[X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/19/2025	
	ROVIDER OR SUPPLIER C SENIOR LIVING			1540 S	ADDRESS, CITY, STATE, ZIP COD OUTH LOGAN STREET WAKA, 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 APPROPRIA 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.		R 00	000			
	Survey dates: Marc	ch 17, 18 and 19, 2025.					
	Facility number: 0	14224					
	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 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency						
٠		on and interview, the facility clean environment on 3 of 3 and 3)	R 0	144	1.Corrections from previous frames cannot be made. No residents were affected by this alleged deficient practice. 2.All residents could have by	S	04/30/2025
LABORATOR	_	VIDER/SUPPLIER REPRESENTATIVE'S SIC	 	3	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Susan Huttel **Executive Director** 04/10/2025

Any defiencystatement 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 disclo days 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: I7S111 Facility ID: 014224 If continuation sheet Page 1 of 8

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 03/19/2025				
	ROVIDER 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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	at 2:50 P.M. the following the first floor: -Room 112 the dooren 108 the dooren 1	r was scuffed with black marks. r and wall aroung the door were l dirty. rooms 116, 117 and 127 was :: ugs were noted in light fixtures way from rooms 229-236. and 243, the doors were dirty. s 311, 312, 321, 325, 329, 330,		affected, however in this case residents were affected. 3.Resident doors have beel cleaned/re-painted for 112, 20 233, 243, 311, 312, 321, 325, 330 and 333. Wall around 108 has be repaired and re-painted. Stained carpet has been shampooed outside of rooms 117 and 127. Debris and dead bugs were removed throughout the hallway of 229-236. 4. Maintenance Director/Designee will monito cleanliness during rounds dain times per week. A areas found to be deficient will logged on our work ticket system and corrected promptly. This will continue on-going.	n 109, 1329,			
R 0216 Bldg. 00	410 IAC 16.2-5-2(Evaluation - Nonc							
99.	failed to obtain sem residents reviewed C) Findings include:	view and interview the facility ni-annual weights for 2 of 7 for weights. (Residents 5 and review, completed on 3/18/2025	R 0216	Corrections from previous frames cannot be made. No residents were affected this alleged deficient practice. All residents could have be affected, however in this case residents were affected.	d by een			

State Form Event ID: 17S111 Facility ID: 014224 If continuation sheet Page 2 of 8

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/19/2025					
	ROVIDER 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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	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 the complete will monitor PCC charting to ensure the Visigns and weights an obtained and entered into PCC during the second week of each month on-going	ghts ugh tal re		
R 0273 Bldg. 00	410 IAC 16.2-5-5. Food and Nutrition	1(f) nal Services - Deficiency					
j. 55	failed to maintain sakitchen. This had the residents who constkitchen. Findings include: During an observation at 9:55 A.M. with Control of the thermometer in the same at t	on and interview, the facility anitary conditions in the see potential to affect 112 of 112 amed food prepared in the son of the kitchen on 3/17/2025 Cook 4, the following was noted: instide the walk-in cooler was be temperature indicated the see Tehrophoit.	R 0273	 Corrections from previous timeframes cannot be made. resident were affected by this alleged deficient practice. All residents could have be affected, however in this case, residents were affected. For the kitchen observation, following are the measure that have been implemented to corany deficiencies. 	en no the		

State Form Event ID: 17S111 Facility ID: 014224 If continuation sheet Page 3 of 8

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED				
			B. WING		03/19/2025			
			CTREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	ROVIDER OR SUPPLIER	8						
	IO OENIOD I IVINO	OF MICHANALA	1540 SOUTH LOGAN STREET					
HELLENI	IC SENIOR LIVING	OF MISHAWAKA	MISHA	AWAKA, IN 46544				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DDOVIDED'S DI AN OF CODDECTION	(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
	-The walk-in freeze	er had opened and closed boxes		a.) The walk in cooler				
	of food stored on th	e floor.		thermometer has been replace	ed.			
				b.) The boxes of food store				
	During an observati	ion of the kitchen on 3/18/2025		the walk in freezer floor has b				
		he Culinary Director (CD), the		discarded.				
	following was noted			c.) Temperature logs have				
	_	nad not been replaced inside		been replaced and are comple	eted			
	the walk-in cooler.			to date.	7.5 u			
		er still had opened and closed		to date.				
	boxes of food on the	-		Staff was rein-serviced on				
		ture logs for the walk-in cooler,		proper storage of food,				
		th-in cooler were incomplete for		temperature logs 7 days per v	veek .			
	the month of March.			tomperature reger adje per v	, ook.			
				4. Culinary Director/Designed	will			
	During an interview	v on 3/18/2025 at 9:25 A.M., the		check/monitor storage and				
	-	anks in incomplete temperature		temperature logs daily 5 times	per			
		or weekend days. In addition,		week for one month, weekly for				
	-	e thermometer should have		one month, bi-monthly for one				
		e walk-in cooler immediately		month and then monthly there				
	-	hould not have been be stored		to ensure proper documentation				
	on the floor.	nound not have been be stored		and storage. Broken or mispl				
	on the noon.			thermometers will replaced	1000			
	An undated policy t	titled "Dry Food Storage		immediately on-going.				
		re" was provided on 3/18/2025		ininediately on-going.				
	*	e CD. The policy indicated,						
		od shall be stored a minimum						
		the floor" A policy for						
		rature logs was not provided						
	before the exit.	ature logs was not provided						
	before the exit.							
R 0379	410 IAC 16.2-5-11	1.1(c)						
		reening - Deficiency						
Bldg. 00	Michial Health Och	coming - Denoioney						
Diag. 00	Rased on observation	on, interview and record	R 0379		04/30/2025			
		failed to ensure a mental health	K 03/9	1.Corrections from previous				
	-	sment was completed for 2 of		frames cannot be made. No	unic			
	•	d for mental health needs.		residents were affected by this				
	(Resident 2 & B)	a for mental nearth needs.		alleged deficient practice.	'			
	(Resident 2 & D)			1.All residents could have b	een			
	Finding includes:							
	Finding includes:			affected, however in this case	IIO			

State Form Event ID: 17S111 Facility ID: 014224 If continuation sheet Page 4 of 8

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

PRINTED: 04/11/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		1						
NAME OF I	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP COD			
HELLEN	HELLENIC SENIOR LIVING OF MISHAWAKA			MISHAWAKA, IN 46544				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY AND ALL OF THE PROP	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION	
TAG	1. A record review 2 P.M., for Residen were not limited to: anxiety disorder. T located in the electr which indiated Resi screening and needs health service provi During an interview DON indicated the the building would resident needed to s She indicated Resid community that he facility probably sh health screening. 2. A a record revie at 2:05 P.M. for Residut were not limited A Brief Interview for indicated the reside impairment. There was no documental health screen completed by a men During an interview the DON indicated mental health service The DON indicated mental health service the DON indicated specific policy rega	on 3/19/2025 at 9:32 A.M., the Nurse Practitioner that came to have suggested wether a see mental health services. Itent 2 had his own PCP in the visited. She indicated the mould have offered him mental was completed on 3/17/2025 sident B. Diagnoses included to major depressive disorder. For Mental Status assessment and moderate cognitive mentation Resident B had a ming and needs assessment that health services provider.	TAG	1	residents were affected. 3. Completing a thorough audit of all current residents in building to determine residents that have major mental illness as define their individual needs assessment and ensur mental health screening has completed. Mental health assessments are being completed per protocol to ensure mental health service Plan Coordinator has been educated in this process. 4. DON/Designee will audiservice plans quarterly after completion for any residents with major psych diagnosis for six months and on-going	e ed by re peen g	DATE	

State Form Event ID: I7S111 Facility ID: 014224 If continuation sheet Page 5 of 8

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
			B. WING 03/19/2025				/2025
	ROVIDER OR SUPPLIER			1540 S	ADDRESS, CITY, STATE, ZIP COD OUTH LOGAN STREET WAKA, IN 46544		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	Ι		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
R 0383	410 IAC 16.2-5-11.1(g)(1-2)						
	Mental Health Screening - Deficiency						
Bldg. 00	Based on observation review, the facility of developed in cooper provider for 2 out of mental health needs. 1. A record review of 2 P.M., for Resident were not limited to: and anxiety disorder reagarding mental high plan for Resident 2, 12/31/2024. During an interview DON indicated that plan for mental heal not have a mental higher record review was P.M. for Resident B not limited to major Interview for Mental the resident had more a comprehensive cooperation with a rethat addressed Residular disorder or anxiety of During an interview the DON indicated the resident had more and the resident had not have a mental had not have a men	on, interview and record failed to ensure a care plan was ration with a mental health of 5 resident reviewed for a. (Resident 2 & B) was completed on 3/18/2025 at to 2. Diagnoses included, but major depressive disorder, or There was no plan of care realth needs on the service which was completed on 3/19/2025 at 9:32 A.M., the Resident 2 did not have a care of the in his service plan and did realth service provider. A a completed on 3/17/2025 at 2:05 a. Diagnoses included but were of depressive disorder. A Briefinal Status assessment indicated derate cognitive impairment. Wice plan indicated there was recare plan developed in mental health service provider dent B's major depressive	R 0	383	1. Corrections from previous to frames cannot be made. No residents were affect by this alleged deficient practions. All residents could have be affected, however in this case residents were affected. Completing a thorough audiall current residents in building determine residents that have major mental illness as defined by their individual neerological assessment and ensure mental health care plans are developed in cooperation with a mental health provider mental health needs. Mental health care plans are being completed per protocol ensure mental health services met. The service plan coordinator has been educate this process. 4. DON/Designee will audit caplans quarterly after completicany residents with major psych diagnosis for six months and ongoing.	ted ce. en no l. dit of g to ds for to are d in are on for	04/30/2025

State Form Event ID: 17S111 Facility ID: 014224 If continuation sheet Page 6 of 8

DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY		
ORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>O</u> (00	COMPLETED		
		B. W	ING		03/19/	2025	
IDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544					
SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
DON indicated t	he facility did not have a						
0 IAC 16.2-5-12	(k)						
ection 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		R 0	414	frames cannot be made. No residents were affected by this alleged deficient practice. 2.All residents could have be affected, however in this case residents were affected. 3.The staff member has bee reeducated on direct resident hand hygiene before and after administration of eye drops an insulin administration. All new employees will be educated during the New Employee Orientation and on-going on the importance of Hand Hygiene during medicati administration. Hand hygiene, eye drop, an 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 x days/week for two months, day	een no n care the d	04/30/2025	
	DER OR SUPPLIER ENIOR LIVING SUMMARY S (EACH DEFICIENCE REGULATORY OR ring an interview DON indicated to cific policy regard explans. DIAC 16.2-5-12 ection Control - sed on observation ed to perform has administration on the dark of practice in generation and includes: During an observation of the dark of the dar	DER OR SUPPLIER ENIOR LIVING OF MISHAWAKA SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ring an interview on 3/19/2025 at 11:02 A.M., DON indicated the facility did not have a cific policy regarding mental health services or e plans. DIAC 16.2-5-12(k) action Control - Deficiency sed on observation and interview, the staff ed to perform hand hygiene before and after administration of eye drops and insulin per the adard of practice for 2 of 5 residents reviewed ing medication administration. (Resident 6 & ding includes: During an observation on 3/18/2025 at 10:09 M., QMA 3 administered dorzol/timol one drop both eyes for Resident 7. She donned gloves I provided the drop to each eye. She removed gloves and proceeded to sign off and prepare next resident's medication. QMA 3 did not sh her hands after removing her gloves. Fing an interview on 3/18/2025 at 10:12 A.M., MA 3 indicated that she should have washed hands before and after administering the dication. During an observation on 3/18/2025 at 11:45 M., QMA 3 prepared admelog 14 units via an ulin pen for Resident 6. She gathered the plies, donned gloves and administered the dication, removed her gloves and signed off	DER OR SUPPLIER ENIOR LIVING OF MISHAWAKA SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ring an interview on 3/19/2025 at 11:02 A.M., DON indicated the facility did not have a cific policy regarding mental health services or e plans. DIAC 16.2-5-12(k) section Control - Deficiency sed on observation and interview, the staff ed to perform hand hygiene before and after administration of eye drops and insulin per the ndard of practice for 2 of 5 residents reviewed ing medication administration. (Resident 6 & ding includes: During an observation on 3/18/2025 at 10:09 M., QMA 3 administered dorzol/timol one drop obth eyes for Resident 7. She donned gloves and proceeded to sign off and prepare next resident's medication. QMA 3 did not sh her hands after removing her gloves. Tring an interview on 3/18/2025 at 10:12 A.M., MA 3 indicated that she should have washed hands before and after administering the dication. During an observation on 3/18/2025 at 11:45 M., QMA 3 prepared admelog 14 units via an alin pen for Resident 6. She gathered the plies, donned gloves and administered the dication, removed her gloves and signed off medication, QMA 3 did not wash her hands er removing her gloves. Tring an interview on 3/18/2025 at 11:53 A.M.,	DER OR SUPPLIER ENIOR LIVING OF MISHAWAKA SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL ring an interview on 3/19/2025 at 11:02 A.M., DON indicated the facility did not have a cific policy regarding mental health services or e plans. DIAC 16.2-5-12(k) section Control - Deficiency sed on observation and interview, the staff ed to perform hand hygiene before and after administration of eye drops and insulin per the adard of practice for 2 of 5 residents reviewed ing medication administration. (Resident 6 & ding includes: During an observation on 3/18/2025 at 10:09 M., QMA 3 administered dorzol/timol one drop both eyes for Resident 7. She donned gloves all provided the drop to each eye. She removed gloves and proceeded to sign off and prepare next resident's medication. QMA 3 did not she her hands after removing her gloves. Puring an interview on 3/18/2025 at 10:12 A.M., IA 3 indicated that she should have washed hands before and after administering the dication. During an observation on 3/18/2025 at 11:45 M., QMA 3 prepared admelog 14 units via an alin pen for Resident 6. She gathered the plies, donned gloves and administered the dication, removed her gloves and signed off medication. QMA 3 did not wash her hands er removing her gloves. Fing an interview on 3/18/2025 at 11:53 A.M.,	DER OR SUPPLIER ENIOR LIVING OF MISHAWAKA SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATION OR Its: DIPARTIPYING INFORMATION ring an interview on 3/19/2025 at 11:02 A.M., DON indicated the facility did not have a cific policy regarding mental health services or e plans. DIAC 16.2-5-12(k) section Control - Deficiency sed on observation and interview, the staff ed to perform hand hygiene before and after administration of eye drops and insulin per the administration of eye drops and insulin administration. All residents were affected. 3. The staff member has bee reeducated on direct resident. hand hygiene before and after administration of eye drops an insulin administrationAll new employees will be educated during the New Employee Orientation and on-going on the importance of Hand Hygiene, eye drop, ar insulin administration. Hand hygiene, eye drop, ar insulin administration insulin administration will be educated during the New Employee Orientation and on-going on the importance of Hand Hygiene during medicat administration. Hand hygiene, eye drop, ar insulin administration insulin admin	DER OR SUPPLIER ENIOR LIVING OF MISHAWAKA STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544 BOWMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Triag an interview on 3/19/2025 at 11:02 A.M., DON indicated the facility did not have a cific policy regarding mental health services or e plans. DIAC 16.2-5-12(k) betton Control - Deficiency seed on observation and interview, the staff ed to perform hand hygiene before and after administration of eye drops and insulin per the indured of practice for 2 of 5 residents reviewed ing medication administration. (Resident 6 & 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. All new employees will be educated during the New Employee Orientation and insulin administration. Puring an observation on 3/18/2025 at 10:12 A.M., ta 3 indicated that she should have washed hands before and after administering the dication. During an observation on 3/18/2025 at 11:45 A., Q.M.A 3 prepared admelog 14 units via an altin pen for Resident 6. She gathered the plics, donned gloves and proceed to sign dischard. She provided the drop to each eye. She removed gloves and proceeded to sign of and prepare next residents medication. QMA 3 did not she her hands after removing her gloves. During an observation on 3/18/2025 at 10:12 A.M., ta 3 indicated that she should have washed hands before and after administering the dication, removed her gloves and signed off medication. QMA 3 did not wash her hands after removing her gloves. An all-clinical staff in-service will be held prior to April 30th, 2025 at 11:53 A.M., and 3/18/2025 at 11:53 A.M.,	

State Form Event ID: 17S111 Facility ID: 014224 If continuation sheet Page 7 of 8

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

PRINTED: 04/11/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/19/2025				
NAME OF PROVIDER OR SUPPLIER HELLENIC SENIOR LIVING OF MISHAWAKA			B. WI	STREET A	ADDRESS, CITY, STATE, ZIP COD OUTH LOGAN STREET WAKA, IN 46544	03/19/	2025
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	SUMMARY STATEMENT OF DEFICIENCIE				on various shifts to ensure proprocedure of Handwashing is followed in medication administration.	рег	

State Form Event ID: 17S111 Facility ID: 014224 If continuation sheet Page 8 of 8