STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF MISHAWAKA	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 the Investigation of Complaint IN00359278 and IN00360164. Complaint IN00359278 - Substantiated. State Residential Findings related to the allegations are cited at R0248. Complaint IN00360164 - Substantiated. No deficiencies related to the allegations are cited. Survey date: August 24 and 25, 2021 Facility number: 014224 Residential Census: 86 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed on September 2, 2021.	R 0000	Please accept this POC as our allegation of compliance.	
R 0248	Health Services - Deficiency	R 0248	A. On 4-7-21, all residents were	09/21/2021

410 IAC 16.2-5-4(f)

(f) The facility shall have available on the premises or on call the services of a licensed nurse at all times.

Based on record review and interview, the facility failed to ensure there was facility personnel on the premises from the hours of 10:53 P.M. on 4/6/21 to 5:43 A.M. on 4/7/21. This deficient practice had the potential to affect 46 of 46 residents residing at the facility.

Finding includes:

A Reportable Incident, dated 4/7/21, indicated the following: "...Brief Description of Incident: 4/7/2021 when day shift Nurse reported to work, it was discovered that the evening shift Nurse and CNA [Certified Nursing Assistant] had left the facility without staff relief. Both the Nurse and CNA were from [name of staffing agency], a nursing agency. Type of Injury: None...."

During an interview, on 8/24/21 at 11:30 A.M., the facility Administrator indicated she was notified of the incident when she came to work the morning of 4/7/21 by LPN [Licensed Practical Nurse] 1, she then notified the Wellness Director and reviewed the video footage from the night before. The

checked, and no
residents were found to be affected by this alleged deficient practice.

B.
On 4-7-21, all residents were checked, and no
residents were found to be affected by this alleged deficient practice.

C.
All Nursing staff will be informed and sign that
they are aware that they can not leave the facility until a relief person has
accepted responsibility for the nursing department. They will also be aware of where the nurse on
call telephone number is posted and that they should call the nurse on call if a
relief person does not show for work.
All agency personnel will be informed and sign the same information if/or
when they work at Hellenic Senior Living – Mishawaka (See Exhibit 1).

New nursing employees will be oriented to
this procedure during general orientation. (See Exhibit 1)

	Nurse and CNA had left the facility at 10:53 P.M. on 4/6/21 without having relief staff on the premises and without notifying the facility's management staff. The nurse who was scheduled for the night shift did not show up for her shift. The Administrator indicated she ensured the safety of the resident's and then reported the incident to the staffing agency and the State of Indiana. On 8/24/21 at 1:00 P.M., the facilities video footage of the front entrance was reviewed. The footage shows that at 10:53:17 P.M., 2 women were seen leaving the facility's front entrance. No other activity was noted until 5:40 A.M. when a dietary worker was seen attempting to enter the building and at 5:43 A.M., when LPN 1 was seen arriving for work and attempting to get into the facility. During an interview, on 8/24/21, at 1:19 P.M., LPN 1 indicated she came to work about 5:45 A.M. the morning of 4/7/21 and attempted to enter the building. She rang the doorbell for someone to let them in but no one came so she sent a dietary worker who was also attempting to enter the building go around back and enter through the dietary entrance. Once in the building, she realized no one had been there during the night shift and she promptly checked		D. The Director of Nursing will monitor that agency staff are informed and have signed that they are aware they can not leave until a relief person is in the facility to relief them and they are aware where the on-call nurse telephone number is located. (See Exhibit 2). Any concerns will be brought to the morning manager meetings. All monitoring and concerns will be reviewed at the quarterly Quality Assurance meetings. The Quality Assurance meetings consist of: Administrator, Director of Nursing, Environmental Service Director, Social Program Director, Marketing Director, Move-In Coordinator & Dietary Manager.	

on every resident to ensure their safety. She found all residents were safe and accounted for and had not missed any medications or treatments. She then notified the Administrator of the facility when she arrived at the facility.

A clinical review conducted on 8/25/21 at 10:30 A.M., indicated no negative outcomes or medications/treatments had been missed between the hours of 10:30 P.M. on 4/6/21 and 6:00 A.M. on 4/7/21.

During an interview, on 8/25/21 at 2:00 P.M., Resident B indicated for the most part she received good care at the facility but there was this one time where her daughter had her call light on for hours to request a pain pill and no one came, her daughter had called her and asked her if she would turn on her light and request a pain pill for her, she did but it was a long time before her light was answered but her daughter did receive a pain pill.

A review of the call light log for the night shift of 4/6/21, was conducted on 8/25/21 at 2:30 P.M.. 2 call lights were noted to be on during the overnight hours one for a period of 1 hour and 25 minutes and 28 seconds and one for 3 hours and 23 minutes and 24 seconds.

During a 2nd interview, conducted with the Administrator, on 8/25/21 at 3:00 P.M., she indicated the agency staff who left the building should have stayed until someone relieved them or notified them that no one came to relieve them.

This State tag is related to Complaint IN00359278.

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4/7/21 by LPN [Licensed Practical Nurse] 1, she then notified the Wellness Director and reviewed the video footage from the night before. The Nurse and CNA had left the facility at 10:53 P.M. on 4/6/21 without having relief staff on the premises and without notifying the facility's management staff. The nurse who was scheduled for the night shift did not show up for her shift. The Administrator indicated she ensured the safety of the resident's and then reported the incident to the staffing agency and the State of Indiana.

On 8/24/21 at 1:00 P.M., the facilities video footage of the front entrance was reviewed. The footage shows that at 10:53:17 P.M., 2 women were seen leaving the facility's front entrance. No other activity was noted until 5:40 A.M. when a dietary worker was seen attempting to enter the building and at 5:43 A.M., when LPN 1 was seen arriving for work and attempting to get into the facility.

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back and enter through the dietary entrance. Once in the building, she realized no one had been there during the night shift and she promptly checked on every resident to ensure their safety. She found all residents were safe and accounted for and had not missed any medications or treatments. She then notified the Administrator of the facility when she arrived at the facility.

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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 SIGNATURE	TITLE	(X6) DATE