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	04/09/2025

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 IN00457168. Complaint IN00457168 - State deficiencies related to the allegations are cited at R0090. Survey dates: April 8 and 9, 2025 Facility number: 014062 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 11, 2025.	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 May 9, 2025.**	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency Based on interview and record review, the facility failed to submit a required facility reportable to the State Department of Health regarding an allegation of misappropriation of property. Jewelry and money were reported as taken without the residents permission. (Resident B) Finding includes: On 4/9/25 at 9:18 a.m. the clinical record of Resident B was reviewed. The diagnosis included, but was not limited to, hypertension. A Brief Interview for Mental Status, dated 8/30/24, indicated Resident B was cognitively intact.	R 0090	**R 090 410 IAC 16.2-5-1.3(g) (1-6) Administration and Management – Deficiency** **1 What correction action will be accomplished for those residents found to have been affected by the deficient practice:** On 4/16/2025, the Executive Director (ED) was re-educated by the Regional Director of Operations on the guidelines of reporting allegations of misappropriation of property to state and local officials based on	05/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
JanAnn Caudill	Executive Director	04/21/2025

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	During an interview on 4/8/25 at 12:30 p.m., Resident B indicated about three weeks ago, someone came into his room while he was out doing activities. When he returned after activities, he observed two of his dresser drawers had been pulled completely out and were lying on the floor upside down. This was reported to the Administrator. The Administrator went to Resident B's room and took pictures of the drawers. Resident B indicated he was missing his wife's wedding ring and 60 dollars in cash. During an interview on 4/9/25 at 8:30 a.m., the Administrator indicated the facility lease agreement stated the facility was not responsible for lost or stolen items. No personal inventory sheet had been filled out. The residents were encouraged to not bring in valuable items to the facility. The Administrator indicated the allegation was not reported to the State Department of Heath. On 4/9/25 at 11:05 a.m., the Administrator provided a document titled Summary of Investigation for Resident B, dated 3/18/25, regarding the allegation for Resident B. The document indicated someone had broke into Resident B's apartment and took a diamond ring and sixty dollars in cash. The resident requested reimbursement for the cash and the ring. On 4/9/25 at 10:56 a.m.. the Director of Nursing provided a policy titled Incident...Reporting, dated 9/30/22 and indicated it was the current policy being used by the facility. A review of the policy indicated "All incidents, accidents, and unusual occurrences that meet the criteria or reporting will be submitted to the proper Federal, State, and local authorities, including but not limited to		timeframes surrounding the allegation per the company policy and procedure, and the state and federal regulation. **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. The Executive Director was re-educated by the Regional Director of Operation on 4/16/2025, the Director of Nursing (DON) will be educated by the Executive Director of reporting allegations per the state and federal guidelines and regulation, and per the company policy and procedure. All staff members are educated on the guidelines and federal regulations on preventing and reporting allegations during their orientation process. The training documentation for Resident Rights is kept in their employee file. **3 What measures will be put into place or systemic changes made to ensure the deficient practice will not occur:** The Executive Director was re-educated on the state and federal guidelines and regulations, and per the company including prevention and reporting allegations. The Regional Director of Operations re-educates the Executive Director 1 x per week	

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	ISDH,..." On 4/9/25 at 12:00 p.m., the current IDOH policy titled Long-Term Care Abuse and Incident reporting, dated 12/8/23 was reviewed. The policy indicated "Licensed Residential Care facilities...C. Types of incidents reportable under state rules...12. Misappropriation of resident property: Deliberate misplacement, exploitation, or wrongful temporary or permanent use of resident's property or money without the residents consent..." This citation relates to Complaint IN00457168.		for two weeks: then 1x per month for 2 months, then 1 x quarterly for the next two quarters, then annually thereafter. **4 How will the facility monitor the performance to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place**: The Regional Director of Operations will review all incidents with the Executive Director prior to making the decision to report the concern and/or allegation to the local and state agencies to ensure all guidelines and timeframes are being met by the federal regulation and the company policy timeframes are being met per the state and federal regulation and the company policy and procedure. **5 By what date the systemic changes will be completed:** **5/9/25**	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure staff received annual dementia and resident rights training for 1 of 3 staff reviewed for annual trainings. (Cook 2)	R 0120	**R120 410 IAC 16.2-5-1.4(e) (1-3) Personnel** **1 What correction action will be accomplished for those residents found to have been affected by the deficient practice:**	05/09/2025

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	Finding includes: On 4/9/25 at 9:30 a.m., the employee record of Cook 2 was reviewed. The record indicated Cook 2 was hired on 10/25/23. Cook 2's annual training records were reviewed. The employee record lacked documentation of any subsequent dementia or resident rights training since Cook 2's hire date of 10/25/23. During an interview on 4/9/25 at 11:00 a.m., the Administrator indicated staff were to complete dementia and resident rights training on an annual basis. Cook 2 should have completed the annual dementia and resident rights training for calendar year 2024. During an interview on 4/9/25 at 12:26 p.m., the Director of Nursing indicated the facility did not have a specific policy that required annual training for dementia and resident rights. The Director of Nursing indicated the facility was to follow the state training regulations.		The Executive Director and/or Director of Nursing will ensure all personnel in all departments and at least annually and for all newly hired personnel pertaining to Dementia Training. Audits were conducted immediately on all employee files for compliance. The Dining Server has completed the Relias Dementia Training and will continue to complete the required Dementia Training annually. All new hires are required to complete their Relias training during the orientation period. The Directors of each department have access to Relias training and will ensure 3 hours of Dementia training are completed by their staff annually. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**. No other residents were found to be affected by this practice. **3 What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Audits will occur at the end of each month by each Department Director, Director of Nursing and/or Executive Director to ensure	

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			Relias compliance. All newly hired associate audits will be performed weekly for one month, then once a month for two months, then annually thereafter. Employee audits will be reviewed during morning meetings for 4 months, with adjustments being made if indicated and addressed at meetings. Any issues with lack of compliance will be addressed by employee re-education and /or discipline or revision to this plan by the Executive Director and/or Director of Nursing. **4 How will the facility monitor the performance to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place:** Audits will occur at the end of each month by each Department Director, Director of Nursing and/or Executive Director to ensure Relias compliance. All newly hired associate audits will be performed weekly for one month, then once a month for 2 months, then annually thereafter. Employee audits will be reviewed during morning meetings for 4 months. Any issues with lack of compliance will be addressed by employee re-education and /or discipline or revision of this plan by the Executive Director and/or Director of Nursing.	

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			5 By what date the systemic changes will be completed: Completion Date 5/9/25	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure foods in a kitchen walk in refrigerator were labeled, dated, and tightly covered for 2 of 2 observations. Findings include: On 4/8/25 at 8:47 a.m., during the initial kitchen tour, inside the kitchen walk-in refrigerator the following was observed, a metal stacking cart with trays, on the trays were a total of 16, small white plates, each plate contained a two by two inch piece of yellow cake with glazed icing. The pieces of cake lacked a label to indicate when they were placed into the refrigerator or the expiration date. During an observation on 4/8/25 at 9:20 a.m., observed 16 small white plates in the walk-in cooler with each plate containing a two by two inch piece of cake that were uncovered and unlabeled. During an interview on 4/8/25 at 8:55 a.m., the Culinary Director indicated that the cakes should have been covered and labeled as they were from the previous night. On 4/8/25 at 9:23 a.m., the Culinary Director provided a copy of Culinary Services Operating Standards with a revision date of 3/2/2021 and	R 0273	**R 273 410IAC 16.2-5-5. 1 (f) Food and Nutritional Services - Deficiency** **1. What correction action will be accomplished for those residents found to have been affected by the deficient practice:** No residents were found to have been affected by the deficient practice. The Dining Service Director and Cooks will have a checklist that will document the labeling, dating, and covering of all open-in-use products three times per day. **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 could have been affected by the deficient practice; however, no residents were affected. **3 What measures will be put into place or systemic changes made to ensure the deficient practice will not occur:** A dining Services in-service will	05/09/2025

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	indicated that it was the current policy in use by the facility. A review of the policy indicated " ...Labeling ... If an item is not being served, it shall be covered, labeled and dated. All bulk foods or food not intended for immediate consumption shall be covered with lid or food film and labeled with item name, date prepared, time and discard date ..." On 4/8/25 at 10:00 a.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated "...refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...discarded...food shall be protected from contamination by storing the food as follows:...(5). In packages, covered containers, or wrappings...wrap food tightly to prevent cross contamination..."		take place Tuesday April 22, 2025, with the Cooks to introduce the Check Off Process for the Opening and Closing Operational Checklist. On April 22nd a Dining Service in-services with the Dining Servers will take place to ensure their knowledge and safe practices concerning labeling, dating, and covering of all open-in-use products. **4 How will the facility monitor the performance to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place**: Corrective action will be monitored with the Daily Opening and Closing Checklist that includes the three times daily observation of correct labeling practices. **5 By what date the systemic changes will be completed:** **5/9/25**	