Susan Huttel

PRINTED: 12/12/2024 FORM APPROVED OMB NO. 0938-039

12/06/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/07/2024	
	ROVIDER OR SUPPLIEF		1540 S	ADDRESS, CITY, STATE, ZIP COD OUTH LOGAN STREET WAKA, IN 46544	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0000					
Bldg. 00	IN00443940, IN004IN00436132.  Complaint IN00442 to the allegations are complaint IN00443 to the allegations are complaint IN00438 to the allegations are complaint IN00438 to the allegations are Survey date: Nover Facility number: 01	8450 - State deficiencies related re cited at R0242. 6132 - State deficiencies related re cited at R0241 and R0247. 6136 - State deficiencies related re cited at R0241 and R0247. 6136 - State deficiencies related re cited at R0241 and R0247.	R 0000		
	Residential Census  These State Resider accordance with 41	ntial Findings are cited in			
	Quaity Reviw comp	pleted on 11/15/2024			
R 0241 Bldg. 00	410 IAC 16.2-5-4( Health Services -				
	failed to administer physician for 3 of 3	and record review, the facility medications as ordered by the residents reviewed for tration, (Residents B, C & D).	R 0241	="" p="" 1 corrections=""> ="" p="">1. Corrections of previous time frames can not made. No residents were affe by the alleged deficient practic ="" p="">2. All residents could have been affected, however	cted ce. d
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: 7NLW11 Facility ID: 014224 If continuation sheet Page 1 of 16

**Executive Director** 

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED	
			B. WI	NG		11/07/2024	
		<u> </u>	<del></del>	CTDEET 4	ADDRESS SITV STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD OUTH LOGAN STREET		
		OF MICHANAZA					
MELLENI	IC SENIOR LIVING	OF MISHAWAKA		MHCINI	WAKA, IN 46544		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1. On 11/6/24 at 3:	05 P.M., Resident B's clinical			case, no residents were affect	ed.	
	record was reviewed. Diagnoses included but				3. All nursing staff in-service		
	were not limited to:	glaucoma, urinary tract			completed 11-14-24 in regards	s to	
	infection ( 10/5/24)	, shortness of breath,			community's policy on Medica	tion	
	depression, dement	ia, gastro-esophageal reflux			Administration, proper		
	disease, bone densi	ty disorder, atherosclerotic			documentation and notificatior	n of	
		active bladder, hyperlipidemia,			provider. Any staff found		
	chronic kidney dise	ease, and neuropathy.			non-compliant will be re-educa	ated	
					and disciplined per facility poli	су.	
		vice Plan, dated 3/6/23 and			4. DON/Designee will audit		
	revised on 10/3/24, indicated the resident required				EMAR documentation 2x daily	′ x5	
	assistance for medi-	cation administration.			days a week x4 weeks, then d	aily	
					5x week x8 weeks, then 3x		
	The current Physici	ian's Orders for medications			weekly for 3months, to ensure		
	included:				procedure completed per polic	y for	
		lminister medications, initiated			proper medication administrati	ion	
	on 3/6/23,				and documentation. Results o	f	
		0 mg tablet before meals for			audits will be brought to Execu		
	reflux disease, initia				Director weekly for review and		
		00 mg capsule two times daily			recommendations for six mont		
	•	ection, initiated on 9/24/24,			and further if deficient practice	:	
		tablet daily for heart disease,			continues.		
	initiated on 3/7/23,				="" p="">		
		00 mg-5 mg tablet two times					
	•	ity, initiated on 3/6/24,					
		ivitamin tablet daily for chronic					
	kidney disease, init						
	-	n 500 mg tablet three times					
		k pain, initiated on 3/6/23,					
		5 mg tablet one time daily for					
	-	ease, initiated on 3/3/23,					
	-	mg tablet every evening for					
	dementia, initiated						
		ssium 100 mg tablet every					
		ension, initiated on 3/3/23,					
		0 mg tablet daily for					
	hyperlipidemia, init						
		mg tablet daily for overactive					
	bladder, initiated or	n 3/3/23.					

State Form Event ID: 7NLW11 Facility ID: 014224 If continuation sheet Page 2 of 16

PRINTED: 12/12/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED  11/07/2024
	PROVIDER OR SUPPLIER		1540 S	ADDRESS, CITY, STATE, ZIP COD OUTH LOGAN STREET WAKA, IN 46544	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	11/6/24, indicated the prescribed medication times: Cimetidine 300 mg disease, 9/1/24 at 7: 9/14/24 at 4:00 P.M. A.M., 9/25/24 at 4:0 and 9/27/24 at 11:00 4:00 P.M., 10/8/24 at 10/24/24 - 10/27/24 -10/31/24 at 4:00 P. at 4:00 P. m., 11/6/2  Doxycycline 100 mg urinary tract infection administered 9/24/2  Aspirin 81 mg table 9/23/24 at 6:00 A.M. Calcium/D3 600 mg 9/1/24 at 6:00 A.M. 6:00 A.M., 9/25/24  Certavite multivitant A.M.,  Acetaminophen 500 9/1/24 at 6:00 A.M. P.M., 9/14/24 at 8:00 A.M. P.M., 9/14/24 at 8:00 P. 10/12/24 at 8:00 P. 10/12/24 at 8:00 P. 10/12/24 at 8:00 P. 10/12/24 at 8:00 P.	ords (MAR), from 9/1/24 to the resident did not receive the ons on the following dates and tablet before meals for reflux 00 A.M. and 11:00 A.M., 1., 9/24/24 at 7:00 A.M. and 11:00 00 P.M., 9/26/34 at 4:00 P.M., 10/6/24 at at 11:00 A.M., 10/10/24 at 4:00 00 P.M., 10/22/24 at 4:00 P.M., at 4:00 P.M. and 10/29/24 M.,11/2/24 at 4:00 P.M., 11/5/24 4 at 4:00 P.M. at 4:00 P.M. at 4:00 P.M. at 4:00 P.M., 11/5/24 at 4:00 P.M., 11/5/24 at 4:00 P.M. at			

State Form Event ID: 7NLW11 Facility ID: 014224 If continuation sheet Page 3 of 16

PRINTED: 12/12/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/07/2024			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	Clopidogrel 75 mg 6:00 A.M.	tablet one time daily, 9/23/24 at					
	2:00 P.M., 9/25-9/2 P.M., 10/10/24-10/ 2:00 P.M., 10/24/24 10/29/24-10/31/24 Losartan Potassium 9/14, 25, 26, and 27	ablet every evening, 9/14/24 at 2:00 P.M., 1/6/24 at 2:00 11/24 at 2:00 P.M., 10/22/24 at 4-10/27/24 at 2:00 P.M., at 2:00 P.M., 11/2/24 at 2:00 P.M. 11/2/24 at 2:00 P.M. 100 mg tablet every evening, 7/24 at 2:00 P.M., 10/6,10,11, 22, 30, and 31/24 at 2:00 P.M.					
	Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.						
	Fesoterodine 4 mg 6:00 A.M.	tablet daily 9/1/24, 9/23/24 at					
	Resident B indicate her medications and The resident indicate medications were a was not able to take	ov on 11/7/24 at 1:03 P.M., and she did not always receive did very often received them late. ted, at times, the morning dministered too late and she te them with the noon te the administrations times ther.					
	record was reviewe were not limited to: squamous cell carci hyperlipidemia, rad gastro-esophageal r	51 P.M., Resident C's clinical d. Diagnoses included but hypertension, arthritis, inoma to the face, liculopathy of lower back, reflux disease, tremor, macular density disorder, and edema.					
	revised on 4/17/24,	rice Plan dated 2/20/23 and indicated the resident required cation administration.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMP	E SURVEY PLETED 7/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	included, One Lorsartan Pota hypertension, initial One Pantoproazoe 2 Gastro-esophageal 1 One Pravastatin 20 hyperlipidemia, init One Propranolol 40 hypertension, initial Review of Resident Administration Rec 11/6/24, indicated t prescribed medicati times:  Lorsartan Potassium 9/30/24, 10/2/24-10 11/1/24-116/24, at 1:  Pantoproazoe 40 m; 9/18/24 at 6:00 A.M.  Pravastatin 20 mg t 9/16/24, 9/18/24, 9/  Propranolol 40 mg t 9/16/24, 9/18/24 at 9:0 9/23/24 at 9:00 2:00 9:00 P.M., 9/15/25 P.M., 9/18/24 at 9:0 9:00 P.M., 9/28/24 P.M., 10/1/24 at 9:0 10/6/24 at 9:00 P.M. 10/15/24 at 9:00 P.M. 10/15/24 at 9:00 P.M. 10/15/24 at 9:00 P.M. 10/22/24 at 9:00 P.M. P.M., 10/27/24 at 9	at mg tablet daily for reflux, initiated on 8/22/22, mg tablet daily at bedtime for riated on 3/19/24, mg tablet 3 times daily for ted on 3/19/24, and the constant of the constant of the resident did not receive the ons on the following dates and an 50 mg tablet daily, 9/22/24 - 1/31/24 at 5:00 A.M., 5:00 A.M.,						

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PRINTED: 12/12/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
			B. WING 11/07/2024				
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	3			OUTH LOGAN STREET		
HELLENI	C SENIOR LIVING	OF MISHAWAKA			NAKA, IN 46544		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·		PR	PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRIES.)			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		0/31/24 at 2:00 P.M., 9:00 P.M.,					
		1., 11/4/24 at 9:00 P.M., 11/5/24					
	at 9:00 P.M., 11/6/2	24 at 9:00 P.M.					
	During an interview on 11/7/24 at 12:11 P.M.						
	_	ed there had been one or two					
	times when her med	dications were administered					
	late.						
	3. On 11/7/24 at 10	0:10 A.M., Resident D's clinical					
		ed. Diagnoses included but					
	were not limited to: schizo-affective disorder,						
	insomnia, type 2 diabetes, hyperlipidemia,						
	• •	on, anxiety, panic disorder,					
	epilepsy, chronic pa						
	osteoarthritis, edem	na and low back pain.					
	The Resident's Serv	vice Plan dated 8/21/23 and					
		ndicated the resident required					
		cation administration.					
	The current Physici	ian's Orders for medications					
	included,	ian's Orders for medications					
	· · ·	ng tablet daily at bedtime for					
		sorder, initiated on 9/3/24,					
		ng tablet, 1/2 tablet at bedtime					
	for insomnia, initiat	-					
		CDUAG 1' C					
	Review of Resident						
		cords (MAR), from 9/1/24 to					
	· ·	the resident did not receive the					
	times:	ions on the following dates and					
	umes.						
	Olanzapine 5 mg ta	blet daily at bedtime, 9/4/24,					
	9/10/24, 9/14/24, 9/	/15/24, 9/25/25/ 9/26/24/ 9/28/24					
		, 10/12/24, 10/15/24, 1022/24,					
	· ·	, 10/26/24, 10/27/24, 10/29/24,					
		, 11/1/24, 11/5/24, 11/6/24, at 8:00					
	P.M.						

State Form Event ID: 7NLW11 Facility ID: 014224 If continuation sheet Page 6 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/07/2024			
	PROVIDER OR SUPPLIE	R G OF MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION			
TAG	Trazadone 50 mg t 9/1/24, 9/6/24, 9/10 9/24/24, 9/25/24, 9/31/24, 10/10/24, 10/26/24, 10/27/24 11/5/24, at 9:00 P.I. During an interview Director of Nursing medications admin concern at the facil received inservices of medications but document medicatin facility's policy.  On 11/6/24 at 4:05 Clinical Operations "Medication Adminidicated it was the administration poli administration of n by the resident's phadministration imm	w on 11/6/24 at 12:44 P.M., the g indicated documentation of istration has been an ongoing ity. She indicated staff had related to the documentation continued to neglect to on administration per the  P.M., the Regional Director of a proved the policy titled, mistration," dated 8/27/24 and e current medication cy. The policy indicated the nedications shall be as ordered sysician and document the nediately after administration.  In the policy indicated the nediately after administration.	TAG	DEFICIENCY	DATE		
Bldg. 00	Health Services - Based on interview failed to follow phy Blood Pressure (B/		R 0242	="" p="" 1=""> ="" p="" 1=""> ="" p="">1. Corrections of previous time frames can not	12/06/2024 be		
	Findings include:  1. On 11/6/24 at 11	:56 A.M., a review of the clinical		made. No residents were affer by the alleged deficient praction ="" p="">2. All residents could have been affected, however	ce. d		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	a. Building <u>00</u>			COMPLETED	
			B. WI			11/07		
							<b>-</b> ·	
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
			1540 SOUTH LOGAN STREET					
HELLENI	IC SENIOR LIVING	G OF MISHAWAKA		MISHAWAKA, IN 46544				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	record for Residen	t C was conducted. The			case, no residents were affec	ted.		
	resident's diagnoses included, but were not				3. All nursing staff in-service			
	limited to: hypertension and arthritis.  A Physician's Order, dated 7/1/24, indicated the				completed 11-14-24 in regard	ls to		
					community's policy on Medica	ation		
					Administration, proper			
	physician had orde	red losartan (medication used			documentation and notificatio	n of		
		pressure) 25 mg (milligrams),			provider. Staff educated to			
	-	and to obtain a B/P assessment			accurately complete all provid	ler		
	with the medication				orders with any/all supplemer			
					documentation in the EMAR a	-		
	A Nursing Progress Order Note, dated 7/4/24 at				ordered. Any staff found			
	4:24 P.M., indicated an order was received for				non-compliant will be re-educ	ated		
	losartan 25 mg, one tablet a day for hypertension,				and disciplined per facility pol			
	but the note did not include the physician's order				4. div	,.		
	to administer the medication at bedtime or to take				p="" > DON/Designee will aud	dit		
	the resident's B/P.				EMAR documentation or any/			
					supplementary documentation			
	A Nursing Progres	s Order Note, dated 7/9/24 at			blood pressures, 2x daily x5 d			
		ed to administer losartan 25 mg			a week x4 weeks, then daily 5	-		
		The note did not include the			week x8 weeks, then 3x week			
	B/P assessment ord				for 3months, to ensure proced	-		
					completed per policy for prope			
	A Nursing Progres	s Order Note, dated 7/18/24 at			medication administration and			
		ed losartan 25 mg at bedtime for			documentation. Results of au			
	· ·	HECK BLOOD PRESSURE			will be brought to Executive	aito		
	DAILY"	LEGIT BLOOD I RESSURE			Director weekly for review and	d/or		
	<i>Di</i> IIE i				recommendations for six mon			
	The Medication A	dministration Record (MAR) for			and further if deficient practice			
		d staff started documenting			continues.	•		
		out did not document a B/P			="" p="">			
	assessment on 7/20				="" p="">			
	assessment on //20	, una ,/22/2 1.			- <b>γ-</b> ΄			
	The MAR for Aug	ust 2024 indicated staff did not						
	_	lent's B/P on the following						
		, 8/13 and 8/30. On 8/7, 8/12,						
		nad been documented as "N/A"						
	without an explanation as to why the B/P had not							
	been obtained as or	-						
	occir obtained as of	140104.						
	During an interview	w, on 11/7/24 at 12:14 P.M., the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETE				
			B. WIN	G		11/07/2024	
NAME OF F	ROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD		
					OUTH LOGAN STREET		
HELLEN	C SENIOR LIVING	OF MISHAWAKA		MISHAV	NAKA, IN 46544		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRE			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	_	g (DON) indicated the resident					
	had been taking her own blood pressures but understood the physician had ordered the B/P's to						
		readings would need to be					
		MAR. The DON provided a					
	booklet with the res	sident's handwritten blood					
	pressure assessmen	ts. The booklet indicated the					
		re started on 7/24/24. There					
		taff were aware of the					
		ssure assessments daily nor					
	were they documenting the blood pressure assessments in the MAR as ordered.						
	assessments in the	WAR as ordered.					
	2. On 11/6/24 at 11	:56 A.M., a review of the clinical					
		D was conducted. The					
	resident's diagnoses	s included, but were not					
	limited to: hyperten	sion and dementia.					
	A Nursing Progress	s Note, dated 10/8/24 at 7:50					
		resident's B/P was 187/100 and					
		t receiving any blood pressure					
		ote indicated the Nurse					
	Practitioner (NP) ha	ad been contacted and had					
		t to be taken to a nearby					
	hospital for an eval	uation					
	A Nursing Progress	s Note, dated 10/9/24 at 7:49					
		NP has evaluated the resident					
	· · · · · · · · · · · · · · · · · · ·	d her assessment and given					
	some orders for the	_					
		1 . 140/0/04					
	<u> </u>	r, dated 10/9/24, indicated					
		ly in AM - Document on PCC", the electronic chart.					
	[1 OIIII CHEK Care]	, the electronic chart.					
	A Nursing Progress	Note, dated 10/14/24 at 11:10					
		NP had seen the resident and					
	new orders were gi	ven to obtain the resident's					
	blood pressure, dail	ly.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
			B. WING 11/07/2024				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI		E COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE		
	pressures had been 10/12, 10/14, 10/17 10/31/24.	per 2024, indicated no blood obtained on 10/9, 10/10, 10/11, , 10/25, 10/26, 10/27 and					
		ember 2024 indicated no blood obtained on 11/1, 11/2 and					
	On 11/6/24 at 4:05 P.M., the Regional Director of Clinical Services provided a policy titled, "Medication Administration", dated 8/27/24, and indicated the policy was the one currently used by the facility. The policy indicated "22 j) Check blood pressure and/or pulse before administrating any medications with orders to monitor and hold medication if beyond ordered high/low parameters. k) Document vital signs and administration immediately after administration refusal will be documented in on the residents EMAR [Electronic Medication Administration Record]"						
R 0247	410 IAC 16.2-5-4(	e)(7)					
	Health Services -	Deficiency					
Bldg. 00	failed to ensure the of 3 residents review administration did rordered or refused rphysician (Resident Findings include:  1. On 11/6/24 at 3:	not receive medications as medications as ordered by the	R 0247	div p="">1. Corrections of previous time frames can not be mad residents were affected by the alleged deficient practice. div p="" 1="" practice. <="" div1 div p="" 1="" practice. <="" div1 div p="">	e. No ne ="">		
		glaucoma, urinary tract		2. All residents could have	peen		
	i		1	1	I		

State Form Event ID: 7NLW11 Facility ID: 014224 If continuation sheet Page 10 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WI	NG	_	11/07/	2024
N	NOT THE COLUMN		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEI	R			OUTH LOGAN STREET		
HELLENI	C SENIOR LIVING	OF MISHAWAKA	_		WAKA, IN 46544		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· · · · · ·	, shortness of breath,			affected, however in this case		
	depression, dementia, gastro-esophageal reflux				residents were affected. 3. Al		
		ty disorder, atherosclerotic			nursing staff in-service comple	eted	
		active bladder, hyperlipidemia,			11-14-24 in regards to		
	chronic kidney dise	ease and neuropathy.			community's policy on Medica	tion	
					Administration, proper		
		vice Plan dated 3/6/23 and			documentation and notification	n of	
	revised on 10/3/24, indicated the resident required				Providers. Any staff found		
	assistance for medi	cation administration.			non-compliant will be re-educa		
					and disciplined per facility poli	cy.	
	The Current Physician's Orders for medications				4.		
	included:				="" p="">		
					div		
		lminister medications, initiated			p="" > DON/Designee will aud		
	on 3/6/23,				EMAR documentation 2x daily	′ x5	
					days a week x4 weeks, then d	aily	
		0 mg tablet before meals for			5x week x8 weeks, then 3x		
	reflux disease, initi	ated on 3/27/23,			weekly for 3months, to ensure	<b>!</b>	
					procedure completed per police	cy for	
		00 mg capsule two times daily			proper medication administrat	ion	
	for urinary tract inf	ection, initiated on 9/24/24,			and documentation. Results o	f	
					audits will be brought to Execu		
		tablet daily for heart disease,			Director weekly for review and	l/or	
	initiated on 3/7/23,				recommendations for six month	ths	
					and further if deficient practice	;	
		00 mg-5 mg tablet two times			continues.		
	daily for bone dens	ity, initiated on 3/6/24,					
		ivitamin tablet daily for chronic					
	kidney disease, init	nated on 3/6/23,					
	-	en 500 mg tablet three times					
	daily for lower back	k pain, initiated on 3/6/23,					
		5 mg tablet one time daily for					
	chronic kidney dise	ease, initiated on 3/3/23,					
	-	mg tablet every evening for					
	dementia, initiated						
	One Losartan Potas	ssium 100 mg tablet every					
					•		

State Form Event ID: 7NLW11 Facility ID: 014224 If continuation sheet Page 11 of 16

PRINTED: 12/12/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/07/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION		
	One Rosuvastatin 1 hyperlipidemia,initi	mg tablet daily for overactive					
	11/6/24, indicated to	B's Medication cords (MAR), from 9/1/24 to the resident did not receive the cons on the following dates and					
	disease, 9/1/24 at 7: 9/14/24 at 4:00 P.M. A.M., 9/25/24 at 4:0 and 9/27/24 at 11:0 4:00 P.M., 10/8/24 P.M., 10/11/24 at 4 10/24/24 - 10/27/24	tablet before meals for reflux :00 A.M. and 11:00 A.M., I., 9/24/24 at 7:00 A.M. and 11:00 00 P.M., 9/26/34 at 4:00 P.M., 0 A.M. and 4:00 P.M., 10/6/24 at at 11:00 A.M., 10/10/24 at 4:00 :00 P.M., 10/22/24 at 4:00 P.M., at 4:00 P.M. and 10/29/24 .M., 11/2/24 at 4:00 P.M., 11/5/24 24 at 4:00 P.M.					
		ng capsule two times daily for on, never documented as $24 - 9/30/24$ .					
	Aspirin 81 mg table 9/23/24 at 6:00 A.M	et daily for heart disease, 1.					
	9/1/24 at 6:00 A.M.	g-5 mg tablet two times daily, ,, 9/14/24 at 2:00 P.M., 9/23/24 at - 9/27/24 at 2:00 P.M.					
	Certavite multivitar A.M.,	min tablet daily, 9/23/24 at 6:00					
	9/1/24 at 6:00 A.M.	0 mg tablet three times daily, and 1:00 P.M., 9/10/24 at 8:00 00 P.M., 9/23/24 at 6:00 A.M.					

State Form Event ID: 7NLW11 Facility ID: 014224 If continuation sheet Page 12 of 16

A BUILDING   QQ   COMPLETED	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE				SURVEY
NAME OF PROVIDER OR SUPPLIER  HELLENIC SENIOR LIVING OF MISHAWAKA  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE (REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  and 1:00 P.M., 9/25/24 at 8:00 P.M., 10/10/24 - 10/12/24 at 8:00 P.M., 10/29/24 - 10/31/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M., 10/24/24 at 8:00 P.M., 10/29/24	AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
1540 SOUTH LOGAN STREET   MISHAWAKA   M 46544			B. WING			11/07	/2024	
1540 SOUTH LOGAN STREET   MISHAWAKA   M 46544				OTE	EET 4	ADDRESS CITY STATE ZIR COR		
MISHAWAKA, IN 46544	NAME OF P	PROVIDER OR SUPPLIER	2					
(X4) ID    SUMMARY STATEMENT OF DEFICIENCIE   FREFIX   GEACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LISC IDENTIFYING INFORMATION   TAG     and 1:00 P.M., 9/25/24 at 8:00 P.M., 9/26/24 at 4:00 P.M., 10/10/24   -10/12/24 at 8:00 P.M., 10/29/24 - 10/31/24 at 8:00 P.M., 10/29/24 - 10/31/24 at 8:00 P.M., 11/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M., 10/29/24-10/31/24 at 8:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 10/22/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.		IC SENIOD I IVINO	OE MISHVWVKV					
PREFIX   CEACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG		OENIOR LIVING	OF MISHAWAKA	IVIIS	эΠA\ 	WANA, IIN 40044		
PREFIX   CRACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
TAG REGULATORY OR LISC IDENTIFYING INFORMATION  and 1:00 P.M., 9/25/24 at 8:00 P.M., 9/26/24 at 4:00  P.M., 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/10/24  - 10/12/24 at 8:00 P.M., 10/29/24 - 10/31/24  at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24  at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24  at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24  at 8:00 P.M., 10/20/27/24 at 2:00 P.M., 16/24 at 2:00  P.M., 10/24-10/11/24 at 2:00 P.M., 16/24 at 2:00  P.M., 10/10/24-10/11/24 at 2:00 P.M., 10/22/24 at 2:00  P.M., 10/24/24-10/27/24 at 2:00 P.M., 10/22/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.  Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION	
P.M., 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/10/24 - 10/12/24 at 8:00 P.M., 10/22/24 at 8:00 P.M., 11/24/24 - 10/27/24 at 8:00 P.M., 11/2/24, 11/5/24, at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M.  Clopidogrel 75 mg tablet one time daily, 9/23/24 at 6:00 A.M.  Donepezil 10 mg tablet every evening, 9/14/24 at 2:00 P.M., 9/25/27 at 2:00 P.M., 1/6/24 at 2:00 P.M., 10/20/24 at 2:00 P.M., 10/20/24 at 2:00 P.M., 10/20/24 at 2:00 P.M., 10/20/24 at 2:00 P.M., 10/29/24 at 2:00 P.M., 10/29/24 at 2:00 P.M., 10/29/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.  Losartan Potassium 100 mg tablet every evening, 9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/24 at 2:00 P.M.  Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC	j	DEFICIENCY)		DATE
- 10/12/24 at 8:00 P.M., 10/22/24 at 8:00 P.M., 10/29/24 - 10/31/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M.  Clopidogrel 75 mg tablet one time daily, 9/23/24 at 6:00 A.M.  Donepezil 10 mg tablet every evening, 9/14/24 at 2:00 P.M., 9/25-9/27 at 2:00 P.M., 1/6/24 at 2:00 P.M., 10/10/24-10/11/24 at 2:00 P.M., 10/22/24 at 2:00 P.M., 10/24/24-10/27/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.  Losartan Potassium 100 mg tablet every evening, 9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/24 at 2:00 P.M.  Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.		and 1:00 P.M., 9/25	5/24 at 8:00 P.M., 9/26/24 at 4:00					
10/24/24 -10/27/24 at 8:00 P.M., 10/29/24 - 10/31/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M.  Clopidogrel 75 mg tablet one time daily, 9/23/24 at 6:00 A.M.  Donepezil 10 mg tablet every evening, 9/14/24 at 2:00 P.M., 10/25-9/27 at 2:00 P.M., 11/0/24 at 2:00 P.M., 10/24/24-10/11/24 at 2:00 P.M., 10/22/24 at 2:00 P.M., 10/24/24-10/27/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.  Losartan Potassium 100 mg tablet every evening, 9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.  Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.		P.M., 9/27/24 at 11	:00 A.M. and 4:00 P.M., 10/10/24					
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2:00 P.M., 10/24/24-10/27/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.  Losartan Potassium 100 mg tablet every evening, 9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/24 at 2:00 P.M. , 11/2/24 at 2:00 P.M. , 11/2/24 at 2:00 P.M.  Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.		· · · · · · · · · · · · · · · · · · ·						
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Losartan Potassium 100 mg tablet every evening, 9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/24 at 2:00 P.M. ,11/2/24 at 2:00 P.M.  Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.		· · · · · · · · · · · · · · · · · · ·	*					
9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/24 at 2:00 P.M. ,11/2/24 at 2:00 P.M. Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.		10/29/24-10/31/24 :	at 2:00 P.M., 11/2/24 at 2:00 P.M.					
9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/24 at 2:00 P.M. ,11/2/24 at 2:00 P.M. Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.		Landar Datanian 100 material and annual and						
24, 25, 26, 27, 29, 30, and 31/24 at 2:00 P.M. ,11/2/24 at 2:00 P.M.  Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.								
,11/2/24 at 2:00 P.M.  Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.								
Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.								
6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.		,11/2/24 at 2.00 1 .N	vi.					
6:00 A.M.  Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.		Rosuvastatin 10 mo	tablet daily 9/1/24 9/13/24 at					
Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.			3 tablet daily, 3/1/24, 3/13/24 at					
6:00 A.M.		0.0071.141.						
6:00 A.M.		Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at						
		_	y - , , , , ,					
2. On 11/6/24 at 3:51 P.M., Resident C's clinical		2. On 11/6/24 at 3:	51 P.M., Resident C's clinical					
record was reviewed. Diagnoses included, but								
were not limited to: hypertension, arthritis,			_					
squamous cell carcinoma to the face,								
hyperlipidemia, radiculopathy of lower back,		1 -						
gastro-esophageal reflux disease, tremor, macular								
degeneration, bone density disorder and edema.								
			J					
The Resident's Service Plan dated 2/20/23 and		The Resident's Serv	vice Plan dated 2/20/23 and					
revised on 4/17/24, indicated the resident required								
assistance for medication administration.								
The current Physician's Orders for medications		The current Physici	an's Orders for medications					

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PRINTED: 12/12/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/07/2024				
NAME OF PROVIDER OR SUPPLIER HELLENIC SENIOR LIVING OF MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  included:		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	One Lorsartan Pota hypertension, initia	ssium 50 mg tablet daily for ted on 9/20/24,						
	Gastro-esophageal	reflux, initiated on 3/22/22, mg tablet daily at bedtime for						
	One Propranolol 40 hypertension, initia	mg tablet 3 times daily for ted on 3/19/24,						
	Review of Resident C's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times:							
		n 50 mg tablet daily, 9/22/24 - 1/31/24 at 5:00 A.M., 5:00 A.M.,						
	Pantoproazoe 40 mg 9/18/24 at 6:00 A.M	g tablet daily, 9/15/24 and fl.,						
	l S	ablet daily at bedtime, 9/15/24, 23/23, at 8:00 P.M.,						
	9:00 P.M., 9/15/25 P.M., 9/18/24 at 9:0 9/23/24 at 9:00 2:00 9:00 P.M., 9/28/24 P.M., 10/1/24 at 9:0 10/6/24 at 9:00 P.M. 2:00 P.M., 9:00 P.M. 10/15/24 at 9:00 P.M.	tablet 3 times daily, 9/12/24 at at 9:00 A.M., 2:00 P.M., 9:00 00 A.M., 2:00 P.M., 9:00 P.M., 9:00 P.M., 9:00 P.M., 9:00 P.M., 9:00 P.M., 9:00 P.M., 9/29/24 at 9:00 P.M., 10/3/24 at 9:00 P.M., 10/9/24 9:00 P.M., 10/11/24 at 4., 10/13/24 at 9:00 P.M., M., 10/18/24 at 9:00 P.M., M., 10/18/24 at 9:00 P.M., M., 10/18/24 at 9:00 P.M., M., 10/25/24 at 2:00 P.M., 9:00						

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PRINTED: 12/12/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 11/07/2024				
NAME OF PROVIDER OR SUPPLIER HELLENIC SENIOR LIVING OF MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	10/29/24 at 2:00 P.M P.M., 9:00 P.M., 10	00 P.M., 10/28/24 at 9:00 P.M., M., 9:00 P.M., 10/30/24 at 2:00 /31/24 at 2:00 P.M., 9:00 P.M., I., 11/4/24 at 9:00 P.M., 11/5/24 24 at 9:00 P.M.						
	record was reviewed	0:10 A.M., Resident D's clinical d. Diagnoses included, but schizo-affective disorder and						
	The Resident's Service Plan dated 8/21/23 and revised on 9/1/24, indicated the resident required assistance for medication administration.							
	The current Physician's Orders for medications included:							
	schizo-affective dis-	ng tablet daily at bedtime for order, initiated on 9/3/24, ng tablet, 1/2 tablet at bedtime ed on 4/2/24,						
	11/6/24, indicated the	D's Medication ords (MAR), from 9/1/24 to he resident did not receive the ons on the following dates and						
	9/10/24, 9/14/24, 9/ 10/10/24, 10/11/24, 10/24/24, 10/25/24,	blet daily at bedtime, 9/4/24, (15/24, 9/25/25/ 9/26/24/ 9/28/24 10/12/24, 10/15/24, 1022/24, 10/26/24, 10/27/24, 10/29/24, 11/1/24, 11/5/24, 11/6/24, at 8:00						
	9/16/24, 9/18/24, 9/	sed on 9/5/24, 911/24, 9/12/24, 19/24, 9/20/24, 9/23/24, 10/5/24, 10/19/24, 10/20/24, 10/21/24,						

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/07/2024			
NAME OF PROVIDER OR SUPPLIER HELLENIC SENIOR LIVING OF MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	9/1/24, 9/6/24, 9/10 9/24/24, 9/25/24, 9/ 9/31/24, 10/10/24, 10/26/24, 10/27/24, 11/5/24, at 9:00 P.M. Trazadone was refu On 11/6/24 at 4:05 Clinical Operations "Medication Admir indicated it was the administration polic following: " the a shall be as ordered and document the a administration. The medication aide will medication refusal reported to the resid	ablet, 1/2 tablet at bedtime, 0/24, 9/11/24, 9/12/24, 9/22/24, 9/26/24, 9/27/24, 9/29/24, 9/30/24, 10/14/24, 10/17/24, 10/25/24, 10/28/24, 11/1/24, 11/3/24, M.  ased on 9/20/24, 9/23/24.  P.M., the Regional Director of a proved the policy titled, nistration," dated 8/27/24 and current medication by the resident's physician dministration of medications by the resident's physician dministration immediately after a licensed nurse or qualified and medication refusal will be dent's attending physician."  as to Complaints IN 00443940						

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