

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 04/27/2023	
NAME OF PROVIDER OR SUPPLIER HELLENIC SENIOR LIVING OF MISHAWAKA		STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SOUTH LOGAN STREET, MISHAWAKA, , 46544					
(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 Complaints IN00391811, IN00399182, and IN00392459. Complaint IN00391811- No deficiencies related to the allegation are cited. Complaint IN00399182 - No deficiencies related to the allegation are cited. Complaint IN00392459 - No deficiencies related to the allegation are cited. Survey dates: April 25, 26 and 27, 2023 Facility number: 014224 Residential census: 131 Hellenic Senior Living of Mishawaka was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey	R 0000					

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and the Investigation of
Complaints IN00391811,
IN00399182, and IN00392459.

Quality review completed
5/8/2023.

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