

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 08/21/2026	
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. Survey date: 8/19/2026-8/21/2026 Facilty number: 014224 Residential Cencus: 122 These deficiencies reflect State Findings cited in accordance with 410 Indiana Adminitrative Code 16.2.5 Quality Review completed on 9/1/2026	R 0000					
R 0117	Personnel - Deficiency 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.	R 0117	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. CPR/First aid class			10/06/2026	

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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 at least one, awake employee had a current cardiopulmonary resuscitation (CPR) and first aid certification while on duty for 4 of 7 days reviewed.

Finding includes:

scheduled for 10/6/26, all clinical staff to be CPR/First aid certified.

4. ED/ designee to audit schedule monthly to ensure staffing pattern in accordance with state regulations.

ED/designee to audit licenses monthly to ensure all clinical staff up to date on CPR/First aid.

5. Practice will be completed for six months and further if deficient practice continues.

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A review of the facility's nursing schedule was completed on 8/21/2026 at 9:54 A.M. The schedule included the nursing schedule from 8/16/2026 through 8/22/2026.

The nursing schedule indicated there was no CPR certified employee on duty on 8/22/2026 and there was no employee with the required first aid certification on 8/19/2026 on the second shift, 8/20/2026 on the first, second and third shifts, 8/21/2026 on the third shift and on 8/22/2026 on the first, second and third shifts.

During an interview with the Director of Nursing (DON), on 8/21/2026 at 11:07 A.M., she indicated at least one staff member should have had a CPR and first aid certification while per each shift.. She indicated although some employees had a certification from an online CPR instruction course, the program had not contained the required hands-on instruction and she had just learned their CPR certifications were not valid for healthcare.

A policy for CPR and first aid certification was requested, on 8/21/2026 at 11:01 A.M. The Director of Nursing indicated the facility did not have a policy for staff requirements for CPR and

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	first aid training and indicated the facility followed the State regulation.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized 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	R 0120	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 All residents could have been affected, however in this case, no residents were affected. 3 Staff to be re-educated on 9/22/26 on requirements of continued education. Any staff found non-compliant will be re-educated and disciplined per facility policy. 4 ED/Designee will audit all current employee training modules to ensure compliance. Any staff to be non-complaint will be removed from schedule until completed. Supervisors/ training modules monthly to ensure education. 5. Practice will be completed for six months and further if deficient practice continues.	09/22/2026

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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.
- (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 2 of 5 employees reviewed had completed annually required training including abuse and neglect, resident rights and dementia care. (Server 2 & CNA 3)

Findings include:

1. Employee records were reviewed, on 8/20/2026 at 1:56 P.M. The following was noted:

A. Server 2 had last completed abuse and neglect training on 7/6/2022, resident rights 7/6/2022 and 8/24/2022 and dementia training on 7/16/2022. There was no documentation Server 2 had completed any of the required annual training

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	since 2022, during the employee's initial training dates. 2. CNA 2 had last completed resident rights training on 5/12/2022 and dementia training on 5/12/2022. There was no documentation CNA 2 had completed the required resident rights and dementia training since 2022. During an interview, on 8/20/2026 at 2:26 P.M., the Business Office Manager indicated the staff should have had their annual online training for abuse and neglect, resident rights, and dementia care. She indicated the department supervisors were expected to ensure their employees had completed the required online training annually. A portion of the Employee Handbook was provided by the Director of Nursing, on 8/21/2026 at 9:05 A.M. The Employee Handbook indicated, "Each month you will be assigned various trainings ...You will also have the in-services required by the State Department of Health as those that [facility name] feels are important ...We ask that you take them seriously and keep current on all trainings"			
R 0144	Sanitation and Safety Standards -	R 0144	1. Corrections from previous	10/14/2026

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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 and interview, the facility failed to maintain a clean environment related to hallway carpeting and resident apartment doors. This deficient practice had the potential to affect 15 resident rooms on 3 of 3 floors. (Resident Rooms 112, 113, 115, 117, 131, 134, 135, 220, 233, 237, 307, 309, 321, 322 and 326) Findings: During an environmental tour of the facility, conducted on 8/19/2026 at 1:48 P.M., the following was observed: carpeting directly in front of the entrance of fifteen (15) resident apartment rooms, Rooms 112, 113, 115, 117, 131, 134, 135, 220, 233, 237, 307, 309, 321, 322 and 326 exhibited large, dark, heavily soiled areas. In addition, f fifteen (15) individual resident apartment doors for resident rooms 112, 113, 115, 117, 131, 134, 135, 220, 233, 237, 307, 309, 321, 322 and 326 had		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. • Carpet cleaning schedule has been created and is to be followed by Maintenance Director and assistant starting 9/21/26. • Kickplates to be installed on all doors by 10/14/26 4. Maintenance Director/Designee to audit carpet cleaning schedule weekly and any additional cleaning to be completed as needed. 5. Practice will be completed for six months and further if deficient practice continues	
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	significant black colored scuff marks, scratches, and scraped paint on the bottom halves of the door and door frames. During an interview with the Maintenance Director, on 8/21/2026 at 2:20 P.M, he indicated the balck marks and scratches were from residents hitting the doors and door frames with their motorized wheelchairs and with their walkers. He indicated the facility was in the process of installing kickplates on all of the resident doors. In addition, he indicated the facility carpeting was cleaned once per month.			
R 0145	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(b) (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, interview, and record review, the facility failed to maintain essential dietary equipment in a safe and operational condition related to the dishwasher. This deficient practice had the potential to affect 122 of 122 residents who consumed food from the kitchen.	R 0145	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. Water Softener scheduled to be installed on 10/5/26. Once installed Dishwasher to be installed 4. ED/Maintenance Director to ensure scheduled installations to remain on time.	10/09/2026

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	Findings: During an initial tour of the kitchen, on 8/19/2026 at 9:32 A.M., with the cook 1, , the commercial dishwashing machine was noted to be out of service, and had been completely disconnected. During an interview Cook 1, she confirmed that the dishwasher had broken down in September 2025 and had not worked since. She indicated the facility had been hand-washing their cookware and silverware and the had utilized styrofoam plates and cups for meal service. During an observation of the meal service, on 8/19/2026 at 10:55 A.M., all 122 residents were served their main courses, side dishes, and beverages on disposable styrofoam plates and cups. A review of a facility maintenance documents, provided by the Maintenance Director on 8/21/2026 at 12:06 P.M., indicated a service note from September 2025 which had deemed the dish washer as unrepairable and requiring a complete replacement. . A new dishwasher had been ordered on 10/6/2025 and had been delivered on 12/23/2025. It was noted in the kitchen in the original packaging. unconnected or set up.		5. Practice will be completed for six months and further if deficient practice continues	
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	During an interview on 8/21/2026 at 12:10 P.M., the Facility Administrator acknowledged that the dishwashing machine had been broken since September 2025 and indicated that they had had the new dishwasher since December 2026. She indicated they were waiting to get a new water softener system installed before installing the new dishwasher. She also indicated the new water softener had been received on 1/10/2026. It was unclear why neither the water softener system, nor the dishwasher had been installed.			
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 and interview, the facility failed to maintain an effective and safe biohazard waste disposal program related to five (5) out of ten (10) biohazard containers overflowing. (Apartment 106, 110, 211, 321 and 328)	R 0155	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. All sharps containers replaced with new empty containers on 9/4/26. 4. DON/Designee to audit all rooms with sharps containers weekly to ensure proper use. 5. Practice will be completed for six months and further if deficient practice continues	09/04/2026

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	Findings: A total of ten (10) resident apartments housing individuals who received staff-administered injections (such as insulin) were observed. In five of those 10 apartments (106, 110, 211, 321, 326), the sharps containers were completely overfilled. Used syringes and lancets were observed protruding past the safety drop-flaps, blocking the containers from sealing or receiving further waste safely. During an inspection of the Insulin Cart, on 8/19/2026 at 1:05 P.M. conducted with QMA #6, the point-of-care red biohazard sharps container, attached to the side of the cart, was observed to be stuffed past its maximum capacity line. Multiple exposed insulin pen needles and blood-testing lancets were wedged tightly into the plastic opening, preventing the top pivoting lid from closing properly. During an interview at the time of the observations, QMA #6 verified the container was too full and indicated there were no replacement sharps containers available. During an interview on 8/21/2026 at 12:06 P.M., the			
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	Director of Nursing (DON) confirmed that allowing sharps containers to overflow violated both the facility's infection control protocol and its standard operating policy for biohazard disposal. A policy regarding biohazard waste disposal was requested on 8/21/2026 but was not provided prior to the survey exit.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to	R 0216	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. Clinical staff re-education to be completed on 9/22/26 to review policy and procedures for weights and vitals. 4. DON/Designee will monitor PCC charting to ensure the weights are obtained and entered into PCC during the second week of each month on-going. 5. Practice will be completed for six months and further if deficient practice continues.	09/22/2026

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	obtain a semi-annual weight for 1 of 8 records reviewed for weights. (Resident 9) Finding includes: A record review for Resident 9 was completed, 8/20/2026 at 10:54 A.M. Diagnoses included, but were not limited to: depression, anxiety disorder, anemia and hypertension. A weight record indicated Resident 9 had a weight documented on 5/2/2025 and 3/16/2026. During an interview with the Director of Nursing (DON), on 8/21/2026 at 11:12 A.M., the DON indicated resident weights should have been completed every 6 months. A policy for weights was requested, on 8/21/2026 at 11:01 A.M. The Director of Nursing indicated the facility did not have a policy for obtaining semi-annual weight and indicated the facility followed the State regulations.			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled	R 0300	1. Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice.	09/22/2026

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	in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation and interview, the facility failed to ensure medications were properly labeled and identifiable in accordance with professional nursing standards in 3 of 3 medication carts. (Medication Cart 1, 2 and 3). Findings: During an inspection of Medication Cart 1, conducted on 8/20/2026 at 3:15 P.M. with QMA 4, the following was observed: A total of twenty-four (24) loose, unidentified pills of various shapes and colors were located loose in the bottom of 3 oral medication drawers. During an interview at that time with QNA 4, she indicated the loose pills could not be safely identified, matched to a prescription, or verified for resident safety. During an inspection of Medication Cart 2, on 8/20/2026 at 3:25 P.M with QMA 5, the following was observed: A total of fifteen (15) loose,		2. All residents could have been affected, however in this case no residents were affected. 3. Clinical staff re-education to be completed on 9/22/26 to review policy and procedures for medication administration and medication labeling. 4. DON/Designee will complete cart audit weekly x 4 weeks then monthly x 5 months to ensure no loose or unlabeled medications are found in cart. 5. Practice will be completed for six months and further if deficient practice continues.	
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	unidentified pills were found scattered throughout the oral medication drawers. During an interview at that time QMA 5 indicated the pills were completely out of their original blister packs, lacked labeling, and could not be identified by drug name or resident name. During an inspection of Medication Cart 3, on 8/20/2026 at 3:35 P.M. conducted with QMA 5, the following was observed: A total of 5 loose, unidentified pills were found scattered throughout the oral medication drawers. During an interview at that time, QMA #5 indicated the pills were completely out of their original blister packs, lacked labeling, and could not be identified by drug name or resident name. During an interview on 8/21/2026 at 3:45 P.M., the Director of Nursing (DON) indicated loose pills in the medication carts should have been wasted immediately when they were noted to have fallen out of the original packaging.			
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R 0302	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(6) (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to ensure that medications and medical supplies were properly stored and removed from active use upon expiration of 1 of 3 Medicaiton carts and 1 of 1 Insulin carts. (Medication Cart 2) Findings: During an inspection of Medication Cart 2, on 8/20/2026 at 3:25 P.M. conducted with QMA #5, one (1) Albuterol inhaler prescribed to Resident 11 was located in the cart. Documentation on the inhaler box and canister indicated an expiration date of June 2026, however, the inhaler was stored as usable inventory for scheduled resident administrations. During an interview at that time with QMA	R 0302	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. Clinical staff re-education to be completed on 9/22/26 to review policy and procedures for expired medications. 4. DON/Designee will complete cart audit monthly to ensure all medications are within date and no expired medications remain in cart. 5. Practice will be completed for six months and further if deficient practice continues.	09/22/2026
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	5 , she indicated Resident 11's inhaler was past its expiration date. During an inspection of the Insulin Cart ,on 8/21/2026 at 3:40 P.M. conducted with QMA 6, a total of twelve (12) boxes of Nano Pen Needles, used for insulin administration, were stored in the cart and actively being used by nursing staff. Review of the manufacturer labels on all twelve (12) boxes revealed an expiration of June 2023. During an interview at that time, QMA 6 indicated the boxes of needles were expired and she was unaware needles expired.			
R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation and interview, the facility failed to ensure acceptable infection control and hand hygiene practices were maintained during medication administration for 1 of 3 staff observed administering medications. (QMA 7)	R 0414	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. QMA Hand hygiene, eye drop, and insulin administration will be covered at all clinical staff in-service. An all-clinical staff in-service will be held on 9/22/26. 4. All new employees will be educated during the New Employee Orientation and on-going on the importance of	09/22/2026

Findings:

During a medication administration observation, on 8/20/2026 at 9:31 A.M. with QMA 7, the following was observed:

QMA 7 prepared and administered oral medications to Resident 12. Upon leaving Resident 12's room, QMA 7 proceeded directly to the medication cart, prepared medications for Resident 13, and administered them without performing hand hygiene or utilizing alcohol-based hand rub between the resident medication administrations.

In addition, QMA 7 then prepared Refresh eye drops for Resident 13. Without washing her hands or using hand sanitizer, QMA 7 pulled a pair of clean, disposable gloves out of the cart drawer, applied them and administered the eye drops to Resident 13's eyes.

After administering the eye drops, QMA 7 removed the disposable gloves, tossed them into the trash receptacle, and immediately began preparing oral medications for the next resident without performing hand hygiene.

During an interview at the time of the observation, QMA 7 indicated she had thought she

Hand Hygiene during medication administration.

5. The DON/Designee will observe staff members 3x weekly x 1 month then weekly x 5 months on various shifts to ensure proper procedure of Handwashing is followed in medication administration.

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FORM APPROVED

OMB NO. 0938-0391

	had washed her hands.			
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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) DATE09/14/2026
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