

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/27/2023	
NAME OF PROVIDER OR SUPPLIER HELLENIC SENIOR LIVING OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaints IN00413204, IN00411062, and IN00411186. Complaint IN00413204 - State deficiencies related to the allegations are cited at R155 and R273. Complaint IN00411062 - State deficiencies related to the allegations are cited at R155. Complaint IN00411186 - State deficiencies related to the allegations are cited at R273. Survey dates: July 26 and 27, 2023 Facility number: 014062 Residential Census: 114 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	The creation and submission of the Plan of correction does not constitute an admission by this provider or an conclusion set forth in the state deficiencies, or any violation or regulation. This provider respectfully requests that this Plan of Correction be considered the letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Review.				

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	Quality review completed July 31, 2023.			
R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l) (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure the staging and dumpster areas were free of rubbish for 2 of 2 observations. Finding includes: 1. During the initial facility tour with the Dietary Manager (DM) on 7/26/23 at 9:45 a.m., the service hall area, located next to the kitchen was observed. The area was known as the "staging area." One of four large 55-gallon plastic barrels contained filled trash bags. Additionally, one 4 wheeled flat-bed cart had multiple filled white trash bags stacked on the cart. On the wall near the plastic barrels, a posted sign indicated, "If you throw trash in these trash cans; you can also take these trash cans to the dumpsters	R 0155	1. The Environmental/Maintenance Director was given instructions on the first day of the survey to remove the trash in the staging area and was notified several times to get the side gate of the dumpster area repaired. No residents were harmed by the deficient practice. 2. All residents have the potential to be affected by the deficient practice, however; no residents were affected by the alleged deficient practice. 3. The systemic change put into place is the Environmental/Maintenance Director is personally responsible for making sure the staging and dumpster areas are free from trash and clear of any debris. Daily checks: three times per day for two weeks; then three times weekly for four weeks. Then monthly and ongoing. The dumpster side gate will be repaired and secured by August 30, 2023,	08/30/2023

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when they are full!"

During an interview at that time, the DM indicated the white trash bags were from the resident's rooms. The Certified Nursing Assistant (CNA) staff collected the trash bags and then dropped them off at the "staging area." The CNA staff were responsible for taking their collected trash to the dumpster.

No staff were visible in the service hall area.

During a follow-up observation with the Maintenance Director on 7/27/23 at 10:23 a.m., the "staging area" in the service hall, located next to the kitchen was observed. Two of four large 55-gallon plastic barrels were filled with trash bags.

During an interview at that time, the Maintenance Director indicated staff were responsible for taking the trash bags to the dumpster. Staff were instructed to not leave the filled trash bags in the "staging area."

No staff were visible in the service hall area.

and is the responsibility of the Maintenance Director.

4. To ensure the deficient practice does not recur, we have developed a Daily, Weekly, and Monthly Checklist Sheet that will be signed by the Environmental/Maintenance Director and the Executive Director and/or designee. The maintenance Director will bring the Checklist Sheet to the morning meeting for discussion and signatures. The Executive Director will monitor compliance.

5. The systemic changes will be completed by August 30, 2023

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2. During the facility tour with the DM on 7/26/23 from 9:50 a.m. to 9:55 a.m., the dumpster container area was observed. The dumpster area was located approximately 60 yards from the kitchen's rear exit door. The following was observed:

- Two dumpster containers were located in an enclosed area. The south side of the enclosure lacked an attached 4-foot six inch gate. The gate was leaning against the interior wall of the enclosure. During an interview at that time, the DM indicated the gate had been broken "for a while." The DM indicated without the gate in place, pests and other animals were able to get into the trash.

- A twin-sized mattress was leaning against the interior wall of the dumpster container area. During an interview at that time, the DM indicated the mattress had been there "for months."

- The following was observed on the ground behind the two dumpsters: opened trash bags and the area was littered with cups, condiment packets, plastic gloves, food containers, plastic wrappers, and other debris.

- The dumpster on the right side of the area had a full black trash bag hanging from the top of the dumpster. Half of the trash bag was inside the dumpster while

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the other half was hanging outside the dumpster.

- On the ground between the two dumpsters was a large was a large and medium-sized unbroken down boxes that were located near a large black colored sticky substance.
- During an interview at that time, the DM indicated the dumpster area was to be kept clean and free of debris.
- No staff were visible near the dumpster area.

On 7/27/23 from 10:15 a.m. to 10:20 a.m., during a follow-up dumpster container area observation with the Maintenance Director, the following was observed:

- Two dumpster containers were located in an enclosed area. The south side of the enclosure lacked an attached 4-foot six-inch gate. The gate was laying on the ground near the enclosure area and had multiple insects crawling on the gate and surrounding area. During an interview at that time, the Maintenance Director indicated the detached gate had been broken "for months."
- A twin-sized mattress was leaning against the interior wall of the dumpster container area.
- The area surrounding the

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dumpsters had multiple used plastic gloves, papers and other debris on the ground.

- No staff were visible near the dumpster area.

On 7/27/23 at 8:40 a.m., the Administrator provided an undated copy of the Outdoor Dumpster Procedure policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...daily tasks-3 times per day/5 days per week...check dumpster area to ensure no trash is on the ground...ensure all boxes are broken down and placed in dumpster..."

On 7/27/23 at 4:10 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..."

This State Residential finding relates to Complaint IN00413204 and Complaint IN00411062.

Based on observation, interview, and record review, the

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facility failed to ensure the staging and dumpster areas were free of rubbish for 2 of 2 observations.

Finding includes:

1. During the initial facility tour with the Dietary Manager (DM) on 7/26/23 at 9:45 a.m., the service hall area, located next to the kitchen was observed. The area was known as the "staging area." One of four large 55-gallon plastic barrels contained filled trash bags. Additionally, one 4 wheeled flat-bed cart had multiple filled white trash bags stacked on the cart. On the wall near the plastic barrels, a posted sign indicated, "If you throw trash in these trash cans; you can also take these trash cans to the dumpsters when they are full!"

During an interview at that time, the DM indicated the white trash bags were from the resident's rooms. The Certified Nursing Assistant (CNA) staff collected the trash bags and then dropped them off at the "staging area." The CNA staff were responsible for taking their collected trash to the dumpster.

No staff were visible in the service hall area.

During a follow-up observation with the Maintenance Director on 7/27/23 at 10:23 a.m., the "staging area" in the service

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hall, located next to the kitchen was observed. Two of four large 55-gallon plastic barrels were filled with trash bags.

During an interview at that time, the Maintenance Director indicated staff were responsible for taking the trash bags to the dumpster. Staff were instructed to not leave the filled trash bags in the "staging area."

No staff were visible in the service hall area.

2. During the facility tour with the DM on 7/26/23 from 9:50 a.m. to 9:55 a.m., the dumpster container area was observed. The dumpster area was located approximately 60 yards from the kitchen's rear exit door. The following was observed:

- Two dumpster containers were located in an enclosed area. The south side of the enclosure lacked an attached 4-foot six inch gate. The gate was leaning against the interior wall of the enclosure. During an interview at that time, the DM indicated the gate had been broken "for a while." The DM indicated without the gate in place, pests and other animals were able to get into the trash.

- A twin-sized mattress was leaning against the interior wall of the dumpster container area. During an interview at that time, the DM indicated the mattress

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had been there "for months."

- The following was observed on the ground behind the two dumpsters: opened trash bags and the area was littered with cups, condiment packets, plastic gloves, food containers, plastic wrappers, and other debris.

- The dumpster on the right side of the area had a full black trash bag hanging from the top of the dumpster. Half of the trash bag was inside the dumpster while the other half was hanging outside the dumpster.

- On the ground between the two dumpsters was a large was a large and medium-sized unbroken down boxes that were located near a large black colored sticky substance.

- During an interview at that time, the DM indicated the dumpster area was to be kept clean and free of debris.

- No staff were visible near the dumpster area.

On 7/27/23 from 10:15 a.m. to 10:20 a.m., during a follow-up dumpster container area observation with the Maintenance Director, the following was observed:

- Two dumpster containers were located in an enclosed area. The south side of the enclosure lacked an attached 4-foot

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six-inch gate. The gate was laying on the ground near the enclosure area and had multiple insects crawling on the gate and surrounding area. During an interview at that time, the Maintenance Director indicated the detached gate had been broken "for months."

- A twin-sized mattress was leaning against the interior wall of the dumpster container area.

- The area surrounding the dumpsters had multiple used plastic gloves, papers and other debris on the ground.

- No staff were visible near the dumpster area.

On 7/27/23 at 8:40 a.m., the Administrator provided an undated copy of the Outdoor Dumpster Procedure policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...daily tasks-3 times per day/5 days per week...check dumpster area to ensure no trash is on the ground...ensure all boxes are broken down and placed in dumpster..."

On 7/27/23 at 4:10 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and

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	returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..." This State Residential finding relates to Complaint IN00413204 and Complaint IN00411062.			
R 0273	Food and Nutritional Services - 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 were served in a sanitary and safe manner for 3 of 3 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Cook 2, Dietary Manager, Server 3, QMA 4) Finding includes: 1. During an initial kitchen observation on 7/26/23 from 9:25 a.m. to 9:45 a.m., the following was observed:	R 0273	1. No residents were found to have been affected by the deficient practice. 2. An audit was completed by the Executive Director to ensure that all Dining Service Staff including the Dining Service Director, Cooks, Servers, and any other community staff entering the kitchen are wearing hairnets that cover all their hair. Hairnets must be worn under all hats to ensure all hair is covered and not hanging down the backs of kitchen. All residents could have been affected by the deficient practice; however, no residents were affected. 3. An in-service	08/30/2023

- Cook 2 was observed walking through out the kitchen area. Cook 2 was observed wearing a cap that covered the hair from the ears to the top of the head. The hair, approximately $\frac{3}{4}$ inch in length, from the ears to the neckline was observed to not be covered.

- The Dietary Manager (DM) was observed walking through out the kitchen area. The DM was observed wearing a baseball hat. Below the baseball hat, the DM was observed to have braids that reached to her lower back area. The braids were observed to not be covered.

- Server 3 was observed walking through out kitchen area and in the dish room washing the morning breakfast dishes. Server 3's bangs, approximately 2 inches in length, were observed to not be covered.

- A sign was observed on the door that staff utilize when entering the kitchen from the service hall. The posted sign indicated, "STOP! You must wear a hairnet beyond these doors ..."

2. During a follow-up kitchen observation on 7/26/23 from 11:35 a.m. to 11:45 a.m., the following was observed:

- Cook 2 was observed walking

was held on August 16, 2023, for all Dining Service Staff. The in-service covered the use of hairnets, hats, and dress code for the department.

4. The Executive Director and/or designee will monitor compliance daily for two weeks; then weekly for four weeks and monthly thereafter.

5. The systemic changes will be corrected by August 30, 2023.

through out the kitchen area and working at the steam table taking the noon meal starting temperatures. Cook 2 was observed wearing a cap that covered the hair from the ears to the top of the head. The hair, approximately $\frac{3}{4}$ inch in length, from the ears to the neckline was observed to not be covered.

- The DM was observed walking through out the kitchen area, including the steam table area where the noon meal was being plated. The DM was observed wearing a baseball hat. Below the baseball hat, the DM was observed to have braids that reached to her lower back area. The braids were observed to not be covered.

3. During a during a follow-up kitchen observation on 7/26/23 from 12:50 p.m. to 12:55 p.m., the following was observed:

- The DM was observed walking throughout out the kitchen where the noon meal was being plated. The DM was observed wearing a baseball hat. Below the baseball hat, the DM was observed to have braids that reached to her lower back area. The braids were observed to not be covered.

- Cook 2 was observed at the steam table plating the noon meal and taking the ending food

temperatures. Cook 2 was observed wearing a cap that covered the hair from the ears to the top of the head. The hair, approximately $\frac{3}{4}$ inch in length, from the ears to the neckline was observed to not be covered.

- Qualified Medication Aide (QMA) 4 was observed at the steam table where the noon meal was being plated. QMA 3 was observed to have multiple hairs, approximately 10 inches in length, in front of both ears. The hair was observed to not be covered.

During an interview on 7/26/23 at 1:00 p.m., the DM indicated "staff hair was to be pulled back and wear a cap or hairnet while in the kitchen."

On 7/27/23 at 8:40 a.m., the Administrator provided a copy of the Hair Restraints policy, dated 2020, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...hair restraints shall be worn by all Dining Services staff when in food production areas, dishwashing areas or when serving food...hair restraints, hats...shall be used to prevent hair from contracting exposed food..."

On 7/27/23 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation

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Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food..."

This State Residential finding relates to Complaint IN00413204 and Complaint IN00411186.

Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 3 of 3 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Cook 2, Dietary Manager, Server 3, QMA 4)

Finding includes:

1. During an initial kitchen observation on 7/26/23 from 9:25 a.m. to 9:45 a.m., the following was observed:

- Cook 2 was observed walking through out the kitchen area. Cook 2 was observed wearing a cap that covered the hair from the ears to the top of the head. The hair, approximately ¾ inch in length, from the ears to the neckline was observed to not be covered.

- The Dietary Manager (DM)

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was observed walking through out the kitchen area. The DM was observed wearing a baseball hat. Below the baseball hat, the DM was observed to have braids that reached to her lower back area. The braids were observed to not be covered.

- Server 3 was observed walking through out kitchen area and in the dish room washing the morning breakfast dishes. Server 3's bangs, approximately 2 inches in length, were observed to not be covered.

- A sign was observed on the door that staff utilize when entering the kitchen from the service hall. The posted sign indicated, "STOP! You must wear a hairnet beyond these doors ..."

2. During a follow-up kitchen observation on 7/26/23 from 11:35 a.m. to 11:45 a.m., the following was observed:

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FORM APPROVED

OMB NO. 0938-0391

- Cook 2 was observed walking through out the kitchen area and working at the steam table taking the noon meal starting temperatures. Cook 2 was observed wearing a cap that covered the hair from the ears to the top of the head. The hair, approximately ¾ inch in length, from the ears to the neckline was observed to not be covered.

- The DM was observed walking through out the kitchen area, including the steam table area where the noon meal was being plated. The DM was observed wearing a baseball hat. Below the baseball hat, the DM was observed to have braids that reached to her lower back area. The braids were observed to not be covered.

3. During a during a follow-up kitchen observation on 7/26/23 from 12:50 p.m. to 12:55 p.m., the following was observed:

- The DM was observed walking throughout out the kitchen where the noon meal was being plated. The DM was observed wearing a baseball hat. Below the baseball hat, the DM was observed to have braids that reached to her lower back area. The braids were observed to not be covered.

- Cook 2 was observed at the steam table plating the noon

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meal and taking the ending food temperatures. Cook 2 was observed wearing a cap that covered the hair from the ears to the top of the head. The hair, approximately $\frac{3}{4}$ inch in length, from the ears to the neckline was observed to not be covered.

- Qualified Medication Aide (QMA) 4 was observed at the steam table where the noon meal was being plated. QMA 3 was observed to have multiple hairs, approximately 10 inches in length, in front of both ears. The hair was observed to not be covered.

During an interview on 7/26/23 at 1:00 p.m., the DM indicated "staff hair was to be pulled back and wear a cap or hairnet while in the kitchen."

On 7/27/23 at 8:40 a.m., the Administrator provided a copy of the Hair Restraints policy, dated 2020, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...hair restraints shall be worn by all Dining Services staff when in food production areas, dishwashing areas or when serving food...hair restraints, hats...shall be used to prevent hair from contracting exposed food..."

On 7/27/23 at 3:30 p.m., a review of the Indiana Food

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Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food..."

This State Residential finding relates to Complaint IN00413204 and Complaint IN00411186.

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