STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/31/2025

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 a State Residential Licensure Survey. Survey dates: January 30 and 31, 2025 Facility number: 014241 Residential Census: 98 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 2/10/2025	R 0000		
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.	R 0116	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 provided to all hiring	02/28/2025

	Based on record review and interview, the facility failed to ensure employee records included documented references for 4 of 5 staff members reviewed for employee records (QMA 6, Server 8, ADON & CNA 9). Finding includes: On 1/31/2025 at 10:16 A.M., a review of employee records was completed. The employee file records lacked documentation references were completed for QMA 6, Server 8, ADON and CNA 9. During an interview, on 1/31/2025 at 11:40 A.M., the Business Office Manager (BOM) indicated the employees there should have been references completed for QMA 6, Server 8, the ADON and CNA 9. On 1/31/2025 at 1:30 P.M., a policy was requested regarding employee references and one was not provided prior to the survey exit. Based on record review and interview, the facility failed to ensure employee records included documented references for 4 of 5 staff members reviewed for employee records (QMA 6,		managers on 2/13/25 on all required documents needed for new hires. 4/designee will audit all current employee files using State Employee File Checklist audit form (attachment 1). Any/all missing documents will be collected and added to the file. Any/all new hires will have file Checklist audit form completed and added to upon hire. 5. Practice will be completed for six months and further if deficient practice continues.	

	Server 8, ADON & CNA 9). Finding includes: On 1/31/2025 at 10:16 A.M., a review of employee records was completed. The employee file records lacked documentation references were completed for QMA 6, Server 8, ADON and CNA 9. During an interview, on 1/31/2025 at 11:40 A.M., the Business Office Manager (BOM) indicated the employees there should have been references completed for QMA 6, Server 8, the ADON and CNA 9. On 1/31/2025 at 1:30 P.M., a policy was requested regarding employee references and one was not provided prior to the survey exit.			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations:	R 0119	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 provided to all hiring managers on 2/13/25 on all required documents needed for	02/28/2025

	(A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to		new hires. 4/designee will audit all current employee files using State Employee File Checklist audit form (attachment 1). Any/all missing documents will be collected and added to the file. Any/all new hires will have file Checklist audit form completed and added to upon hire. 5. Practice will be completed for six months and further if deficient practice continues.	

	ensure employee records included job specific orientation documentation for 1 of 5 staff members reviewed for employee records (CNA 9). Findings include: 1. On 1/31/2025 at 11:10 A.M., an employee record review was completed for CNA 9. CNA 9 was hired on 4/24/2024. The record lacked documentation CNA 9 had completed a job specific orientation after she was hired. During an interview on 1/31/2025 at 11:40 A.M., the BOM indicated there was no job specific orientation documentation for CNA 9. On 1/31/2025 at 1:30 P.M., a policy was requested regarding job specific orientations and one was not provided prior to the survey exit. Based on record review and interview, the facility failed to ensure employee records included job specific orientation documentation for 1 of 5 staff members reviewed for employee records (CNA 9). Findings include:			

	1. On 1/31/2025 at 11:10 A.M., an employee record review was completed for CNA 9. CNA 9 was hired on 4/24/2024. The record lacked documentation CNA 9 had completed a job specific orientation after she was hired. During an interview on 1/31/2025 at 11:40 A.M., the BOM indicated there was no job specific orientation documentation for CNA 9. On 1/31/2025 at 1:30 P.M., a policy was requested regarding job specific orientations and one was not provided prior to the survey exit.			
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	R 0120	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 staff to be re-educated on 2/26/25 on requirements of continued education. Any staff found non-compliant will be re-educated and disciplined per facility policy.	02/28/2025

	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 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 staff members received dementia training annually for 1 of 5 staff members reviewed for staff education and training. (Cook 7)		4 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.	

	Finding includes: On 1/31/2025 at 11:30 A.M., a review of the employee records was completed. The employee record for Cook 7 lacked documentation an annual dementia training education had been completed. During an interview, on 1/31/2025 at 11:40 A.M., the BOM indicated Cook 7 had not completed the required annual dementia training education. On 1/31/2025 at 1:30 P.M., a policy was requested regarding annual dementia training and one was not provided prior to the survey exit. Based on record review and interview, the facility failed to ensure staff members received dementia training annually for 1 of 5 staff members reviewed for staff education and training. (Cook 7) Finding includes: On 1/31/2025 at 11:30 A.M., a review of the employee records was completed. The employee record for Cook 7 lacked documentation an annual dementia training education had been completed. During an interview, on 1/31/2025 at 11:40 A.M., the BOM indicated Cook 7 had not completed the required annual			

	dementia training education. On 1/31/2025 at 1:30 P.M., a policy was requested regarding annual dementia training and one was not provided prior to the survey exit.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of	R 0121	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 provided to all hiring managers on 2/13/25 on all required documents needed for new hires. 4/designee will audit all current employee files using State Employee File Checklist audit form (attachment 1). All staff found to be non-compliant with health screening protocol to have screening completed by DON. Any/all new employees to be seen by DON prior to working with residents to complete screening. All staff will then annually have screening completed during the same month, (2026). 5. Practice will be completed for	02/28/2025

	infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure staff members received tuberculosis (TB) 2nd step testing upon hire and TB annual risk assessments for 5 of 5 staff members reviewed for employee records (QMA 6, Cook 7, Server 8, ADON & CNA 9). Finding includes: On 1/31/2025 at 10:16 A.M., a review of employee records was completed. An employee record review indicated QMA 6 was hired on 10/20/2023 and Cook 7 was hired on 10/25/2023. The files lacked documentation either		six months and further if deficient practice continues.	

	employees had received an annual TB risk assessment. An employee record review indicated Server 8 was hired on 10/2/2024, the ADON was hired on 7/1/2024 and CNA 9 was hired on 4/24/2024. The records lacked documentation Server 8, the ADON and CNA 9 received their 2nd step TB testing upon hire. During an interview, on 1/31/2025 at 11:56 A.M., the DON indicated QMA 6, Cook 7, Server 8, the ADON and CNA 9 should have had their TB 2nd step testing and/or TB annual risk assessments completed. On 1/31/2025 at 1:30 P.M., a policy was requested regarding TB 2nd step testing an annual TB risk assessments and one was not provided prior to the survey exit. Based on record review and interview, the facility failed to ensure staff members received tuberculosis (TB) 2nd step testing upon hire and TB annual risk assessments for 5 of 5 staff members reviewed for employee records (QMA 6, Cook 7, Server 8, ADON & CNA 9). Finding includes:			

	On 1/31/2025 at 10:16 A.M., a review of employee records was completed. An employee record review indicated QMA 6 was hired on 10/20/2023 and Cook 7 was hired on 10/25/2023. The files lacked documentation either employees had received an annual TB risk assessment. An employee record review indicated Server 8 was hired on 10/2/2024, the ADON was hired on 7/1/2024 and CNA 9 was hired on 4/24/2024. The records lacked documentation Server 8, the ADON and CNA 9 received their 2nd step TB testing upon hire. During an interview, on 1/31/2025 at 11:56 A.M., the DON indicated QMA 6, Cook 7, Server 8, the ADON and CNA 9 should have had their TB 2nd step testing and/or TB annual risk assessments completed. On 1/31/2025 at 1:30 P.M., a policy was requested regarding TB 2nd step testing an annual TB risk assessments and one was not provided prior to the survey exit.			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear	R 0296	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice.	02/28/2025

	written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review and interview, the facility failed to ensure narcotics were counted and documented every shift for 3 of 3 narcotic count log books reviewed. (1st floor, 2nd floor & 3rd floor) Findings include: 1. During a medication storage observation, on 1/31/2025 at 11:15 AM. with QMA 4, on the 1st floor, the following was observed: - the narcotic shift count sheets lacked 4 nursing staff signatures from 1/17/2025 to 1/30/2025, to show the narcotic count had been completed between the oncoming and the off going nursing staff members 2. During a medication storage observation, on 1/31/2025 at 11:25 A.M. with QMA 5, on the 2nd floor, the following was observed: - the narcotic shift count sheets lacked 8 signatures, from 1/17/2025 to 1/30/2025, to show the narcotic count had been completed between the oncoming and the off going nursing staff members.		2 residents could have been affected, however in this case, no residents were affected. 3 nursing staff in-service to be completed 2/26/25in regard to community's policy on Medication Administration (MED- 06) (attachment 2 Controlled Substance Management (MED-11) (attachment 3 Any staff found non-compliant will be re-educated and disciplined per facility policy. 4.DON/Designee will audit narcotic counts sheets 5x week x4 weeks, then 3x weekly for 4 weeks, then weekly x 4 months to ensure procedure completed per policy for proper documentation. Results of audits will be brought to Director weeklyfor review and/or recommendations for six months and further if deficient practice continues. (attachment 4)	

	3. During a medication storage observation, on 1/31/2025 at 11:33 A.M. with QMA 3, on the 3rd floor, the following was observed: - the narcotic shift count sheets lacked 4 signatures from 1/12/2025 to 1/22/2025, to show the narcotic count had been completed between the oncoming and the off going nursing staff members On 1/31/2025 at 12:47 P.M., the Director of Nursing provided a policy titled, "Controlled Substance Management", dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy indicated: "... Controlled Substance Shift Counts: 1. Shift counts are performed at the end of each shift or when the person responsible for medications changes... Whenever a QMA or licensed nurse leaves the floor and another QMA or licensed nurse is responsible to med's, a complete count will take place by the person going off the cart and the person coming on the cart...." Based on observation, record review and interview, the facility failed to ensure narcotics were counted and documented every shift for 3 of 3 narcotic count log books reviewed. (1st floor, 2nd floor & 3rd floor)			

	Findings include: 1. During a medication storage observation, on 1/31/2025 at 11:15 AM. with QMA 4, on the 1st floor, the following was observed: - the narcotic shift count sheets lacked 4 nursing staff signatures from 1/17/2025 to 1/30/2025, to show the narcotic count had been completed between the oncoming and the off going nursing staff members 2. During a medication storage observation, on 1/31/2025 at 11:25 A.M. with QMA 5, on the 2nd floor, the following was observed: - the narcotic shift count sheets lacked 8 signatures, from 1/17/2025 to 1/30/2025, to show the narcotic count had been completed between the oncoming and the off going nursing staff members. 3. During a medication storage observation, on 1/31/2025 at 11:33 A.M. with QMA 3, on the 3rd floor, the following was observed: - the narcotic shift count sheets lacked 4 signatures from 1/12/2025 to 1/22/2025, to show the narcotic count had been completed between the oncoming and the off going nursing staff members			

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R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of	R 0356	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 of all current resident charts to be completed by DON/designee to ensure all required documentation is present for emergency binder. Any chart found to be lacking appropriate charting will be updated and added to binder.	02/28/2025

	record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review, observation and interview, the facility failed to ensure emergency information binders were accurate and complete with all required resident information for 19 of 98 residents. Findings include: 1. The emergency binder for the 1st floor was reviewed on 1/31/2025 and indicated the following: - The resident information lacked a picture and a hospital preference for four residents who resided on the first floor. 2. The emergency binder for the 2nd floor was reviewed on 1/31/2025 and indicated the following: - The resident information lacked a picture and/or a		4.DON/Designee will audit emergency binders monthly starting March 2025 to ensure all appropriate documentation can be found in emergency binder. Audit will be completed for six months and further if deficient practice continues.	

hospital preference for seven residents who resided on the second floor.

3. The emergency binder for the 3rd floor was reviewed on 1/31/2025 and indicated the following:

- The resident information lacked a picture and/or hospital preference for 8 residents who resided on the third floor

During an interview, on 1/31/2025 at 12:45 P.M., the Director of Nursing indicated the face sheets in the emergency binder should have had pictures and hospital preferences listed.

On 1/31/2025 at 1:29 P.M. the Administrator indicated the facility did not have a policy for emergency binders.

Based on record review, observation and interview, the facility failed to ensure emergency information binders were accurate and complete with all required resident information for 19 of 98 residents.

Findings include:

1. The emergency binder for the 1st floor was reviewed on 1/31/2025 and indicated the following:

- The resident information lacked a picture and a hospital

	preference for four residents who resided on the first floor. 2. The emergency binder for the 2nd floor was reviewed on 1/31/2025 and indicated the following: - The resident information lacked a picture and/or a hospital preference for seven residents who resided on the second floor. 3. The emergency binder for the 3rd floor was reviewed on 1/31/2025 and indicated the following: - The resident information lacked a picture and/or hospital preference for 8 residents who resided on the third floor During an interview, on 1/31/2025 at 12:45 P.M., the Director of Nursing indicated the face sheets in the emergency binder should have had pictures and hospital preferences listed. On 1/31/2025 at 1:29 P.M. the Administrator indicated the facility did not have a policy for emergency binders.			
R 0379	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(c) (c) If a person is a recipient of Medicaid or federal SSI and has a	R 0379	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice.	02/28/2025

	major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record. Based on record review and interview, the facility failed to ensure a comprehensive care plan for major mental illness was completed for 1 of 7 residents reviewed for care plans (Resident 6) Finding includes: The record for Resident 6 was reviewed on 1/31/2025 at 10:41 A.M. Diagnoses included, but were not limited to: panic disorder and major depressive disorder. The current Physician's Orders included the medication venlafaxine (an antidepressant medication) 75 milligrams (mg) extended release capsule taken by mouth once per day and clonazepam (an antianxiety medication) 1 mg tablet taken		2 residents could have been affected, however in this case, no residents were affected. 3 of all current resident charts with major psych diagnosis to be completed by DON/designee to ensure all required interventions are in place and documented. 4.DON/Designee will audit service plans quarterlyafter audit for all with major psych six months and further if deficient practice continues.	

by mouth four times per day.

A current Care Plan regarding psychiatric services, initiated on 5/27/2022, indicated Resident 6 received psychiatric services through (name of a local mental health service provider). Interventions included but were not limited to the following: "mental health needs will be met with assistance from (Names of mental health and general health care providers) provides monthly visits for symptom management and counseling related to panic disorder."

A current Care Plan regarding behavior management, included the following: "...Resident 6 will be able to identify factors/interventions that help to prevent/minimize inappropriate behaviors. Resident often becomes anxious and persevates on specific items. Resident will often approach nursing staff numerous times, requesting multiple blood pressure checks consecutively, or will question repetitively medications. Resident can be difficult to redirect. Interventions included and were limited to: When resident demonstrates anxious behavior, be concise and clear with him. Hear his concerns and readdress or redirect as needed. Resident received mental health service through (Name of Mental Health services provider) Care staff will

report any changes from baseline behaviors...

During an interview, on 1/31/2025 at 11:56 A.M., the DON indicated Resident 6's care plans that addressed his mental health needs were not comprehensive and did not include input from the psychiatric care providers.

On 1/31/2025 at 12:49 P.M., the DON provided a policy titled, "Resident Service Plans," dated 9/30/2022 and indicated it was the policy currently being used by the facility. The policy indicated: "Policy: The community utilizes an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the needs of the resident ...."

Based on record review and interview, the facility failed to ensure a comprehensive care plan for major mental illness was completed for 1 of 7 residents reviewed for care plans (Resident 6)

Finding includes:

The record for Resident 6 was reviewed on 1/31/2025 at 10:41 A.M. Diagnoses included, but were not limited to: panic disorder and major depressive disorder.

The current Physician's Orders

included the medication venlafaxine (an antidepressant medication) 75 milligrams (mg) extended release capsule taken by mouth once per day and clonazepam (an antianxiety medication) 1 mg tablet taken by mouth four times per day.

A current Care Plan regarding psychiatric services, initiated on 5/27/2022, indicated Resident 6 received psychiatric services through (name of a local mental health service provider). Interventions included but were not limited to the following: "mental health needs will be met with assistance from (Names of mental health and general health care providers) provides monthly visits for symptom management and counseling related to panic disorder."

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	anxious behavior, be concise and clear with him. Hear his concerns and readdress or redirect as needed. Resident received mental health service through (Name of Mental Health services provider) Care staff will report any changes from baseline behaviors... During an interview, on 1/31/2025 at 11:56 A.M., the DON indicated Resident 6's care plans that addressed his mental health needs were not comprehensive and did not include input from the psychiatric care providers. On 1/31/2025 at 12:49 P.M., the DON provided a policy titled, "Resident Service Plans," dated 9/30/2022 and indicated it was the policy currently being used by the facility. The policy indicated: "Policy: The community utilizes an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the needs of the resident ...."				

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