STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00358221. Complaint IN00358221 - Substantiated. A State Residential deficiency related to the allegations is cited at R306. Survey date: July 19, 2021 Facility number: 014062 Residential Census: 113 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality Review completed on July 23, 2021.	R 0000	This plan of correction is submitted as required under State and Federal Law; the submission of this plan of correction does not constitute an admission of wrongdoing on behalf of the community.	
R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate	R 0306	The LPN who inappropriately disposed of the medications was terminated due to non-compliance with the proper disposal of narcotic medications. All residents had the potential of	08/31/2021

	federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure expired narcotic medications were properly disposed of for 2 of 3 residents reviewed for medication disposal. (Resident B and Resident C) Findings include: 1. On 7/19/2021 at 12:15 p.m., Resident B's clinical record was reviewed. Diagnosis included, but were not limited to chronic pain.		being effect by the inappropriate narcotic disposal practice completed by the LPN. All nurses of the community will be re-educated on the proper disposal of narcotic medication. The narcotic destruction sheets will be spot checked by the administrator on a bi-weekly basis for the next 90-days. Following the initial 90-days the narcotic destruction sheets will then be monitored by the administrator on a monthly basis. All nurses of the community will be re-educated on or before 8/31/2021 regarding the proper disposal of narcotics. Monitoring of the narcotic destruction sheets will begin immediately.	

Physician orders, dated 7/1/2021 through 7/31/2021, indicated Resident B's medications included, but were not limited to norco (a pain medication) 5-325 mg (milligrams) 1 tablet by mouth every 6 hours as needed for pain.

A review of the Extended Pharmacy Narcotic Inventory Sheets for Resident B indicated 3 medication cards of 90 pills each were destroyed on 7/13/2021, with two nurse signatures present.

During an interview, on 7/19/2021 at 1:15 p.m., the Administrator indicated on 6/25/2021, the former Director of Nursing (DON) pulled the 3 medication cards of 90 pills each from the locked narcotic box for Resident B, because the medications had expired. The DON left the medications in her office and had not properly disposed of them. The medication was not disposed until 7/13/2021.

2. On 7/19/2021 at 10:30 a.m., Resident C's clinical record was reviewed. Diagnosis included, but were not limited to breast cancer.

Physician orders, dated 7/1/2021 through 7/31/2021, indicated Resident C's medications included, but were

not limited to oxycodone (a pain medication) HCL (hydrochloride) ER (extended release) 10 mg 1 tablet by mouth twice daily as needed for pain.

A review of the Extended Pharmacy Narcotic Inventory Sheet for Resident C indicated 20 pills were destroyed on 6/25/2021, by the DON. The narcotic sheet lacked documentation of another nurse co-signing with the DON.

During an interview, on 7/19/2021 at 1:20 p.m., the Administrator indicated on 6/25/2021, the former DON pulled the medication from the locked as needed narcotic box for Resident C, because the medication had expired. The DON disposed of the medication alone and did not have a 2nd nurse witness the disposal.

On 7/19/2021 at 1:45 p.m., the Administrator provided the facility's policy, "Disposal of Medication" dated February 2010, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... It is the policy of this facility to properly dispose of medications ..." The policy did not indicate the disposal of narcotics.

This State Residential Finding relates to Complaint IN00358221.

Based on interview and record review, the facility failed to ensure expired narcotic medications were properly disposed of for 2 of 3 residents reviewed for medication disposal. (Resident B and Resident C)

Findings include:

1. On 7/19/2021 at 12:15 p.m., Resident B's clinical record was reviewed. Diagnosis included, but were not limited to chronic pain.

Physician orders, dated 7/1/2021 through 7/31/2021, indicated Resident B's medications included, but were not limited to norco (a pain medication) 5-325 mg (milligrams) 1 tablet by mouth every 6 hours as needed for pain.

A review of the Extended Pharmacy Narcotic Inventory Sheets for Resident B indicated 3 medication cards of 90 pills each were destroyed on 7/13/2021, with two nurse signatures present.

During an interview, on 7/19/2021 at 1:15 p.m., the Administrator indicated on 6/25/2021, the former Director of Nursing (DON) pulled the 3 medication cards of 90 pills each from the locked narcotic box for Resident B, because the medications had expired. The

DON left the medications in her office and had not properly disposed of them. The medication was not disposed until 7/13/2021.

2. On 7/19/2021 at 10:30 a.m., Resident C's clinical record was reviewed. Diagnosis included, but were not limited to breast cancer.

Physician orders, dated 7/1/2021 through 7/31/2021, indicated Resident C's medications included, but were not limited to oxycodone (a pain medication) HCL (hydrochloride) ER (extended release) 10 mg 1 tablet by mouth twice daily as needed for pain.

A review of the Extended Pharmacy Narcotic Inventory Sheet for Resident C indicated 20 pills were destroyed on 6/25/2021, by the DON. The narcotic sheet lacked documentation of another nurse co-signing with the DON.

During an interview, on 7/19/2021 at 1:20 p.m., the Administrator indicated on 6/25/2021, the former DON pulled the medication from the locked as needed narcotic box for Resident C, because the medication had expired. The DON disposed of the medication alone and did not have a 2nd nurse witness the disposal.

On 7/19/2021 at 1:45 p.m., the

	Administrator provided the facility's policy, "Disposal of Medication" dated February 2010, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... It is the policy of this facility to properly dispose of medications ..." The policy did not indicate the disposal of narcotics. This State Residential Finding relates to Complaint IN00358221.			

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.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE