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	05/18/2023

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 an State Residential Licensure Survey. This visit included the Investigation of Complaints IN00406437 and IN00408602. Complaint IN00406437 - State deficiency related to the allegations is cited at R0064. Complaint IN00408602 - State deficiencies related to the allegations are cited at R0029, R0041, R0053, R0086, and R0295. Survey dates: May 17 and 18, 2023 Facility number: 014166 Residential Census: 119 These State Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 29, 2023.	R 0000	**Facility ID: 014166** **Hellenic Senior Living of New Albany** **2632 Grant Line Road** **New Albany, IN 47150** 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 revised plan of correction as of June 26, 2023 **Complaint IN00406437-State deficiency related to the allegations is cited at R0064.** **Complaint IN00408602-State deficiencies related to the allegations are cited at R0029, R0041, R0053, R0086, and R0295.** **410 IAC 16.2-5-1.2(d) Residents' Rights-Deficiency.** While no residents were negatively affected per current investigation, HSL provided Inservice education to employees regarding HSL's Senior Living Abuse Policy, to avoid any future incidents; and provide awareness for at risk residents. **1. Please describe what the facility did to correct the deficient practice.** Staffing In-Service was held	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Robinson	Executive Director	06/26/2023

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			5/25/23 by the Executive Director. Training/education provided on Hellenic Senior Living Abuse Policy dated 9/30/33 Incident/Accident/Unusual Occurrence Investigation and Reporting. Resident Rights reviewed 5/25/23 with staff. Employees signed acknowledgment/understanding of policy and agreed to follow policy as a condition of employment. **2. What measures will be put into place or what systemic changes will be made to ensure that the deficient proactive does not recure?** The employee implicated in this incident was terminated. HSL Abuse policy will be received yearly by ED and or DON for employees continued awareness and compliance. Additionally, all new hires will be required to undergo this training as part of their onboarding process. Employees will also be encouraged to seek assistance with any issues regarding stress mgmt., anger issue and burnout. HSL will offer reimbursement for any classes taken (please see www.onlinecevcredit.com). **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?**	

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			All residents are at potential risk for the aforementioned deficient practice; however, residents with greater staff needs, physical and mental issues have the potential to be more time-consuming and interactive with staff, therefore, these residents have the potential to be at greater risk. Management will be more cognizant of the need for appropriate staffing to deal with any possibility of the above: real or perceived. Staff will be made aware by HSL that no type of abuse will not be tolerated and that any abuse-real or perceived will be dealt with swiftly an accordingly. **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 HSL management. HSL will also encourage all employees to be resident advocates to ensure the safety of all residents. HSL management will track all complaints of any type of alleged abuse via grievance forms (which are readily available to all	

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			residents), verbal complaints, phone calls, emails or anonymous in nature. 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 in this revision will be implemented 6.26.23 and will be on-going. **410 IAC 16.2-5-1.2 (hh) Residents' Rights-Noncompliance.** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected by misappropriation of controlled medications. **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?** Employee was terminated, see process below. A thorough investigation was completed immediately by the Administrator. MAR reviewed, call light alert system reviewed, met with resident, met with nurse that signed out meds and camera system reviewed. The nurse was suspended pending investigation then terminated. The incident was	

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			reported to state and Life Span, information given to Attorney General's office. ***Note This incident occurred and was properly dealt with in April prior to the Annual State Survey.*** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** A MAR Audit was conducted and will be on-going by the Director of Nursing weekly. **3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure?** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends to ensure narcotics are counted every shift with the oncoming and off going nursing staff. The audit of five residents on MAR will continue for five additional weeks to assure insulin is given as directed by physician. If insulin is missed an education will follow with staff. If more than one resident is found during audit that didn't receive insulin, then additional weeks will be added until zero holes show.	

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			4. Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure. DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends. Director of Nursing and or Executive Director will do a weekly Medication Administration (MAR) review on five residents to ensure compliance, starting 6/8/23-7/6/23) see MAR audit sheet attached) If holes show up on MAR, education with clinical staff will be given and audit will continue another five weeks. **5. For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends to ensure narcotics are counted every shift with the oncoming and off going nurse. Precautions will be enforced to ensure that all controlled substances have been properly accounted for and destroyed as indicated, to prevent drug diversions by DON or designer.	

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			An audit of MAR will be put in place for five weeks to assure insulin is given as directed by physician. If insulin is missing an education will follow with clinical staff and audit will continue another five weeks. **410IAC 16.2-5=1.4(b)** **Personnel-Deficiency** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected by misappropriation of controlled medications. **1.&3. Please describe what the facility did to correct the deficient practice.** **Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure.** A) An RN was hired for the Director of Nursing position and started 6/5/2023 which allows another nurse to be on call 24/7 and to be at facility Monday-Friday 7a-5p along with overseeing all immediate assessments date is obtained relative to the incident, interventions, necessary to stabilize the residents as needed with falls etc. B) Interviews are being conducted for the Assisted	

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			Director of Nursing. C) Additional staff on the third shift were corrected prior to the Survey findings. Sufficient staff is on all shifts. D) CPR/First Aid additional class scheduled in June 2023 which will allow one awake staff member with CPR and First aid and ongoing classes as needed. CPR/First Aid binder will be kept in Executive Director office for verification. **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** An audit was completed of all previous incidents in Point Click Care, PCC for proper follow ups. **4. & 5. Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** The Executive Director will monitor the staffing schedule weekly along with the CPR/First aid binder/certification on each	

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			employee scheduled. **410 IAC 16.2-5-1,5(k) Sanitation and Safety Standards-Deficiency** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected by the plate warmer not always holding temp. **1. Please describe what the facility did to correct the deficient practice.** Maintenance work order was put in Tels system and cord replaced 6/6/23 on plate warmer. Temps are being audited daily before and during all meals for proper temperature. **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** Reviewed/audited by Dietary Manager with residents during June 2023, Chief Cancel. **3,4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & 5. Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice findings, please provide if**	

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			ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Dietary Manager educated on the importance of properly doing a workorder for any repairs needed. Dietary Manager will ongoing temp meals prior to serving and during serving. **410 IAC 16.2-5-1.5(M) Sanitation and Safety Standards-Deficiency.** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected. **1. Please describe what the facility did to correct the deficient practice.** Dietary staff were educated by Dietary Manager on 6/7/23 and review of Dry Food Storage policy and procedure and Refrigerated Storage policy and procedure. (*See attached*) **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** Discussion with residents by	

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			Dietary Manager during Chief Cancel **3, 4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** Ongoing education will be provided by the Dietary Manager for Dietary staff and any new hires within the first week of training. Ongoing education with (all) staff on inputting work orders timely on any needed repairs. **410 IAC 16.2-5-6(a) Pharmaceutical Services-Noncompliance** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected. **1. Please describe what the facility did to correct the**	

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			deficient practice. Nursing staff In-service held 6/5/23 (*see attached*) **Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** Audit completed by Executive Director on all residents who. self-administrator medication to make sure they had access to their own medication in their rooms and not in nurse refrigerator. **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** The Executive Director audited all residents' refrigerators 6/5/23 within their unit to confirm insulin was present if listed as a self-administer of own medication and checked nurse's refrigerator to confirm no self-administer medication was present. Proper storage in place… **3, 4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.**	

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			For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Nurse and QMA's educated on proper management of resident's medication once received from pharmacy and properly communicating with Director of Nursing and or Executive Director on reporting of missing medication 6/5/23. (*See attached)* Ongoing education… *Revised changes will be effective June 26, 2023*	
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on record review and interview, the facility failed to ensure residents were treated with dignity and respect for 1 of 8 residents reviewed for resident rights. (Resident C) Findings include: During an interview on 5/17/23 at 9:36 a.m., Resident C indicated she and QMA (Qualified Medication Aide) 4 had gotten into a fight. QMA 4 yelled at her that she wasn't going to be disrespected and went down the hallway	R 0029	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 revised plan of correction as of June 26, 2023 **Complaint IN00406437-State deficiency related to the allegations is cited at R0064.**	06/26/2023

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	screaming and cursing. During an interview on 5/17/23 at 12:35 p.m., the ED indicated she had conversations with the resident Monday 5/15/23, but she had just turned in her grievance form that morning on 5/17/23. QMA 4 told her the resident was very upset with her. She told QMA 4 to call her if there were any further concerns. On Monday the resident reported to her that QMA 4 told her they couldn't find her insulin. QMA 4 then came into her room with another staff member while she was sleeping and was looking in her refrigerator. The resident said she was asleep when they came in. That should not have taken place and she told the resident she would look into it. She gave her a grievance form on Monday and circled back Wednesday morning and asked her to complete it, which she did. She had not tried to call anyone else. It seemed like it was an incident that was just between her and QMA 4. She had not investigated it yet because she was waiting on the grievance form from the resident. During an interview on 5/17/23 at 1:20 p.m., the ED indicated the insulin issue was brought to her attention on Sunday and she thought they fixed it, but in fact they didn't find it and she didn't find that out until Monday. QMA 4 told her she had left her a statement on the incident and she did find it. It informer her of how the resident spoke to QMA 4 and that QMA 4 was upset. During an interview on 5/17/23 at 2:05 p.m., CNA 8 indicated on Saturday Resident C asked QMA 4 to double check on her insulin, but the resident stated the QMA told her it was not her job to look for it. QMA 4 said she didn't work for the resident, that the resident worked for her, and that her working was what paid for her Medicare. She was		**Complaint IN00408602-State deficiencies related to the allegations are cited at R0029, R0041, R0053, R0086, and R0295.** **410 IAC 16.2-5-1.2(d) Residents' Rights-Deficiency.** While no residents were negatively affected per current investigation, HSL provided Inservice education to employees regarding HSL's Senior Living Abuse Policy, to avoid any future incidents; and provide awareness for at risk residents. **1. Please describe what the facility did to correct the deficient practice.** Staffing In-Service was held 5/25/23 by the Executive Director. Training/education provided on Hellenic Senior Living Abuse Policy dated 9/30/33 Incident/Accident/Unusual Occurrence Investigation and Reporting. Resident Rights reviewed 5/25/23 with staff. Employees signed acknowledgment/understanding of policy and agreed to follow policy as a condition of employment. **2. What measures will be put into place or what systemic changes will be made to ensure that the deficient proactive does not recure?** The employee implicated in this incident was terminated. HSL Abuse policy will be received	

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	pretty certain everybody on the floor could have heard her that's how loud she was being, and Resident C was just around the corner at the elevator. She did not talk to the resident about it. The only thing the resident said later on was she was napping in her room and woke up to QMA 4 and another staff member going through her refrigerator. The clinical record for Resident C was reviewed on 5/18/23 at 11:00 a.m. The resident's diagnoses included, but were not limited to, type 2 Diabetes Mellitus, bipolar disorder, and anxiety disorder. The Resident Grievance Form, dated 5/17/23 at 11:30 a.m., indicated the resident had a concern on May 13th, she indicated QMA 4 yelled at her. QMA 4's hand written statement, dated 5/13/23, indicated on the morning of 5/13/23 the resident approached her at 9:00 a.m. and asked for her insulin. She told the resident she had just walked in the door and if insulin was what she needed, she could check in the refrigerator for it. Later on in the day she approached her again telling her she worked for her and she'd better find her insulin. She went on to tell her she wrote her paychecks and she had better find her medication. QMA 4 informed the resident she checked and did not find her insulin. The resident accused her of lying and said she had called her pharmacy and they informed her a facility staff member had signed to receive the medication and she had better go do her job. The Resident Rights policy, dated 9/30/23, provided on 5/17/23 at 12:25 p.m. by the ED, included, but was not limited to, "... 6. Each associate will take on the role of advocate within the community for the resident to work to ensure		yearly by ED and or DON for employees continued awareness and compliance. Additionally, all new hires will be required to undergo this training as part of their onboarding process. Employees will also be encouraged to seek assistance with any issues regarding stress mgmt., anger issue and burnout. HSL will offer reimbursement for any classes taken (please see www.onlinecevcredit.com). **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 aforementioned deficient practice; however, residents with greater staff needs, physical and mental issues have the potential to be more time-consuming and interactive with staff, therefore, these residents have the potential to be at greater risk. Management will be more cognizant of the need for appropriate staffing to deal with any possibility of the above: real or perceived. Staff will be made aware by HSL that no type of abuse will not be tolerated and that any abuse-real or perceived will be dealt with swiftly an accordingly. **4. How will corrective actions**	

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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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	that his or her rights are recognized daily as care and services are provided. Resident should be treated with consideration, respect, and recognition of their dignity and individuality..." This State tag relates to Complaint IN00408602.		**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 HSL management. HSL will also encourage all employees to be resident advocates to ensure the safety of all residents. HSL management will track all complaints of any type of alleged abuse via grievance forms (which are readily available to all residents), verbal complaints, phone calls, emails or anonymous in nature. 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 in this revision will be implemented 6.26.23 and will be on-going.	
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both;			

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	(C) a family member; (D) family groups; or (E) other individuals. Based on record review and interview, the facility failed to report and investigate allegations of abuse in a timely manner for 1 of 8 residents reviewed for abuse. (Resident C) Findings include: During an interview on 5/17/23 at 9:36 a.m., Resident C indicated she and QMA (Qualified Medication Aide) 4 had gotten into a fight. QMA 4 yelled at her that she wasn't going to be disrespected and went down the hallway screaming and cursing. She had talked to the Executive Director (ED) about it. During an interview on 5/17/23 at 12:35 p.m., the ED indicated she had conversations with the resident Monday 5/15/23, but she had just turned in her grievance form that morning on 5/17/23. QMA 4 told her the resident was very upset with her. She told QMA 4 to call her if there were any further concerns. She came in Monday morning and went to speak with Resident C. She had not followed through with everything yet. QMA 4 called off yesterday evening. She was going to be terminated anyway. She had not yet interviewed any of the other staff. QMA 6 had not worked yet. She had not reported the incident to the State yet. The resident indicated in her grievance she turned in on 5/17/2 that QMA 4 yelled at her and it sounded like there was a screaming match going on. The resident voiced to her she did not like QMA 4. She had tried to call QMA 4, but had not tried to call QMA 6. She gave her a grievance form on Monday and circled back Wednesday morning and asked her to complete it, which she did. She had not tried to call anyone else. It seemed like it	R 0041	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 revised plan of correction as of June 26, 2023 **Complaint IN00406437-State deficiency related to the allegations is cited at R0064.** **Complaint IN00408602-State deficiencies related to the allegations are cited at R0029, R0041, R0053, R0086, and R0295.** **410 IAC 16.2-5-1.2(d) Residents' Rights-Deficiency.** While no residents were negatively affected per current investigation, HSL provided Inservice education to employees regarding HSL's Senior Living Abuse Policy, to avoid any future incidents; and provide awareness for at risk residents. **1. Please describe what the facility did to correct the deficient practice.** Staffing In-Service was held 5/25/23 by the Executive Director. Training/education provided on Hellenic Senior Living Abuse Policy dated 9/30/33 Incident/Accident/Unusual Occurrence Investigation and	06/26/2023

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	was an incident that was just between her and QMA 4. She had not investigated it yet because she was waiting on the grievance from the resident. She had not been made aware of the allegation of staff yelling at the resident until she saw the grievance on 5/17/23. During an interview on 5/17/23 at 12:52 p.m., QMA 7 indicated QMA 5 had told her Monday morning Resident C had brought a concern to her of the incident over the weekend. QMA 8 told her the patient reported to her that QMA 4 had been yelling and screaming back and forth with her. The ED had told her she was aware of the situation and it was being taken care of, but she was not sure if she was aware of the yelling. If a staff member was yelling at a resident she would say that was abuse and they had 2 hours to report it. It should be reported but she guessed she didn't say anything because the ED told her she was aware of the situation and was handling it. She knew the ED was aware of a heightened altercation between the two of them. During an interview on 5/17/23 at 1:03 p.m., QMA 5 indicated she was not there when it happened but on Monday morning she was made aware by CNAs (Certified Nurse Aide) 8 and 9 who worked the weekend that QMA 4 had yelled at the resident. CNA 8 and 9 were there when it happened. They told her Resident C and QMA 4 got loud and were arguing back and forth. She was told this information first thing in the morning around 7 a.m., but did not talk to the ED about it until around 10:00 a.m. or 11:00 a.m. She thought she was aware of the incident. During an interview on 5/17/23 at 2:05 p.m., CNA 8 indicated she did hear the yelling but that was around lunchtime, it was her and CNA 9 who		Reporting. Resident Rights reviewed 5/25/23 with staff. Employees signed acknowledgment/understanding of policy and agreed to follow policy as a condition of employment. **2. What measures will be put into place or what systemic changes will be made to ensure that the deficient proactive does not recure?** The employee implicated in this incident was terminated. HSL Abuse policy will be received yearly by ED and or DON for employees continued awareness and compliance. Additionally, all new hires will be required to undergo this training as part of their onboarding process. Employees will also be encouraged to seek assistance with any issues regarding stress mgmt., anger issue and burnout. HSL will offer reimbursement for any classes taken (please see www.onlinecevcredit.com). **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 aforementioned deficient practice; however, residents with greater staff needs, physical and mental issues have the potential to be more time-consuming and	

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	heard it. They were going to another resident's room, QMA 4 came around the corner and stated, " ... That b***h has got me f****d up ..." She also said she didn't work for the resident, that the resident worked for her, and that her working was what paid for her Medicare. She was pretty certain everybody on the floor could have heard her that's how loud she was being, and Resident C was just around the corner at the elevator. She did not talk to the resident about it. They did not call the ED and she did not think anyone else did. She would have considered QMA 4's behavior abusive and they were supposed to report it right then and there. She was just trying to keep to herself because it was her first day back. Looking back she would have probably called the ED right then and there. They were always told to call the ED. They did not have a Director of Nursing to call and they didn't have any nurses. She did talk to the ED on Monday and told her that Resident C wanted to talk to her and she said she was aware. She did not tell her then about the yelling because she had to go to morning meeting. During an interview on 5/17/23 at 2:27 p.m., the ED indicated no one told her about the yelling match. She met QMA 5 in the hall Monday morning and she told her they had a situation. She was aware of the insulin concern and she thought that was what it was about. The 2 CNA's came to talk to her and asked if she had heard about the resident and QMA 4 but they never got into any conversation about yelling. During an interview on 5/18/23 at 9:15 a.m., Resident C indicated QMA 4 had yelled at her, she told the resident she had disrespected her and she wasn't going to take it. She was yelling all the way down the hall. She felt it was definitely directed at her. QMA 4 was screaming down the		interactive with staff, therefore, these residents have the potential to be at greater risk. Management will be more cognizant of the need for appropriate staffing to deal with any possibility of the above: real or perceived. Staff will be made aware by HSL that no type of abuse will not be tolerated and that any abuse-real or perceived will be dealt with swiftly an accordingly. **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 HSL management. HSL will also encourage all employees to be resident advocates to ensure the safety of all residents. HSL management will track all complaints of any type of alleged abuse via grievance forms (which are readily available to all residents), verbal complaints, phone calls, emails or anonymous in nature. Corrective action will be based on the above criteria in a timely manner. 5. **By what date will the**	

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	hall. She felt the staff member disrespected her, and she was worried the staff member would come back and try to blame it on her. QMA 4 was really nasty and she felt she was abusive to her. The staff member had never liked her since day on. She was " ... mad as hell ..." The clinical record for Resident C was reviewed on 5/18/23 at 11:00 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, bipolar disorder, and anxiety disorder. The Resident Grievance Form, dated 5/17/23 at 11:30 a.m., indicated the resident had a concern on May 13th, she indicated QMA 4 yelled at her. The staff member started to scream and yell all down the hall. QMA 4's hand written statement, dated 5/13/23 indicated she had taken a lot of verbal abuse from the resident and it was very disturbing. She was rude and verbally vulgar. Her behavior was getting worse. They needed to look into ways to solve her verbal abuse. Her mental illness was getting worse. The Incident/Accident/Unusual Occurrence Investigation and Reporting policy, dated 9/30/22, provided on 5/18/23 at 11:22 a.m. by the ED, included, but was not limited to, "... Procedure... 1. All personnel are responsible to report in a timely and efficient manner, to their immediate supervisor and/or to the Executive Director any event which is unexpected, unintended, undesirable or which departs from the routine operation of the company and its facilities... 4. The Executive Director... will follow the Indiana State Department of Health's Reportable Incidents Policy for the protocol for reporting the incidents that are deemed serious and meet the reporting requirements... 5. For all		**systemic changes be completed?** The systemic changes noted in this revision will be implemented 6.26.23 and will be on-going.	

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	incidents/accidents/unusual occurrences, the Director of Nursing will coordinate an investigation..." This State tag relates to Complaint IN00408602.			
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on record review and interview, the facility failed to ensure residents were treated free from verbal abuse for 1 of 8 residents reviewed for abuse. (Resident C) Findings include: During an interview on 5/17/23 at 9:36 a.m., Resident C indicated she and QMA (Qualified Medication Aide) 4 had gotten into a fight. She talked to the Executive Director (ED) about it. She did not want QMA 4 anywhere near her. During an interview on 5/18/23 at 9:15 a.m., Resident C indicated QMA 4 had yelled at her, she told the resident she had disrespected her and she wasn't going to take it. The QMA was yelling all the way down the hall. She felt it was definitely directed at her. QMA 4 was really nasty and she felt she was abusive to her. The staff member had never liked her since day one. She was " ... mad as hell ..." The clinical record for Resident C was reviewed on 5/18/23 at 11:00 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, bipolar disorder, and anxiety disorder. During an interview on 5/17/23 at 12:35 p.m., the ED indicated she had conversations with the	R 0053	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 revised plan of correction as of June 26, 2023 **Complaint IN00406437-State deficiency related to the allegations is cited at R0064.** **Complaint IN00408602-State deficiencies related to the allegations are cited at R0029, R0041, R0053, R0086, and R0295.** **410 IAC 16.2-5-1.2(d) Residents' Rights-Deficiency.** While no residents were negatively affected per current investigation, HSL provided Inservice education to employees regarding HSL's Senior Living Abuse Policy, to avoid any future incidents; and provide awareness for at risk residents. **1. Please describe what the facility did to correct the deficient practice.**	06/26/2023

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	resident Monday 5/15/23, but she had just turned in her grievance form that morning on 5/17/23. QMA 4 told her the resident was very upset with her. She told QMA 4 to call her if there were any further concerns. She came in Monday morning and went to speak with Resident C. She had not followed through with everything yet. QMA 4 called off yesterday evening. She was going to be terminated anyway. She had not yet interviewed any of the other staff. QMA 6 had not worked yet. She had not reported the incident to the State yet. The resident indicated in her grievance she turned in on 5/17/2 that QMA 4 yelled at her and it sounded like there was a screaming match going on. The resident voiced to her she did not like QMA 4. She had tried to call QMA 4, but had not tried to call QMA 6. At 1:20 p.m., the ED indicated the issue with the QMA and the resident, related to the insulin, were brought to her attention on Sunday. During an interview on 5/17/23 at 12:52 p.m., QMA 7 indicated QMA 5 had told her Monday morning Resident C had brought a concern to her of the incident over the weekend. QMA 8 told her the patient reported to her that QMA 4 had been yelling and screaming back and forth with her. During an interview on 5/17/23 at 1:03 p.m., QMA 5 indicated she was not there when it happened but on Monday morning she was made aware by CNAs (Certified Nurse Aide) 8 and 9 who worked the weekend that QMA 4 had yelled at the resident. CNA 8 and 9 were there when it happened. They told her Resident C was upset about her insulin and they got loud and were arguing back and forth. During an interview on 5/17/23 at 2:05 p.m., CNA 8 indicated she did hear the yelling but that was		Staffing In-Service was held 5/25/23 by the Executive Director. Training/education provided on Hellenic Senior Living Abuse Policy dated 9/30/33 Incident/Accident/Unusual Occurrence Investigation and Reporting. Resident Rights reviewed 5/25/23 with staff. Employees signed acknowledgment/understanding of policy and agreed to follow policy as a condition of employment. **2. What measures will be put into place or what systemic changes will be made to ensure that the deficient proactive does not recure?** The employee implicated in this incident was terminated. HSL Abuse policy will be received yearly by ED and or DON for employees continued awareness and compliance. Additionally, all new hires will be required to undergo this training as part of their onboarding process. Employees will also be encouraged to seek assistance with any issues regarding stress mgmt., anger issue and burnout. HSL will offer reimbursement for any classes taken (please see www.onlinecevcredit.com). **3. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be**	

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	around lunchtime, it was her and CNA 9 who heard it. They were going to another resident's room, QMA 4 came around the corner and stated, " ... That b***h has got me f****d up ..." She also said she didn't work for the resident, that the resident worked for her, and that her working was what paid for her medicare. She was pretty certain everybody on the floor could have heard her that's how loud she was being, and Resident C was just around the corner at the elevator. She did not talk to the resident about it. The only thing the resident said later on was she was napping in her room and woke up to QMA 4 and another staff member going through her refrigerator. The Resident Grievance Form, dated 5/17/23 at 11:30 a.m., indicated the resident had a concern on May 13th, she indicated QMA 4 yelled at her. The staff member started to scream and yell all the way down the hall. QMA 4 and another staff member were in her refrigerator that night and passed the medication back and forth while she waited for her daughter. QMA 4's hand written statement, dated 5/13/23, indicated on the morning of 5/13/23 the resident approached her at 9:00 a.m. and asked for her insulin. She told the resident she had just walked in the door and if insulin was what she needed she could check in the refrigerator for it. Later on in the day she approached her again telling her she worked for her and she'd better find her insulin. She went on to tell her she wrote her paychecks and she had better find her medication. QMA 4 informed the resident she checked and did not find her insulin. The resident accused her of lying and said she had called her pharmacy and they informed her a facility staff member had signed to receive the medication and she had better go do her job. She had taken a lot of verbal		**taken?** All residents are at potential risk for the aforementioned deficient practice; however, residents with greater staff needs, physical and mental issues have the potential to be more time-consuming and interactive with staff, therefore, these residents have the potential to be at greater risk. Management will be more cognizant of the need for appropriate staffing to deal with any possibility of the above: real or perceived. Staff will be made aware by HSL that no type of abuse will not be tolerated and that any abuse-real or perceived will be dealt with swiftly an accordingly. **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 HSL management. HSL will also encourage all employees to be resident advocates to ensure the safety of all residents. HSL management will track all complaints of any type of alleged abuse via grievance forms (which	

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	abuse from the resident and it was very disturbing. She was rude and verbally vulgar. Her behavior was getting worse. They needed to look into ways to solve her verbal abuse. The resident's mental illness was getting worse. The Resident Rights policy, dated 9/30/23, provided on 5/17/23 at 12:25 p.m. by the ED, included, but was not limited to, "... v... Residents have the right to be free from... mental abuse... w... Residents have the right to be free from verbal abuse..." This State tag relates to Complaint IN00408602.		are readily available to all residents), verbal complaints, phone calls, emails or anonymous in nature. 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 in this revision will be implemented 6.26.23 and will be on-going.	
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 controlled medications were secured which resulted in a staff member taking controlled medications for 2 of 4 residents reviewed for misappropriation. (Residents B and U) Findings include: 1. A facility incident report, dated 4/12/23, indicated Resident B was questioning why she didn't have 2 hydrocodone (a opioid pain medication) left in her bottle. The DON (Director of Nursing) reviewed the MAR (Medication Administration Record) and noticed that the hydrocodone was signed out on 4/3/23 at 8:00	R 0064	**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?** Employee was terminated, see process below. A thorough investigation was completed immediately by the Administrator. MAR reviewed, call light alert system reviewed, met with resident, met with nurse that signed out meds and camera system reviewed. The nurse was	06/26/2023

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	p.m. and then again on 4/4/23 at 1:00 a.m. The physician's order was written for 1 tablet every day as needed for moderate pain. The resident would usually ask for a pain pill once or twice a week. The clinical record for Resident B was reviewed on 5/17/2023 at 10:00 a.m. The diagnoses included, but were not limited to, abscess of the mouth, neuropathy, and muscle spasms. A physician's order, dated 4/12/2023, indicated the resident received hydrocodone 5/325 mg (milligrams) 1 tablet daily as needed for pain. The review of the call light alert system report for Resident B indicated the resident did not alert the nurse for a pain pill at 1:00 am, and the nurse did not enter the room. The review of the of the Individual Resident Control Medication Record, dated 4/3/23 and 4/4/23, indicated the resident's hydrocodone 5/325 mg 1 tablet daily was signed out by LPN (Licensed Practical Nurse) 2 at 8:00 p.m. and 1:00 a.m. During an interview on 5/17/23 at 9:30 a.m., the resident indicated she rarely took pain medication. She had a tooth infection and was in a lot of pain, but she did not want to take a narcotic. She did not ask for a pain pill and the nurse did not bring her in one. During an interview on 5/17/23 at 1:00 p.m., the ED (Executive Director) indicated she did an investigation on the missing medication. The nurse on duty signed out Resident B's narcotic at 8:00 p.m. and then signed it out again at 1:00 a.m. The resident's physician order was for her to		suspended pending investigation then terminated. The incident was reported to state and Life Span, information given to Attorney General's office. ***Note This incident occurred and was properly dealt with in April prior to the Annual State Survey.*** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** A MAR Audit was conducted and will be on-going by the Director of Nursing weekly. **3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure?** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends to ensure narcotics are counted every shift with the oncoming and off going nursing staff. The audit of five residents on MAR will continue for five additional weeks to assure insulin is given as directed by physician. If insulin is missed an education will follow with staff. If more than one resident is found during audit that didn't receive insulin, then additional weeks will be added	

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		A. BUILDING 00 B. WING	05/18/2023

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	receive hydrocodone 1 time a day. She reviewed the camera system and the nurse was not seen entering the resident's room to give her the 1:00 a.m. dose of medication. The nurse had signed out on the narcotic sheet that the medication was given. When she interviewed the resident she indicated she did not ask for a pain pill at 1:00 a.m. There would have only been 5 hours after her last dose and the medication couldn't have been administered. It would have only been 5 hours apart. During an interview on 5/18/23 at 12:40 p.m., LPN 10 indicated the narcotics should be counted every shift with the oncoming and off going nurse. At times he did not have a nurse to count the narcotics with because the QMA's (Qualified Medication Aide) could not count the narcotics. He would do his own narcotic count to make sure none were missing before he started his shift. He would notify management if the narcotic count was not correct. 2. The review of a document presented by the facility, dated 4/11/23 at 1:00 p.m., indicated the facility had another incident of 14 narcotics that were replaced with Excedrin and the Excedrin was scratched off the tablets. Resident U's medication was locked in the narcotic cart and was noticed by the QMA during a narcotic count at the end of her shift. During an interview on 5/18/23 at 2:00 p.m., the ED indicated she did not do an investigation because the employees that worked during the time of the missing narcotics were no longer working at the facility. She was unable to determine who would have taken the medication. The medication had expired.		until zero holes show. **4. Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends. Director of Nursing and or Executive Director will do a weekly Medication Administration (MAR) review on five residents to ensure compliance, starting 6/8/23-7/6/23) see MAR audit sheet attached) If holes show up on MAR, education with clinical staff will be given and audit will continue another five weeks. **5. For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends to ensure narcotics are counted every shift with the oncoming and off going nurse. Precautions will be enforced to ensure that all controlled substances have been properly accounted for and destroyed as indicated, to prevent	

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	A current policy, titled Clinical Policy and Procedure Manual, dated 9/30/22 and received from the Administrator on 5/17/23 at 11:35 a.m., 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..." This State residential finding relates to Complaint IN00406437.		drug diversions by DON or designer. An audit of MAR will be put in place for five weeks to assure insulin is given as directed by physician. If insulin is missing an education will follow with clinical staff and audit will continue another five weeks.	
R 0086 Bldg. 00	410 IAC 16.2-5-1.3(a)(1-2) Administration and Management - Deficiency The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on observation, record review and interview, the facility failed to ensure the administration of medication as ordered by the physician for 1 of 3 residents reviewed for medication administration. (Resident B) Findings include: During an observation on 5/18/23 at 10:38 a.m., LPN (Licensed Practical Nurse) 10 went to	R 0086	**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?** Employee was terminated, see process below. A thorough investigation was	06/26/2023

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	administer insulin to Resident B. The resident's 7:00 a.m. dose of Insulin was highlighted in red as late. LPN 10 indicated he wasn't quite sure what to do because the resident's order was set for 7:00 a.m., but also specified to administer with breakfast, and he had held off on administering the medication to her until she got breakfast. She had just then gotten ready to eat breakfast, and by that time her next dose of insulin was already due to be given. He indicated he would administer her next dose of insulin and contact the doctor regarding the 7:00 a.m. dose. He obtained the resident's Humulin 70/30 kwikpen injector and dialed up 50 units and administered it to the resident in her left upper extremity. The clinical record for Resident B was reviewed on 5/17/2023 at 10:00 a.m. Diagnoses included, but were not limited to, Diabetes Mellitus, diabetic neuropathy, and chronic kidney disease. A physician's order, dated 8/23/22, indicated staff were to administer 20 units of humulin 70/30 insulin daily with breakfast, 50 units of humulin 70/30 subcutaneous with lunch and dinner. A physician's order, dated 3/1/22, indicated staff were to administer 20 units of Lantus insulin subcutaneously at bedtime. The review of the MAR (Medication Administration Record) indicated the following for the resident's medication administration: - Humulin 70/30 insulin 20 units with breakfast was not administered on May 13, 14, 15, 17, and 18, 2023. - Humulin 70/30 insulin 50 units lunch and dinner was not administered on May 13, 14, 15,16, and 17, 2023.		completed immediately by the Administrator. MAR reviewed, call light alert system reviewed, met with resident, met with nurse that signed out meds and camera system reviewed. The nurse was suspended pending investigation then terminated. The incident was reported to state and Life Span, information given to Attorney General's office. ***Note This incident occurred and was properly dealt with in April prior to the Annual State Survey.*** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** A MAR Audit was conducted and will be on-going by the Director of Nursing weekly. **3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure?** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends to ensure narcotics are counted every shift with the oncoming and off going nursing staff. The audit of five residents on MAR will continue for five additional weeks to assure insulin is given	

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	- Lantus insulin 20 units at bedtime was not administered on May 13, 14, 15, and 17, 2023. The review of the self administration assessment, dated 5/5/20, indicated the resident did not self administer her medications. During an interview on 5/17/23 at 9:45 a.m., Resident B indicated anytime her blood sugar wasn't over 150 the staff would not give her insulin to her. When the resident informed the staff she needed her insulin and the doctor had ordered it to be given a staff member told her the NP (Nurse Practitioner) was not a doctor and she wasn't going to give her the insulin. Staff told her that her blood sugar would bottom out. She indicated the NP called the facility on Friday, 5/12/23, and talked to the facility and said she wanted her orders followed and the nurse said she would not give the insulin if the resident's blood sugar was not over 150. During an interview on 5/18/23 at 9:55 a.m., the ED (Executive Director) indicated she wasn't sure what the blank holes on the MAR meant. She called QMA (Qualified Medication Aide) 7 and she indicated the medication could have been discontinued or the resident gave themselves their own insulin. During an interview on 5/18/23 at 12:40 p.m., LPN 10 indicated when a medication was given he would check yes on the clinical record that the medication was given. If the medication wasn't given there would be a screen where staff would check the reason why the medication wasn't given. The MAR should have indicated if the medication was given and if not why. During an interview on 5/18/23 at 12:48 a.m., QMA		as directed by physician. If insulin is missed an education will follow with staff. If more than one resident is found during audit that didn't receive insulin, then additional weeks will be added until zero holes show. **4. Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends. Director of Nursing and or Executive Director will do a weekly Medication Administration (MAR) review on five residents to ensure compliance, starting 6/8/23-7/6/23) see MAR audit sheet attached) If holes show up on MAR, education with clinical staff will be given and audit will continue another five weeks. **5. For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends to ensure narcotics are counted	

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	7 indicated all medications that staff give the residents should be signed out on the MAR. There should not be any blanks on the MAR if the resident did not self administer her medications. Resident B did not self administer her own insulin. During an interview on 5/18/23 at 2:20 p.m., NP 11 indicated she had reached out to the facility about the staff not giving the resident her insulin. The Lantus was a long acting insulin and it would not cause her to become hypoglycemic. She called the facility and talked to QMA 7 about this issue. She sent a written order with the resident's family member after an office visit to give to the facility indicating she wanted her orders followed and for the long acting insulin to be given at bedtime as ordered. The facility had not notified her about holding the insulin. The resident was not at her A1C goal and the insulin should be given as ordered. A current policy, titled Medication Administration dated 9/30/22, and received from the Executive Director on 5/18/22 at 11:22 a.m., indicated "... 3. Medications ordered to be given per subcutaneous will be administered by licensed nurses in accordance with the physician's orders. Insulins may be administered subcutaneous by a QMA only if the QMA is listed on ISDH Registry with the Insulin Administration sub-type before administering insulin..." This state residential finding relates to Complaint IN00408602.		every shift with the oncoming and off going nurse. Precautions will be enforced to ensure that all controlled substances have been properly accounted for and destroyed as indicated, to prevent drug diversions by DON or designer. An audit of MAR will be put in place for five weeks to assure insulin is given as directed by physician. If insulin is missing an education will follow with clinical staff and audit will continue another five weeks.	
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			

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	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 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 the appropriate number of staff were in the facility to meet the resident needs related to as needed pain medication, assessments, a minimum number as staff members on duty, and a staff member with current First Aid certification on duty 24 hours a day. This deficient practice had the potential to affect all 119 residents currently residing in the facility. Findings include: 1. During an interview on 5/17/23 at 10:19 a.m., Resident 4 indicated the facility had just one staff at night. During a confidential interview, between 5/17/23	R 0117	**410IAC 16.2-5=1.4(b)** **Personnel-Deficiency** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected by misappropriation of controlled medications. **1.&3. Please describe what the facility did to correct the deficient practice.** **Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure.**	06/26/2023

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	and 5/18/23, Staff B indicated a QMA (Qualified Medication Aide) would ask a nurse before administering PRN (as needed) medications, but there had not been a day shift nurse recently. For the last 2 weeks, PRN pain medications were administered without a nurse's permission, because they didn't want the residents to go without. There had been no DON or ADON (Assistant Director of Nursing). They were supposed to have a nurse for 12 hours a day. They ran with 2 QMAs daily. The new nurse, LPN (Licensed Practical Nurse) 10 had just finished orientation and worked 3 days a week. The night shift nurse was prn and tried to pick up 3 days a week. The facility struggled to find nursing staff. A QMA could do everything except the nursing care. There was no one to do assessments for falls. The corporate nurse would type up an assessment remotely, without seeing the resident. There were incidences of no nursing staff. The last DON that was hired, never started. The corporate nurse wouldn't come down to help. She just wanted them to get a nurse to come in. The Executive Director wanted QMAs 24 hours a day. The April 2023 Daily Schedule indicated the following: - On 4/28/23, three QMAs and 2 CNAs (Certified Nurse Aides) worked from 7:00 a.m. to 7:00 p.m. One CNA worked from 3:00 p.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 4/29/23, two QMAs and three CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 4/29/23 to 4/30/23, two CNAs worked from 7:00 p.m. to 7:00 a.m., and one CNA worked from 3:00 p.m. to 11:00 p.m. No nurse was scheduled or		A) An RN was hired for the Director of Nursing position and started 6/5/2023 which allows another nurse to be on call 24/7 and to be at facility Monday-Friday 7a-5p along with overseeing all immediate assessments date is obtained relative to the incident, interventions, necessary to stabilize the residents as needed with falls etc. B) Interviews are being conducted for the Assisted Director of Nursing. C) Additional staff on the third shift were corrected prior to the Survey findings. Sufficient staff is on all shifts. D) CPR/First Aid additional class scheduled in June 2023 which will allow one awake staff member with CPR and First aid and ongoing classes as needed. CPR/First Aid binder will be kept in Executive Director office for verification. **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** An audit was completed of all previous incidents in Point Click Care, PCC for proper follow ups. **4. & 5. Please describe how the corrective actions will be monitored to ensure the deficient practice will not**	

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	in the building. - On 4/30/23, two QMAs and three CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 4/30/23 to 5/1/23, two CNAs worked from 7:00 p.m. to 7:00 a.m., and one CNA worked from 3:00 p.m. to 11:00 p.m. No nurse was scheduled or in the building. The May 2023 Daily Schedule indicated the following: - On 5/1/23, two QMAs and two CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/1/23 to 5/2/23, one CNA worked from 7:00 p.m. to 7:00 a.m. No nurse was scheduled or in the building. - On 5/2/23, one QMA and three CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/2/23 to 5/3/23, one CNA worked from 7:00 p.m. to 7:00 a.m. No nurse was scheduled or in the building. No other staff members were in the facility from 7:00 p.m. to 7:00 a.m. - On 5/3/23 to 5/4/23, two CNAs worked from 7:00 p.m. to 7:00 a.m. No nurse was scheduled or in the building. - On 5/4/23, two QMAs and two CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled for in the building.		**recure.** **For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** The Executive Director will monitor the staffing schedule weekly along with the CPR/First aid binder/certification on each employee scheduled.	

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	- On 5/4/23 to 5/5/23, two CNAs worked from 7:00 p.m. to 7:00 a.m. No nurse was scheduled or in the building. - On 5/5/23, one QMA and two CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/5/23 to 5/6/23, two CNAs worked from 7:00 p.m. to 7:00 a.m. No nurse was schedule or in the building. - On 5/6/23, two QMAs and two CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/6/23 to 5/7/23, one CNA worked from 7:00 p.m. to 7:00 a.m. No nurse was scheduled or in the building. No other staff members were in the facility from 7:00 p.m. to 7:00 a.m. - On 5/8/23, two QMAs and two CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/8/23 to 5/9/23, one CNA worked from 7:00 p.m. to 7:00 a.m., and one CNA worked from 3:00 p.m. to 11:00 p.m. No nurse was scheduled or in the building. - On 5/9/23, two QMAs and two CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/9/23 to 5/10/23, one CNA worked from 7:00 p.m. to 7:00 a.m., and one CNA worked from 3:00 p.m. to 11:00 p.m. No nurse was scheduled or in the building. No other staff members were in the facility from 7:00 p.m. to 7:00 a.m. and 3:00 p.m. to 11:00 p.m.			

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	- On 5/10/23 to 5/11/23, two CNAs worked from 7:00 p.m. to 7:00 a.m., and one CNA worked from 3:00 p.m. to 11:00 p.m. No nurse was scheduled or in the building. - On 5/11/23, two QMAs and two CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/12/23, two QMAs and two CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/13/23, two QMAs and three CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/13/23 to 5/14/23, two CNAs worked from 7:00 p.m. to 7:00 a.m. No nurse was scheduled or in the building. - On 5/14/23, two QMAs and four CNAs worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/14/23 to 5/15/23, two CNAs worked from 7:00 p.m. to 7:00 a.m. No nurse was scheduled or in the building. - On 5/15/23, two QMAs and three CNAs all worked from 7:00 a.m. to 7:00 p.m. No nurse was scheduled or in the building. - On 5/15/23 to 5/16/23, two CNAs worked from 7:00 p.m. to 7:00 a.m. No nurse was scheduled or in the building. - On 5/16/23 to 5/17/23, two CNAs worked from 7:00 p.m. to 7:00 a.m. and one CNA worked from			

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		A. BUILDING 00 B. WING	05/18/2023

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	3:00 p.m. to 11:00 p.m. - On 5/17/23 to 5/18/23, three CNAs were scheduled to work from 7:00 p.m. to 7:00 a.m. No nurse was scheduled or in the building. The upcoming schedule from 5/19/23, 5/22/23, 5/23/23, 5/25/23, 5/27/23, 5/28/23, and 5/29/23 indicated there were no nurses on the day or night shift schedule. During a record review on 1/18/23 at 10:20 a.m., the ED (Executive Director) provided a note, which indicated the last day the former DON worked was on 4/27/23, when she just walked out. On 5/18/23 at 11:15 a.m., the ED provided a copy of the timesheets for CNA 12. On 5/8/23 and 5/9/23 there was only one staff member in the building. CNA 12 worked the night shift from 6:45 p.m. to 7:00 a.m. (11.75 hours) on both nights. During an interview on 5/18/23 at 11:53 a.m., LPN 10 indicated the orientations were for 12 hours a day for 3 days. He was then placed on his own. He worked the 7:00 a.m. to 7:00 p.m. shift and had to stay until as late as 8:00 p.m. to complete tasks. He felt there wasn't enough staff, but indicated that was at any place he had been. During an interview on 5/18/23 at 9:48 a.m., Resident 4 indicated she had a recent fall in the shower and pulled the call cord. There were two staff members (no nurse) on duty and no one assessed her, they just wanted to send her to the emergency room. During an interview on 5/18/23 at 12:40 p.m., LPN 10 indicated the narcotics should be counted every shift with the oncoming and off going			

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	nurse. At times he did not have a nurse to count the narcotics with, because QMAs could not count the narcotics. He would do his own narcotic count to make sure none were missing before he started his shift. During an interview on 5/18/23 at 10:30 a.m., CNA 3 indicated when the DON walked out. They only had a QMA to go to. If a resident fell, that was an issue with a resident. She would tell the QMA and the QMA would do the follow up. During an exit conference interview on 5/18/23 at 5:25 p.m., the ED indicated one of the two nurses were on call 24 hours a day for 7 days a week. If a CNA or QMA needed a nurse, one of the two nurses would be called. If a fall occurred, the resident would be brought to the conference room for the clinical nurse to conduct a tele-visit assessment, remotely. Even if the resident had a possible broken bone or head injury, they would be brought down to the conference room or sent directly to the emergency room of a hospital. 2. The review of the staff schedule for May 11 through May 17, 2023, indicated a lack of any staff members with First Aid certification for the 7:00 p.m. to 7:00 a.m. shift on May 13, 14, and 17, and from 11:00 p.m. until 7:00 a.m. on May 11, 2023. During an interview on 5/18/23 at 5:20 p.m., the Executive Director indicated they only had five staff members with First Aid certification. Prior to April of 2023, she was not pursuing any First Aid. They were advised they did not need it by their corporation. She was not aware of the regulation requiring one awake staff member with First Aid. The Incident/Accident/Unusual Occurrences Investigation and Report policy, dated 9/30/22, was provided by the ED on 5/18/23 at 11:22 a.m.			

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	The policy included, but was not limited to, " ... 2. The charge nurse will be responsible for immediate responses to any incident, accident or unusual occurrence involving a resident ... c. Documentation of the incident/accident/unusual occurrence in the resident's medical record ... f. Communication of the need for post-incident assessment and documentation in accordance with the Pertinent Charting Protocol ..." The Falls policy, dated 9/30/22, was provided by the ED on 5/18/23 at 2:58 p.m. The policy included, but was not limited to, "... 11. Each resident fall will be evaluated by the above licensed nurse after all immediate assessment data is obtained relative to the incident, and interventions necessary to stabilize the resident have been completed..."			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure the kitchen equipment was maintained or replaced in the timely manner to provide warm foods to residents. This had the potential to affect all 119 residents residing in the facility. Findings include: During an interview on 5/17/23 at 10:19 a.m., Resident 4 indicated the food was cold and she ate in the dining room. A test tray was obtained on 5/17/23 at 11:40 a.m.	R 0154	Discussion with residents by Dietary Manager during Chief Cancel **3, 4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice**	06/26/2023

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	The following food temperatures were obtained by the Dietary Manager after she removed the cover from the plate: -Vegetable soup- temperature was 149 degrees -Salisbury steak-temperature was 127 degrees -Confetti corn-temperature was 137 degrees -Scalloped potatoes temperature were 131 degrees The Dietary Manager indicated the Salisbury steak would have to be pulled from the serving table and reheated. During an interview on 5/17/23 at 11:55 a.m., the Dietary Manager indicated the plate warmer had been down for a month. She would be the one to put in the order. She would have put in the work order by now, but the Maintenance Director had so many other repairs to complete, she hadn't put in the order. She would now put in the order for the new plug. During an interview on 5/17/23 at 12:05 p.m., Resident 9 indicated she had the main meal of Salisbury steak, corn, and scalloped potatoes. The food was pretty cold today and it was cold more often than it was not here lately. It was too cold for her liking. During an interview on 5/17/23 at 12:05 p.m., Resident, 10 indicated she had the main meal. The corn was undercooked and almost cold. She ate in the dining room. During an interview on 5/18/23 at 10:55 a.m., Cook 13 indicated the plate warmer had been broken since before October 2022. The current Equipment Use, Storage, Warranty, and Repairs policy and procedure was provided by the Executive Director on 5/18/23 at 4:52 p.m. The policy included, but was not limited to, "...		**findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** Ongoing education will be provided by the Dietary Manager for Dietary staff and any new hires within the first week of training. Ongoing education with (all) staff on inputting work orders timely on any needed repairs. **410 IAC 16.2-5-6(a) Pharmaceutical Services-Noncompliance** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected. **1. Please describe what the facility did to correct the deficient practice.** Nursing staff In-service held 6/5/23 (*see attached*) **Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** Audit completed by Executive Director on all residents who self-administrator medication to make sure they had access to their own medication in their	

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	Ensure that you read the directions on all of the equipment within the kitchen... how to maintain the equipment..."		rooms and not in nurse refrigerator. **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** The Executive Director audited all residents' refrigerators 6/5/23 within their unit to confirm insulin was present if listed as a self-administer of own medication and checked nurse's refrigerator to confirm no self-administer medication was present. Proper storage in place… **3, 4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** Nurse and QMA's educated on proper management of resident's medication once received from	

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			pharmacy and properly communicating with Director of Nursing and or Executive Director on reporting of missing medication 6/5/23. (*See attached)* Ongoing education… *These changes will be effective June 8, 2023*	
R 0156 Bldg. 00	410 IAC 16.2-5-1.5(m) Sanitation and Safety Standards - Deficiency (m) The facility's food supplies shall meet the standards of 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure foods were monitored for expiration. This deficiency had the potential to affect all 119 residents residing in the facility. Findings include: During a tour of the kitchen on 5/17/23 at 10:55 a.m., in the dry goods room, the following was observed: - A cake mix package was unsealed and wrapped loosely with plastic wrap. - Biscuit mix package was dated as opened in February. No expiration date was on the package. - 5 bottles of thickened liquids with an expiration date of 6/17/22. At that time, the Dietary Manager indicated no residents were receiving the thickened liquids. Those were ordered by the previous Manager, but it was still her responsibility to remove expired foods. During an observation in the walk in refrigerator	R 0156	Discussion with residents by Dietary Manager during Chief Cancel **3, 4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice findings, please provide if ongoing** **system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** Ongoing education will be provided by the Dietary Manager for Dietary staff and any new hires within the	06/26/2023

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	on 5/18/23 at 10:58 a.m., 8 packages of bologna were observed. One package was half full and was dated with an open date of 3/10/23. The expiration dates on all 8 packages was 5/17/23. During an interview on 5/18/23 at 11:02 a.m., the Dietary Manager indicated she checked the food's expiration dates daily and the foods were rotated when new stock was received. During an interview on 5/18/23 at 10:55 a.m., the Cook indicated the sandwiches were prepared upon request from a resident. On 5/18/23 at 11:00 a.m., the Always Available Menu was provided by the Dietary Manager. The list indicated on Wednesdays the alternate meal was vegetable soup with a bologna sandwich. The current Dry Food Storage policy and procedure was provided by the ED (Executive Director) on 5/18/23 at 4:52 p.m. The policy included, but was not limited to, "... Container covers shall be resistant and nonabsorbent... g) The dry food storage shall be rotated... first in, first out." The current Refrigerated Storage policy and procedure was provided by the ED on 5/18/23 at 4:52 p.m. The policy included, but was not limited to, "... e) The refrigerated food storage shall be rotated... first in, first out..."		first week of training. Ongoing education with (all) staff on inputting work orders timely on any needed repairs. **410 IAC 16.2-5-6(a) Pharmaceutical Services-Noncompliance** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected. **1. Please describe what the facility did to correct the deficient practice.** Nursing staff In-service held 6/5/23 (*see attached*) **Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** Audit completed by Executive Director on all residents who self-administrator medication to make sure they had access to their own medication in their rooms and not in nurse refrigerator. **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** The Executive Director audited all residents' refrigerators 6/5/23 within their unit to confirm insulin was present if listed as a	

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			self-administer of own medication and checked nurse's refrigerator to confirm no self-administer medication was present. Proper storage in place… **3, 4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice findings, please provide if ongoing** **system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** Nurse and QMA's educated on proper management of resident's medication once received from pharmacy and properly communicating with Director of Nursing and or Executive Director on reporting of missing medication 6/5/23. (*See attached)* Ongoing education… *These changes will be effective June 8, 2023*	
R 0295	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance			

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Bldg. 00	(a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, record review, and interview, the facility failed to ensure medications were stored in the resident's refrigerator for a resident who self administered medications for 1 of 8 residents reviewed for pharmaceutical services. (Resident C) Findings include: During an interview on 5/17/23 at 9:36 a.m., Resident C indicated over the weekend she had gone four days without her insulin. QMA (Qualified Medication Aide) 4 told her they didn't have her insulin. Resident C called her pharmacy and confirmed it had been delivered to the facility and signed for as received by a staff member. She noticed her insulin wasn't available on Wednesday or Thursday, and she ran out. QMA 5 brought the medication in to her the following Monday. She was out of her insulin for four days. She talked to the Executive Director (ED) about it. During an interview on 5/17/23 at 12:35 p.m., the ED indicated she had conversations with the resident Monday 5/15/23, but she had just turned in her grievance form that morning on 5/17/23. She had voiced a concern about QMA 4 that her insulin had not been given. QMA 4 had called her on Sunday and said she could not find the resident's insulin. She told her to take a second employee with her and double check the resident's refrigerator. QMA 4 told her the resident was very upset with her. She told QMA 4 to call her if there were any further concerns. She came in Monday morning and went to speak with Resident C. She was told the insulin was given to her Monday	R 0295	**Facility ID: 014166** **Hellenic Senior Living of New Albany** **2632 Grant Line Road** **New Albany, IN 47150** 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 revised plan of correction as of June 26, 2023 **Complaint IN00406437-State deficiency related to the allegations is cited at R0064.** **Complaint IN00408602-State deficiencies related to the allegations are cited at R0029, R0041, R0053, R0086, and R0295.** **410 IAC 16.2-5-1.2(d) Residents' Rights-Deficiency.** While no residents were negatively affected per current investigation, HSL provided Inservice education to employees regarding HSL's Senior Living Abuse Policy, to avoid any future incidents; and provide awareness for at risk residents. **1. Please describe what the facility did to correct the deficient practice.**	06/26/2023

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	morning, and it never was given to her by QMA 4. They located the insulin. It came in on the 10th and it was there the whole time. She was aware the resident did not receive the insulin on Sunday, but her grievance form she turned in said she missed it four days. She had not followed through with everything yet. During an interview on 5/17/23 at 1:20 p.m., the ED indicated the insulin issue was brought to her attention on Sunday and she thought they fixed it, but in fact they didn't find it and she didn't find that out until Monday. During an interview on 5/17/23 at 2:05 p.m., CNA (Certified Nurse Aide) 8 indicated on Saturday the resident had been asking all morning for her insulin. She had called her pharmacy and told them it had been delivered, but QMA 4 told her it wasn't there. So the resident went in her room and looked again and still could not find it. She asked QMA 4 to double check but the resident stated the QMA told her it was not her job to look for it. During an observation on 5/18/23 at 9:14 a.m., Resident C obtained her Tresiba Flex pen 200 unit syringe from her bedroom. The label on the medication was intact and indicated it had been dispensed on 5/9/23. During an interview on 5/18/23 at 9:15 a.m., Resident C indicated normally staff brought her insulin to her as soon as it was delivered. The clinical record for Resident C was reviewed on 5/18/23 at 11:00 a.m. The resident's diagnoses included, but were not limited to, type 2 Diabetes Mellitus, bipolar disorder, and anxiety disorder. The Resident Grievance Form, dated 5/17/23 at		Staffing In-Service was held 5/25/23 by the Executive Director. Training/education provided on Hellenic Senior Living Abuse Policy dated 9/30/33 Incident/Accident/Unusual Occurrence Investigation and Reporting. Resident Rights reviewed 5/25/23 with staff. Employees signed acknowledgment/understanding of policy and agreed to follow policy as a condition of employment. **2. What measures will be put into place or what systemic changes will be made to ensure that the deficient proactive does not recure?** The employee implicated in this incident was terminated. HSL Abuse policy will be received yearly by ED and or DON for employees continued awareness and compliance. Additionally, all new hires will be required to undergo this training as part of their onboarding process. Employees will also be encouraged to seek assistance with any issues regarding stress mgmt., anger issue and burnout. HSL will offer reimbursement for any classes taken (please see www.onlinecevcredit.com). **3. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be**	

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	11:30 a.m., indicated the resident had a concern on May 13th. Part of the concern was that she was out of insulin for four days. QMA 4's hand written statement, dated 5/13/23, indicated on the morning of 5/13/23 the resident approached her at 9:00 a.m. asking for her insulin. She told the resident she had just walked in the door and if insulin was what she needed she could check in the refrigerator for it. Later on in the day she approached her again telling her she worked for her and she'd better find her insulin. QMA 4 informed the resident she checked and did not find her insulin. The resident accused her of lying and said she had called her pharmacy and they informed her a facility staff member had signed to receive the medication. The Pharmacy Delivery sheet indicated Resident C's Tresiba Flex 200 unit pen was delivered on 5/10/23 at 7:09 a.m. and signed by LPN (Licensed Practical Nurse) 10. During an interview on 5/18/23 at 1:11 p.m., LPN 10 indicated he did remember receiving some medications from the pharmacy on 5/11/23 and there were some insulins in there. He was not aware of whose all they were. They had a refrigerator on the third floor that had insulins in it. He placed the insulin in the third floor refrigerator. His first day working at the facility was 5/1/23, and he was still learning the residents. He just tried to get the medications put away as fast as possible. He now knew if it was a resident who took their own medication, they may have the medication in their room. He would just take it to the resident and ask them where they want it. He knew he signed for insulins but did not know who they were for, he did not take any medications to any residents, he placed them all in the		**taken?** All residents are at potential risk for the aforementioned deficient practice; however, residents with greater staff needs, physical and mental issues have the potential to be more time-consuming and interactive with staff, therefore, these residents have the potential to be at greater risk. Management will be more cognizant of the need for appropriate staffing to deal with any possibility of the above: real or perceived. Staff will be made aware by HSL that no type of abuse will not be tolerated and that any abuse-real or perceived will be dealt with swiftly an accordingly. **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 HSL management. HSL will also encourage all employees to be resident advocates to ensure the safety of all residents. HSL management will track all complaints of any type of alleged abuse via grievance forms (which	

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	refrigerator. He didn't know to take them to the residents. During an interview on 5/18/23 at 2:00 p.m., QMA 5 indicated she had found the resident's insulin on Monday morning. She located it in the refrigerator on the third floor and it was in there. It was in a dark brown plastic bag so it was harder to find it, but it did not take her long to find it. They normally would give the medications straight to the residents who self administered, but she did believe LPN 10 who was new there, had signed for it and he probably did not know. She gave it to the resident then on Monday morning. She did not know for sure how long the resident went without her insulin, she believed the resident told her it was 3 days. This State tag relates to Complaint IN00408602.		are readily available to all residents), verbal complaints, phone calls, emails or anonymous in nature. 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 in this revision will be implemented 6.26.23 and will be on-going. **410 IAC 16.2-5-1.2 (hh) Residents' Rights-Noncompliance.** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected by misappropriation of controlled medications. **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?** Employee was terminated, see process below. A thorough investigation was completed immediately by the Administrator. MAR reviewed, call light alert system reviewed, met with resident, met with nurse that signed out meds and camera system reviewed. The nurse was suspended pending investigation	

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			then terminated. The incident was reported to state and Life Span, information given to Attorney General's office. ***Note This incident occurred and was properly dealt with in April prior to the Annual State Survey.*** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** A MAR Audit was conducted and will be on-going by the Director of Nursing weekly. **3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure?** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends to ensure narcotics are counted every shift with the oncoming and off going nursing staff. The audit of five residents on MAR will continue for five additional weeks to assure insulin is given as directed by physician. If insulin is missed an education will follow with staff. If more than one resident is found during audit that didn't receive insulin, then additional weeks will be added until zero holes show.	

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			4. Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure. DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends. Director of Nursing and or Executive Director will do a weekly Medication Administration (MAR) review on five residents to ensure compliance, starting 6/8/23-7/6/23) see MAR audit sheet attached) If holes show up on MAR, education with clinical staff will be given and audit will continue another five weeks. **5. For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** DON will monitor the narcotic count sheet Friday-Monday and designate a nurse on weekends to ensure narcotics are counted every shift with the oncoming and off going nurse. Precautions will be enforced to ensure that all controlled substances have been properly accounted for and destroyed as indicated, to prevent drug diversions by DON or	

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			designer. An audit of MAR will be put in place for five weeks to assure insulin is given as directed by physician. If insulin is missing an education will follow with clinical staff and audit will continue another five weeks. **410IAC 16.2-5=1.4(b)** **Personnel-Deficiency** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected by misappropriation of controlled medications. **1.&3. Please describe what the facility did to correct the deficient practice.** **Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure.** A) An RN was hired for the Director of Nursing position and started 6/5/2023 which allows another nurse to be on call 24/7 and to be at facility Monday-Friday 7a-5p along with overseeing all immediate assessments date is obtained relative to the incident, interventions, necessary to stabilize the residents as needed with falls etc. B) Interviews are being	

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			conducted for the Assisted Director of Nursing. C) Additional staff on the third shift were corrected prior to the Survey findings. Sufficient staff is on all shifts. D) CPR/First Aid additional class scheduled in June 2023 which will allow one awake staff member with CPR and First aid and ongoing classes as needed. CPR/First Aid binder will be kept in Executive Director office for verification. **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** An audit was completed of all previous incidents in Point Click Care, PCC for proper follow ups. **4. & 5. Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** The Executive Director will monitor the staffing schedule weekly along with the CPR/First aid	

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			binder/certification on each employee scheduled. **410 IAC 16.2-5-1,5(k) Sanitation and Safety Standards-Deficiency** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected by the plate warmer not always holding temp. **1. Please describe what the facility did to correct the deficient practice.** Maintenance work order was put in Tels system and cord replaced 6/6/23 on plate warmer. Temps are being audited daily before and during all meals for proper temperature. **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** Reviewed/audited by Dietary Manager with residents during June 2023, Chief Cancel. **3,4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & 5. Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice**	

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			findings, please provide if ongoing system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped. Dietary Manager educated on the importance of properly doing a workorder for any repairs needed. Dietary Manager will ongoing temp meals prior to serving and during serving. **410 IAC 16.2-5-1.5(M) Sanitation and Safety Standards-Deficiency.** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected. **1. Please describe what the facility did to correct the deficient practice.** Dietary staff were educated by Dietary Manager on 6/7/23 and review of Dry Food Storage policy and procedure and Refrigerated Storage policy and procedure. (*See attached*) **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.**	

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			Discussion with residents by Dietary Manager during Chief Cancel **3, 4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & Please describe how the corrective actions will be monitored to ensure the deficient practice will not recure.** **For all deficient practice findings, please provide if ongoing** **system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** Ongoing education will be provided by the Dietary Manager for Dietary staff and any new hires within the first week of training. Ongoing education with (all) staff on inputting work orders timely on any needed repairs. **410 IAC 16.2-5-6(a) Pharmaceutical Services-Noncompliance** While all residents have the potential to have been affected in a negative manner, no resident was identified as being negatively affected. **1. Please describe what the**	

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			facility did to correct the deficient practice. Nursing staff In-service held 6/5/23 (*see attached*) **Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** Audit completed by Executive Director on all residents who. self-administrator medication to make sure they had access to their own medication in their rooms and not in nurse refrigerator. **2. Please describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice.** The Executive Director audited all residents' refrigerators 6/5/23 within their unit to confirm insulin was present if listed as a self-administer of own medication and checked nurse's refrigerator to confirm no self-administer medication was present. Proper storage in place… **3, 4, & 5. Please describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recure. & Please describe how the corrective actions will be monitored to ensure the deficient practice will not**	

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			recure. **For all deficient practice findings, please provide if ongoing** **system of monitoring or the criteria or threshold the Quality Assurance Program will use to determine whether further monitoring is necessary or if the monitoring can be stopped.** Nurse and QMA's educated on proper management of resident's medication once received from pharmacy and properly communicating with Director of Nursing and or Executive Director on reporting of missing medication 6/5/23. (*See attached)* Ongoing education… *Revised changes will be effective June 26, 2023*	