PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> COM		COMPL	ATE SURVEY DMPLETED 1/22/2024		
	ROVIDER OR SUPPLIER C SENIOR LIVING		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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00 R 0052	This visit was for the Investigation of Complaint IN00446891. Complaint IN00446891 - State deficiencies related to the allegations are cited at R0214 and R0052. Survey date: November 21 & 22, 2024. Facility number: 014224 Residential Census: 111 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 11/26/2024		000				
Bldg. 00	Based on interview and record review, the facility failed to ensure services for monitoring and evaluation were provided to a resident, who received anticoagulant medication, after an unwitnessed fall and failed to ensure interventions to prevent further falls were implemented to prevent neglect for 1 of 3 residents reviewed for falls. (Resident B) These deficient practices resulted in Resident B having three unwitnessed falls with three hours and 15 minutes, a significant change in level of consciousness, and required emergent treatment for intubation with emergency surgery for a subdural hematoma. Finding includes:		R 0	052	="" p="">1. Corrections of previous time frames cannot be made. ="" p="">2. All residents could have been affected, however is case, no other residents were affected. 3. All nursing staff in-service completed 11-22-24 in regard community's policy on falls, documentation and follow-up. staff found non-compliant will be re-educated and disciplined perfacility policy. 4. DON/Design will review PCC daily x5 days/week for six months to ensure procedure completed pr	n this to Any oe er	01/31/2025

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

TITLE (X6) DATE

Susan Huttel Executive Director 01/28/2025

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 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: N71R11 Facility ID: 014224 If continuation sheet Page 1 of 9

PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI		ULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	a. Building <u>00</u>		COMPLETED		
THE TEXT OF CONDECTION			B. WI	NG		11/22/	2024	
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	t .			OUTH LOGAN STREET			
HELLENI	IC SENIOR LIVING	OF MISHAWAKA			NAKA, IN 46544			
IILLLLINI	- COLINION LIVING			WIIGHAN	777 11 0 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION	
TAG	i	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		55 A.M., Resident B's clinical			policy for any and all falls. Fall			
		d. Diagnoses included, bipolar			Task form completed for all fal			
		ostructive pulmonary disease,			and completed by DON/Design			
		natoid arthritis, depression,			Results of forms will be brough			
	osteoarthritis, anem	iia, and chronic pain.			Director weekly for review and			
					recommendations for six mont			
		Number 105 dated 9/15/24 and			and further if deficient practice	!		
	-	cility to the Indiana State			continues.			
	-	Ith, indicated on 9/14/24 at 6:30			="" p="">			
		as found on the floor in the			="" p="">			
	· ·	apartment door with her						
		keup all over the hallway. 911						
		ately while the resident						
	_	nd vital signs were taken.						
		lent Follow-up dated 9/20/24,						
		nt had an emergency						
	-	natoma evacuation and was						
	unresponsive.							
	Daview of Docident	B's Nursing Progress Notes						
		024 at 4:24 P.M., the resident						
		oor by Certified Nursing						
		after getting up to to to the						
	` ' '	dent denied injuries and there						
		ries. The progress note						
	_	ractical Nurse, (LPN) 4, spoke						
		amily member. The family						
		he thought the resident had						
		e medication in the morning,						
		ime medication. The Progress						
		esident was very loopy and						
		the notation and that the fall						
		edication issue had been						
	^	ector of Nursing. There was no						
	_	indicated the resident's						
		notified of the fall or possible						
		n addition, there was no						
		V 4 had assessed Resident B						
	for any injuries from							
	1 111 111 111 1111	·						

State Form Event ID: N71R11 Facility ID: 014224 If continuation sheet Page 2 of 9

PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	COMPLETED 11/22/2024				
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 SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDERS PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	CCTION (X5) ULD BE COMPLETION DATE				
A Nursing Progress Note regarding a second fall was documented by LPN 4 on 9/14/2024 at 5:43 P.M. The note indicated Resident B fell while trying to go to the bathroom again and although she had a call pendant around her neck, she had not pushed it. There was not documentation that the resident's physician had been notified of the fall and there was no documentation LPN 4 had assessed Resident B for injuries after her second fall. A Nursing Progress Note regarding a third fall was documented by the Director of Nursing and						
dated 9/14/2024 at 6:39 P.M. The note indicated the Director of Nursing found Resident B lying on the floor in the hallway outside her room with her walker near her and makeup all over the hallway and indicated it was a ground level fall. The progress note indicated the resident had agonal (labored and irregular) breathing, and the Director of Nursing called for other nursing help at that time.						
A Nursing Progress Note documented by the Director of Nursing on 9/14/2024 at 6:40 P.M., indicated she had called 911, the resident was vomiting blood out of mouth and nose, and remained on her left side with continued agonal breathing and was nable to respond to commands. A fall nursing assessment with vital signs was initiated after the third fall. A Nursing Progress Note dated 9/14/2024 at 6:51 P.M., indicted the Director of Nursing						
documented that the Emergency Medical Services had arrived, intubated the resident and initiated life saving measures. A Nursing Progress Note dated 9/14/2024 at 8:05 P.M., indicated the resident's physician was						

State Form Event ID: N71R11 Facility ID: 014224 If continuation sheet Page 3 of 9

PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey Pleted 2/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET MISHAWAKA, IN 46544					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION notified that the resident was taken to a local		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) OULD BE COMPLETION PPROPRIATE DATE			
	hospital following a	ground level fall on 9/14/24.						
	P.M., indicated the Resident B was in I emergency cranioto	Note dated 9/15/2024 at 3:45 local hospital reported ntensive Care following an my for a hematoma evacuation tical condition, intubated, and						
	indicated the reside based partially on a	isk Assessment dated 9/10/24, nt was at a high risk for falling history of previous falls, use weakness,and associated						
	address, "Behaviors 4/20/23, which ind any changes from b Service Plans also i 12/12/22 and revise resident was at risk	ce Plans included plans to c.," dated 5/6/22 and revised on icated Care Staff were to report aseline behaviors. The included, "Falls," dated d on 9/10/24, that indicated the for falls due to a history of dication which caused and bruising.						
	Director of Nursing facility on 9/14/24 a second time. The D she was in another rexiting that apartme ground in the hall o apartment. The Dir Resident B was leavouting, had been us time and had her maker when she fell. Indicated she called	on 11/21/24 at 2:00 P.M., the indicated she arrived at the after Resident B had fallen the irector of Nursing indicated resident's apartment and upon ent, found Resident B on the utside of Resident B's ector of Nursing indicated ring her apartment to go on an ing her rollator walker at the akeup bag and mascara with The Director of Nursing for immediate assistance from led 911 for emergency						

State Form Event ID: N71R11 Facility ID: 014224 If continuation sheet Page 4 of 9

PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 11/22/2024				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1540 SOUTH LOGAN STREET					
HELLEN	IC SENIOR LIVING	OF MISHAWAKA	MISHA	WAKA, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	assistance. The Dire resident was consciby the time paramet vomited blood whill her side with agona paramedics intubate. The Director of Nunnotified of Resident evening and instruct to the Emergency R. Director of Nursing Resident B had take morning rather than that the physician state falls and of the self-administered the morning of 9/14/24 indicated LPN 4 did assessments after eight 9/14/24, and fall assinitiated and charted. During an interview Regional Nurse Corphysician should have the twich could have the falls on 9/14/24, and the resident's falls. On 11/21/24 at 12:50 Consultant provided Response Procedure indicated, " should fall,The physician notification is component of the provided Response Procedure indicated, " should fall,The physician further instructions. notification is component of the provided Response Procedure indicated in the physician should fall,The physician further instructions.	ector of Nursing indicated the ence at the time of the fall and dics arrived, the resident had e she remained on the floor on I breathing, and the ed the resident upon arrival. It is in gindicated she had been to the B's previous falls that the LPN to send the resident toom for an evaluation. The sindicated it was unknown if the her bedtime medication that the her daytime medication and thould have been notified of concern the resident may have the incorrect medications on the concern the the latter of Nursing I not document any ther of the first two falls on sessments should have been	IAU		DATE			

State Form Event ID: N71R11 Facility ID: 014224 If continuation sheet Page 5 of 9

PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		B. WING 11/22/20				/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	₹			OUTH LOGAN STREET		
HELLENI	C SENIOR LIVING	OF MISHAWAKA			WAKA, IN 46544		
112222141	O OLIVION LIVING	Of Whoth WW to t		WIIOTIX	, III +00++		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
		9/30/22. The policy indicated,					
		e evaluated as soon as possible					
		rred in an attempt to identify					
	_	rs that need immediate					
	correction"						
	This 444	1 f 1					
		al finding relates to Complaint					
	IN00446891.						
R 0214	410 IAC 16.2-5-2((a)					
	Evaluation - Defic						
Bldg. 00	Evaluation Bollo	ionoy					
3	Based on interview	and record review, the facility	R 0	214	="" p="">1. Corrections of		01/31/2025
		fall assessments following two	10.	21 7	previous time frames cannot b	e	01/31/2023
		lents reviewed for falls,			made.		
	(Residents B).	,			="" p="">2. All residents could		
	,				have been affected, however i		
	Finding includes:				case, no other residents were		
					affected.		
	On 11/21/24 at 11:5	55 A.M., Resident B's clinical			3. All nursing staff in-service		
	record was reviewe	d. Diagnoses included but			completed 11-22-24 in regard	to	
	were not limited to:	bipolar disorder, chronic			community's policy on falls,		
		ary disease, hypertension,			documentation and follow-up.	Any	
	rheumatoid arthritis	s, depression, osteoarthritis,			staff found non-compliant will	be	
	anemia and chronic	pain.			re-educated and disciplined pe	er	
					facility policy. 4. DON/Desigr	iee	
		Number 105 dated 9/15/24 and			will review PCC daily x5		
	-	cility to the Indiana State			days/week for six months to		
	_	lth, indicated on 9/14/24 at 6:30			ensure procedure completed p		
	·	as found on the floor in the			policy for any and all falls. Fall		
	-	apartment door with her			Task form completed for all fa		
		keup all over the hallway. 911			and completed by DON/Desig		
		ately while the resident			Results of forms will be brough		
	_	nd vital signs were taken.			Director weekly for review and		
		lent Follow-up dated 9/20/24,			recommendations for six mont		
		nt had an emergency			and further if deficient practice	!	
	•	natoma evacuation and			continues.		
	remained unrespons	sive.			="" p="">		
	Review of Resident	B's Progress Notes indicated					

State Form Event ID: N71R11 Facility ID: 014224 If continuation sheet Page 6 of 9

PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO	DD -
HELLENI	IC SENIOR LIVING	OF MISHAWAKA		OUTH LOGAN STREET WAKA, IN 46544	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	PPROPRIATE
TAG			TAG	DEFICIENCY)	DATE
		4 P.M., the resident was found ertified Nursing Assistant			
		ng up to to to the bathroom.			
	` /	injuries and there were no			
		e Nursing Progress note			
	•	ractical Nurse, (LPN) 4 spoke			
	with Resident B's fa	amily member, who stated she			
	thought the resident	took her night time			
		norning rather than her daytime			
		ursing Progress note indicated			
		ry loopy and weak at the time			
		that the fall and the possible			
		d been reported to the Director was no documentation that			
	_	nt had been assessed after her			
		nt's physician had been			
		or possible medication error.			
	nounce of the family	Possoci incuration 41101.			
	A Nursing Progress	Note regarding a second fall			
	was documented by	LPN 4 on 9/14/2024 at 5:43			
	P.M. The note indic	eated Resident B had fallen			
	while trying to go to	o the bathroom and that she			
	_	round her neck, but did not			
	_	no documentation of fall			
		n completed for Resident B's			
	second fall.				
	A Nursing Progress	Note regarding a third fall			
	0 0	the Director of Nursing and			
		9 P.M. The note indicated the			
		found Resident B lying on the			
	_	y outside her room, with her			
		makeup all over the hallway.			
	The note indicated	the resident had incurred a			
		he Nursing Progress note			
		nt had agonal (labored and			
		and the Director of Nursing			
	had called for other	nursing help at that time.			
	A Nursing Progress	Note, documented by the			

State Form Event ID: N71R11 Facility ID: 014224 If continuation sheet Page 7 of 9

PRINTED: 01/31/2025 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 11/22/2024				
	PROVIDER OR SUPPLIER		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			
	indicated she had ca vomiting blood out had remained on he agonal breathing, un	assessment with vital signs was						
	P.M. by the Directo Emergency Medica	Note, dated 9/14/2024 at 6:51 or of Nursing, indicated I Services arrived to the ne resident and initiated life						
	P.M., indicated the Resident B was in I emergency cranioto	Note dated 9/15/2024 at 3:45 local hospital had reported ntensive Care following an my for hematoma evacuation tical condition, intubated, and						
	9/10/24, indicated s based partially on a	isk Assessment completed on he was at high risk for falling history of previous falls, use weakness and associated						
	"Behaviors," dated which indicated Car changes from baseli Plans also included, revised on 9/10/24, was at risk for falls	nt Service Plans included, 5/6/22 and revised on 4/20/23, re Staff were to report any ine behaviors. The Service , "Falls," dated 12/12/22 and which indicated the resident due to a history of falls and which caused bleeding and						
	Director of Nursing	on 11/21/24 at 2:00 P.M., the indicated she arrived to the after Resident B's second fall of						

State Form Event ID: N71R11 Facility ID: 014224 If continuation sheet Page 8 of 9

PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

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 11/22/2024						
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	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		or of Nursing indicated she						
		lents' apartment and upon						
		ent, found Resident B on the						
	_	utside of Resident B's						
	_	rector of Nursing indicated						
		ving her apartment to go on an						
	_	ing her rollator walker at the akeup bag and mascara out						
		Director of Nursing indicated						
		ediate assistance from LPN 4						
		for emergency assistance. The						
		; indicated the resident was						
		at the time of the fall but by						
	1	s arrived, the resident had						
		e she remained on the floor on						
	her side and had dis	splayed agonal breathing. The						
		ed the resident upon their						
	arrival. The Directo	or of Nursing indicated LPN 4						
	did not document a	ny assessments after either of						
		n 9/14/24, and fall assessments						
	should have been in	nitiated and charted.						
		v on 11/21/24 at 2:10 P.M., the						
		nsultant indicated fall						
		xpected to have been						
	_	ted following each of Resident						
	B's falls on 9/14/24	•						
	On 11/21/24 at 12:	55 P.M., the Regional Nurse						
	Consultant provided	d a policy titled, Fall						
		0/30/22. The policy indicated,						
	"Residents will be evaluated as soon as possible after a fall has occurred in an attempt to identify any causative factors that need immediate							
	correction"							
	This state residentia	al finding relates to Complaint						
	IN00446891.	a maing relates to Complaint						
	IN00446891.							

State Form Event ID: N71R11 Facility ID: 014224 If continuation sheet Page 9 of 9