

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                              |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br><br>08/17/2023 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>HELLENIC SENIOR LIVING OF ELKHART |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>2528 BYPASS ROAD, ELKHART, , 46514 |                                  |                                                                 |  |                                                 |  |
| (X4) ID<br>PREFIX TAG                                                 | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID PREFIX<br>TAG                                                                   | PROVIDER'S PLAN OF CORRECTION... |                                                                 |  | (X5)<br>COMPLETION<br>DATE                      |  |
| R 0000                                                                | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00410224 and IIN00410493.</p> <p>Complaint IN00410224 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00410493 - No deficiencies related to the allegations are cited.</p> <p>Survey date: August 16, and 17, 2023</p> <p>Facility number: 014241</p> <p>Residential Census: 117</p> <p>Hellenic Senior Living Of Elkhart was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00410224 and IN00410493.</p> <p>Quality review completed 8/22/2023.</p> | R 0000                                                                             |                                  |                                                                 |  |                                                 |  |

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.)

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| LABORATORY DIRECTOR'S OR<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE | TITLE | (X6) DATE |
|-----------------------------------------------------------------------------|-------|-----------|