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	01/07/2025

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 was an offsite Licensure Investigation Survey Survey Date: January 7, 2025 Facility: #014224 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed January 7, 2025	R 0000		
R 9999 Bldg. 00	16.2-5-1.1 Licenses (1) The facility shall submit a renewal application to the director at least forty-five (45) days prior to the expiration of the license. This state rule was not met as evidenced by: Based on document review, the facility failed to ensure it had timely renewed their license to operate as a residential care facility before their current license expired on November 30, 2024 The agency received the facility's renewal application and payment post marked December 17, 2024, which was not at least 45 days of the current license expiration date of November 30, 2024.	R 9999	1. No residents were affected by this alleged deficient practice 2. Payment was received by ISDH on 12-4-24 via Visa Card but failed to return application along with payment. Application was received via email to ISDH on 12-20-24 via Home Office. Facility received new license for 2025 on 1-6-2025. 3. Facility has added renewal date submission date of September 5, 2025, (ongoing annually) to calendar to ensure application and payment is made timely. 4. Licensure received 1-6-25	01/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Huttel	Executive Director	01/16/2025

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.