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	11/22/2024

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 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	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense 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 0052	=”” p=””>1. Corrections of previous time frames cannot be made. =”” p=””>2. All residents could have been affected, however in this case, no other residents were affected. 3. All nursing staff in-service completed 11-22-24 in regard to community's policy on falls, documentation and follow-up. Any staff found non-compliant will be re-educated and disciplined per facility policy. 4. DON/Designee will review PCC daily x5 days/week for six months to ensure procedure completed per	01/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Huttel	Executive Director	01/28/2025

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	On 11/21/24 at 11:55 A.M., Resident B's clinical record was reviewed. Diagnoses included, bipolar disorder, chronic obstructive pulmonary disease, hypertension, rheumatoid arthritis, depression, osteoarthritis, anemia, and chronic pain. Review of Incident Number 105 dated 9/15/24 and submitted by the facility to the Indiana State Department of Health, indicated on 9/14/24 at 6:30 P.M., Resident B was found on the floor in the hallway outside her apartment door with her walker near and makeup all over the hallway. 911 was called immediately while the resident remained in place and vital signs were taken. Review of the Incident Follow-up dated 9/20/24, indicated the resident had an emergency craniotomy for hematoma evacuation and was unresponsive. Review of Resident B's Nursing Progress Notes indicated on 9/14/2024 at 4:24 P.M., the resident was found on the floor by Certified Nursing Assistant (CNA) 5, after getting up to to to the bathroom. The resident denied injuries and there were no visible injuries. The progress note indicated Licence Practical Nurse, (LPN) 4, spoke with Resident B's family member. The family member indicated she thought the resident had taken her night time medication in the morning, rather than her daytime medication. The Progress note indicated the resident was very loopy and weak at the time of the notation and that the fall and the possible medication issue had been reported to the Director of Nursing. There was no documentation that indicated the resident's physician had been notified of the fall or possible medication error. In addition, there was no documentation LPN 4 had assessed Resident B for any injuries from her fall.		policy for any and all falls. Fall Task form completed for all falls and completed by DON/Designee. Results of forms will be brought to Director weekly for review and/or recommendations for six months and further if deficient practice continues. ="" p=""> ="" p="">	

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	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			

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	notified that the resident was taken to a local hospital following a ground level fall on 9/14/24. A Nursing Progress Note dated 9/15/2024 at 3:45 P.M., indicated the local hospital reported Resident B was in Intensive Care following an emergency craniotomy for a hematoma evacuation and remained in critical condition, intubated, and unresponsive. Resident B's Fall Risk Assessment dated 9/10/24, indicated the resident was at a high risk for falling based partially on a history of previous falls, use of a cane or walker, weakness,and associated diagnoses. The resident's Service Plans included plans to address, "Behaviors," dated 5/6/22 and revised on 4/20/23, which indicated Care Staff were to report any changes from baseline behaviors. The Service Plans also included, "Falls," dated 12/12/22 and revised on 9/10/24, that indicated the resident was at risk for falls due to a history of falls and was on medication which caused increased bleeding and bruising. During an interview on 11/21/24 at 2:00 P.M., the Director of Nursing indicated she arrived at the facility on 9/14/24 after Resident B had fallen the second time. The Director of Nursing indicated she was in another resident's apartment and upon exiting that apartment, found Resident B on the ground in the hall outside of Resident B's apartment. The Director of Nursing indicated Resident B was leaving her apartment to go on an outing, had been using her rollator walker at the time and had her makeup bag and mascara with her when she fell. The Director of Nursing indicated she called for immediate assistance from LPN 4 and then called 911 for emergency			

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	assistance. The Director of Nursing indicated the resident was conscience at the time of the fall and by the time paramedics arrived, the resident had vomited blood while she remained on the floor on her side with agonal breathing, and the paramedics intubated the resident upon arrival. The Director of Nursing indicated she had been notified of Resident B's previous falls that evening and instructed LPN to send the resident to the Emergency Room for an evaluation. The Director of Nursing indicated it was unknown if Resident B had taken her bedtime medication that morning rather than her daytime medication and that the physician should have been notified of the falls and of the concern the resident may have self-administered the incorrect medications on the morning of 9/14/24. The Director of Nursing indicated LPN 4 did not document any assessments after either of the first two falls on 9/14/24, and fall assessments should have been initiated and charted. During an interview on 11/21/24 at 2:10 P.M., the Regional Nurse Consultant indicated Resident B's physician should have been notified that the resident may have taken the incorrect medication which could have contributed to the resident's falls on 9/14/24, and should have been notified of the resident's falls. On 11/21/24 at 12:55 P.M., the Regional Nurse Consultant provided the policy titled, Fall Response Procedures, dated 9/30/22. The policy indicated, "... should a resident experience a fall,...The physician is contacted immediately for further instructions...Documentation of physician notification is completed in the resident record..." On 11/21/24 at 12:55 P.M., the Regional Nurse Consultant provided a policy titled, Fall			

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	Prevention, dated 9/30/22. 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 residential finding relates to Complaint IN00446891.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on interview and record review, the facility failed to document fall assessments following two falls for 1 of 3 residents reviewed for falls, (Residents B). Finding includes: On 11/21/24 at 11:55 A.M., Resident B's clinical record was reviewed. Diagnoses included but were not limited to: bipolar disorder, chronic obstructive pulmonary disease, hypertension, rheumatoid arthritis, depression, osteoarthritis, anemia and chronic pain. Review of Incident Number 105 dated 9/15/24 and submitted by the facility to the Indiana State Department of Health, indicated on 9/14/24 at 6:30 P.M., Resident B was found on the floor in the hallway outside her apartment door with her walker near and makeup all over the hallway. 911 was called immediately while the resident remained in place and vital signs were taken. Review of the Incident Follow-up dated 9/20/24, indicated the resident had an emergency craniotomy for hematoma evacuation and remained unresponsive. Review of Resident B's Progress Notes indicated	R 0214	=" " p=" ">1. Corrections of previous time frames cannot be made. =" " p=" ">2. All residents could have been affected, however in this case, no other residents were affected. 3. All nursing staff in-service completed 11-22-24 in regard to community's policy on falls, documentation and follow-up. Any staff found non-compliant will be re-educated and disciplined per facility policy. 4. DON/Designee will review PCC daily x5 days/week for six months to ensure procedure completed per policy for any and all falls. Fall Task form completed for all falls and completed by DON/Designee. Results of forms will be brought to Director weekly for review and/or recommendations for six months and further if deficient practice continues. =" " p=" ">	01/31/2025

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	on 9/14/2024 at 4:24 P.M., the resident was found on the floor by a Certified Nursing Assistant (CNA) 5 after getting up to to to the bathroom. The resident denied injuries and there were no visible injuries. The Nursing Progress note indicated Licence Practical Nurse, (LPN) 4 spoke with Resident B's family member, who stated she thought the resident took her night time medication in the morning rather than her daytime medication. The Nursing Progress note indicated the resident was very loopy and weak at the time of the notation and that the fall and the possible medication error had been reported to the Director of Nursing. There was no documentation that indicated the resident had been assessed after her fall or that the resient's physician had been notified of the fall or possible medication error. 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 had fallen while trying to go to the bathroom and that she had a call pendant around her neck, but did not push it. There was no documentation of fall assessment had been completed for Resident B's second fall. A Nursing Progress Note regarding a third fall was documented by the Director of Nursing and on 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. The note indicated the resident had incurred a ground level fall. The Nursing Progress note indicated the resident had agonal (labored and irregular) breathing and the Director of Nursing had called for other nursing help at that time. A Nursing Progress Note, documented by the			

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	Director of Nursing on 9/14/2024 at 6:40 P.M., indicated she had called 911, the resident had vomiting blood out of her mouth and nose and had remained on her left side with continued agonal breathing, unable to respond to commands. A fall assessment with vital signs was initiated for the third fall. A Nursing Progress Note, dated 9/14/2024 at 6:51 P.M. by the Director of Nursing, indicated Emergency Medical Services arrived to the facility, intubated the resident and initiated life saving measures. A Nursing Progress Note dated 9/15/2024 at 3:45 P.M., indicated the local hospital had reported Resident B was in Intensive Care following an emergency craniotomy for hematoma evacuation and remained in critical condition, intubated, and unresponsive. Resident B's Fall Risk Assessment completed on 9/10/24, indicated she was at high risk for falling based partially on a history of previous falls, use of a cane or walker, weakness and associated diagnoses. The resident's current Service Plans included, "Behaviors," dated 5/6/22 and revised on 4/20/23, which indicated Care Staff were to report any changes from baseline behaviors. The Service Plans also included, "Falls," dated 12/12/22 and revised on 9/10/24, which indicated the resident was at risk for falls due to a history of falls and was on medication which caused bleeding and bruising. During an interview on 11/21/24 at 2:00 P.M., the Director of Nursing indicated she arrived to the facility on 9/14/24 after Resident B's second fall of			

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	the day. The Director of Nursing indicated she was in another residents' apartment and upon exiting that apartment, found Resident B on the ground in the hall outside of Resident B's apartment. The Director of Nursing indicated Resident B was leaving her apartment to go on an outing, had been using her rollator walker at the time and had her makeup bag and mascara out when she fell. The Director of Nursing indicated she called for immediate assistance from LPN 4 and then called 911 for emergency assistance. The Director of Nursing indicated the resident was initially conscience at the time of the fall but by the time paramedics arrived, the resident had vomited blood while she remained on the floor on her side and had displayed agonal breathing. The paramedics intubated the resident upon their arrival. The Director of Nursing indicated LPN 4 did not document any assessments after either of the first two falls on 9/14/24, and fall assessments should have been initiated and charted. During an interview on 11/21/24 at 2:10 P.M., the Regional Nurse Consultant indicated fall assessments were expected to have been completed and charted 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 a policy titled, Fall Prevention, dated 9/30/22. 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 residential finding relates to Complaint IN00446891.			