cleaned the first week of July. - The regular oven and the convection oven were last cleaned the beginning of July.			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered			

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	07/10/2024

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
	by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, record review, and interview, the facility failed to ensure the safe storage of medications in 3 of 6 resident rooms observed (Residents 8, 9, and 2) Findings include: 1. During an observation of medication administration on 7/10/24 at 8:52 a.m., Resident 1's upper cabinet had 1 medication cup with opened celecoxib, pregabalin, eliquis, rispirdal, melatonin, and donepezil were out of the medication lock box sitting on the cabinet shelf. The medications were last documented in the MAR (Medication Administration Record) as administered on 7/9/24. During an interview on 7/10/24 at 8:55 a.m., LPN 8 (Licensed Practical Nurse), indicated she was not sure when the medications were placed in the medication cup and into the cabinet. The resident was not sure how long the pills had been there or when they were last given. There was no lock on the cabinet door and the resident had access to the pills. LPN 8 reviewed the MAR and indicated the medications were ordered for administration during the evening shift. The resident's current medications were administered. There was a half tablet of the atenolol on the the LPN 8"S computer keyboard. The nurse picked up the half tablet of atenolol and indicated "oops" and gave the medication to the resident. The resident did not want his apartment door locked. The record for Resident 1 was reviewed on 7/10/24 at 1:59 p.m. The resident's diagnoses included, but were not limited to, dementia, type 2 diabetes	R 0304	**(R 304) 410 IAC 16.2-5-6€ Pharmaceutical Services-Deficiency** While no residents were negatively affected, an investigation was conducted, MAR reviewed by Director of Nursing, (all) rooms that had medication administered was checked and any missing locks for medication box was provided and medication secured. Nursing and QMA In-service are scheduled for July 31st. **1 Please describe what the facility did to correct the deficient practice.** (all) residents' rooms were checked and locks provided on medication cabinets/boxes where needed by Director of Nursing and Assistant Director of Nursing. In-service/education scheduled July 31st - no medication should be kept in a cup in the unlocked cabinet or anywhere in resident's room. Nursing staff must give medication directly to residents during med pass and if any medication box lock gets missed placed or lost during med pass, nursing staff must obtain a new lock immediately from Director of Nursing because medicine or treatment cabinets/boxes or rooms shall be appropriately always locked except when	07/31/2024

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	07/10/2024

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
	mellitus, psychosis, acute pain, major depressive disorder, and hypertension. The physician's order, dated 3/1/22, indicated to administer 23 mg (milligrams) of donepezil at bedtime. The physician's order, dated 3/1/22, indicated to administer 0.5 mg of risperdal every evening. The care plan, dated 5/25/22, indicated medical management, interventions included, but were not limited to, the resident required assistance for medication administration; ordering of medications; communication with the pharmacy, laboratory appointments, and special preparation. The physician's order, dated 3/10/23, indicated to administer 100 mg celecoxib twice daily. The physician's order, dated 1/10/24, indicated to administer 25 mg of pregabalin twice daily. The physician's order, dated 2/29/24, indicated to administer 5 mg of Eliquis twice daily. The physician's order, dated 3/1/24, indicated to administer 1 mg of melatonin at bedtime. During an interview on 7/10/24 at 10:15 a.m., LPN 8 indicated residents should take their medication when given. No medication should be kept in a cup in the unlocked cabinet. She indicated that all medication boxes had locks. 2. During an observation of medication administration on 7/10/24 at 8:54 a.m., LPN 8, obtained the medication box from the upper cabinet for Resident 9. The medication box did not have a lock on the box and the cabinet lacked a		authorized personally are present. **2.What measures will be put into place or what systemic change will be made to ensure that the deficient proactive does not recure?** Ongoing checks of resident's medication cabinets/boxes will be checked by Director of Nursing and Assist Director of Nursing to assure the deficient proactive does not recure. **1 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents are at potential risk for the mentioned deficient practice; however, a review/inspect of (all) residents' rooms was conducted by the Director of Nursing and Assistant Director of Nursing. **2 How will corrective actions be monitored to ensure the deficient practice will not recure? Please explain the criteria or threshold and Quality Assurance Program will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.**	

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	07/10/2024

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
	lock. The record for Resident 9 was reviewed on 7/10/24 at 2:04 p.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, hypothyroidism, hyperlipidemia, pain, and hypertension. The care plan, dated 2/20/23, indicated Insulin and blood sugar management. The intervention, indicated the resident required assistance for blood sugar checks and supplies. The care plan lacked documentation of the resident requiring assistance for other medications. The record lacked documentation of a physician's order for the resident to self-administer her medications. During an interview on 7/10/24 at 10:15 a.m., LPN 8 indicated Resident 9's medication box didn't have a lock and she would take one to place on it. The cabinets don't have locks. Someone could take the box if the resident's rooms were kept unlocked. 3. During an observation of Resident 2's room 7/10/24 at 9:57 a.m., his medications were in a large plastic clear freezer bag on the floor. The bag was so full it could not be closed. The resident indicated there was no room for it in the locked box. The resident had 2 bottles of mirtazapine, a bottle of lasix, a bottle of propanol, and a bottle of sodium chloride on the counter. The resident indicated he needed a larger box, but the facility had not provided him with one. He was waiting for the nurse to administer his medications at that time. The medication box in his room was on the floor and not in the cabinet. The resident's room		A review/inspection of (all) residents rooms/medication cabinets was conducted by Director of Nursing and Assistant Director of Nursing and ongoing checks will be done. *All systemic changes noted in this deficiency will be completed on or before 7/31/24* Affective date 7/24/24	

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	07/10/2024

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
	entry door was unlocked. The record for Resident 2 was reviewed on 7/10/24 at 2:10 p.m. The resident's diagnoses included, but were not limited to, cardiomyopathy, insomnia, tremor, cannabis abuse, hyperlipidemia, bipolar disorder, benign neoplasm of the prostate, inflammatory polyps of the colon, radial styloid tenosynovitis, low back pain, hypertension, tobacco use, alcohol abuse, and peripheral vascular disease. The care plan, dated 8/28/23, indicated medication management. The intervention indicated the resident received non-contracted pharmacy used for medication management with the Veteran's Administration. The care plan lacked documentation of the resident requiring assistance for other medications. During an interview on 7/10/24 at 10:15 a.m., LPN 8 indicated Resident 2 had asked nursing staff to administer his medications. During an interview on 7/10/24 at 1:29 p.m., the DON (Director of Nursing), indicated the medications were kept locked in a medication box in each resident's room. The resident's would choose to lock or unlock their door to their rooms. If a nurse was to administer medications, she should stay with the resident until the medication was taken. She had educated the nursing staff on this and posted a sign all over the building to indicate this. She had educated nurses and QMA's (Qualified Nurse Aides) on this expectation last on 5/22/24. Resident 2 may have just received his medications and that was why they were sitting out. The resident could have			

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	07/10/2024

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
	asked her for another medication lock box, if he needed it. The resident had not been educated on locking his medications in a box. The nurse should have put his extra medications in the cabinet. The signage for medication administration was provided by the DON on 7/10/24 at 2:10 p.m. The sign indicated "ALL residents must be OBSERVED taking their prescribed medication as it is given. We absolutely can NOT leave medication in rooms at ANY TIME. This has been addressed several times before, but I am revisiting, in case there are those of you that may not be aware. I know I can count on all of you to adhere to company policies ..." The Resident Self-Management and Storage of Medication policy, dated 10/3/22, included, but was not limited to, " ... 1. If a resident is allowed to keep their own medications, the Director of Nursing ensures: a) The resident demonstrates the ability to safely and appropriately manage their medications and medications can be safely stored in their room ... c) All medications must be kept in a secure environment that is accessible only to the resident, individuals authorized by the resident, and the Community Licensed Staff. Locked storage (such as a container, cabinet, etc.) is maintained in the resident's room to prevent access by other residents. The resident's apartment must be kept locked at any time when the resident is out of the apartment. Medications may not be left sitting out in a resident's room ..."			