STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/23/2026

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 Investigation of Intakes 470156, 470231,470245 470253, 470300, and 470303. Intake 470156 - State deficiencies related to the allegations are cited at R0407. Intake 470231 - State deficiencies related to the allegations are cited at R0407. Intake 470245 - State deficiencies related to the allegations are cited at R0407. Intake 470253 - State deficiencies related to the allegations are cited at R0407. Intake 470300 - State deficiencies related to the allegations are cited at R0407. Intake 470303 - State deficiencies related to the allegations are cited at R0407. Survey date: June 23, 2026	R 0000		

	Facility number: 014241 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 25, 2026			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed to maintain an effective infection control program related to identification, treatment, and monitoring of a bed bug infestation. 1 of 3 residents	R 0407	1. All residents could have been affected, however in this case, no other residents were affected. 2. All staff in-service completed 7/1/2026 regarding community's updated bed bug policy for identifying, reporting, preparing and follow-up. Any staff found non-compliant will be re-educated and disciplined per facility policy. 3. Maintenance Director will review Bed Bug tracking log daily x5 days/week for one month, then weekly going forward to ensure procedure completed per policy for any bed bug activity. Bed Bug Incident Report for all staff are in the Tracking Binder located at the front desk, in all nurse’s stations, and with management. Tracking logs will be brought to Executive Director weekly for review and/or recommendations	07/08/2026

reviewed experienced presumed bedbug bites requiring treatment from a specialist (Resident O).

Findings include:

On 6/23/26, at various times during the survey, staff were observed wearing shoe/ankle/calf covers on their feet and getting onto the elevator to go up to resident rooms. Another employee was observed wearing a full hazmat suit while going into a resident room to remove a chair. Numerous isolation carts with drawers were observed outside resident rooms on one hallway on the 2nd floor of the facility. On the door frames was a letter to the resident from corporate staff explaining the current situation with bed bugs in the facility.

During an interview, on 6/23/26 at 1:30 P.M., Resident O's family member indicated they reported to staff concerns with the resident having bug bites and allegedly seeing bed bugs in the resident's room. The family member indicated they obtained a 3rd party pest control inspector to look at the resident's room after not receiving a timely response from the facility. The inspection done on 6/12/26 was positive for live bedbugs found in the resident's room near a laundry hamper

and on a blanket on her recliner chair. Her room was treated and family provided with a service report. The report indicated the pest control inspector's professional report included the bedbugs had been in the room "for several months at least". The family member provided copies of text messages from the resident complaining of finding bedbugs on her skin, being bitten, and family's exchanges with corporate staff via emails.

A Dermatologist visit note, dated 6/9/26, indicated Resident O had been seen for a rash on her arms, legs, and trunk. The rash was itchy, red, and present for several months. She was diagnosed with papular urticaria (itchy rash), a common condition caused by a hypersensitivity reaction to insect bites. The doctor was unable to determine the specific type of insect by appearance of the bites but with the distribution of the rash, history and living in an assisted living facility, he indicated he would favor bed bug bites. The doctor "strongly" encouraged the resident's apartment be inspected and treated by an exterminator. She was prescribed a topical cream and advised to use an antihistamine for itching.

Pest Control Service Reports,

provided by the Administrator on 6/23/26 at 3:45 p.m., indicated the following:

-5/13/26, indicated 5 resident rooms were inspected with 4 rooms being treated for bed bugs. The report indicated the 4 rooms treated had been poorly prepped prior to inspection. The inspector indicated the 4 rooms were "messy, cluttered, and needed cleaned up" for a thorough inspection and applied treatment to be effective .

There were no Pest Control Service Reports provided between 5/13/26 and 6/5/26.

-On 6/5/26, 16 resident rooms were inspected and treated. The report, provided by the facility, hadn't indicated if live bedbugs had been found, if rooms were being re-treated, were newly discovered, or the pre-treatment condition of the rooms.

-6/8/26, according to the Administrator was the final visit by the Pest Control Service prior to the new one, indicated a new infestation was found in a room not treated at previous visits.

-6/20/26, indicated the newly contracted Pest Control Service had been in and inspected 8 rooms, finding live bed bugs in 2 of the rooms. The 2 rooms where live bed bugs were found were treated on 6/5/26. A

recommendation was made to remove the recliner chair from one of the rooms treated due to heavy infestation.

On 6/23/26 at 1:05 P.M., the Environmental Service Director was interviewed. He indicated the facility had just changed pest control service providers and going forward, he would be responsible for contacting the provider and ensuring timely follow up. He indicated he removed the recliner chair on this day, as recommended on 6/20/26 for the heavily infested chair. He indicated there was no resident in the room where the recliner chair had been and the resident had been relocated on 6/3/26 and her recliner chair left in her room which was next to Resident O's room.

On 6/23/26 at 3:53 P.M., the Administrator was interviewed. She indicated staff had not kept track of where bedbug infestations were at the facility and had relied on the Pest Control Service to monitor and track where infestations were, when they were treated, and when re-inspections were due and completed. She nor nursing staff had used the tracking log provided by the previous Pest Control Service as they hadn't had access to it. When asked about pre-treatment activities, she indicated staff were to

provide instructions for prepping the room for treatment but were not responsible for physically preparing the rooms. Residents were expected to prepare their rooms for treatment. Additionally, residents were expected to immediately report infestations, follow all pest control instructions, and maintain good housekeeping. The Administrator indicated a new Bed Bug Policy was put in place beginning June 19, 2026, and provided a copy of the new policy.

The Bed Bug Policy, initiated 6/19/26, indicated the following: The facility would utilize appropriate infection control and prevention when dealing with bed bugs. When bed bugs were identified, Pest Control Services would be immediately notified and timely visit made. When bed bugs were suspected or confirmed, the resident would be cared for using "Contact Precautions". Staff were to remove all linens from the bed and place in plastic bags for transport to the laundry and washed and dried in temperatures exceeding 120 degrees. The bed mattress was to be removed from the bed and stood on end to end on one side of the bed and box springs removed and stood up on the other side of the bed. All drawers were to be removed

	from the dresser and nightstands. Rooms were to be vacuumed and bags replaced and discarded. After treatment of the room, housekeeping staff would clean the room. Treatment was to include rooms adjacent to rooms where infestations were found. Staff were responsible for opening up an Infection Control Event on the electronic health record for presence of or suspicion of bed bugs for ongoing monitoring and surveillance. The Director of Nursing would be responsible for tracking residents with infestations and closing the Event after the case had been resolved. The bedbug policy had not addressed the residents' clothing or personal items in the room and what pre-treatment preparation was to be done or who was responsible. This Citation relates to Intakes 470156, 470231,470245 470253, 470300, and 470303.			

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) DATE07/09/2026