STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/28/2022

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00395238 and IN00397689. This visit included a COVID-19 Quality Assurance Walk Through. Complaint IN00395238 - Substantiated. No deficiencies cited related to allegations are cited. Complaint IN00397689 - Substantiated. State deficiencies related to the allegations are cited at R241, R406, and R407. Survey date: December 27 and 28, 2022 Facility number: 014062 Residential Census: 109 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 29, 2022.	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 request that this Plan of Correction be considered the letter of Credible Allegation and Requests a Desk Review in lieu of a Post Survey Review.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure a staff member that was qualified to administer insulin (prescription injectable medication used for diabetes) was available to administer insulin. Three residents, diagnosed	R 0241	**R- 241** **1. What corrective action (s) will be accomplished for those residents found to be affected by the deficient practice?**	01/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
JanAnn Caudill	Executive Director	01/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	with Diabetes Mellitus, did not receive insulin as ordered by the physician. (Resident B, Resident C, Resident D) Finding included: During an interview on 12/27/22 at 9:27 a.m., the Resident Council President indicated she became the Resident Council President in November 2022 and spoke to the Administrator about some residents that did not receive their insulin because there wasn't any staff that could administer the medication. During an interview on 12/28/22 at 5:10 a.m., QMA 1 (Qualified Medication Aide) indicated she has had residents report they did not receive their insulin on the previous shift. She tells the residents to make sure they tell someone they need their insulin because there had been a few days when there wasn't a nurse in the facility and the QMA that worked was not able to administer insulin. During an interview on 12/28/22 at 8:02 a.m., the DON (Director of Nursing) indicated there were residents that did not receive insulin when she was out of the facility because there wasn't a staff member that was able to administer insulin. 1. The clinical record for Resident B was reviewed on 12/28/22 at 9:43 a.m. The diagnosis included, but was not limited to, Diabetes Mellitus. The Physician's orders included, but were not limited to: - Start 5/12/22, Accucheck (blood sugar monitoring device) every evening related to type 2 Diabetes Mellitus. - Start 9/7/22, Fasting Accucheck at 5:00 a.m., call		It is the policy of this provider that medication ordered to be given per subcutaneous will be administered by licensed nurse in accordance with the physicians orders. Insulin may be administered subcutaneous by a QMA only if the QMA is listed on the ISDH Registry with Insulin Administration sub-type before administering insulin at this community. The Executive Director has directed the DON and nursing scheduler to establish a rotating On-Call schedule for the licensed nurses and insulin certified QMA's. The community has also hired an ADON who will share a separate On-Call schedule with the DON to ensure this deficient practice does not recur. **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 insulin dependent residents have the potential to be affected. A review of the residents of the resident EMAR's was completed for each resident identified in the survey. The review did not find any adverse consequences and no harm to the affected resident was noted by their attending physician. **3. What measures will be put into place or what systemic**	

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	the doctor for blood sugar below 70 or above 200 related to type 2 Diabetes Mellitus. - Start 9/7/22, Lantus injection (long acting insulin) 100 units/ml (milliliter), inject 20 units subcutaneously (into the fat layer under the skin) in the morning related to type 2 Diabetes Mellitus The December 2022 MAR (Medication Administration Record) indicated: Resident B did not receive Lantus on 12/16/22, 12/17/22, 12/18/22. Resident B did not have an Accucheck completed on 12/16/22. Resident B did not have a fasting Accucheck completed on 12/16/22 and 12/17/22. 2. The clinical record for Resident C was reviewed on 12/28/22 at 9:51 a.m. The diagnosis included, but was not limited to, Diabetes Mellitus. The Physician's orders included, but were not limited to: - Start 10/18/22, Accucheck at 4:00 p.m. related to type 2 Diabetes Mellitus - Start 11/22/22, Fasting Accucheck at 6:00 a.m. related to type 2 Diabetes Mellitus - Start 12/6/22, Lantus solostar solution 100 units/ml, inject 18 units subcutaneously in the morning related to type 2 Diabetes Mellitus. - Start 12/6/22, Novolog Flexpen (rapid acting insulin) 100 units/ml, inject 10 units subcutaneously two times daily related to type 2 Diabetes Mellitus - Start 12/6/22,Novolog Flexpen 100 units/ml, inject 6 units subcutaneously in the evening related to type 2 Diabetes Mellitus.		**changes the facility will make to ensure that the deficient practice does not recur?** The DON and ADON will share an On-Call status. In addition to the On-Call status, a rotating schedule for the licensed nurses and insulin certified QMA's has been established to ensure the deficient practice does not recur. All other QMA's have been encouraged to get insulin certified. The community will continue to hire license nurses and insulin certified QMA's on an ongoing basis. The DON will audit the affected residents EMAR's daily for (4) four weeks; then (3) three times weekly for (4) weeks and ongoing. Notice of any deficient practice by the licensed nurses and/or insulin certified QMA's; the DON will re-educate and proceed with a Performance Review Action. **4. How the corrective action (s) will be to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and what date the systemic changes will be completed?** **A)** The DON will audit the affected residents EMAR's daily for (4) four weeks; then, three (3) times per week for (4) four weeks; thereafter ongoing. **B)** Prior to the posting of the nursing On-Call rotating schedule	

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	The December 2022 MAR indicated: Resident C did not receive Lantus on 12/12/22, 12/16/22, 12/17/22, and 12/18/22. Resident C did not receive Novolog twice daily on 12/12/22, 12/16/22, 12/17/22, 12/18/22, and the afternoon of 12/19/22. Resident C did not receive the evening dose of Lantus on 12/16/22 and 12/18/22. Resident C did not have an Accucheck completed on the morning of 12/12/22, morning and evening of 12/16/22, morning of 12/17/22, and the evening of 12/18/22. 3. The clinical record for Resident D was reviewed on 12/28/22 at 10:06 a.m. The diagnosis included, but was not limited to, Diabetes Mellitus. The Physician's orders included, but were not limited to: - Start 9/5/22, Basaglar Kwikpen (long acting insulin) 100 units/ml, inject 50 units subcutaneously in the evening related to type 2 Diabetes Mellitus. - Start 9/6/22, Basaglar Kwikpen 100units/ml, inject 50 units subcutaneously in the morning related to type 2 diabetes mellitus. - Start 9/7/22, Insulin aspart (rapid acting insulin) 100 units/ml, inject 22 units subcutaneously in the evening related to type 2 Diabetes Mellitus. - Start 9/8/22, Insulin aspart (rapid acting insulin) 100 units/ml, inject 22 units subcutaneously in the morning related to type 2 Diabetes Mellitus. The December 2022 MAR indicated: Resident D did not receive Basaglar Kwikpen on		the DON will review the schedule with the Executive Director to ensure all days are covered with two (2) nursing staff that can administer insulin on any shift during the (24) twenty-four hour period including weekends and holidays. To clarify the (2) nursing staff: DON or ADON and licensed nurse or insulin certified QMA are available in case of call-in's from normally scheduled staff. **5. The systemic changes will be completed by 1/28/2023.**	

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	the morning and evening of 12/16/22, morning of 12/17/22, and the morning and evening of 12/18/22. Resident D did not receive insulin aspart on the morning and evening of 12/16/22, morning of 12/17/22, and morning and evening of 12/18/22. On 12/28/22 at 12:00 p.m., the facility was unable to provide a policy regarding qualified staff to administer insulin. This State tag relates to Complaint IN00397689.			
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on interview and record review, the facility failed to implement infection control practices to prevent the spread of COVID-19 for 2 of 4 employees reviewed. COVID-19 positive staff returned to work before their isolation was completed per facility policy. This had the potential to affect 109 of 109 residents in the facility. (Employee 1, Employee 2) Finding included: 1. During an interview on 12/28/22 at 7:45 a.m., Employee 1 indicated she tested positive for COVID-19 on 12/19/22. She was asked to return to work on 12/20/22 (day 1 after positive test). She tested positive again, at work, on 12/20/22 and left work. She was released to return to work by her physician, so she went back to work again on	R 0406	**R-406** **1. What corrective action (s) will be accomplished for those residents found to be affected by the deficient practice?** It is the policy of this provider to establish and maintain an infection control practices designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Hellenic Senior Living Employees will follow CDC guidelines and the Indiana Department of Health guidelines with regard to work status for those who are exposed to or have	01/28/2023

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	12/24/22 (day 5 after first positive test). 2. During an interview on 12/28/22 at 8:02 a.m., Employee 2 indicated she tested positive for COVID-19 on 12/12/22 with a rapid test. She was short of breath and congested. On 12/14/22, she went to the hospital and tested positive for COVID-19 and the influenza. She came back to work on 12/17/22 (day 5 after positive test). She informed the Administrator that she wasn't released to return to work by her doctor and the Administrator told her it was her responsibility to be at work. During an interview on 12/28/22 at 11:16 a.m., the Administrator indicated Employee 1 did return to work before she should have. She was not aware of any other employees that returned to work before they should have after testing positive for COVID-19. On 12/28/22 at 8:40 a.m., the Administrator provided a copy of a facility policy, titled COVID-19, dated 3/1/21, and indicated this was the current policy used by the facility. A review of the policy indicated if you have tested positive for COVID-19 or have symptoms regardless of vaccination status, isolate and stay home from work for 5 days. Day 0 is first day of symptoms or positive test. Day 1 is the first full day after your symptoms or your positive test. After 5 days, if you have no symptoms and you are fever free for 24 hours without the use of fever-reducing medication, you may return to work on the 6th day and wear a mask for days 6 through 10. This State tag relates to Complaint IN00397689.		tested positive for COVID-19. Staff were re-educated by the Executive Director and the DON regarding the need to report any symptoms identified on the COVID-19 staff screening tool to the nurse or their manager on duty prior to reporting to their assigned department. An antigen test will be performed to verify the staff member is positive and will be sent home to isolate and follow the CDC guidelines. Any staff member who tests positive will need to have a physician release form prior to returning to work. The resident's experienced minimal if any negative outcome related to this deficient concern. **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?** All residents have the potential to be affected. The resident's experienced minimal if any negative outcome related to this deficient concern. Two residents tested positive while in the hospital and came out of isolation on 1/5/23. One resident who tested positive on 12/16/22 came out of isolation on 12/27/22; two residents tested positive on 12/28/22 and came out of isolation on 1/5/23. Staff were re-educated by the Executive Director and the DON	

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			regarding the need to report any symptoms identified on the COVID-19 staff screening tool to the nurse or their manager on duty prior to reporting to their assigned department. The licensed nurse and management staff will review any staff members with symptoms identified on the COVID-19 staff screening tool and (a) approve the staff member to work or (b) send the staff member for testing and home to isolate until employee is cleared by a physician to return work. We have reinstituted the CDC guidelines and IDOH guidelines. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The staff COVID-19 screening tool is now up to date. All employees are expected to sign in before going to their department. The DON and BOM will be responsible for reviewing the staff COVID-19 screening tool daily. A typed or hand written report will be given to the Executive Director during the morning meeting by the DON and BOM. 4. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance; the staff	

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			COVID-19 screening tool will be reviewed by the department managers during daily morning meetings. Any discrepancies will be reported immediately to the DON, ADON, BOM, and ED at the start of each shift. Reviews will be daily for two weeks, weekly for one month, then quarterly ongoing. **5. By What date the systemic changes will be completed?** Compliance date: 1/28/2023	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to ensure COVID-19 outbreak cases of employees were reported to the state health department for 2 of 4 employees reviewed. (Employee 1, Employee 2) Finding includes: During an interview on 12/28/22 at 7:45 a.m., Employee 1 indicated she tested positive for	R 0407	**R-407** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** All unvaccinated staff will be tested twice weekly. All staff will wear masks and follow the community's infection control	01/28/2023

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	COVID-19 on 12/19/22. During an interview on 12/28/22 at 8:02 a.m., Employee 2 indicated she tested positive for COVID-19 on 12/12/22 with a rapid test. During an interview on 12/28/22 at 11:16 a.m., the Administrator indicated the COVID-19 positive cases were not reported to the state health department. The Long-Term Care Facility Covid-19 Data Submission Guidelines, dated 3/8/22, was reviewed on 12/28/22 at 11:25 a.m. The review of the document indicated an outbreak case alert is 1 or more confirmed resident and/or staff cases in a facility where no confirmed cases were identified during a 4-week period prior to the most recent week. Residential care facilities are required to report outbreak cases if the cases meet criteria for outbreak case alert. This State tag relates to Complaint IN00397689.		policies. All cases of COVID-19 whether staff or residents will be reported to the IDOH. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken?** All residents have the potential to be affected by the deficient practice. All staff will be in serviced on 12/17/23 by the DON, DM, ESD, and Executive Director on infection control relating to COVID-19 outbreaks. All unvaccinated staff will be tested twice weekly and documentation will be placed in a file in the Executive Directors office. **3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?** All unvaccinated staff will be tested twice weekly. All staff will wear masks and follow the CDC guidelines and the IDOH guidelines dated September 2022 and any future guidelines by CDC and IDOH as well as the community's policies and procedures regarding COVID-19 outbreaks. All cases of COVID-19 whether staff or residents will be reported to the IDOH. **4. How the corrective action (s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place? During the monthly QA meeting, the results of monitoring the unvaccinated staff will be reviewed to ensure that this POC is being followed. A review of all policies regarding COVID-19 outbreaks continue to stay in place. The number of reported COVID-19 cases are reported to the IDOH will also be a part of the monthly QA meetings. **5. By what date the systemic changes will be completed?** Completed Date: 1/28/2023.	