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	08/25/2023

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00411127 and IN00411345. Complaint IN00411127 - No deficiencies related to the allegations are cited. Complaint IN00411345 - No deficiencies related to the allegation is cited. Unrelated deficiencies are cited. Survey dates: August 24 and 25, 2023 Facility number: 014166 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 29, 2023.	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure misappropriation of resident property did not occur for 2 of 3 residents reviewed for resident rights. (Residents C and E) Findings include:	R 0064	**Facility ID: 014166** **Hellenic Senior Living of New Albany** **2632 Grant Line Road** **New Albany, IN 47150**	09/06/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Robinson	Executive Director	09/06/2023

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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	1. The clinical record for Resident C was reviewed on 8/25/23 at 11:20 a.m. The diagnosis included, but was not limited to, osteoarthritis. During an interview on 8/25/23 at 9:45 a.m., Resident C indicated she had not missed any doses of her pain medication. During an interview on 8/25/23 at 9:45 a.m., Resident C was observed sitting in her recliner in her apartment with no signs of any pain or discomfort. She indicated she had not missed any doses of her pain medication. The physician's order, dated 6/8/23, indicated the resident was to receive Hydrocodone-APAP (narcotic pain medication) 7.5-325 mg (milligrams) four times a day for pain. Review of the July 2023 controlled medication record sheet indicated on 7/4/23 at 7:00 p.m., the resident had a total of 5 Hydrocodone left. On 7/5/23 at 7:00 a.m., a new controlled medication record was started with a new card of 30 Hydrocodone. The written statement from QMA (Qualified Medication Aide) 4, undated and untimed, indicated on 7/5/23 there were 5 unlabelled pills in a pill cup in the narcotic drawer. She disposed of them in the sharps container. On 8/24/23 at 1:20 p.m., the Executive Director indicated the sharps containers were looked through and no medications were found. During a telephone interview on 8/25/23 at 9:23 a.m., LPN (Licensed Practical Nurse) 7 indicated prior to the end of her shift the resident had 9		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 with this revised plan of correction as of Sept 5, 2023. **(R 064) 410 IAC 16.2-5-1.2(hh) Residents' Rights-Noncompliance** While no residents were negatively affected, Investigation was completed and Inservice on lost or stolen resident property and finding of the investigation was reported to the resident. **1. Please describe what the facility did to correct the deficient practice.** Investigation completed, state reportable completed, Attorney General's office updated, employees terminated, and Clinical In-service held 7/13/23 for the review of HSL's policies and education provided on lost or stolen resident property specific (medication) **2. What measures will be put into place or what systemic change will be made to ensure that the deficient proactive does not recure?** The employees (QMA's) implicated in this incident were terminated. Clinical Policy and Procedure Manual was reviewed on lost or stolen resident property with a focus of resident's medications 7/13/23. Also	

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	Hydrocodone's left after her last dose was administered at 7:00 p.m. on 7/4/23. During a telephone interview on 8/25/23 at 10:57 a.m., QMA 5 indicated when she came in to work on 7/5/23 at 7:00 a.m., she was the only QMA working. The other scheduled nurse was due in at 8:00 a.m. She always counted the cart prior to starting her medication pass. The resident, according to her narcotic sheet, should have had 5 Hydrocodone left and the card was empty. She took the medication cards and the narcotic count sheet to the Director of Nursing. 2. The clinical record for Resident E was reviewed on 8/25/23 at 11:10 a.m. The diagnoses included, but were not limited to, gout, diabetes and leg pain. The physician's order, dated 5/17/23, indicated the resident was to receive Oxycodone/APAP (narcotic pain medication) 7.5-325 mg three times a day for pain. Review of the July 2023 controlled medication sheet indicated, on 7/3/23 at 7:00 a.m., the resident had 5 Oxycodone left. The next administration entry was dated 7/5/23 at 7:00 a.m. The medication sheet indicated, prior to the 7/5/23 at 7:00 a.m. administration there were 29 Oxycodone left. This left a discrepancy of 6 Oxycodone tablets missing. During a telephone interview on 8/25/23 at 10:57 a.m., QMA 5 indicated when she came to work on 7/5/23 at 7:00 a.m., there was a discrepancy with the amount of Oxycodone tablets the resident had left. She took the medication cards and the narcotic count sheet to the Director of Nursing. During an interview on 8/25/23 at 11:42 a.m., the		indicated the community supports and enforces safe procedures for the management, storage, and administration of controlled substance medication. Scheduled II medications have special prescriptive requirements. Precautions will be enforced to ensure that all controlled substances have been properly accounted for, and destroyed as indicated, to prevent drug diversion and education given to all clinical staff. **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, a count from incoming and outgoing staff will be performed to verify correct count on all meds. **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 monitoring of all corrective actions will be done by	

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	Director of Nursing indicated they could not account for the missing medication. A current policy, titled Clinical Policy and Procedure Manual, dated 9/30/22., indicated "... The Community supports and enforces safe procedures for the management, storage, and administration of controlled substance medication. Scheduled II medications have special prescriptive requirements. Precautions will be enforced to ensure that all controlled substances have been properly accounted for, and destroyed as indicated, to prevent drug diversions..."		HSL management. HSL will review Clinical Policy and Procedure Manual and education during floor training with all new hire clinical staff. Corrective action will be based on the above criteria in a timely manner. **5. By what date will the systemic changes be completed?** The systemic changes noted was Completed 7/13/23. Education will be ongoing for new hires and current staff.	
R 0305 Bldg. 00	410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance (f) Residents may use the pharmacy of their choice for medications administered by the facility, as long as the pharmacy: (1) complies with the facility policy receiving, packaging, and labeling of pharmaceutical products unless contrary to state and federal laws; (2) provides prescribed service on a prompt and timely basis; and (3) refills prescription drugs when needed, in order to prevent interruption of drug regimens. Based on interview and record review, the facility failed to ensure a licensed nurse received and signed for medications delivered to the facility for 7 of 27 pharmacy delivery sheets reviewed for pharmacy services. Findings include: Review of the July 2023 pharmacy delivery sheets indicated on 7/5/23, 7/6/23, 7/8/23, 7/10/23, 7/14/23, 7/15/23 and 7/19/23, medications were delivered to the facility and signed for by QMA (Qualified	R 0305	**(R 305) 410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services** While no residents were negatively affected, Investigation was completed and Inservice on lost or stolen resident property and finding of the investigation was reported to the resident. **1. Please describe what the facility did to correct the deficient practice.** Employee named in above	09/06/2023

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	Medications Aide) 5. On 7/8/23, medications were delivered to the facility and signed for by QMA 4. During a telephone interview on 8/25/23 at 10:57 a.m., QMA 5 indicated she was not sure if QMAs were suppose to sign for receiving medications from the pharmacy. When she was the only one working and the pharmacy delivered medications, she had been signing the acknowledgement of medication receipt upon delivery. During a interview on 8/25/23 at 12:16 p.m., The Executive Director indicated QMA's should not be signing for medications from the pharmacy, only licensed nurses. On 8/25//23 at 12:12 p.m., the Administrator provided a current copy of the document titled "Medication Administration" dated 9/30/2023. It included, but was not limited to, "Procedure...Licensed nurses will be responsible for signing acknowledgement of medication receipt upon delivery from the pharmacy representative...."		deficient was terminated. Inservice held and nursing staff educated 7/13/23. Only nurses could sign for medication received from pharmacy. Pharmacy hours for drop off of medication have been changed around LPN's and RN's schedule. **2. What measures will be put into place or what systemic change will be made to ensure that the deficient proactive does not recure?** The employee's implicated in this incident was terminated. Ongoing education by DON and or ED with staff and new hires. Pharmacy hours for drop off has been changed to assure LPN or RN is present for drop off/sign for medication. **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 identified deficient practice; however, with ongoing education in place and holding staff accountable will limit the risk. Ongoing Inservice with staff will make staff aware by HSL policy and procedures and expectations. 4. **How will corrective actions be monitored to ensure the deficient practice will not**	

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			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 monitoring of all corrective actions will be done by HSL management with a weekly review of pharmacy medication delivery sheets. HSL will also encourage all employees to be resident advocates to ensure the safety of all resident's belongings including medication but not limited to medications. **5.By what date will the systemic changes be completed?** The systemic changes noted have already been implemented on 7/13/23, was completed prior to surveyor visit/findings.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, interview and record review, the facility failed to ensure staff accurately documented the administration of narcotic pain	R 0349	**(R 349) 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records-Noncompliance.**	10/14/2023

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	medication for 2 of 3 residents reviewed for clinical record documentation. (Residents C and E) Findings include: 1. The clinical record for Resident C was reviewed on 8/25/23 at 11:20 a.m. The diagnosis included, but was not limited to, osteoarthritis. During an interview on 8/25/23 at 9:45 a.m., Resident C was observed sitting in her recliner in her apartment with no signs of any pain or discomfort. She indicated she received her pain medication four times a day, every day, as ordered by her physician. The physician's order, dated 6/8/23, indicated the resident was to receive Hydrocodone-APAP (narcotic pain medication) 7.5-325 mg (milligrams) four times a day for pain. Review of the July 2023 controlled medication record sheet indicated the resident received the pain medication at 7:00 p.m. on 7/1/23, 7/3/23, 7/4/23, 7/5/23, 7/6/23, 7/8/23, 7/10/23, 7/11/23, 7/12/23 and 7/14/23. The July 2023 medication administration lacked documentation of the administration of the above scheduled doses. During an interview on 8/25/23 at 12:50 p.m., LPN (Licensed Practical Nurse) 8 indicated when narcotic pain medication was administered, it should be signed out on the controlled record sheet and then signed off on the medication administration record. 2. The clinical record for Resident E was reviewed on 8/25/23 at 11:10 a.m. The diagnoses included,		While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected by the facility failing to ensure staff accurately documented the administration of narcotic pain medication. 1. **What corrective action will be accomplished for the residents found to have been affected by the deficient practice after the date of survey exists?** Inservice held with all clinical staff 7/13/23. DON will review the weekly controlled record sheet to ensure staff sign off on the medication administration records, ongoing. **3.How other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?** All residents are at potential risk for the identified deficient practice; however, with ongoing education in place and holding staff accountable will limit the risk. Ongoing Inservice with staff will make staff aware by HSL policy and procedures and expectations with administration of medication. **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**	

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	but were not limited to, gout, diabetes and leg pain. The physician's order, dated 5/17/23, indicated the resident was to receive Oxycodone/APAP (narcotic pain medication) 7.5-325 mg three times a day for pain. Review of the July 2023 controlled medication sheet indicated the resident received the pain medication on the following dates and times: - 7/01/23 at 7:00 p.m. - 7/06/23 at 7:00 p.m. - 7/08/23 at 7:00 p.m. - 7/10/23 - 7/14/23 at 7:00 p.m. - 7/17/23 - 7/19/23 at 7:00 p.m. - 7/21/23 at 7:00 a.m., 1:00 p.m. and 7:00 p.m. - 7/22/23 at 7:00 a.m., 1:00 p.m. and 7:00 p.m. - 7/23/23 at 7:00 a.m., 1:00 p.m. and 7:00 p.m. - 7/24/23 at 7:00 a.m. and 1:00 p.m. - 7/28/23 - 7/31/23 at 7:00 p.m. The July 2023 medication administration record lacked documentation of the administration of the medication. Review of the August 2023 controlled medication sheet indicated the resident received the pain medication of the following dates and times: - 8/01/23 - 8/11/23 at 7:00 p.m. - 8/12/23 at 7:00 a.m., 1:00 p.m. and 7:00 p.m. - 8/13/22 - 8/23/23 at 7:00 p.m. The August 2023 medication administration record lacked documentation of the administration of the medication. On 8/25/23 at 12:12 p.m., the Executive Director		**be used to determine whether further monitoring is necessary or if the monitoring can be stopped.** Five residents' medication administration will be reviewed through EMAR system for six weeks and ongoing for additional six weeks if any holes show during this time frame. **5. By what date will the systemic changes be completed?** 10/14/23	

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	provided a current copy of the document titled "Medication Administration" dated 9/30/22. It included, but was not limited to, "Procedure...The licensed nurse and the qualified medication aide will administer medications by completing the following steps...Document...administration immediately after administration...."			