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	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELLENIC SENIOR LIVING OF ELKHART	2528 BYPASS ROAD ELKHART, IN 46514

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: January 30 and 31, 2025 Facility number: 014241 Residential Census: 98 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 2/10/2025	R 0000		
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure employee records included documented references for 4 of 5 staff members reviewed for employee records (QMA 6, Server 8, ADON & CNA 9). Finding includes: On 1/31/2025 at 10:16 A.M., a review of employee records was completed. The employee file records lacked documentation references were completed for QMA 6, Server 8, ADON and CNA 9. During an interview, on 1/31/2025 at 11:40 A.M., the Business Office Manager (BOM) indicated the employees there should have been references completed for QMA 6, Server 8, the ADON and CNA 9.	R 0116	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 provided to all hiring managers on 2/13/25 on all required documents needed for new hires. 4/designee will audit all current employee files using State Employee File Checklist audit form (attachment 1). Any/all missing documents will be collected and added to the file. Any/all new hires will have file Checklist audit form completed and added to upon hire. 5. Practice will be completed for	02/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Robinson	Director of Clinical Services	03/10/2025

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.

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	On 1/31/2025 at 1:30 P.M., a policy was requested regarding employee references and one was not provided prior to the survey exit.		six months and further if deficient practice continues.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance Based on record review and interview, the facility failed to ensure employee records included job specific orientation documentation for 1 of 5 staff members reviewed for employee records (CNA 9). Findings include: 1. On 1/31/2025 at 11:10 A.M., an employee record review was completed for CNA 9. CNA 9 was hired on 4/24/2024. The record lacked documentation CNA 9 had completed a job specific orientation after she was hired. During an interview on 1/31/2025 at 11:40 A.M., the BOM indicated there was no job specific orientation documentation for CNA 9. On 1/31/2025 at 1:30 P.M., a policy was requested regarding job specific orientations and one was not provided prior to the survey exit.	R 0119	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 provided to all hiring managers on 2/13/25 on all required documents needed for new hires. 4/designee will audit all current employee files using State Employee File Checklist audit form (attachment 1). Any/all missing documents will be collected and added to the file. Any/all new hires will have file Checklist audit form completed and added to upon hire. 5. Practice will be completed for six months and further if deficient practice continues.	02/28/2025
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure staff members received dementia training annually for 1 of 5 staff members reviewed for staff education and training. (Cook 7) Finding includes:	R 0120	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no	02/28/2025

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	On 1/31/2025 at 11:30 A.M., a review of the employee records was completed. The employee record for Cook 7 lacked documentation an annual dementia training education had been completed. During an interview, on 1/31/2025 at 11:40 A.M., the BOM indicated Cook 7 had not completed the required annual dementia training education. On 1/31/2025 at 1:30 P.M., a policy was requested regarding annual dementia training and one was not provided prior to the survey exit.		residents were affected. 3 staff to be re-educated on 2/26/25 on requirements of continued education. Any staff found non-compliant will be re-educated and disciplined per facility policy. 4 designee will audit all current employee training modules to ensure compliance. Any staff to be non-complaint will be removed from schedule until completed. Supervisors/ training modules monthly to ensure education . 5. Practice will be completed for six months and further if deficient practice continues.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure staff members received tuberculosis (TB) 2nd step testing upon hire and TB annual risk assessments for 5 of 5 staff members reviewed for employee records (QMA 6, Cook 7, Server 8, ADON & CNA 9). Finding includes: On 1/31/2025 at 10:16 A.M., a review of employee records was completed. An employee record review indicated QMA 6 was hired on 10/20/2023 and Cook 7 was hired on 10/25/2023. The files lacked documentation either employees had received an annual TB risk assessment. An employee record review indicated Server 8 was	R 0121	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 provided to all hiring managers on 2/13/25 on all required documents needed for new hires. 4/designee will audit all current employee files using State Employee File Checklist audit form (attachment 1). All staff found to be non-compliant with health screening protocol to have screening completed by DON. Any/all new employees to be seen by DON prior to working with	02/28/2025

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	hired on 10/2/2024, the ADON was hired on 7/1/2024 and CNA 9 was hired on 4/24/2024. The records lacked documentation Server 8, the ADON and CNA 9 received their 2nd step TB testing upon hire. During an interview, on 1/31/2025 at 11:56 A.M., the DON indicated QMA 6, Cook 7, Server 8, the ADON and CNA 9 should have had their TB 2nd step testing and/or TB annual risk assessments completed. On 1/31/2025 at 1:30 P.M., a policy was requested regarding TB 2nd step testing an annual TB risk assessments and one was not provided prior to the survey exit.		residents to complete screening. All staff will then annually have screening completed during the same month, (2026). 5. Practice will be completed for six months and further if deficient practice continues.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance Based on observation, record review and interview, the facility failed to ensure narcotics were counted and documented every shift for 3 of 3 narcotic count log books reviewed. (1st floor, 2nd floor & 3rd floor) Findings include: 1. During a medication storage observation, on 1/31/2025 at 11:15 AM. with QMA 4, on the 1st floor, the following was observed: - the narcotic shift count sheets lacked 4 nursing staff signatures from 1/17/2025 to 1/30/2025, to show the narcotic count had been completed between the oncoming and the off going nursing staff members 2. During a medication storage observation, on 1/31/2025 at 11:25 A.M. with QMA 5, on the 2nd floor, the following was observed:	R 0296	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 nursing staff in-service to be completed 2/26/25 in regard to community's policy on Medication Administration (MED- 06) (attachment 2 Controlled Substance Management (MED-11) (attachment 3 Any staff found non-compliant will be re-educated and disciplined per facility policy. 4. DON/Designee will audit narcotic counts sheets 5x week x4 weeks, then 3x weekly for 4	02/28/2025

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	- the narcotic shift count sheets lacked 8 signatures, from 1/17/2025 to 1/30/2025, to show the narcotic count had been completed between the oncoming and the off going nursing staff members. 3. During a medication storage observation, on 1/31/2025 at 11:33 A.M. with QMA 3, on the 3rd floor, the following was observed: - the narcotic shift count sheets lacked 4 signatures from 1/12/2025 to 1/22/2025, to show the narcotic count had been completed between the oncoming and the off going nursing staff members On 1/31/2025 at 12:47 P.M., the Director of Nursing provided a policy titled, "Controlled Substance Management", dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy indicated: "... Controlled Substance Shift Counts: 1. Shift counts are performed at the end of each shift or when the person responsible for medications changes... Whenever a QMA or licensed nurse leaves the floor and another QMA or licensed nurse is responsible to med's, a complete count will take place by the person going off the cart and the person coming on the cart...."		weeks, then weekly x 4 months to ensure procedure completed per policy for proper documentation. Results of audits will be brought to Director weekly for review and/or recommendations for six months and further if deficient practice continues. (attachment 4)	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review, observation and interview, the facility failed to ensure emergency information binders were accurate and complete with all required resident information for 19 of 98 residents. Findings include:	R 0356	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected. 3 of all current resident charts to	02/28/2025

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	1. The emergency binder for the 1st floor was reviewed on 1/31/2025 and indicated the following: - The resident information lacked a picture and a hospital preference for four residents who resided on the first floor. 2. The emergency binder for the 2nd floor was reviewed on 1/31/2025 and indicated the following: - The resident information lacked a picture and/or a hospital preference for seven residents who resided on the second floor. 3. The emergency binder for the 3rd floor was reviewed on 1/31/2025 and indicated the following: - The resident information lacked a picture and/or hospital preference for 8 residents who resided on the third floor During an interview, on 1/31/2025 at 12:45 P.M., the Director of Nursing indicated the face sheets in the emergency binder should have had pictures and hospital preferences listed. On 1/31/2025 at 1:29 P.M. the Administrator indicated the facility did not have a policy for emergency binders.		be completed by DON/designee to ensure all required documentation is present for emergency binder. Any chart found to be lacking appropriate charting will be updated and added to binder. 4. DON/Designee will audit emergency binders monthly starting March 2025 to ensure all appropriate documentation can be found in emergency binder. Audit will be completed for six months and further if deficient practice continues.	
R 0379 Bldg. 00	410 IAC 16.2-5-11.1(c) Mental Health Screening - Deficiency Based on record review and interview, the facility failed to ensure a comprehensive care plan for major mental illness was completed for 1 of 7 residents reviewed for care plans (Resident 6) Finding includes:	R 0379	1 Corrections of previous time frames cannot be made. No residents were affected by the alleged deficient practice. 2 residents could have been affected, however in this case, no residents were affected.	02/28/2025

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	The record for Resident 6 was reviewed on 1/31/2025 at 10:41 A.M. Diagnoses included, but were not limited to: panic disorder and major depressive disorder. The current Physician's Orders included the medication venlafaxine (an antidepressant medication) 75 milligrams (mg) extended release capsule taken by mouth once per day and clonazepam (an antianxiety medication) 1 mg tablet taken by mouth four times per day. A current Care Plan regarding psychiatric services, initiated on 5/27/2022, indicated Resident 6 received psychiatric services through (name of a local mental health service provider). Interventions included but were not limited to the following: "mental health needs will be met with assistance from (Names of mental health and general health care providers) provides monthly visits for symptom management and counseling related to panic disorder." A current Care Plan regarding behavior management, included the following: "...Resident 6 will be able to identify factors/interventions that help to prevent/minimize inappropriate behaviors. Resident often becomes anxious and persevates on specific items. Resident will often approach nursing staff numerous times, requesting multiple blood pressure checks consecutively, or will question repetitively medications. Resident can be difficult to redirect. Interventions included and were limited to: When resident demonstrates anxious behavior, be concise and clear with him. Hear his concerns and readdress or redirect as needed. Resident received mental health service through (Name of Mental Health services provider) Care staff will report any changes from baseline behaviors...		3 of all current resident charts with major psych diagnosis to be completed by DON/designee to ensure all required interventions are in place and documented. 4. DON/Designee will audit service plans quarterly after audit for all with major psych six months and further if deficient practice continues.	

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	During an interview, on 1/31/2025 at 11:56 A.M., the DON indicated Resident 6's care plans that addressed his mental health needs were not comprehensive and did not include input from the psychiatric care providers. On 1/31/2025 at 12:49 P.M., the DON provided a policy titled, "Resident Service Plans," dated 9/30/2022 and indicated it was the policy currently being used by the facility. The policy indicated: "Policy: The community utilizes an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the needs of the resident ...."			