STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/09/2025

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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00457168. Complaint IN00457168 - State deficiencies related to the allegations are cited at R0090. Survey dates: April 8 and 9, 2025 Facility number: 014062 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 11, 2025.	R 0000	**The creation and submission of the Plan of correction does not constitute an admission by this provider, or a conclusion set forth in the state of deficiencies, or any violation or regulation. This provider respectfully requests that this Pan of Correction be considered the letter of Credible Allegation and Requests a Desk Review in lieu of a Post Survey Review. Completion Date of May 9, 2025.**	
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible	R 0090	**R 090 410 IAC 16.2-5-1.3(g) (1-6) Administration and Management – Deficiency**	05/09/2025

	for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that		**1** **What** **correction action will be accomplished for those residents found to have been affected by the deficient practice:** On 4/16/2025, the Executive Director (ED) was re-educated by the Regional Director of Operations on the guidelines of reporting allegations of misappropriation of property to state and local officials based on timeframes surrounding the allegation per the company policy and procedure, and the state and federal regulation. **2** **How will the facility identify other residents having the potential to be affected by the same deficient** **practice and what corrective action will be taken:** All residents have the potential to be affected. The Executive Director was re-educated by the Regional Director of Operation on 4/16/2025, the Director of Nursing (DON) will	

	indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to submit a required facility reportable to the State Department of Health regarding an allegation of misappropriation of property. Jewelry and money were reported as taken without the residents permission. (Resident B) Finding includes: On 4/9/25 at 9:18 a.m. the clinical record of Resident B was reviewed. The diagnosis included, but was not limited to, hypertension.		be educated by the Executive Director of reporting allegations per the state and federal guidelines and regulation, and per the company policy and procedure. All staff members are educated on the guidelines and federal regulations on preventing and reporting allegations during their orientation process. The training documentation for Resident Rights is kept in their employee file. **3** **What** **measures will be put into place or systemic changes made to ensure the deficient practice will not occur:** The Executive Director was re-educated on the state and federal guidelines and regulations, and per the company including prevention and reporting allegations. The Regional Director of Operations re-educates the Executive Director 1 x per week for two weeks: then 1x per month for 2 months, then 1 x quarterly for the next two quarters, then annually thereafter.	

	A Brief Interview for Mental Status, dated 8/30/24, indicated Resident B was cognitively intact. During an interview on 4/8/25 at 12:30 p.m., Resident B indicated about three weeks ago, someone came into his room while he was out doing activities. When he returned after activities, he observed two of his dresser drawers had been pulled completely out and were lying on the floor upside down. This was reported to the Administrator. The Administrator went to Resident B's room and took pictures of the drawers. Resident B indicated he was missing his wife's wedding ring and 60 dollars in cash. During an interview on 4/9/25 at 8:30 a.m., the Administrator indicated the facility lease agreement stated the facility was not responsible for lost or stolen items. No personal inventory sheet had been filled out. The residents were encouraged to not bring in valuable items to the facility. The Administrator indicated the allegation was not reported to the State Department of Heath. On 4/9/25 at 11:05 a.m., the Administrator provided a document titled Summary of Investigation for Resident B, dated 3/18/25, regarding the allegation for Resident B. The		**4** **How will the facility monitor the performance** **to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place**: The Regional Director of Operations will review all incidents with the Executive Director prior to making the decision to report the concern and/or allegation to the local and state agencies to ensure all guidelines and timeframes are being met by the federal regulation and the company policy timeframes are being met per the state and federal regulation and the company policy and procedure. **5** **By** **what date the systemic changes will be completed: 5/9/25**	

	document indicated someone had broke into Resident B's apartment and took a diamond ring and sixty dollars in cash. The resident requested reimbursement for the cash and the ring. On 4/9/25 at 10:56 a.m.. the Director of Nursing provided a policy titled Incident...Reporting, dated 9/30/22 and indicated it was the current policy being used by the facility. A review of the policy indicated "All incidents, accidents, and unusual occurrences that meet the criteria or reporting will be submitted to the proper Federal, State, and local authorities, including but not limited to ISDH,..." On 4/9/25 at 12:00 p.m., the current IDOH policy titled Long-Term Care Abuse and Incident reporting, dated 12/8/23 was reviewed. The policy indicated "Licensed Residential Care facilities...C. Types of incidents reportable under state rules...12. Misappropriation of resident property: Deliberate misplacement, exploitation, or wrongful temporary or permanent use of resident's property or money without the residents consent..." This citation relates to Complaint IN00457168.			

	Based on interview and record review, the facility failed to submit a required facility reportable to the State Department of Health regarding an allegation of misappropriation of property. Jewelry and money were reported as taken without the residents permission. (Resident B) Finding includes: On 4/9/25 at 9:18 a.m. the clinical record of Resident B was reviewed. The diagnosis included, but was not limited to, hypertension. A Brief Interview for Mental Status, dated 8/30/24, indicated Resident B was cognitively intact. During an interview on 4/8/25 at 12:30 p.m., Resident B indicated about three weeks ago, someone came into his room while he was out doing activities. When he returned after activities, he observed two of his dresser drawers had been pulled completely out and were lying on the floor upside down. This was reported to the Administrator. The Administrator went to Resident B's room and took pictures of the drawers. Resident B indicated he was missing his wife's wedding ring and 60 dollars in cash. During an interview on 4/9/25 at			

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R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice	R 0120	**R120** **410 IAC 16.2-5-1.4(e) (1-3)** **Personnel** **1 What correction action will be** **accomplished for those residents found to have been affected by the deficient practice:** The Executive Director and/or Director of Nursing will ensure all personnel in all departments and at least annually and for all newly hired personnel pertaining to Dementia Training. Audits were	05/09/2025

	per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure staff received annual dementia and resident rights training for 1 of 3 staff reviewed for annual trainings. (Cook 2) Finding includes: On 4/9/25 at 9:30 a.m., the		conducted immediately on all employee files for compliance. The Dining Server has completed the Relias Dementia Training and will continue to complete the required Dementia Training annually. All new hires are required to complete their Relias training during the orientation period. The Directors of each department have access to Relias training and will ensure 3 hours of Dementia training are completed by their staff annually. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**. No other residents were found to be affected by this practice. **3 What measures will be put in place or what systemic changes the facility will make**	

	employee record of Cook 2 was reviewed. The record indicated Cook 2 was hired on 10/25/23. Cook 2's annual training records were reviewed. The employee record lacked documentation of any subsequent dementia or resident rights training since Cook 2's hire date of 10/25/23. During an interview on 4/9/25 at 11:00 a.m., the Administrator indicated staff were to complete dementia and resident rights training on an annual basis. Cook 2 should have completed the annual dementia and resident rights training for calendar year 2024. During an interview on 4/9/25 at 12:26 p.m., the Director of Nursing indicated the facility did not have a specific policy that required annual training for dementia and resident rights. The Director of Nursing indicated the facility was to follow the state training regulations. Based on interview and record review, the facility failed to ensure staff received annual dementia and resident rights training for 1 of 3 staff reviewed for annual trainings. (Cook 2) Finding includes: On 4/9/25 at 9:30 a.m., the employee record of Cook 2 was reviewed. The record indicated		**to ensure that the deficient practice does not recur?** Audits will occur at the end of each month by each Department Director, Director of Nursing and/or Executive Director to ensure Relias compliance. All newly hired associate audits will be performed weekly for one month, then once a month for two months, then annually thereafter. Employee audits will be reviewed during morning meetings for 4 months, with adjustments being made if indicated and addressed at meetings. Any issues with lack of compliance will be addressed by employee re-education and /or discipline or revision to this plan by the Executive Director and/or Director of Nursing. **4 How will the facility monitor the performance to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place:**	

	Cook 2 was hired on 10/25/23. Cook 2's annual training records were reviewed. The employee record lacked documentation of any subsequent dementia or resident rights training since Cook 2's hire date of 10/25/23. During an interview on 4/9/25 at 11:00 a.m., the Administrator indicated staff were to complete dementia and resident rights training on an annual basis. Cook 2 should have completed the annual dementia and resident rights training for calendar year 2024. During an interview on 4/9/25 at 12:26 p.m., the Director of Nursing indicated the facility did not have a specific policy that required annual training for dementia and resident rights. The Director of Nursing indicated the facility was to follow the state training regulations.		Audits will occur at the end of each month by each Department Director, Director of Nursing and/or Executive Director to ensure Relias compliance. All newly hired associate audits will be performed weekly for one month, then once a month for 2 months, then annually thereafter. Employee audits will be reviewed during morning meetings for 4 months. Any issues with lack of compliance will be addressed by employee re-education and /or discipline or revision of this plan by the Executive Director and/or Director of Nursing**.** **5** **By** **what date the systemic changes will be completed:** **Completion Date 5/9/25**	
R 0273	Food and Nutritional Services -	R 0273	**R 273**	05/09/2025

Deficiency

410 IAC 16.2-5-5.1(f)

(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.

Based on observation, interview, and record review, the facility failed to ensure foods in a kitchen walk in refrigerator were labeled, dated, and tightly covered for 2 of 2 observations.

Findings include:

On 4/8/25 at 8:47 a.m., during the initial kitchen tour, inside the kitchen walk-in refrigerator the following was observed, a metal stacking cart with trays, on the trays were a total of 16, small white plates, each plate contained a two by two inch piece of yellow cake with glazed icing. The pieces of cake lacked a label to indicate when they were placed into the refrigerator or the expiration date.

During an observation on 4/8/25 at 9:20 a.m., observed 16 small white plates in the walk-in cooler with each plate containing a two by two inch piece of cake that were uncovered and unlabeled.

During an interview on 4/8/25 at 8:55 a.m., the Culinary Director indicated that the cakes should

410IAC 16.2-5-5. 1 (f) Food and Nutritional Services - Deficiency

1. What correction action will be accomplished for those residents found to have been affected by the deficient practice:

No residents were found to have been affected by the deficient practice. The Dining Service Director and Cooks will have a checklist that will document the labeling, dating, and covering of all open-in-use products three times per day.

2 How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

All residents could have been affected by the deficient practice; however, no residents were affected.

3 What

	have been covered and labeled as they were from the previous night. On 4/8/25 at 9:23 a.m., the Culinary Director provided a copy of Culinary Services Operating Standards with a revision date of 3/2/2021 and indicated that it was the current policy in use by the facility. A review of the policy indicated " ...Labeling ... If an item is not being served, it shall be covered, labeled and dated. All bulk foods or food not intended for immediate consumption shall be covered with lid or food film and labeled with item name, date prepared, time and discard date ..."		**measures will be put into place or systemic changes made to ensure the deficient practice will not occur:** A dining Services in-service will take place Tuesday April 22, 2025, with the Cooks to introduce the Check Off Process for the Opening and Closing Operational Checklist. On April 22nd a Dining Service in-services with the Dining Servers will take place to ensure their knowledge and safe practices concerning labeling, dating, and covering of all open-in-use products. **4 How will the facility monitor the performance to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place**: Corrective action will be monitored with the Daily Opening and Closing Checklist that includes the three times daily observation of correct labeling practices.	

	On 4/8/25 at 10:00 a.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated "...refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...discarded...food shall be protected from contamination by storing the food as follows:...(5). In packages, covered containers, or wrappings...wrap food tightly to prevent cross contamination..." Based on observation, interview, and record review, the facility failed to ensure foods in a kitchen walk in refrigerator were labeled, dated, and tightly covered for 2 of 2 observations. Findings include: On 4/8/25 at 8:47 a.m., during the initial kitchen tour, inside the kitchen walk-in refrigerator the following was observed, a metal stacking cart with trays, on the trays were a total of 16, small white plates, each plate contained a two by two inch piece of yellow cake with glazed icing. The pieces of cake lacked a label to indicate when they were placed into the refrigerator		**5** **By what date the systemic changes** **will be completed: 5/9/25**	

or the expiration date.

During an observation on 4/8/25 at 9:20 a.m., observed 16 small white plates in the walk-in cooler with each plate containing a two by two inch piece of cake that were uncovered and unlabeled.

During an interview on 4/8/25 at 8:55 a.m., the Culinary Director indicated that the cakes should have been covered and labeled as they were from the previous night.

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	establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...discarded...food shall be protected from contamination by storing the food as follows:...(5). In packages, covered containers, or wrappings...wrap food tightly to prevent cross contamination..."			

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