STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/16/2025

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 PSR of the Investigation of Intake IN00462643 completed on July 21, 2025. Complaint IN00462643 - Corrected. Survey date: October 16, 2025. Facility number: 014241 Facility Census: 113 Hellenic of Elkhart was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the PSR to the Investigation of Intake IN00462643. Quality Review completed on 10/27/2025 This visit was for the PSR (Post Survey Revisit) to the PSR of the Investigation of Intake IN00462643 completed on July 21, 2025. Complaint IN00462643 -	R 0000		

	Corrected. Survey date: October 16, 2025. Facility number: 014241 Facility Census: 113 Hellenic of Elkhart was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the PSR to the Investigation of Intake IN00462643. Quality Review completed on 10/27/2025			
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.	R 0036		10/29/2025
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be	R 0052		10/29/2025

	free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.			

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