STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF ELKHART	2528 BYPASS ROAD, ELKHART, , 46514

(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 PSR (Post Survey Revisit) to the Investigation of Complaints IN00463336, IN00463090 and IN00462643 completed on July 21, 2025. Complaint IN00462643 - Not Corrected. Survey date: August 27, 2025 Facility number: 014241 Facility Census: 111 This State finding is cited in accordance with 410 IAC 16.2-5. Quality Review completed on 9/2/2025 This visit was for the PSR (Post Survey Revisit) to the Investigation of Complaints IN00463336, IN00463090 and IN00462643 completed on July 21, 2025. Complaint IN00462643 - Not	R 0000		

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R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the physician was notified timely of a resident's fall for 2 of 3 residents reviewed for change in conditions/ falls. (Residents F and G)	R 0036	1.All residents could have been affected, however in this case no other residents were affected. 2. Clinical Policy 3 Response to Falls, Policy 3.1 Refusal to Transport and Policy 3.1F Refusal to Transport Form were reviewed with all nurses, QMAs during in-serviceon 8/29. Individual re-education on unusual occurrences, documentation, and physician notification completed 9/1/25-9/5/25 3. PCP will be notified as stated in Clinical Policy 3 Response to Falls. verification of PCP notification will be documented in electronic charting system (PCC) with the time PCP was notified of the fall following Clinical Policy Response to Falls 4. DON/designated	10/07/2025

	Findings Include: 1. Resident F's record was reviewed on 8/27/25 at 12:38 p.m. Diagnoses included, but were not limited to, diabetes mellitus, essential hypertension and peripheral vascular disease. The resident was assessed, on 2/26/25, and was alert and oriented with no cognitive deficiencies. The resident's Service Plan, last reviewed on 8/11/25, indicated he required blood sugar monitoring and insulin management for diabetes mellitus, transportation assistance, housekeeping assistance and daily safety checks. An Incident Report, dated 8/26/25 at 10:59 P.M., indicated while the resident was outside smoking, he slid out of his chair. The report indicated there was no injury. The resident's son was notified at 11:09 P.M. of the fall, but the Physician notification documentation was blank. There was no Nursing Progress Note related to the fall in the resident's record. The Incident Report had been completed by Qualified Medication Assistant (QMA) 1. During an interview on 8/27/25 at 1:45 p.m., the Executive Director (ED) indicated she had not been aware of the resident's fall on 8/26/25. When asked		nurse/Executive Directors will review PCC each morning for incidents including falls and will bring to morning meeting Monday-Friday for IDT Review. The above protocols will be followed indefinitely without an end date.	

	why there were no Nursing Progress Notes or Physician notifications completed regarding the fall, the ED indicated, during an interview on 8/27/25 at 3:15 P.M., that there had been no licensed nurses on duty last night (8/26/25), but the Assistant Director of Nursing (ADON) had been notified via a text message of the fall. 2. Resident G's record was reviewed on 8/27/25 at 1:13 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease stage 3, duodenal ulcer and repeated falls. On 12/24/24 the resident was assessed and found to be cognitively intact. The resident's Service Plan, last reviewed on 8/11/25, indicated she required medication management, transportation arrangement, daily wellness checks and assistance with laundry. An Incident Report, dated 8/26/25 at 11:31 P.M., indicated the resident hall a fall while attempting to transfer herself from the recliner into her wheelchair in her room. The injury section of the form was blank. The family had been notified at 11:40 P.M., but the Physician notification documentation was blank. There was no Nursing Progress			

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no licensed nurses on duty last night, but the Assistant Director of Nursing (ADON) had been notified via text message of the fall.

QMA 1 was unavailable for an interview.

Review of the facility's current policy, titled "Fall Response Procedures", revised 8/2025 indicated, "...Should a resident experience a fall, staff will provide immediate care and follow through with Service Planning...5. The physician is contacted immediately for further instructions. Physical therapy may be ordered as appropriate. Documentation of physician notification is completed in the resident record...."

Although the facility had completed an in-service related to "Fall Response Procedures" on 7/23/25 for all caregiver, the facility failed to follow their policy to ensure the physician was notified timely of falls and residents received timely assessment of injuries related to falls.

This deficiency was cited on 7/21/25. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on record review and interview, the facility failed to

ensure the physician was notified timely of a resident's fall for 2 of 3 residents reviewed for change in conditions/ falls. (Residents F and G)

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R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, record review and interview, the facility failed to ensure residents were free from neglect related to the lack of timely physician notification and lack of timely assessment and treatment of residents after a fall for 2 of 3 residents reviewed for neglect.	R 0052	1.All residents could have been affected, however in this case no other residents were affected. 2. Clinical Policy 3 Response to Falls, Policy 3.1 Refusal to Transport and Policy 3.1F Refusal to Transport Form were reviewed with all nurses, QMAs during in-serviceon 8/29. Individual re-education on unusual occurrences, documentation, and physician notification completed 9/1/25-9/5/25	10/08/2025

(Residents F and G)

Findings Include:

1. Resident F's record was reviewed on 8/27/25 at 12:38 p.m. Diagnoses included, but were not limited to, diabetes mellitus, essential hypertension and peripheral vascular disease.

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During an interview on 8/27/25 at 1:37 P.M., Resident F indicated he had been outside smoking and "blacked out". He

3. PCP will be notified as stated in Clinical Policy 3 Response to Falls. verification of PCP notification will be documented in electronic charting system (PCC) with the time PCP was notified of the fall following Clinical Policy Response to Falls

4. DON/designated nurse/Executive Directors will review PCC each morning for incidents including falls and will bring to morning meeting Monday-Friday for IDT Review.

The above protocols will be followed indefinitely without an end date.

indicated he had fallen out of his chair onto the concrete patio. He indicated another resident had found him, about an hour later, and went to get staff. He indicated staff had assisted him back into his chair and there had been no assessment by the facility staff or any ambulance notified. He indicated his back was sore from being on the concrete for so long.

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During an interview on 8/27/25 at 3:18 p.m., the ADON indicated she had been notified of the resident's fall, on 8/26/25 at 11:04 P.M.. on the facilities nursing app and the notification had indicated there were no injuries. She indicated If there had been injuries, staff were supposed to call her phone as she did not hear the app notification when she was sleeping. She indicated she was

not aware the resident had reported he had "blacked out." She indicated the new policy indicated an ambulance should be called to assess a resident if a nurse was not available to assess residents after a fall.

2. Resident G's record was reviewed on 8/27/25 at 1:13 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease stage 3, duodenal ulcer and repeated falls.

On 12/24/24 the resident was assessed and found to be cognitively intact. The resident's Service Plan, last reviewed on 8/11/25, indicated she required medication management, transportation arrangement, daily wellness checks and assistance with laundry.

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moved her and had torn her skin on her arm. She indicated no one had assessed her until she went to the nurse's station this morning when she noticed the bleeding.

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QMA 1 was unavailable for interview.

Review of the facility's current

policy, titled, "Fall Response Procedures", revised 8/2025, indicated, "...Should a resident experience a fall, staff will provide immediate care and follow through with Service Planning...1. Should a resident fall, caregivers are instructed to summon immediate assistance from the Director of Nursing or licensed nurse on duty. If the nurse is not physically present staff should call 911 for evaluation. Caregivers do not move the resident except to protect against further injury, as in the case of dangerous environment...." and, "...5. The physician is contacted immediately for further instructions. Physical therapy may be ordered as appropriate. Documentation of physician notification is completed in the resident record...."

The current facility document, titled "Documentation Cheat Sheet", indicated, "...Fall: Complete progress note, incident report and incident log (falls with injury MUST be called in to DON and ED. DON needs to be notified via text on all falls..."

Although the facility had completed an in-service related to "Fall Response Procedures" and "Documentation Cheat Sheet", on 7/23/25 for all caregivers, the nursing staff had not followed the policy on

8/26/2025.

This deficiency was cited on 7/21/25. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on observation, record review and interview, the facility failed to ensure residents were free from neglect related to the lack of timely physician notification and lack of timely assessment and treatment of residents after a fall for 2 of 3 residents reviewed for neglect. (Residents F and G)

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fall, she indicated, on 8/27/25 at 3:15 P.M., that there had been no licensed nurses on duty last night, but the Assistant Director of Nursing (ADON) had been notified via text message of the fall.

During an interview on 8/27/25 at 3:18 p.m., the ADON indicated she had been notified of the fall via the facilities nursing app last night at 11:31 P.M. and the notification indicated there had been no injuries. She indicated if there were injuries, staff were supposed to call her phone as she did not hear the app notification when she was sleeping.

QMA 1 was unavailable for interview.

Review of the facility's current policy, titled, "Fall Response Procedures", revised 8/2025, indicated, "...Should a resident experience a fall, staff will provide immediate care and follow through with Service Planning...1. Should a resident fall, caregivers are instructed to summon immediate assistance from the Director of Nursing or licensed nurse on duty. If the nurse is not physically present staff should call 911 for evaluation. Caregivers do not move the resident except to protect against further injury, as in the case of dangerous

environment...." and, "...5. The physician is contacted immediately for further instructions. Physical therapy may be ordered as appropriate. Documentation of physician notification is completed in the resident record...."

The current facility document, titled "Documentation Cheat Sheet", indicated, "...Fall: Complete progress note, incident report and incident log (falls with injury MUST be called in to DON and ED. DON needs to be notified via text on all falls..."

Although the facility had completed an in-service related to "Fall Response Procedures" and "Documentation Cheat Sheet", on 7/23/25 for all caregivers, the nursing staff had not followed the policy on 8/26/2025.

This deficiency was cited on 7/21/25. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on observation, record review and interview, the facility failed to ensure residents were free from neglect related to the lack of timely physician notification and lack of timely assessment and treatment of residents after a fall for 2 of 3 residents reviewed for neglect.

(Residents F and G)

Findings Include:

1. Resident F's record was reviewed on 8/27/25 at 12:38 p.m. Diagnoses included, but were not limited to, diabetes mellitus, essential hypertension and peripheral vascular disease.

The resident was assessed, on 2/26/25, and was alert and oriented with no cognitive deficiencies. The resident's Service Plan, last reviewed on 8/11/25, indicated he required blood sugar monitoring and insulin management for diabetes mellitus, transportation assistance, housekeeping assistance and daily safety checks.

An Incident Report, dated 8/26/25 at 10:59 P.M., indicated while the resident was outside smoking, he slid out of his chair. The report indicated there was no injury. The resident's son was notified at 11:09 P.M. of the fall, but the Physician notification documentation was blank. There was no Nursing Progress Note related to the fall in the resident's record. The Incident Report had been completed by Qualified Medication Assistant (QMA) 1.

During an interview on 8/27/25 at 1:37 P.M., Resident F indicated he had been outside smoking and "blacked out". He

indicated he had fallen out of his chair onto the concrete patio. He indicated another resident had found him, about an hour later, and went to get staff. He indicated staff had assisted him back into his chair and there had been no assessment by the facility staff or any ambulance notified. He indicated his back was sore from being on the concrete for so long.

During an interview on 8/27/25 at 1:45 p.m., the Executive Director (ED) indicated she had not been aware of the resident's fall on 8/26/25. When asked why there were no Nursing Progress Notes or Physician notifications completed regarding the fall, the ED indicated, during an interview on 8/27/25 at 3:15 P.M., that there had been no licensed nurses on duty last night (8/26/25), but the Assistant Director of Nursing (ADON) had been notified via a text message of the fall

During an interview on 8/27/25 at 3:18 p.m., the ADON indicated she had been notified of the resident's fall, on 8/26/25 at 11:04 P.M.. on the facilities nursing app and the notification had indicated there were no injuries. She indicated If there had been injuries, staff were supposed to call her phone as she did not hear the app notification when she was sleeping. She indicated she was

not aware the resident had reported he had "blacked out." She indicated the new policy indicated an ambulance should be called to assess a resident if a nurse was not available to assess residents after a fall.

2. Resident G's record was reviewed on 8/27/25 at 1:13 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease stage 3, duodenal ulcer and repeated falls.

On 12/24/24 the resident was assessed and found to be cognitively intact. The resident's Service Plan, last reviewed on 8/11/25, indicated she required medication management, transportation arrangement, daily wellness checks and assistance with laundry.

An Incident Report, dated 8/26/25 at 11:31 P.M., indicated the resident hall a fall while attempting to transfer herself from the recliner into her wheelchair in her room. The injury section of the form was blank. The family had been notified at 11:40 P.M., but the Physician notification documentation was blank. There was no Nursing Progress Note entered for the night of 8/26/25. The Incident Report was completed by QMA 1.

An Incident Note, dated 8/27/25 at 9:45 A.M., indicated the resident had had a fall during the night and had injury to her hands, which had caused blood to be deposited throughout her apartment. The resident had transferred herself to a wheelchair after the fall and was unsure of time, only that it had been dark outside. The resident had came to nurses station and had been assessed at this time (8/27/25 at 9:45 A.M.). Vitals had been obtained and documented. There was an Injury to her right hand, digit 2 knuckles, a skin tear. The skin tear Measured 1 cm x 1 cm with the skin flap intact, a dressing was applied to protect the wound. The resident Denied other injuries or pain due to the fall. The NP (Nurse Practitioner) was made aware of fall and skin tear.

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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 SIGNATURELinsey Fitterling	TITLEExecutive Director	(X6) DATE10/14/2025