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	05/03/2024

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00428972. Complaint IN00428972 - No deficiencies related to the allegations are cited. Survey date: May 2 and 3, 2024 Facility number: 014062 Residential Census: 114 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 6, 2024.	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 any violation or regulation. This provider respectfully requests that this Pan of Correction be considered the letter of Credible Allegation and Requests a Desk Review in lieu of a Post Survey Review. Completion Date of June 3, 2024.	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
JanAnn Caudill	Executive Director	05/20/2024

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.

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	receiving residential nursing services or 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 interview and record review, the facility failed to ensure all shifts had at least one working staff member who was First Aid certified for 9 of 21 shifts reviewed. Finding includes: On 5/3/24 at 8:30 a.m., the Administrator provided a copy of the "as worked" staff schedule from 4/25/24 through 5/1/24. A review of the document indicated the following: - The work schedule identified 3-eight-hour shifts per day. The "first shift" hours were from 7:00 a.m. to 3:00 p.m.; "second shift" hours were from 3:00 p.m. to 11:00 p.m.; and the "third shift" hours were from 11:00 p.m. to 7:00 a.m. - The schedule identified staff members who worked that particular shift and who were designated as being the certified First Aid (training course that provides individuals the knowledge and skills to respond to a medical emergency until more qualified help arrives) staff member for that shift. - Qualified Medication Aide (QMA) 3 was identified as the designated First Aid certified staff member who worked the second shift for 3 shifts (4/27/24, 4/29/24, and 4/30/24).	R 0117	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **The Executive Director audited current staff files for CPR and basic first aid certificates. Current staff not certified will be by 5/15/2024. At this time no residents have been identified as having been affected.** **2 How will the facility 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 deficient practice, however; no residents have been affected. The ED or designee will ensure that new clinical staff have completed CPR and basic first aid training during basic orientation, prior to working the floor. Ongoing monitoring of the schedule to ensure each shift is staffed with**	06/03/2024

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	- QMA 4 was identified as the designated First Aid certified staff member who worked the third shift for 4 shifts (4/25/24, 4/29/24, 4/30/24 and 5/1/24). - QMA 5 was identified as the designated First Aid certified staff member who worked the second shift for 2 shifts (4/25/24 and 5/1/24). The facility lacked documentation that QMA 3, QMA 4, and QMA 5 were First Aid certified. During an interview on 5/3/24 at 11:00 a.m., the Director of Nursing indicated the facility was unable to provided First Aid certifications for QMA 3, QMA 4, and QMA 5. During an interview on 5/3/24 at 11:00 a.m., the Administrator indicated all shifts were to have at least one First Aid certified staff member working that shift. During an interview on 5/3/24 at 11:40 a.m., the Administrator indicated the facility lacked a specific policy that required at least one certified First Aid staff member for every shift.		**at least one CPR and First Aid certified team member, this will mitigate the risk of residents being negatively impacted.** **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** **The Executive Director or designee will provide twice a year CPR and first aid certification opportunities. The Executive Director will review staff schedules before posting to ensure at least 1 person on shift has current CPR and first aid certifications. The Clinical Director will ensure that new clinical staff have completed CPR and Basic First Aid training during basic orientation, prior to working the floor.** **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?** **The Executive Director and/or Clinical Director will audit 5 staff license and certification records weekly for four weeks, then monthly for three months to ensure CPR and Basic First Aid certification. Results will be**	

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			reviewed monthly during Morning meeting. Monitoring will be ongoing. **5 By what date the systemic changes will be completed: 6/3/2024.**	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure a CNA had an active CNA certification prior to working as a CNA for 1 of 9 CNA's reviewed. (CNA 6) Findings include: On 5/3/24 at 8:30 a.m., the Administrator provided the facility's staff roster. CNA 6's personnel records were reviewed and indicated the following: - CNA 6 was hired as a CNA on 9/5/22. - CNA 6's Job Description document indicated "...Job position title: Nursing Care Partner...adhere to...Nurse Aide Scope of Practice...must be certified and provide documentation indicating successful completion	R 0118	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **The clinical staff member who did not renew her certification was immediately terminated. The Executive Director audited current staff files for professional licenses, QMA and C.N.A. certifications to ensure all clinical staff have current license in place. No residents have been identified as having been affected.** **2 How will the facility identify other residents having the potential to be affected by the same deficient practice and**	06/03/2024

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	of a Basic Nursing Assistant Training Program and Competency Exam (CNA)..." The document was signed by CNA 6 on 8/30/22. CNA 6's CNA certification status was reviewed and indicated the certification had expired on 2/17/24. No other subsequent CNA certification was available. On 5/3/24 at 12:15 p.m., the Director of Nursing provided CNA 6's "as worked schedule" from 2/17/24 through 5/1/24. A review of the report indicated CNA 6 had worked as a CNA, without a valid CNA certification, for 47 eight hour shifts during that time period. During an interview on 5/3/24 at 12:30 p.m., the Director of Nursing indicated CNA 6 had been working as a Resident Care Partner (also known as a CNA) since her hire date of 9/5/22. The facility "just realized" CNA 6's certification had expired on 2/17/24. During an interview on 5/3/24 at 12:45 p.m., the Administrator indicated the facility lacked a specific policy for monitoring to ensure nursing staff licenses and certifications were current, active, and valid. CNA staff members were to only work as a CNA when they had a current, active, and valid CNA certification.		**what corrective action will be taken?** **All residents have the potential to be affected by the deficient practice, however; no residents have been negatively affected. The Executive Director and/or designee will ensure that new hire clinical staff have current professional license and/or QMA and C.N.A certifications prior to employment. Ongoing audits of the clinical staff licenses will be completed monthly, this will mitigate the risk of residents being negatively impacted.** **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** **The Executive Director or designee will audit the clinical staff license monthly to ensure the clinical staff have renewed their Professional License, QMA and C.N.A. Certifications. If found that a clinical staff person's license is not renewed; that clinical staff person will be removed from the schedule until renewal of license takes place. Should a license of a clinical staff person fail to renew their license employment will terminate.** **4 How the corrective action(s) will be monitored to ensure the deficient practice**	

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			will not recur, i.e., what quality assurance program will be put into place? **The Executive Director and/or designee will audit 5 staff licenses weekly for four weeks, then monthly for three months. Monitoring will be ongoing. Results will be reviewed monthly during the Morning meeting for three consecutive months.** **5 By what date the systemic changes will be completed:** **6/3/2024.**	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on interview, record review, and observation, the facility failed to ensure the dining room was in good repair for 1 of 1 observations of the dining room. (Resident 31, Resident 121, Resident 125) Findings include: During an interview on 5/2/24 at 12:33 p.m., Resident 31 indicated "there was black mold on the dining room wall. The black mold had been there for months.". The air conditioner condensation leaked down the wall. During an observation on 5/2/24 at 12:44 p.m., the following was observed.	R 0144	**1** **What Corrective action(s)will b e accomplished for those residents found to have been affected by the deficient practice?** **No residents were affected by the deficient practice.** **2 How will the facility identify other residents having the potential to be affected by the same deficient practices and what corrective actions will be taken?** **All residents have the potential to be affected by the deficient**	06/03/2024

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	- Grayish drip stains on the dining room wall from the air conditioner (A/C) unit to the floor. The A/C unit was hanging near the ceiling above the first table in the dining room on the left side of the room. - The trim on the base of the wall had a thick black substance approximately 1/4 inch thick. The black area was approximately 6 inches long. - The laminate flooring next to the wall was buckled and not adhered to the floor in an approximately 2 foot area. During an interview on 5/2/24 at 12:45 p.m., Resident 121 indicated the laminate flooring was coming up in the same area as the air conditioner leaks. During an interview on 5/2/24 at 12:46 p.m., Resident 125 indicated the black on the base trim "is black mold." During an interview on 5/2/24 at 1:33 p.m., the Administrator indicated the wall had been like that for a few months. A work order had been submitted for repairs. The facility was currently without a Maintenance Director. During an interview on 5/3/24 at 12:00 p.m., the Administrator indicated the facility was unable to provide a written work order for the maintenance of the dining room wall. On 5/3/27 at 11:33 a.m., the Administrator provided the Resident Hand Book. The hand book indicated "The environmental services department prepares units prior to move in, makes any necessary repairs to the units and common areas, provides weekly cleaning...If there is a		**practice, however; no residents were affected by the deficient practice. The Dining Service Director and/or designee will check the dining room base boards and floor for cleanliness. All dining staff will be assigned to clean the base boards and flooring in the dining room. A work order is in place for the flooring and leak from the heating/air conditioner to be repaired.** **3. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur?** **A new Maintenance/Environmental Director has been hired with a start date of May 28, 2024. In the interim the Director of Operations has scheduled a maintenance employee at the 232 Senior Living Apartments to come to this community to assist with maintenance concerns. The Dining Services Director has instructed his staff to clean the dining room base boards and floor after meals and at the end of the day.** **4 How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** **The Dining Service Director**	

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	maintenance issue that needs to be addressed contact the receptionist, Business office or nursing staff for assistance, and they will notify Environmental Services to have the issue taken care of. "		**and/or designee will check the dining room base boards and floor for cleanliness. All dining staff will be assigned to clean the base boards and flooring in the dining room. The Registered Dietician will do an audit of the dining room base board and dining room floors on her Dietician report during her routine visits. The Dining Service Director will meet with the Executive Director weekly to discuss any dining room concerns as well as reviewing the daily cleaning schedule of the base boards and dining room floor.** **5 By what date will the systemic changes be completed: 6/3/2024.**	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure the side sliding dumpster doors were kept closed when not in use and that the dumpster area was free of rubbish for 1 of 2 observations. Finding includes: During the facility tour with Cook 2 on 5/2/24 from	R 0155	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **No residents were harmed by the deficient practice.** **2. How will the facility identify other residents having the potential to be affected by**	06/03/2024

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	9:25 a.m. to 9:30 a.m., the dumpster container area was observed. The dumpster area was located approximately 60 yards from the kitchen's rear exit door. The following was observed: - Two dumpster containers were located in an enclosed area. Both dumpster containers had two side sliding dumpster doors. One side sliding dumpster door on each dumpster container was observed to not be closed. Inside the dumpster containers multiple filled trash bags were visible. - The following was observed on the ground near and behind the two dumpster containers: multiple opened trash bags and the area was littered with cups, plastic gloves, opened food containers, plastic wrappers, small bones, a large broken down cardboard box, and other debris. - During an interview at that time, Cook 2 indicated the dumpster area was to be kept clean, free of debris and the side sliding doors were to be kept closed when not in use. - No staff were visible near the dumpster area. On 5/3/24 at 8:30 a.m., the Administrator provided an undated copy of the Outdoor Dumpster Procedure policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...daily tasks-3 times per day/5 days per week...check dumpster area to ensure no trash is on the ground...ensure all lids are closed and doors are shut...ensure all boxes are broken down and placed in dumpster..." On 5/3/24 at 3:10 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for		**the same deficient practice and what corrective action will be taken?** **All residents have the potential to be affected by the deficient practice, however; no residents were harmed by this alleged deficient practice.** **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** **The Executive Director on May 4, 2024, informed the Dining Service Director via a text regarding the proper process of making sure the dumpster doors/lids are closed when not in use; as well as being clear of any debris. The Dining Service Director will provide a written in-service education to all Dining Service Staff on the proper practices with the dumpster. The in-service will be completed by May20, 2024.** **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place?** **The Maintenance/Environmental Director, Dining Service Director or Cook will audit**	

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	refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..."		**the dumpster area daily through May 31, 2024, three times a week for the month of May and June 2024, then weekly for the next three months: July, August, and September of 2024. The Executive Director will also do a once-a-month random check to ensure the dumpster practices are in place and being adhered to per the Dumpster Monthly Check Form. If any described checks discover non-compliance the schedule for audits will resume with daily checks and continue as stated cycle above.** **5. By What date the systemic changes will be completed: 06/03/2024.**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires			

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	change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were signed and dated by the resident or the resident's representative for 2 of 7 residents reviewed. (Resident 228, Resident 337) 1. On 5/2/24 at 10:30 a.m., the clinical record of Resident 337 was reviewed. Resident 337 had a service plan dated 10/18/23. The service plan was not signed or dated by the resident or the resident's representative. 2. On 5/2/24 at 10:55 a.m., the clinical record of Resident 228 was reviewed. Resident 228 had a service plan dated 2/20/24. The service plan was not signed or dated by the resident or the resident's representative. During an interview on 5/3/24 at 9:10 a.m., the Assistant Director of Nursing indicated the signed and dated service plans for Resident 337 and Resident 228 were not available. On 5/3/24 at 10:07 a.m., the Assistant Director of Nursing provided a policy titled Resident Service	R 0217	**1 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** **It is the practice of this provider to ensure that federal participation requirements for Residential Care Facilities who participate in the HCBS for the Medicaid Waiver program are met in accordance with federal and state law. A review of the charts for two residents (2) "affected" residents will be reviewed to ensure service plans are signed and dated by resident and/or the residents Responsible Representative.** **2 2. How will the facility identify other residents having the potential to be affected by the same alleged deficient**	06/03/2024

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	Plans, dated 9/30/22, and indicated it was the current policy being used by the facility. A review of the policy indicted "Procedure ...9. Service plans shall be signed and dated by the resident."		**practice be identified and what corrective action(s) will be taken?** **All residents have the potential to be affected by the deficient practice, however no harm has come to any resident. On May 5, 2024, the community conducted a thorough audit of service plans for current residents to ensure service plans are signed and dated by residents or resident representatives to ensure compliance. ADON and DON are in the process of updating resident service plans as well as ensuring all service plans have the residents and/or resident responsible representatives signatures.** **3 3. What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?** **The Resident Service Plan policy reflects resident service plans will be reviewed with residents and/or the resident representative initially and any time a change to the service plan is made. Said service plans will be signed by resident and/or the resident representative. The ADON will**	

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		A. BUILDING 00 B. WING	05/03/2024

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			be responsible for ensuring all resident service plans are signed by the resident and/or the resident representative. **4 4. How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?** **The clinical software we use to track resident service plans is PCC. This software tells DON and ADON to know when service plans are due. We use this as a part of our quality assurance plan and can monitor the due dates when a resident's service plan is due. The ADON will schedule a service plan meeting with the residents and/or their representatives. All resident service plans will be signed by the resident and/or resident responsible representative will be monitored using the list of service plans due dates in PCC will be monitored on normal business days for one month (daily), weekly for four weeks, and then monthly ongoing. The Executive Director and DON will monitor compliance during the morning meetings that are held daily.** **5 5. By what date the**	

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			systemic changes will be completed: 6/3/2024.	