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	12/05/2023

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

(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 IN00421386. Complaint IN00421386 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited Survey date: December 5, 2023 Facility number: 014166 Residential Census: 113 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on December 10, 2023.	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.* *This facility alleges substantial compliance with this plan of correction as of December 15, 2023* Complaint INOO421386-No deficiencies related to the allegations was sited but This State Residential Findings are cited in accordance with 410 IAC 16.2-5. (Administration Management-Deficiency) Rule not met as evidenced by: Based on interview and record review, the facility management failed to inform the division within twenty-four (24) hours of becoming aware of an unusual occurrence with two residents. (Resident B and Resident C). Resident B fell outside in front of the facility on 8/5/23 at 6:59 p.m. ED was made aware of the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy S. Robinson	Executive Director	12/14/2023

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			incident at 48 hours by DON and reported the incident to the division on 8/7/23. 8/7/23 Director of Nursing, DON and Assistant Director of Nursing, ADON were educated by ED on the process for reportable incidents and time frame required and noted in PCC. Resident C fell in their apartment at facility 11/30/23. DON stated he would complete reportable but didn't. ED completed reportable 12/4/23 when she found out DON hadn't done it. Note: Director of Nursing, Scott Profitt was terminated 12/4/23… *While all residents have the potential to have been affected in a negative manner, no residents were identified as being negatively affected by reporting incident at 48 hours instead of 24.* **1 Please describe what the facility did to correct the deficient practice.** 8/7/23 ED educated DON and ADON on reporting process and advised DON if unable to input reportable timely to contact ED before the 24-hour time frame required. 12/14/23 Inservice held with current DON and ADON to re-educate on reporting process.	

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			Note: 12/4/23 Director of Nursing, Scott Profitt was terminated due to this type of deficient practice as Resident B was repeated 11/30/23 with Resident C. *2.* **Please describe how the facility reviewed all residents 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 of (all) recent falls/incidents of the same nature and binder reviewed in ED office with no other findings of any failed/missed/late reportable. **3.Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure.** ED will complete all reportable and new DON, Chris Shoemaker as back up only. (note: Previous DON Scott Profitt, RN was terminated due to incident of this nature reoccurring two times) **4.Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** In-serve held 12/14/23 All incidents will be reported every	

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			morning in the Morning meeting to ED and weekends they will be called in to ED by DON or by staff if unable to reach DON. **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 will review all incidents daily and report to ED in morning meeting unless it's a weekend and staff will contact Director of Nursing and ED directly via phone. *Affective date 12/14/23*	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or			

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	(D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility management failed to report incidents to the Indiana Department of Health, in a timely manner, when two residents (Resident B and Resident C) sustained falls resulting in a fracture for 2 of 3 residents reviewed for reportable incidents. Findings include:	R 0090	**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*	12/14/2023

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	1. The clinical record for Resident B was reviewed on 12/5/23 at 10:00 a.m. The diagnoses included, but was not limited to, chronic pain syndrome, cervicalgia, and history of left displaced femoral neck fracture. The incident report, dated 8/7/23, indicated the resident had fallen outside and sustained a fractured hip while gardening outside in front of the building. The progress note, dated 8/5/23 at 6:59 p.m., indicated the resident had fallen outside in front of the facility. The progress note, dated 8/5/23 at 8:55 p.m., indicated the resident was sent to the emergency department related to a fall. The progress note, dated 8/7/23 at 10:14 a.m., indicated the incident had just been reported to the ED (Executive Director), the reportable was entered, and the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) were educated on the process for reportable incidents. The hospital x-ray, dated 8/5/23 at 10:48 p.m., indicated an acute fracture of the left femoral neck. During an interview on 12/5/23 at 12:22 p.m., the ED indicated the DON failed to inform her of the resident's fracture, therefore, was not reported within the required 24 hour period time frame. 2. The clinical record for Resident C was reviewed on 12/5/23 at 11:04 a.m. The diagnosis included, but was not limited to, closed fracture of the right humerus. The incident report, dated 12/4/23, indicated		*facility or its staff members. Rather, it is submitted for compliance purposes.* *This facility alleges substantial compliance with this plan of correction as of December 15, 2023* Complaint INOO421386-No deficiencies related to the allegations was sited but This State Residential Findings are cited in accordance with 410 IAC 16.2-5. (Administration Management-Deficiency) Rule not met as evidenced by: Based on interview and record review, the facility management failed to inform the division within twenty-four (24) hours of becoming aware of an unusual occurrence with two residents. (Resident B and Resident C). Resident B fell outside in front of the facility on 8/5/23 at 6:59 p.m. ED was made aware of the incident at 48 hours by DON and reported the incident to the division on 8/7/23. 8/7/23 Director of Nursing, DON and Assistant Director of Nursing, ADON were educated by ED on the process for reportable incidents and time frame required and noted in PCC. Resident C fell in their apartment at facility 11/30/23.	

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	Resident C had fallen and was sent to the emergency department with a diagnosis of a right shoulder fracture. The DON did not update the ED and did not complete a reportable. The progress note, dated 11/30/23 at 8:55 a.m., indicated the resident was sent to the emergency department due to a fall. The progress note, dated 11/30/23 at 9:31 a.m., indicated the resident returned from the emergency department with no new orders. The progress note, dated 12/4 23 at 11:54 a.m., indicated the incident was reported but went in late due to the DON not completing nor updating the team. The hospital x-ray report, dated 11/30/23 at 9:09 a.m., indicated the resident had a transverse fracture through the surgical neck of the humerus. During an interview on 12/5/23 at 9:31 a.m., the ED indicated the resident had fallen on Thursday morning and fractured his shoulder. The DON did not tell anyone and she found out through another staff member. The DON assured her on Friday (12/1/23) that he would put the reportable in. The DON dropped the ball because it should have been reported within 24 hours and he did not report it. On 12/5/23 at 12:54 p.m., the Executive Director provided a current copy of the document titled "Incident/Accident/ Unusual Occurrence Investigation and Reporting" dated 9/30/22. It included, but was not limited to, "Policy...For the safety and well being of the residents, all incidents...will be handled in a uniform, prompt and efficient manner...All incidents...that meet the		DON stated he would complete reportable but didn't. ED completed reportable 12/4/23 when she found out DON hadn't done it. Note: Director of Nursing, Scott Profitt was terminated 12/4/23… *While all residents have the potential to have been affected in a negative manner, no residents were identified as being negatively affected by reporting incident at 48 hours instead of 24.* **1 Please describe what the facility did to correct the deficient practice.** 8/7/23 ED educated DON and ADON on reporting process and advised DON if unable to input reportable timely to contact ED before the 24-hour time frame required. 12/14/23 Inservice held with current DON and ADON to re-educate on reporting process. Note: 12/4/23 Director of Nursing, Scott Profitt was terminated due to this type of deficient practice as Resident B was repeated 11/30/23 with Resident C. *2.* **Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. Facility will maintain current and accurate resident**	

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	criteria for reporting will be submitted to the proper...State...authorities, including...ISDH...."		**files.** An audit was completed by ED of (all) recent falls/incidents of the same nature and binder reviewed in ED office with no other findings of any failed/missed/late reportable. **3.Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure.** ED will complete all reportable and new DON, Chris Shoemaker as back up only. (note: Previous DON Scott Profitt, RN was terminated due to incident of this nature reoccurring two times) **4.Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** In-serve held 12/14/23 All incidents will be reported every morning in the Morning meeting to ED and weekends they will be called in to ED by DON or by staff if unable to reach DON. **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 will review all incidents daily and	

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			report to ED in morning meeting unless it's a weekend and staff will contact Director of Nursing and ED directly via phone. *Affective date 12/14/23*	