STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELLENIC SENIOR LIVING OF MISHAWAKA	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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00449170, IN00451454 & IN00452967. Complaint IN00449170 - No deficiencies related to the allegations are cited. Complaint IN00451454 - No deficiencies related to the allegations are cited. Complaint IN00452967 - No deficiencies related to the allegations are cited. Survey dates: March 17, 18 and 19, 2025. Facility number: 014224 Census Bed Type: Residential: 112 Census Payor Type: Medicaid: 102 Other: 10 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 3/25/2025	R 0000		
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency Based on observation and interview, the facility failed to maintain a clean environment on 3 of 3 floors. (Floors 1, 2 and 3) Findings include:	R 0144	1.Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 2.All residents could have been	04/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Huttel	Executive Director	04/10/2025

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	During an observation of the facility on 3/17/2025 at 2:50 P.M. the following was noted: On the first floor: -Room 112 the door was scuffed with black marks. -Room 108 the door and wall aroung the door were very scuffed up and dirty. -The carpet outside rooms 116, 117 and 127 was stained. On the second floor: -Debris and dead bugs were noted in light fixtures throughout the hallway from rooms 229-236. -Rooms 209, 233 and 243, the doors were dirty. On the third floor: -The doors to rooms 311, 312, 321, 325, 329, 330, and 333 were very dirty and scuffed. During an interview on 3/19/2025 at 9:02 A.M. the Maintenance Director indicated he needed corporate approval to paint the doors. He indicated they cleaned and painted resident rooms when a resident moved out, but there was no routine maintenance schedule for cleaning or painting room doors. He indicated there was no facility policy related to building maintenance.		affected, however in this case no residents were affected. 3.Resident doors have been cleaned/re-painted for 112, 209, 233, 243, 311, 312, 321, 325, 329, 330 and 333. Wall around 108 has been repaired and re-painted. Stained carpet has been shampooed outside of rooms 116, 117 and 127. Debris and dead bugs were removed throughout the hallway of 229-236. 4. Maintenance Director/Designee will monitor for cleanliness during rounds daily 5 times per week. Any areas found to be deficient will logged on our work ticket system and corrected promptly. This will continue on-going.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on record review and interview the facility failed to obtain semi-annual weights for 2 of 7 residents reviewed for weights. (Residents 5 and C) Findings include: 1. During a record review, completed on 3/18/2025	R 0216	1. Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case no residents were affected.	04/30/2025

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HELLENIC SENIOR LIVING OF MISHAWAKA	1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544

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	at 10:00 A.M., Resident 5's record lacked a semi-annual weight that should have been completed in October of 2024.The last weight was completed in April 2024. 2. During a record review, completed on 3/17/2025 at 2:15 P.M.,Resident C's record lacked a semi-annual weight that should have been done in October of 2024. During an interview on 3/19/2025 at 10:24 A.M., the DON indicated the facility had a monthly vital sign fair and the residents were expected to attend so staff could record weights and vital signs. If a resident did not attend, staff did not seek them out to ensure their weight or vital signs were obtained. The DON indicated the facility did not have a policy specifically for obtaining resident weights every six months.		3. Sited residents without semi-annual weights have been obtained and recorded in PCC. - Monthly vital sign and weights will be completed the second week of each month (Tuesday's) via health clinic. - Room to room vital signs/weights for those who missed the clinic, will be obtained on Wednesday through Friday. 4) DON/Designee will monitor PCC charting to ensure the Vital signs and weights are obtained and entered into PCC during the second week of each month on-going	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to maintain sanitary conditions in the kitchen. This had the potential to affect 112 of 112 residents who consumed food prepared in the kitchen. Findings include: During an observation of the kitchen on 3/17/2025 at 9:55 A.M. with Cook 4, the following was noted: -The thermometer instide the walk-in cooler was broken. The outside temperature indicated the cooler was 36 degrees Fahrenheit.	R 0273	1. Corrections from previous timeframes cannot be made. No resident were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. For the kitchen observation, the following are the measure that have been implemented to correct any deficiencies.	04/30/2025

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	-The walk-in freezer had opened and closed boxes of food stored on the floor. During an observation of the kitchen on 3/18/2025 at 9:10 A.M. with the Culinary Director (CD), the following was noted: -The thermometer had not been replaced inside the walk-in cooler. -The walk-in freezer still had opened and closed boxes of food on the floor. -The daily temperature logs for the walk-in cooler, freezer and the reach-in cooler were incomplete for the month of March. During an interview on 3/18/2025 at 9:25 A.M., the CD indicated the blanks in incomplete temperature logs were mostly for weekend days. In addition, the CD indicated the thermometer should have been replaced in the walk-in cooler immediately and boxes of food should not have been be stored on the floor. An undated policy titled "Dry Food Storage Policy and Procedure" was provided on 3/18/2025 at 11:45 A.M. by the CD. The policy indicated, "...Containers of food shall be stored a minimum of six inches above the floor...." A policy for maintaining temperature logs was not provided before the exit.		a.) The walk in cooler thermometer has been replaced. b.) The boxes of food stored in the walk in freezer floor has been discarded. c.) Temperature logs have been replaced and are completed to date. Staff was rein-serviced on proper storage of food, temperature logs 7 days per week. 4. Culinary Director/Designee will check/monitor storage and temperature logs daily 5 times per week for one month, weekly for one month, bi-monthly for one month and then monthly thereafter to ensure proper documentation and storage. Broken or misplaced thermometers will replaced immediately on-going.	
R 0379 Bldg. 00	410 IAC 16.2-5-11.1(c) Mental Health Screening - Deficiency Based on observation, interview and record review, the facility failed to ensure a mental health screening and assessment was completed for 2 of 5 residents reviewed for mental health needs. (Resident 2 & B) Finding includes:	R 0379	1.Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 1.All residents could have been affected, however in this case no	04/30/2025

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	1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder and anxiety disorder. There was no doumentation located in the electronic or paper medical record which indiated Resident 2 had a mental health screening and needs assessment, from any mental health service provider, completed. During an interview on 3/19/2025 at 9:32 A.M., the DON indicated the Nurse Practitioner that came to the building would have suggested wether a resident needed to see mental health services. She indicated Resident 2 had his own PCP in the community that he visited. She indicated the facility probably should have offered him mental health screening. 2. A a record review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the resident had moderate cognitive impairment. There was no documentation Resident B had a mental health screening and needs assessment completed by a mental health services provider. During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have a mental health services provider. During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the faciity did not have a specific policy regarding provding mental health services for residents with major mental health diagnosis.		residents were affected. 3. Completing a thorough audit of all current residents in building to determine residents that have major mental illness as defined by their individual needs assessment and ensure mental health screening has been completed. Mental health assessments are being completed per protocol to ensure mental health services are met. The Service Plan Coordinator has been educated in this process. 4. DON/Designee will audit service plans quarterly after completion for any residents with major psych diagnosis for six months and on-going	

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R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency Based on observation, interview and record review, the facility failed to ensure a care plan was developed in cooperation with a mental health provider for 2 out of 5 resident reviewed for mental health needs. (Resident 2 & B) Finding includes: 1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder, and anxiety disorder. There was no plan of care reagarding mental health needs on the service plan for Resident 2, which was completed on 12/31/2024. During an interview on 3/19/2025 at 9:32 A.M., the DON indicated that Resident 2 did not have a care plan for mental health in his service plan and did not have a mental health service provider.2. A a reecord review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the resident had moderate cognitive impairment. A review of the service plan indicated there was not a comprehensive care plan developed in cooperation with a mental health service provider that addressed Resident B's major depressive disorder or anxiety diagnosis. During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have mental health services or a mental health care plan.	R 0383	1. Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 2 All residents could have been affected, however in this case no residents were affected. 3. Completing a thorough audit of all current residents in building to determine residents that have major mental illness as defined by their individual needs assessment and ensure mental health care plans are developed in cooperation with a mental health provider for mental health needs. Mental health care plans are being completed per protocol to ensure mental health services are met. The service plan coordinator has been educated in this process. 4. DON/Designee will audit care plans quarterly after completion for any residents with major psych diagnosis for six months and ongoing.	04/30/2025

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	During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the facility did not have a specific policy regarding mental health services or care plans.			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency Based on observation and interview, the staff failed to perform hand hygiene before and after the administration of eye drops and insulin per the standard of practice for 2 of 5 residents reviewed during medication administration. (Resident 6 & 7) Finding includes: 1. During an observation on 3/18/2025 at 10:09 A.M., QMA 3 administered dorzol/timol one drop to both eyes for Resident 7. She donned gloves and provided the drop to each eye. She removed the gloves and proceeded to sign off and prepare the next resident's medication. QMA 3 did not wash her hands after removing her gloves. During an interview on 3/18/2025 at 10:12 A.M., QMA 3 indicated that she should have washed her hands before and after administering the medication. 2. During an observation on 3/18/2025 at 11:45 A.M., QMA 3 prepared admelog 14 units via an insulin pen for Resident 6. She gathered the supplies, donned gloves and administered the medication, removed her gloves and signed off the medication. QMA 3 did not wash her hands after removing her gloves. During an interview on 3/18/2025 at 11:53 A.M., QMA 3 indicated she should have washed her	R 0414	1.Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 2.All residents could have been affected, however in this case no residents were affected. 3.The staff member has been reeducated on direct resident care hand hygiene before and after the administration of eye drops and insulin administration. ·All new employees will be educated during the New Employee Orientation and on-going on the importance of Hand Hygiene during medication administration. ·Hand hygiene, eye drop, and insulin administration will be covered at all clinical staff in-service. ·An all-clinical staff in-service will be held prior to April 30th, 2025 1.The DON/Designee will observe staff members daily x5 days/week for two months, daily x3 days/week for two months then daily x 1 day/week for two months	04/30/2025

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	hands before and after the administration of the insulin. On 3/18/2025 at 2:25 P.M., the DON provided a policy titled, "Insulin Administration QMA," dated 9/22/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: 11. Wash and dry hands thoroughly or use alcohol-based hand rub. 12. Put on gloves. 18. Dispose of supplies. Remove gloves. Wash hands with soap and water or alcohol-based hand rub....." On 3/19/2025 at 10:30 A.M., the ED provided a policy titled, "Hand Hygiene," dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Staff must always wash their hands when assisting a resident, including: a) Before and after putting on disposable gloves. b) Before and after resident contact involving personal care. e) Before assisting a resident with medication. g) After hand contact with any body fluids. 5. The use of gloves does not replace handwashing or the use of alcohol-based hand sanitizer....."		on various shifts to ensure proper procedure of Handwashing is followed in medication administration.	