STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF NEW ALBANY	2632 GRANT LINE ROAD, NEW ALBANY, , 47150

(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 Intake 469616. Intake 469616 - No deficiencies related to the allegations are cited. Survey dates: May 26 and 27, 2026. Facility number: 014166 Residential Census: 122 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 28, 2026.	R 0000	No response required for 0000	
R 0027	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(b) (b) Residents have the right to a dignified existence,	R 0027	TAG 0027 – WATER TEMPERATURE MANAGEMENT Preparation and submission of	07/01/2026

	self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on observation and interview, the facility failed to ensure residents had access to water at a temperature that was comfortable for 4 of 8 residents interviewed. (Residents J, K, L and O) Findings include: During a tour of the facility rooms, on 5/26/26 at 12:16 p.m., the Maintenance Director obtained water temperatures in the following rooms: -On 5/26/26 at 12:20 p.m., in Room 101 the water temperature was 102.5 degrees Fahrenheit (F). -On 5/26/26 at 12:27 p.m., in Room 110 the water temperature was 105.4 degrees F. -On 5/26/26 at 12:36 p.m., in Room 232 the water temperature was 119.4 degrees F. -On 5/26/26 at 12:45 p.m., in Room 315 the water temperature was 115.7 degrees		this Plan of Correction does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because it is required by State and Federal regulations. Corrective Action for Residents Found to be Affected: The Maintenance Director immediately inspected and adjusted the facility water heaters to ensure proper operation and temperature consistency. Water heater ignition issues were addressed and repaired. Water temperatures in resident rooms 101, 110, 232, and 315 were rechecked and adjusted to ensure temperatures were maintained within acceptable comfort and safety ranges. Residents identified as affected were interviewed regarding satisfaction with water temperatures. How Other Residents Having the Potential to be Affected Will Be Identified: All resident apartments and common area sinks/showers will be audited for appropriate water temperature levels to ensure residents have access to water at safe and comfortable temperatures. Any variances	

	F. On 5/26/26 at 12:47 p.m., the Maintenance Director indicated he needed to check one of the water heaters to make sure the heater was firing on. He indicated the water coming out of the faucet was not hot enough. In the past he had checked to see what was going on with the water heater and the water heater was not firing. During an observation and interview with the Maintenance Director, on 5/26/26 at 12:35 p.m., the water heater had an ignition failure signal at 119 degrees F on the water heater panel. The Maintenance Director indicated it wasn't staying at 140 degrees F. It should have been at 140 degrees F. He had last checked it last week. During an interview, on 5/27/26 at 9:40 a.m., Resident J indicated the water temperature had been lukewarm or cooler in the shower. She had hurried in and hurried out of the shower, because it was too cold. During an interview, on 5/27/26 at 9:53 a.m., Resident K indicated the water wasn't hot enough. She couldn't get the water temperature high enough to wash the dishes. She felt the dishes weren't as clean because she didn't like when		identified will be corrected immediately. Measures Put Into Place/Systemic Changes: The facility developed and implemented a Water Temperature Monitoring Policy. Maintenance staff will complete and document routine water temperature checks weekly on all water heaters and monthly random room temperature audits. Any malfunction or temperature variance will be addressed immediately. The Executive Director will ensure adequate maintenance coverage is available when the Maintenance Director is absent. Monitoring: The Executive Director or designee will audit weekly water temperature logs for four weeks, then monthly thereafter to ensure ongoing compliance. Findings will be reviewed during Quality Assurance meetings. Completion Date: 07/01/2026	

	the water was this cool. During an interview, on 5/27/26 at 10:00 a.m., Resident L indicated the water hadn't been hot enough. During an interview, on 5/27/26 at 11:06 a.m., the Executive Director (ED) indicated there were issues of leaks in pipes. There was no Assistant Maintenance Director to help when the Maintenance Director was out, so there was an issue with repairs or replacements of resident bulbs, etc. The Maintenance Director probably contacted the plumbing company yesterday. She wasn't sure what the issue was, but cool water temperatures had been an ongoing fight for three years. She had been told by the residents that the water runs out fast or got cool quickly. During a follow-up observation of the water heater, on 5/27/26 at 11:19 a.m., the tank indicated the temperature was staying at 140 degrees F. During an interview, on 5/27/26 at 12:31 p.m., Resident O indicated the water temperature in her kitchenette was cold. She had to run the water long to get it to warm up. She had to heat the water in the microwave for washing dishes. During an interview, on 5/27/26			

	at 2:15 p.m., the Director of Nursing (DON) indicated the facility had no policy for water temperature management. The facility followed state regulations for water temperatures.			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel	R 0092	TAG 0092 – FIRE DRILLS Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because it is required by State and Federal regulations. Corrective Action: The facility immediately implemented a monthly fire drill schedule to ensure drills are conducted on each shift in accordance with State guidelines. Missing documentation forms were recreated where possible, and updated fire drill documentation forms were implemented to include observations and staff response details. How Other Residents Having the Potential to be Affected Will Be Identified: All residents residing in the facility had the potential to be affected by this deficient	07/01/2026

	present. Based on record review and interview, the facility failed to ensure fire drills were conducted monthly per State guidelines on each shift. This deficient practice had the potential to affect 122 of 122 residents living in the facility. Findings include: The review, on 5/27/26 at 10:05 a.m., of the monthly Fire Drill reports lacked documentation of any fire drills conducted in May, June, July, August, September, October, November, December 2025. The review of the fire drills conducted in January, February, March, April and May 2026 showed an attendance list but lacked details regarding the fire drill observation. During an interview, on 5/26/26 at 12:30 p.m., the Maintenance Director indicated that fire drills were to be completed monthly. During an interview, on 5/27/26 at 2:00 p.m., the Director of Nursing (DON) indicated that the facility did not have a Fire Drill policy. The facility followed the State guidelines.		practice. Future fire drills will ensure all shifts and departments participate appropriately. Measures Put Into Place/Systemic Changes: The facility developed and implemented a Fire Drill Policy outlining frequency, documentation requirements, and drill rotation by shift. The Maintenance Director and Executive Director were educated regarding required monthly fire drills and proper documentation procedures. Monitoring: The Executive Director or designee will review fire drill documentation monthly for three months to ensure drills are completed on all shifts with required observations documented. Results will be reviewed through the facility Quality Assurance process. Completion Date: 07/01/2026	
R 0117	Personnel - Deficiency	R 0117	TAG 0117 – FIRST AID/CPR	07/01/2026

	410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with 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 record review and interview, the facility failed to ensure that staff were First Aid certified on each shift for 13 of 16 night shifts reviewed and failed to ensure staff were Cardiopulmonary Resuscitation (CPR) certified on each shift for		CERTIFICATION Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because it is required by State and Federal regulations. Corrective Action: Staff schedules were immediately reviewed to identify shifts lacking CPR and/or First Aid certified personnel. Staff with expired certifications were scheduled for immediate recertification. The facility ensured certified staff coverage was assigned to every shift. How Other Residents Having the Potential to be Affected Will Be Identified: All residents residing in the facility had the potential to be affected by this deficient practice. All current staff certification records were audited to verify compliance. Measures Put Into Place/Systemic Changes: The facility implemented a CPR and First Aid Certification Tracking System to monitor expiration dates and ensure each shift has properly certified staff assigned. The Director of	

	9 of 16 night shifts.This deficient practice had the potential to affect 122 of 122 residents living in the facility. Findings include: The review, on 5/27/27 at 10:00 a.m., of the staff schedule between the dates of 5/16/26 and 5/31/26 indicated the following: - On May 18, 2026, during the night shift, no staff were certified with First Aid. - On May 19, 2026, during the night shift, no staff were certified with First Aid. - On May 21, 2026, during the night shift, no staff were certified with First Aid. - On May 22, 2026, during the night shift, no staff were certified with First Aid. - On May 23, 2026, during the night shift, no staff were certified with First Aid. - On May 24, 2026, during the night shift, no staff were certified with First Aid. - On May 25, 2026, during the night shift, no staff were certified with First Aid. - On May 26, 2026, during the night shift, no staff were certified		Nursing and scheduling personnel were educated on staffing requirements for CPR and First Aid coverage on all shifts. A policy was developed regarding required certification coverage and renewal monitoring. Monitoring: The Director of Nursing or designee will audit staff schedules and certification records weekly for four weeks, then monthly thereafter to ensure ongoing compliance. Findings will be reviewed through the Quality Assurance process. Completion Date: 07/01/2026	

	with First Aid. - On May 27, 2026, during the night shift, no staff were certified with First Aid. - On May 28, 2026, during the night shift, no staff were certified with First Aid. - On May 29, 2026, during the night shift, no staff were certified with First Aid. - On May 30, 2026, during the night shift, no staff were certified with First Aid. - On May 31, 2026, during the night shift, no staff were certified with First Aid. - On May 18, 2026, during the night shift, no staff were certified with CPR. - On May 19, 2026, during the night shift, no staff were certified with CPR. - On May 21, 2026, during the night shift, no staff were certified with CPR. - On May 22, 2026, during the night shift, no staff were certified with CPR. - On May 23, 2026, during the night shift, no staff were certified with CPR. - On May 24, 2026, during the			

	night shift, no staff were certified with CPR. - On May 25, 2026, during the night shift, no staff were certified with CPR. - On May 28, 2026, during the night shift, no staff were certified with CPR. - On May 29, 2026, during the night shift, no staff were certified with CPR. During an interview, on 5/27/26 at 12:35 p.m., the Director of Nursing (DON) indicated that on the second shift the only staff to have CPR was Qualified Medication Aide (QMA) 6. She did not have First Aid. Licensed Practical Nurse (LPN) 8's CPR and First Aid certification had expired. The LPN had not noticed her certification expired until the DON asked her for her card. During an interview, on 5/27/26 at 2:15 p.m., the DON indicated he had no policy for CPR and First Aid certification for staff on each shift. The facility followed the State regulations for CPR and First Aid coverage.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized	R 0120	TAG 0120 – DEMENTIA, RESIDENT RIGHTS, AND ABUSE TRAINING	07/01/2026

	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 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.		Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because it is required by State and Federal regulations. Corrective Action: The identified staff members (LPN 9, LPN 11, and Housekeeper 10) were scheduled to complete annual dementia, resident rights, and abuse training. Employee education files were reviewed and updated as training was completed. How Other Residents Having the Potential to be Affected Will Be Identified: All employee education records were audited to identify any additional staff lacking required annual training. Measures Put Into Place/Systemic Changes: The facility implemented an annual education tracking system to monitor due dates for dementia, resident rights, and abuse prevention training. A policy was developed outlining annual training requirements and documentation expectations. Department	

	(D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure staff received annual dementia, resident rights, and abuse training for 3 of 5 staff reviewed for annual training. (LPN 9, LPN 11,and Housekeeper 10) Findings include: On 5/27/26, the Director of Nursing (DON) provided a list of the facility's employees with the job title and start dates listed for each of the employees. On 5/27/26 at 10:30 a.m., the annual training records were reviewed. The employee records of Licensed Practical Nurse (LPN) 9 hired on 8/2/21, Housekeeper 10 hired on 8/21/23, and LPN 11 hired on 1/10/24 lacked documentation of the annual dementia, resident rights, and abuse training. During an interview, 5/27/26 at 12:15 p.m., the DON indicated that the resident rights and dementia education was due yearly, but he indicated that the training had not been kept up to		managers were educated on ensuring staff remain current with required education. Monitoring: The Director of Nursing or designee will conduct monthly audits of employee training records for three months to ensure compliance with annual education requirements. Results will be reviewed during Quality Assurance meetings. Completion Date: 07/01/2026	

	date. During an interview, 5/27/26 at 2:00 p.m., the Executive Director (ED) indicated that there was no policy regarding employee training records, and the facility followed the State guidelines regarding the records.			
R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure residents' pets had a current rabies vaccination for 6 of 15 pet vaccination records reviewed. (Canine 1, 2, 3, 4, 5, and Feline 1) Findings include: On 5/26/26, the Director of Nursing (DON) provided a binder with a list of facility pets. The facility's pet vaccination records were reviewed on 5/26/26 at 1:00 p.m. The following were pets that lacked documentation of an up-to-date rabies vaccination: 1. Canine 1 with rabies	R 0151	TAG 0151 – PET VACCINATIONS Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because it is required by State and Federal regulations. Corrective Action: Residents with pets lacking current rabies vaccination documentation were notified immediately and required to provide updated vaccination records. Any pets without current vaccination records are restricted from the facility until proper documentation was obtained. How Other Residents Having the Potential to be Affected Will Be Identified:	07/01/2026

	vaccination expiration of 12/17/25. 2. Canine 2 with rabies vaccination expiration of 4/21/26. 3. Canine 3 with rabies vaccination expiration of 5/6/26. 4. Canine 4 with rabies vaccination expiration of 5/5/26. 5. Canine 5 with rabies vaccination expiration of 2/2/26. 6. Feline 1 with rabies vaccination expiration of 5/7/26. During an interview, on 5/27/26 at 1:30 p.m., the Executive Director (ED) indicated that all the vaccination records were provided. No further records were found. The ED indicated there was no policy on having pets in the facility, but the facility did have a Pet Rules Attachment to the lease agreement. The review of the attachment indicated, but was not limited to, "Restrictions on any animal ...4. Must have written certification from a veterinarian that the animal has received all necessary shots and tick/flea treatment. This must be done annually ..."		All pet records were audited to verify current rabies vaccination documentation was maintained for each pet residing in the facility. Measures Put Into Place/Systemic Changes: The facility implemented a Pet Vaccination Tracking Log to monitor expiration dates for all resident pet vaccinations. A formal Pet Policy was developed outlining vaccination requirements, annual documentation requirements, and follow-up procedures for expired records. Monitoring: The Executive Director or designee will review pet vaccination records monthly to ensure ongoing compliance with vaccination requirements. Findings will be reviewed through the Quality Assurance process. Completion Date: 07/01/2026	
R 0296	Pharmaceutical Services - Noncompliance	R 0296	TAG 0296 – QMA TRAINING PROTOCOL	07/01/2026

	410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on record review and interview, the facility failed to ensure Qualified Medication Aides (QMAs) received annual training for medication administration for 3 of 4 QMAs reviewed. (QMAs 3, 4, 5) Findings include: During the review of the Annual QMA In-Services, on 5/26/26 at 9:30 a.m., QMA 3's training lacked documentation of any medication in-services in the last year. The last training documented for QMA 3 was on 6/25/24. During an interview, on 5/27/26 at 11:46 a.m., the Director of Nursing (DON) indicated QMA 4 and QMA 5 had no Annual QMA in-services for medication administration. The facility's on-line training wouldn't be specific to QMAs. He didn't know the Annual QMA in-service specific to medication administration was supposed to be conducted. During an interview, on 5/27/26 at 1:01 p.m., the DON indicated		Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because it is required by State and Federal regulations. Corrective Action: QMA 3, QMA 4, and QMA 5 were scheduled for and completed annual medication administration in-service education specific to Qualified Medication Aides. Training documentation will be updated in employee files. How Other Residents Having the Potential to be Affected Will Be Identified: All QMA employee files ware being audited to verify completion of required annual medication administration training. Measures Put Into Place/Systemic Changes: The facility is adding an annual QMA Training Policy outlining medication administration education requirements specific to Qualified Medication Aides. The Director of Nursing was educated regarding annual QMA in-service requirements and documentation expectations. A training tracking	

	the facility did not have a policy for Annual QMA training. He would just follow what the QMAs were allowed to do.		system is being implemented to monitor due dates and completion. Monitoring: The Director of Nursing or designee will audit QMA education records monthly for three months to ensure required medication administration training remains current. Results will be reviewed during Quality Assurance meetings. Completion Date: 07/01/2026	

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 SIGNATUREChris Shoemaker	TITLEExecutive Director	(X6) DATE06/05/2026