

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 09/03/2025	
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 Post Survey Revisit (PSR) to the Investigation of Complaints IN00457341, IN00459840, IN00460059, and IN00463236 completed on 7/16/25. Complaint IN00457341 - Corrected Complaint IN00459840 - Corrected Complaint IN00460059 - Corrected Complaint IN00463236 - Not corrected. Survey dates: September 2 & 3, 2025 Facility number: 014224 Residential Census: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on	R 0000					

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9/5/2025

This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00457341, IN00459840, IN00460059, and IN00463236 completed on 7/16/25.

Complaint IN00457341 - Corrected

Complaint IN00459840 - Corrected

Complaint IN00460059 - Corrected

Complaint IN00463236 - Not corrected.

Survey dates: September 2 & 3, 2025

Facility number: 014224

Residential Census: 113

These State Residential Findings are cited in accordance with 410 IAC 16.2-5.

Quality Review completed on 9/5/2025

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R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview, and record review, the facility failed to ensure facility room doors, public toilets and a shower room ceiling were clean, functional and in good repair on 3 of 3 halls and in the hall adjacent to the main dining room area. (100, 200 and 300 halls) Finding includes: During a tour of the facility, conducted on 9/2/25 from 11:00 A.M. to 12:07 P.M., the following was observed: The hallway entrance doors to rooms 001, 117, 214, 224, 303, 329, 330, 331, 333, and 334 were observed to have significant gouges, black scuff marks, and missing paint. The shower in room 114 was noted to have a 5 gallon yellow bucket with approximately 1 inch of standing water below an open area of broken down drywall in the ceiling of the shower. The broken down ceiling drywall was	R 0144	1. Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case no residents were affected. 3. a) Kick Plates approved 9/2, ordered on 9/8, shipped on 9/23 scheduled to be delivered on 9/29. Will be installed on all resident doors by 10/13 as well as repainted. b) Room 114 Shower stall cleaned out on 9/23, Maintenance Director Viewed plumbing on 9/24. Plumbers to come into building on 9/26 and 9/30 to view plumbing for repair. Entire room to be clean on 10/1/25 with ED and Maintenance Director assistance. Resident to then have 30-day room inspections completed by ED or MD. c) Residents notified of continued issues of 1st floor bathrooms at resident council on 9/12 by ED. Updated on plan to renovate. Memo to be given to all residents on 9/26 with all recommendations given by plumber. Memo sign to be placed in public restrooms on 9/26/26. Plumbers to come into the building on 9/26 and 9/30 to view bathrooms to review for bid to repair. 4. ED will monitor the progress of all the 3 of the above cited situations for continued progress and	10/13/2025
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approximately 24" x 12" and rectangle in size and shape. A visible floor joist was noted above the dry wall. The floor joist had stains that appeared to be water stains. Multiple small black bugs were flying around in the shower area, The bathroom counter around the sink was covered with multiple, dead, small black bugs. Resident D had multiple other bottles and containers in the shower area that he indicated were there waiting to be washed and that the yellow bucket and a couple of other containers were there for collecting the water that leaked from the shower above.

On 9/2/25 at 11:43 A.M., during an interview with the Maintenance Director, he indicated the hall way entrance doors to rooms 001, 117, 214, 224, 303, 329, 330, 331, 333, and 334 continued to have scuff marks, gouges, and missing paint that had not been cleaned or repainted. The Maintenance Director indicated he had gotten a quote for metal kick plates for all of the facility doors on 8/29/25 and had requested to purchase the kick plates just today, 9/2/25. The Maintenance Director indicated the lower portion of the doors would be covered with metal panels when he received the approval to purchase them. The Maintenance Director indicated he did not currently have

completion. This will continue on-going until completed.

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approval for the kick plates and they had not been ordered. There had been no other repairs made to the doors since the Annual survey completed on 7/16/2025.

During an interview with the Maintenance Director, on 9/2/25 at 11:43 A.M., he indicated the shower in room 214 had a leak from the shower area that continued to drip into the shower area of room 114. He indicated he had not patched the ceiling in room 114 because the area between the floor of 214 and the ceiling of 114 in ceiling was still damp. The Maintenance Director indicated he had been unable to locate the source of the leak, so he had not attempted to repair the ceiling in room 114. The Maintenance Director was unable to verbalize a plan or timeframe to repair the leak in room 214 or the ceiling in room 114 . In addition, the Maintenance Director indicated he had not consulted with a plumber in an attempt to locate the root cause of the leak.

During an interview, on 9/2/25 at 11:45 A.M., Resident D indicated water had been dripping from the ceiling of his shower area for about two years and no one had attempted to repair the ceiling.

During an observation, on

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9/2/25 at 2:00 P.M., of the men's public restroom next to the dining room, a sign was posted on the door that indicated the restroom was "out of order". During the restroom observation there was a strong mal-odor of feces noted, the left sink did not have running water, and the handicapped toilet floor was smeared with feces in a 2 ft x 2 ft area in front of the toilet. The toilet was full of feces and the rim and toilet seat were smeared with feces.

During an observation, on 9/2/25 at 2:05 P.M., of the women's public restroom, located across the hall from the men's restroom, a sign was posted on the door that indicated the restroom was "temporarily out of order until further notice". During the restroom observation, there was a strong mal-odor of feces noted. The first toilet stall was filled with toilet tissue and feces. The handicapped toilet was stuffed with toilet tissue.

During an interview, on 9/2/25 at 2:10 P.M., Employee 5 (E 5), indicated the toilets by the dining room, both men's and women's were out (out of order) constantly. E 5 Indicated the toilets had been working the previous week on Friday, but did not believe they had worked since the previous Friday.

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During an interview, on 9/2/25 at 2:14 P.M., Resident B, indicated she was sick of the restrooms by the dining room always being closed. She indicated they were the only toilets on the first floor residents. She indicated any resident, who needed a restroom, had to return to their apartment or use the public toilets located on another floor. Resident B indicated they were the only restrooms available to visitors and vendors on the first floor, so all kinds of people were going to the second and third floors to use the restrooms. She indicated she was uncomfortable with strangers walking all over the building. Resident B indicated the residents had no place to wash their hands near the dining room.

During an interview, on 9/2/25 at 2:21 P.M., Resident F indicated the restrooms by the dining room were "out of order" almost every day, though at times they might work for a bit and then go back down. She indicated the facility owners indicated the plumbing in the public restrooms was not going to be fixed because it was too costly. Resident F indicated it was very inconvenient to go back up to her apartment to use the restroom if she was on the first floor having dinner.

During an interview, on 9/2/25 at

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2:23 P.M., the Dietary Manager indicated the dining room bathrooms were closed for repairs most days of the week. He indicated the plumbing was not installed correctly so the toilets constantly backed up. He indicated the toilets were not generally available for the residents to use.

During an interview, on 9/2/25 at 2:40 P.M. Employee 3 indicated residents rarely had access to the dining room restrooms because they were usually "out of order". Employee 3 Indicated residents seemed frustrated because the facility was not able to solve the problem.

During an interview, on 9/2/25 at 2:45 P.M., the Administrator indicated the restrooms by the dining room were frequently out of order due to the way the plumbing had been installed. She indicated it had been an ongoing problem. The Administrator indicated she was not aware how long the shower ceiling in room 114 had been dripping, but was aware of the concern since the facility was cited for the concern on 7/16/25. The Administrator did not verbalize or share any plan or timeframe to repair the damage to the bathroom ceiling in room 114.

During an interview, on 9/2/25 at 2:52 P.M. the Maintenance

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Director indicated the Men's and Women's toilets by the dining room were "out of order" for a time very often and he had fixed the toilets as needed. The Maintenance Director indicated the bathroom plumbing had been incorrectly installed and so very often, when the toilets were flushed, the water in the toilet would run backwards back into the toilet rather than out into the septic system, and the toilets had to be pulled out and augured to unplug the line. The Maintenance Director indicated he had to auger the toilets out several times each week. He indicated he was at the facility on 8/31/25 to fix the same issue with the sink in the kitchen, but the toilets had been in working order at that time. The Maintenance Director indicated he had checked the toilet on this day, 9/2/25, and found them to be in working order. The Maintenance Director indicated he could not be at the facility 24/7 to maintain the toilets, could not make sure the toilets were always working, and could not do anything about it. The Maintenance Director did not have any plans to correct the concern or the root cause of the toilets backing up.

On 9/3/25 at 11:00 A.M., Resident Council Minutes were reviewed. Resident Council Minutes dated 7/11/25, indicated there was a great

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concern over the restrooms by the dining room always being down and closed and the response was that it would always be an issue until the facility found out who was clogging them. There was no mention of the incorrectly installed plumbing or any mention of having a professional plumber repair the incorrectly installed plumbing to prevent the toilets from not flushing.

Resident Council Minutes, dated 8/8/25, indicated the rest rooms near the dining room were still a problem. The response indicated the toilets would probably continue to be a problem because of the way the original builders had engineered the layout of the sewage drains. The only other choice was to start over and that would "never occur."

During an observation, on 9/3/25 at 10:15 A.M., with the Assistant Director of Nursing of the ceiling in the shower room of Room 114, active dripping was noted coming from the decaying drywall area of the ceiling above the shower. The water had been collecting into a quart sized plastic yogurt container that was overflowing into the shower pan area.

On 9/2/25 at 12:00 P.M., the Administrator provided an Environmental Services

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Program policy titled Maintenance of Occupied Apartments, dated 3/21, that indicated, "Occupied apartments must be regularly maintained...must be completed within one business day..."

On 9/2/25 at 12:00 P.M., the Administrator provided the policy, "Hellenic Senior Living Policy and Procedure Manual, Resident Rights," dated 9/30/22. The policy indicated, "...This community seeks to provide each of our resident an environment in which he or she can feel valued and fulfill his or her purpose. In order to create this environment, this community has committed to honoring the rights of each resident...Each associate will take on the role of advocate within the community for the resident to work to ensure that his or her rights are recognized daily as care and services are required...Residents have the right to a dignified existence..."

This deficiency was cited on 7/16/2025. The facility failed to implement a systemic plan of correction to prevent recurrence.

This citation relates to Complaint IN00463236.

Based on observation, interview, and record review, the facility failed to ensure facility

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room doors, public toilets and a shower room ceiling were clean, functional and in good repair on 3 of 3 halls and in the hall adjacent to the main dining room area. (100, 200 and 300 halls)

Finding includes:

During a tour of the facility, conducted on 9/2/25 from 11:00 A.M. to 12:07 P.M., the following was observed:

The hallway entrance doors to rooms 001, 117, 214, 224, 303, 329, 330, 331, 333, and 334 were observed to have significant gouges, black scuff marks, and missing paint.

The shower in room 114 was noted to have a 5 gallon yellow bucket with approximately 1 inch of standing water below an open area of broken down drywall in the ceiling of the shower. The broken down ceiling drywall was approximately 24" x 12" and rectangle in size and shape. A visible floor joist was noted above the dry wall. The floor joist had stains that appeared to be water stains. Multiple small black bugs were flying around in the shower area, The bathroom counter around the sink was covered with multiple, dead, small black bugs. Resident D had multiple other bottles and containers in the shower area

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that he indicated were there waiting to be washed and that the yellow bucket and a couple of other containers were there for collecting the water that leaked from the shower above.

On 9/2/25 at 11:43 A.M., during an interview with the Maintenance Director, he indicated the hall way entrance doors to rooms 001, 117, 214, 224, 303, 329, 330, 331, 333, and 334 continued to have scuff marks, gouges, and missing paint that had not been cleaned or repainted. The Maintenance Director indicated he had gotten a quote for metal kick plates for all of the facility doors on 8/29/25 and had requested to purchase the kick plates just today, 9/2/25. The Maintenance Director indicated the lower portion of the doors would be covered with metal panels when he received the approval to purchase them. The Maintenance Director indicated he did not currently have approval for the kick plates and they had not been ordered. There had been no other repairs made to the doors since the Annual survey completed on 7/16/2025.

During an interview with the Maintenance Director, on 9/2/25 at 11:43 A.M., he indicated the shower in room 214 had a leak from the shower area that continued to drip into the

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shower area of room 114. He indicated he had not patched the ceiling in room 114 because the area between the floor of 214 and the ceiling of 114 in ceiling was still damp. The Maintenance Director indicated he had been unable to locate the source of the leak, so he had not attempted to repair the ceiling in room 114. The Maintenance Director was unable to verbalize a plan or timeframe to repair the leak in room 214 or the ceiling in room 114 . In addition, the Maintenance Director indicated he had not consulted with a plumber in an attempt to locate the root cause of the leak.

During an interview, on 9/2/25 at 11:45 A.M., Resident D indicated water had been dripping from the ceiling of his shower area for about two years and no one had attempted to repair the ceiling.

During an observation, on 9/2/25 at 2:00 P.M., of the men's public restroom next to the dining room, a sign was posted on the door that indicated the restroom was "out of order". During the restroom observation there was a strong mal-odor of feces noted, the left sink did not have running water, and the handicapped toilet floor was smeared with feces in a 2 ft x 2 ft area in front of the toilet. The toilet was full of feces and

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the rim and toilet seat were smeared with feces.

During an observation, on 9/2/25 at 2:05 P.M., of the women's public restroom, located across the hall from the men's restroom, a sign was posted on the door that indicated the restroom was "temporarily out of order until further notice". During the restroom observation, there was a strong mal-odor of feces noted. The first toilet stall was filled with toilet tissue and feces. The handicapped toilet was stuffed with toilet tissue.

During an interview, on 9/2/25 at 2:10 P.M., Employee 5 (E 5), indicated the toilets by the dining room, both men's and women's were out (out of order) constantly. E 5 Indicated the toilets had been working the previous week on Friday, but did not believe they had worked since the previous Friday.

During an interview, on 9/2/25 at 2:14 P.M., Resident B, indicated she was sick of the restrooms by the dining room always being closed. She indicated they were the only toilets on the first floor residents. She indicated any resident, who needed a restroom, had to return to their apartment or use the public toilets located on another floor. Resident B indicated they were the only restrooms available to

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visitors and vendors on the first floor, so all kinds of people were going to the second and third floors to use the restrooms. She indicated she was uncomfortable with strangers walking all over the building. Resident B indicated the residents had no place to wash their hands near the dining room.

During an interview, on 9/2/25 at 2:21 P.M., Resident F indicated the restrooms by the dining room were "out of order" almost every day, though at times they might work for a bit and then go back down. She indicated the facility owners indicated the plumbing in the public restrooms was not going to be fixed because it was too costly. Resident F indicated it was very inconvenient to go back up to her apartment to use the restroom if she was on the first floor having dinner.

During an interview, on 9/2/25 at 2:23 P.M., the Dietary Manager indicated the dining room bathrooms were closed for repairs most days of the week. He indicated the plumbing was not installed correctly so the toilets constantly backed up. He indicated the toilets were not generally available for the residents to use.

During an interview, on 9/2/25 at 2:40 P.M. Employee 3 indicated

residents rarely had access to the dining room restrooms because they were usually "out of order". Employee 3 Indicated residents seemed frustrated because the facility was not able to solve the problem.

During an interview, on 9/2/25 at 2:45 P.M., the Administrator indicated the restrooms by the dining room were frequently out of order due to the way the plumbing had been installed. She indicated it had been an ongoing problem. The Administrator indicated she was not aware how long the shower ceiling in room 114 had been dripping, but was aware of the concern since the facility was cited for the concern on 7/16/25. The Administrator did not verbalize or share any plan or timeframe to repair the damage to the bathroom ceiling in room 114.

During an interview, on 9/2/25 at 2:52 P.M. the Maintenance Director indicated the Men's and Women's toilets by the dining room were "out of order" for a time very often and he had fixed the toilets as needed. The Maintenance Director indicated the bathroom plumbing had been incorrectly installed and so very often, when the toilets were flushed, the water in the toilet would run backwards back into the toilet rather than out into the septic system, and the toilets

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had to be pulled out and augured to unplug the line. The Maintenance Director indicated he had to auger the toilets out several times each week. He indicated he was at the facility on 8/31/25 to fix the same issue with the sink in the kitchen, but the toilets had been in working order at that time. The Maintenance Director indicated he had checked the toilet on this day, 9/2/25, and found them to be in working order. The Maintenance Director indicated he could not be at the facility 24/7 to maintain the toilets, could not make sure the toilets were always working, and could not do anything about it. The Maintenance Director did not have any plans to correct the concern or the root cause of the toilets backing up.			
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area.

On 9/2/25 at 12:00 P.M., the Administrator provided an Environmental Services Program policy titled Maintenance of Occupied Apartments, dated 3/21, that indicated, "Occupied apartments must be regularly maintained...must be completed within one business day..."

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This deficiency was cited on 7/16/2025. The facility failed to implement a systemic plan of correction to prevent recurrence.

This citation relates to

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FORM APPROVED

OMB NO. 0938-0391

Complaint IN00463236.

Based on observation, interview, and record review, the facility failed to ensure facility room doors, public toilets and a shower room ceiling were clean, functional and in good repair on 3 of 3 halls and in the hall adjacent to the main dining room area. (100, 200 and 300 halls)

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covered with multiple, dead, small black bugs. Resident D had multiple other bottles and containers in the shower area that he indicated were there waiting to be washed and that the yellow bucket and a couple of other containers were there for collecting the water that leaked from the shower above.

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at 11:43 A.M., he indicated the shower in room 214 had a leak from the shower area that continued to drip into the shower area of room 114. He indicated he had not patched the ceiling in room 114 because the area between the floor of 214 and the ceiling of 114 in ceiling was still damp. The Maintenance Director indicated he had been unable to locate the source of the leak, so he had not attempted to repair the ceiling in room 114. The Maintenance Director was unable to verbalize a plan or timeframe to repair the leak in room 214 or the ceiling in room 114 . In addition, the Maintenance Director indicated he had not consulted with a plumber in an attempt to locate the root cause of the leak.

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During an interview, on 9/2/25 at 2:10 P.M., Employee 5 (E 5), indicated the toilets by the dining room, both men's and women's were out (out of order) constantly. E 5 Indicated the toilets had been working the previous week on Friday, but did not believe they had worked since the previous Friday.

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During an interview, on 9/2/25 at 2:21 P.M., Resident F indicated the restrooms by the dining room were "out of order" almost every day, though at times they might work for a bit and then go back down. She indicated the facility owners indicated the plumbing in the public restrooms was not going to be fixed because it was too costly. Resident F indicated it was very inconvenient to go back up to her apartment to use the restroom if she was on the first floor having dinner.

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residents to use.

During an interview, on 9/2/25 at 2:40 P.M. Employee 3 indicated residents rarely had access to the dining room restrooms because they were usually "out of order". Employee 3 Indicated residents seemed frustrated because the facility was not able to solve the problem.

During an interview, on 9/2/25 at 2:45 P.M., the Administrator indicated the restrooms by the dining room were frequently out of order due to the way the plumbing had been installed. She indicated it had been an ongoing problem. The Administrator indicated she was not aware how long the shower ceiling in room 114 had been dripping, but was aware of the concern since the facility was cited for the concern on 7/16/25. The Administrator did not verbalize or share any plan or timeframe to repair the damage to the bathroom ceiling in room 114.

During an interview, on 9/2/25 at 2:52 P.M. the Maintenance Director indicated the Men's and Women's toilets by the dining room were "out of order" for a time very often and he had fixed the toilets as needed. The Maintenance Director indicated the bathroom plumbing had been incorrectly installed and so very often, when the toilets were

flushed, the water in the toilet would run backwards back into the toilet rather than out into the septic system, and the toilets had to be pulled out and augured to unplug the line. The Maintenance Director indicated he had to auger the toilets out several times each week. He indicated he was at the facility on 8/31/25 to fix the same issue with the sink in the kitchen, but the toilets had been in working order at that time. The Maintenance Director indicated he had checked the toilet on this day, 9/2/25, and found them to be in working order. The Maintenance Director indicated he could not be at the facility 24/7 to maintain the toilets, could not make sure the toilets were always working, and could not do anything about it. The Maintenance Director did not have any plans to correct the concern or the root cause of the toilets backing up.

On 9/3/25 at 11:00 A.M., Resident Council Minutes were reviewed. Resident Council Minutes dated 7/11/25, indicated there was a great concern over the restrooms by the dining room always being down and closed and the response was that it would always be an issue until the facility found out who was clogging them. There was no mention of the incorrectly installed plumbing or any

mention of having a professional plumber repair the incorrectly installed plumbing to prevent the toilets from not flushing.

Resident Council Minutes, dated 8/8/25, indicated the rest rooms near the dining room were still a problem. The response indicated the toilets would probably continue to be a problem because of the way the original builders had engineered the layout of the sewage drains. The only other choice was to start over and that would "never occur."

During an observation, on 9/3/25 at 10:15 A.M., with the Assistant Director of Nursing of the ceiling in the shower room of Room 114, active dripping was noted coming from the decaying drywall area of the ceiling above the shower. The water had been collecting into a quart sized plastic yogurt container that was overflowing into the shower pan area.

On 9/2/25 at 12:00 P.M., the Administrator provided an Environmental Services Program policy titled Maintenance of Occupied Apartments, dated 3/21, that indicated, "Occupied apartments must be regularly maintained...must be completed within one business day..."

On 9/2/25 at 12:00 P.M., the

Administrator provided the policy, "Hellenic Senior Living Policy and Procedure Manual, Resident Rights," dated 9/30/22. The policy indicated, "...This community seeks to provide each of our resident an environment in which he or she can feel valued and fulfill his or her purpose. In order to create this environment, this community has committed to honoring the rights of each resident...Each associate will take on the role of advocate within the community for the resident to work to ensure that his or her rights are recognized daily as care and services are required...Residents have the right to a dignified existence..."

This deficiency was cited on 7/16/2025. The facility failed to implement a systemic plan of correction to prevent recurrence.

This citation relates to Complaint IN00463236.

Based on observation, interview, and record review, the facility failed to ensure facility room doors, public toilets and a shower room ceiling were clean, functional and in good repair on 3 of 3 halls and in the hall adjacent to the main dining room area. (100, 200 and 300 halls)

Finding includes:

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During a tour of the facility, conducted on 9/2/25 from 11:00 A.M. to 12:07 P.M., the following was observed:

The hallway entrance doors to rooms 001, 117, 214, 224, 303, 329, 330, 331, 333, and 334 were observed to have significant gouges, black scuff marks, and missing paint.

The shower in room 114 was noted to have a 5 gallon yellow bucket with approximately 1 inch of standing water below an open area of broken down drywall in the ceiling of the shower. The broken down ceiling drywall was approximately 24" x 12" and rectangle in size and shape. A visible floor joist was noted above the dry wall. The floor joist had stains that appeared to be water stains. Multiple small black bugs were flying around in the shower area, The bathroom counter around the sink was covered with multiple, dead, small black bugs. Resident D had multiple other bottles and containers in the shower area that he indicated were there waiting to be washed and that the yellow bucket and a couple of other containers were there for collecting the water that leaked from the shower above.

On 9/2/25 at 11:43 A.M., during an interview with the Maintenance Director, he

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indicated the hall way entrance doors to rooms 001, 117, 214, 224, 303, 329, 330, 331, 333, and 334 continued to have scuff marks, gouges, and missing paint that had not been cleaned or repainted. The Maintenance Director indicated he had gotten a quote for metal kick plates for all of the facility doors on 8/29/25 and had requested to purchase the kick plates just today, 9/2/25. The Maintenance Director indicated the lower portion of the doors would be covered with metal panels when he received the approval to purchase them. The Maintenance Director indicated he did not currently have approval for the kick plates and they had not been ordered. There had been no other repairs made to the doors since the Annual survey completed on 7/16/2025.

During an interview with the Maintenance Director, on 9/2/25 at 11:43 A.M., he indicated the shower in room 214 had a leak from the shower area that continued to drip into the shower area of room 114. He indicated he had not patched the ceiling in room 114 because the area between the floor of 214 and the ceiling of 114 in ceiling was still damp. The Maintenance Director indicated he had been unable to locate the source of the leak, so he had not attempted to repair the

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ceiling in room 114. The Maintenance Director was unable to verbalize a plan or timeframe to repair the leak in room 214 or the ceiling in room 114 . In addition, the Maintenance Director indicated he had not consulted with a plumber in an attempt to locate the root cause of the leak.

During an interview, on 9/2/25 at 11:45 A.M., Resident D indicated water had been dripping from the ceiling of his shower area for about two years and no one had attempted to repair the ceiling.

During an observation, on 9/2/25 at 2:00 P.M., of the men's public restroom next to the dining room, a sign was posted on the door that indicated the restroom was "out of order". During the restroom observation there was a strong mal-odor of feces noted, the left sink did not have running water, and the handicapped toilet floor was smeared with feces in a 2 ft x 2 ft area in front of the toilet. The toilet was full of feces and the rim and toilet seat were smeared with feces.

During an observation, on 9/2/25 at 2:05 P.M., of the women's public restroom, located across the hall from the men's restroom, a sign was posted on the door that indicated the restroom was "

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temporarily out of order until further notice". During the restroom observation, there was a strong mal-odor of feces noted. The first toilet stall was filled with toilet tissue and feces. The handicapped toilet was stuffed with toilet tissue.

During an interview, on 9/2/25 at 2:10 P.M., Employee 5 (E 5), indicated the toilets by the dining room, both men's and women's were out (out of order) constantly. E 5 Indicated the toilets had been working the previous week on Friday, but did not believe they had worked since the previous Friday.

During an interview, on 9/2/25 at 2:14 P.M., Resident B, indicated she was sick of the restrooms by the dining room always being closed. She indicated they were the only toilets on the first floor residents. She indicated any resident, who needed a restroom, had to return to their apartment or use the public toilets located on another floor. Resident B indicated they were the only restrooms available to visitors and vendors on the first floor, so all kinds of people were going to the second and third floors to use the restrooms. She indicated she was uncomfortable with strangers walking all over the building. Resident B indicated the residents had no place to wash their hands near the dining

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room.

During an interview, on 9/2/25 at 2:21 P.M., Resident F indicated the restrooms by the dining room were "out of order" almost every day, though at times they might work for a bit and then go back down. She indicated the facility owners indicated the plumbing in the public restrooms was not going to be fixed because it was too costly. Resident F indicated it was very inconvenient to go back up to her apartment to use the restroom if she was on the first floor having dinner.

During an interview, on 9/2/25 at 2:23 P.M., the Dietary Manager indicated the dining room bathrooms were closed for repairs most days of the week. He indicated the plumbing was not installed correctly so the toilets constantly backed up. He indicated the toilets were not generally available for the residents to use.

During an interview, on 9/2/25 at 2:40 P.M. Employee 3 indicated residents rarely had access to the dining room restrooms because they were usually "out of order". Employee 3 Indicated residents seemed frustrated because the facility was not able to solve the problem.

During an interview, on 9/2/25 at 2:45 P.M., the Administrator

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indicated the restrooms by the dining room were frequently out of order due to the way the plumbing had been installed. She indicated it had been an ongoing problem. The Administrator indicated she was not aware how long the shower ceiling in room 114 had been dripping, but was aware of the concern since the facility was cited for the concern on 7/16/25. The Administrator did not verbalize or share any plan or timeframe to repair the damage to the bathroom ceiling in room 114.

During an interview, on 9/2/25 at 2:52 P.M. the Maintenance Director indicated the Men's and Women's toilets by the dining room were "out of order" for a time very often and he had fixed the toilets as needed. The Maintenance Director indicated the bathroom plumbing had been incorrectly installed and so very often, when the toilets were flushed, the water in the toilet would run backwards back into the toilet rather than out into the septic system, and the toilets had to be pulled out and augured to unplug the line. The Maintenance Director indicated he had to auger the toilets out several times each week. He indicated he was at the facility on 8/31/25 to fix the same issue with the sink in the kitchen, but the toilets had been in working order at that time. The

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Maintenance Director indicated he had checked the toilet on this day, 9/2/25, and found them to be in working order. The Maintenance Director indicated he could not be at the facility 24/7 to maintain the toilets, could not make sure the toilets were always working, and could not do anything about it. The Maintenance Director did not have any plans to correct the concern or the root cause of the toilets backing up.

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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 SIGNATURESarah Robinson	TITLEExecutive Director	(X6) DATE09/30/2025
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