| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 05/15/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for a State Residential Licensure Survey.<br><br>Survey dates: May 14 and 15, 2026<br><br>Facility number: 014062<br><br>Residential Census: 112<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed May 20, 2026. | R 0000 | The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective June 1, 2026. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC and supporting documents submitted. | |
| R 0086 | Administration and Management - Deficiency<br><br>410 IAC 16.2-5-1.3(a)(1-2)<br><br>The licensee:<br><br>(1) is responsible for compliance with all applicable laws; and<br><br>(2) has full authority and responsibility for the: | R 0086 | **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>No residents were negatively affected by the deficient practice. Upon identification, the facility immediately completed and submitted the renewal | 06/01/2026 |

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| | (A) organization;<br><br>(B) management;<br><br>(C) operation; and<br><br>(D) control;<br><br>of the licensed facility.<br><br>The delegation of any authority by the licensee does not diminish the responsibilities of the licensee.<br><br>Based on record review and interview, the facility failed to ensure a current and valid Clinical Laboratory Improvement Amendments (CLIA) certification (for the purposes of performing laboratory examinations or procedures) was maintained as required.<br><br>Finding includes:<br><br>On 5/14/26 at 1:12 p.m., the Executive Director (ED) provided a copy of the facility's current CLIA certification document. A review of the document indicated the certification's expiration date was 2/4/26. No subsequent CLIA certification was available.<br><br>During an interview on 5/14/26 at 1:15 p.m., the ED indicated the CLIA certification's expiration date was in February of 2026 and it should have been renewed by it's expiration date. The facility had continued to perform blood glucose testing | | application and payment for the CLIA waiver. Documentation of renewal has been maintained in the facility compliance records.<br><br>**2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All facility licenses, permits, certifications, and regulatory documents were reviewed to identify any additional expired or soon-to-expire documents. No additional expired regulatory documents were identified.<br><br>**3. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur?**<br><br>The facility implemented a regulatory compliance tracking log that includes expiration dates for all licenses, permits, certifications, and waivers. The Executive Director or designee will receive reminder notifications at least 60 days prior to expiration to ensure timely renewal submission. | |

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| | and other outside vendors had also completed various resident blood draws even though the facility's CLIA certification had expired.<br><br>During an interview on 5/15/26 at 10:10 a.m., the ED indicated the facility lacked a specific policy for maintaining a current CLIA certification. The facility was to follow all federal and state rules and regulations. | | **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>The Executive Director or designee will audit the regulatory compliance log monthly for six months to verify that all documents remain current. Findings will be reviewed during Quality Assurance meetings, and corrective action will be initiated promptly if concerns are identified.<br><br>**5. By what date will the systemic changes be completed?**<br><br>Systemic changes will be completed by: 6/1/26 | |
| R 0151 | Sanitation & Safety Standards -Noncompliance<br><br>410 IAC 16.2-5-1.5(h)<br><br>(h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.<br><br>Based on interview and record review, the facility failed to ensure pets who were housed within the facility had received the required annual rabies vaccinations and wellness | R 0151 | **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>No residents were negatively affected by the deficient practice. Upon identification, the residents were immediately notified. Current vaccination documentation was obtained for one pet, and the other resident was issued notice to obtain an updated rabies vaccination. | 06/01/2026 |

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| | examinations for 2 of 6 pets reviewed vaccination records. (Resident 160, Resident 206)<br><br>Finding includes:<br><br>1. On 5/14/26 at 11:15 a.m., the ED provided a copy of Resident 160's feline pet's vaccination records. A review of the documentation included an invoice from the veterinary clinic utilized by the resident. The document indicated Resident 160's pet had received a feline rabies one year booster and a wellness exam on 4/23/25. The next rabies booster vaccination and wellness exam was due on 4/23/26. The record lacked any subsequent vaccinations for the feline.<br><br>During an interview at that time, the ED indicated Resident 160's feline pet's rabies vaccination and wellness exam was past due.<br><br>2. On 5/15/26 at 9:40 a.m., the ED provided a copy of Resident 206's feline pet's vaccination records. A review of the documentation indicated the feline's rabies vaccination and wellness exam was due on 1/14/26. Included in the documentation provided was a copy of an invoice from the veterinary clinic utilized by the resident. The documentation indicated the feline had not received the annual rabies one | | Current vaccination records were secured and placed in the pet file.<br><br>**2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>The facility reviewed all pet records maintained within the community to verify that required veterinary documentation and rabies vaccinations were current. Any missing, incomplete, or expired documentation identified during the audit was addressed promptly through resident notification and follow-up.<br><br>**3. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur?**<br><br>The facility implemented a pet compliance tracking log that includes vaccination expiration dates and required veterinary documentation. The Executive Director or designee will review the log monthly and notify pet owners before expiration dates to ensure timely renewal and continued compliance with facility policy.<br><br>**4. How will the corrective action(s) be monitored to** | |

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| | year booster and a wellness exam until 4/22/26.<br><br>During an interview at that time, the ED indicated Resident 206's pet vaccination was delinquent.<br><br>During an interview on 5/15/26 at 9:50 a.m., the ED indicated all pets who were housed within the facility were required to have current rabies vaccinations on file. The facility lacked documentation that support Resident 206 and Resident 160's pets had maintained current rabies vaccinations.<br><br>On 5/15/26 at 9:25 a.m., the ED provided an undated copy of the facility's annual rabies vaccination document and indicated it was the current policy in use by the facility. A review of the document indicated, " ...in accordance with your residential lease and Indiana state law, Hellenic Senior Living must obtain evidential records of annual Rabies vaccination records from every residential pet owner ..."<br><br>On 5/15/26 at 3:00 p.m., a review of the Rabies Vaccination Requirements located at 345 Indiana Administrative Code 1-5-2 indicated, "...all cats...3 months of age and older must be vaccinated against rabies..." | | **ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>The Executive Director or designee will conduct monthly audits of all pet files for six months to verify that required documentation remains current and compliant with facility policy. Findings will be reviewed during Quality Assurance meetings, and corrective action will be initiated promptly if concerns are identified.<br><br>**5. By what date will the systemic changes be completed?**<br><br>Systemic changes will be completed by: 6/1/26 | |

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| R 0349 | Clinical Records - Noncompliance<br><br>410 IAC 16.2-5-8.1(a)(1-4)<br><br>(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:<br><br>(1) Complete.<br><br>(2) Accurately documented.<br><br>(3) Readily accessible.<br><br>(4) Systematically organized.<br><br>Based on interview and record review, the facility failed to ensure physician orders for monthly weight and monthly vital signs were obtained and documented in the clinical record for for 3 of 7 residents reviewed for physician orders. (Resident 205, Resident 211, Resident 212)<br><br>Findings include:<br><br>1. On 5/14/26 at 12:15 p.m., Resident 205's clinical record was reviewed and indicated the following:<br><br>Resident 205's diagnoses included, but were not limited to, anxiety disorder, major depressive disorder, and hypertension (high blood | R 0349 | 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br><br>**Missing weights and vital signs were obtained promptly and documented in the medical record for all residents affected following a 100% resident audit.**<br><br>1. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>**The facility conducted a 100% audit of all current residents to verify completion and documentation of monthly weights and monthly vital signs for the month of May. Physician orders were obtained to remove monthly weights and vital signs from orders as this was not company policy, but an order automatically added at time of admission for each new resident by previous management.**<br><br>1. What measures will be put into place or what systemic changes will the facility make to ensure | 06/01/2026 |

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| | pressure).<br><br>Resident 205 had an active physician's order with a start date of 4/1/25 and no end date for "monthly weights every day shift every 1 month(s) starting on the 1st for 3 day(s) ...".<br><br>Resident 205 had an active physician's order with a start date of 3/4/25 and no end date for "monthly vitals [vitals or vital signs are generally considered to include blood pressure, pulse rate, respiration rate, body temperature, and often include oxygen saturation levels] one time a day starting on the 1st and ending on the 5th of every month for monitoring ...".<br><br>Resident 205's clinical record lacked weight monitoring as ordered for the months of December 2025, January 2026, March 2026, and April 2026.<br><br>Resident 205's clinical record lacked vital sign monitoring as ordered for the months of December 2025, January 2026, and March of 2026.<br><br>2. On 5/14/26 at 12:45 p.m., Resident 211's clinical record was reviewed and indicated the following:<br><br>Resident 211's diagnoses included, but were not limited to, Alzheimer's disease (a progressive, irreversible brain | | the deficient practice does not recur?<br><br>**Physician orders were obtained to discontinue monthly weight and vitals signs on all current residents. Full set of vital signs and weight will be obtained on admission and semi-annually. The facility implemented a Semi-Annual Vital Signs and Weight Tracking Log to monitor completion of weights and vital signs semi-annually for all residents. (Copy attached of Semi-Annual Vital Signs and Weight Tracking Log). The Director of Nursing or designee will check the 1st week of each month beginning 6/1/26 for any semi-annual weights and vital signs that need to be obtain during the current month and the following month. The Director of Nursing or designee will identify all residents on the vital signs and weight tracking log that require semiannual vital signs and weights to be obtained and ensure both vital signs and weights are obtained semi-annually. The Director of Nursing or designee will monitor this monthly during the 1st week of the month for the next 12 months to ensure compliance** | |

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| | disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), chronic obstructive pulmonary disorder (a progressive, incurable lung disease that restricts airflow), and hypertension.<br><br>Resident 211 had a physician's order with a start date of 3/1/25 and an end date of 3/7/26 for "monthly weights every day shift every 1 month(s) starting on the 1st for 3 day(s) for weight."<br><br>Resident 211 had a physician's order with a start date of 3/1/25 and an end date of 3/7/26 for "vitals monthly every day shift every 1 month(s) starting on the 1st for 3 day(s) for vitals."<br><br>Resident 211's clinical record lacked weight monitoring as ordered for the months of December 2025, January 2026, February 2026, and March of 2026.<br><br>Resident 211's clinical record lacked vital sign monitoring as ordered for the months of December 2025, January 2026, February 2026, and March of 2026.<br><br>3. On 5/14/26 at 1:15 p.m., Resident 212's clinical record was reviewed and indicated the following:<br><br>Resident 212's diagnoses | | How will the corrective action(s) be monitored to ensure the deficient practice will not recur?<br><br>**The Director of Nursing or designee will check the 1st week of each month beginning 6/1/26 for any semi-annual weights and vital signs that need to be obtain during the current month and the following month. The Director of Nursing or designee will identify all residents on the vital signs and weight tracking log that require semiannual vital signs and weights to be obtained and ensure both vital signs and weights are obtained semi-annually. The Director of Nursing or designee will monitor this monthly during the 1st week of the month for the next 12 months to ensure compliance**<br><br>5. By what date will the systemic changes be completed?<br><br>**Systemic changes will be completed by: 6/1/2026** | |

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| | included, but were not limited to, heart disease, Crohn's disease (a chronic inflammatory bowel disease where the immune system attacks the digestive tract), and hypertension.<br><br>Resident 212 had a physician's order with a start date of 10/1/24 and an end date of 4/2/26 for "monthly weights every day shift every 1 month(s) starting on the 1st for 3 day(s)."<br><br>Resident 212 had a physician's order with a start date of 10/1/24 and an end date of 4/2/26 for "vitals monthly every day shift every 1 month(s) starting on the 1st for 3 day(s)."<br><br>Resident 212's clinical record lacked weight monitoring as ordered for the months of December 2025, January 2026, February 2026, and March of 2026.<br><br>Resident 212's clinical record lacked vital sign monitoring as ordered for the months of December 2025, January 2026, February 2026, and March of 2026.<br><br>During an interview on 5/15/26 at 10:00 a.m., the ED (Executive Director) and the Director of Clinical Services indicated that the weights and vitals were not documented and should have been recorded as ordered. | | | |

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| | On 5/15/26 at 10:15 a.m., the ED provided a copy of the Medication Administration policy, dated 9/30/22, and indicated it was the current policy in use by the facility. The ED indicated that they did not have a specific policy for following physicians' orders, but that physician orders for weights or vitals should be followed as ordered by the physician just as with the administration of medications, to be completed as ordered and documented appropriately. | | | |
| R 0410 | Infection Control - Noncompliance<br><br>410 IAC 16.2-5-12(e)(f)(g)<br><br>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.<br><br>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. | R 0410 | 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br><br>**The residents identified as missing the second step tuberculin skin tests and/or readings received the 1st step tuberculin skin test and will receive the 2nd step 1-3 weeks following the 1st step.**<br><br>1. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>**A 100% audit of resident records was conducted to verify a 2 step tuberculin skin** | 06/01/2026 |

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| | (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br><br>Based on interview and record review, the facility failed to ensure a resident was provided the second step of a two-step Mantoux skin test (tool used for screening for tuberculosis) upon admission for 1 of 7 resident reviewed for tuberculosis skin tests. (Resident 126)<br><br>Finding includes:<br><br>On 5/14/26 at 12:25 p.m., Resident 126's clinical record was reviewed. The diagnoses included, but were not limited to, atherosclerotic heart disease of native coronary artery without angina pectoris (a condition where plaque slowly builds up in the heart's naturally occurring arteries (native) restricting blood flow without causing chest pain) and Gastro-esophageal reflux disease without esophagitis.<br><br>Resident 126's clinical record lacked documentation of a second step Mantoux skin test.<br><br>During an interview on 5/15/26 at 9:10 a.m., the DON (Director of Nursing) indicated that she could only find documentation for Resident 126's first step | | **test was completed upon admission and required readings were completed and documented appropriately. No other residents were affected than the 1 identified.**<br><br>1. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur?<br><br>**The facility implemented a Admission 2-Step Tuberculin Skin Test Tracking Log for all new admission 2-step tuberculin skin tests and readings. The Director of Nursing or designee will ensure the 1st step is given on date of admission and the 2nd step is administered within 1-3 weeks following using the Admission 2-Step Tuberculin Skin Test Tracking Log for all new admissions. This practice will occur on every admission indefinitely to ensure compliance with state regulations.**<br><br>1. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?<br><br>**The facility implemented a Admission 2-Step Tuberculin Skin Test Tracking Log for all** | |

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| | admission Mantoux skin test which was negative and that the facility followed State guidelines, and he should have had a second one.<br><br>On 5/15/26 at 9:57 a.m., the DCS (Director of Clinical Services) provided a Hellenic Senior Living Clinical Policy and Procedure Manual, with a reviewed date of 12/2025, and indicated it was the current policy in use by the facility. The policy indicated if the initial Mantoux test reaction is negative, the second test will be given one week to three weeks after the first test. | | **new admission 2-step tuberculin skin tests and readings. The Director of Nursing or designee will ensure the 1st step is given on date of admission and the 2nd step is administered within 1-3 weeks following using the Admission 2-Step Tuberculin Skin Test Tracking Log for all new admissions. This practice will occur on every admission indefinitely to ensure compliance with state regulations.**<br><br>5. By what date will the systemic changes be completed?<br><br>**Systemic changes will be completed by: 6/1/26** | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETeresa Glidden | TITLEExecutive Director | (X6) DATE05/29/2026 |