

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/19/2023
NAME OF PROVIDER OR SUPPLIER COMMUNITY DEVELOPMENT CORPORATION OF MISHAWAKA, IN		STREET ADDRESS, CITY, STATE, ZIP CODE 500 LINCOLNWAY EAST, MISHAWAKA, , 46544			
(X4) ID PREFIX TAG R 0000	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG R 0000	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00415721. Complaint IN00415721- No deficiencies related to the allegations are cited. Survey dates: September 18 &19, 2023 Facility number: 012688 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/19/23.				

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R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the emergency binder was complete and accurate with all required resident information for 1 of 6 residents whose emergency information was	R 0356	by 10/16/2023 and will be updated for each resident to include the following then added to the emergency binder: 1) The residents name, sex, room or apartment number, phone number, age or date of birth 2)Hospital of Choice 3) Name and phone number of any legally authorized representative 4) Name and phone number of the resident's physician of record 5) Name andtelephonenumber of the family members or other persons tobe contact in the event of an emergency or death 6)Informationof any known allergies 7)Photographof resident	10/18/2023
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	reviewed. (Resident D) Finding includes: On 9/18/2023, the emergency binder for the facility was reviewed. Resident D's clinical information sheet lacked an advance directive, hospital preference, and emergency contact information. During an interview, on 9/18/2023 at 2:10 P.M., the Wellness Director indicated the emergency binder should have had Resident D's advance directives, hospital preference, and emergency contact information. The Wellness Director indicated the facility didn't have a policy on emergency binders. An undated checklist, titled "Emergency Checklist", was provided by the Wellness Director on 9/18/2023 at 2:30 P.M. The checklist indicated the emergency binder should contain a face sheet containing emergency contact, code status, and hospital preference. Based on record review and interview, the facility failed to ensure the emergency binder was complete and accurate with all required resident information for 1 of 6 residents whose emergency information was reviewed. (Resident D)		8) Copy of the residents advanced directives, if available Each chart will include an audit checklist to ensure the proper procedure has been followed. The Administrator, Director of Nursing, or designated staff member will alternate auditing charts monthly for a period of six months and will continue quarterly thereafter. Changes and findings will be noted in monthly quality assurance meeting minutes. An in-service regarding updating and comprehensive documentation of each resident's emergency contact form will be completed with all nursing staff.	
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Finding includes:

On 9/18/2023, the emergency binder for the facility was reviewed. Resident D's clinical information sheet lacked an advance directive, hospital preference, and emergency contact information.

During an interview, on 9/18/2023 at 2:10 P.M., the Wellness Director indicated the emergency binder should have had Resident D's advance directives, hospital preference, and emergency contact information. The Wellness Director indicated the facility didn't have a policy on emergency binders.

An undated checklist, titled "Emergency Checklist", was provided by the Wellness Director on 9/18/2023 at 2:30 P.M. The checklist indicated the emergency binder should contain a face sheet containing emergency contact, code status, and hospital preference.

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R 0379	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(c) (c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record. Based on record review and interview, the facility failed to obtain a mental health needs assessment for a resident prior to admission for 1 of 3 residents reviewed for major mental illness. (Resident 6) Finding includes: A record review was completed on 9/18/2023 at 11:37 A.M. Diagnoses included, but were not limited to: paranoid schizophrenia, major depression, and generalized anxiety. A Physician's Order, dated	R 0379	have been audited for mental health diagnosis & needs by 10/16/2023. All staff will be educated on the importance of including mental health screening for every assessment, regardless of resident records, history, or self-proclamation at time of move-in. an audit checklist to ensure the proper procedure has been followed. The Administrator, Director of Nursing, or designated staff member will alternate auditing charts monthly for a period of six months and will continue quarterly thereafter. Changes and findings will be noted in monthly quality assurance meeting minutes.	10/18/2023
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3/7/2023, indicated Resident 6 received citalopram 20 milligrams daily, and starting 3/8/2023, Resident 6 received Vraylar 1.5 milligrams daily.

A mental health screening form was not found in the clinical record.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated if a resident has a major mental illness a form will be used titled, "Mental Health Screening". She indicated this form would be completed at or before admission, and there was not a specific policy for major mental illness.

On 9/18/2023 at 2:26 P.M., a review of Resident 6's overflow record was completed. A "Mental Health Screening" form was not found.

A current policy was provided on 9/18/2023 at 2:45 P.M., by the Wellness Director. The policy titled, "Admission Health Assessment", was revised on 9/18/2023. The policy indicated, " ...To provide guidance to the staff for pre-admission mental health screening
...Pre-admission: The facility shall obtain and review the history of treatment received by the prospective resident for major mental illness that has occurred within the two (2)

years ...The facility shall complete an assessment prior to admission and in conjunction with a mental health center consultation if needed. A copy of the completed assessment shall be maintained in the clinical record"

Based on record review and interview, the facility failed to obtain a mental health needs assessment for a resident prior to admission for 1 of 3 residents reviewed for major mental illness. (Resident 6)

Finding includes:

A record review was completed on 9/18/2023 at 11:37 A.M. Diagnoses included, but were not limited to: paranoid schizophrenia, major depression, and generalized anxiety.

A Physician's Order, dated 3/7/2023, indicated Resident 6 received citalopram 20 milligrams daily, and starting 3/8/2023, Resident 6 received Vraylar 1.5 milligrams daily.

A mental health screening form was not found in the clinical record.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated if a resident has a major mental illness a form will be used titled, "Mental Health Screening". She

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	indicated this form would be completed at or before admission, and there was not a specific policy for major mental illness. On 9/18/2023 at 2:26 P.M., a review of Resident 6's overflow record was completed. A "Mental Health Screening" form was not found. A current policy was provided on 9/18/2023 at 2:45 P.M., by the Wellness Director. The policy titled, "Admission Health Assessment", was revised on 9/18/2023. The policy indicated, " ...To provide guidance to the staff for pre-admission mental health screening ...Pre-admission: The facility shall obtain and review the history of treatment received by the prospective resident for major mental illness that has occurred within the two (2) years ...The facility shall complete an assessment prior to admission and in conjunction with a mental health center consultation if needed. A copy of the completed assessment shall be maintained in the clinical record"			
R 0382	Mental Health Screening - Noncompliance 410 IAC 16.2-5-11.1(f) (f) Each resident with a major mental illness must have a	R 0382	An updated chart audit checklist will be developed by 10/16/2023 to ensure all residents with major mental illness will be assessed within 30 days in conjunction	10/18/2023

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comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility.

Based on record review and interview, the facility failed to complete a comprehensive care plan within 30 days for 3 of 3 residents reviewed for major mental illness. (Residents D, 6, and 5)

Findings include:

1. A record review of Resident D was completed on 9/18/2023 at 10:54 A.M. Diagnoses included, but were not limited to: depression, anxiety, bipolar disorder, and post-traumatic stress disorder.

A form titled, "Mental Health Screen", indicated Resident D had a diagnosis of bipolar disorder and anxiety disorder. The form indicated Resident D was being treated by her primary care physician for her mental illnesses.

A review of the current Physician's Orders dated 9/1/2023-9/30/2023, indicated Resident D had an order on 1/12/2023 for quetiapine 300 milligrams at bedtime. On 6/1/2023, Resident D had an order for buspirone 30 milligrams twice a day. On 6/2/2023 resident D had an order for duloxetine 60

with the mental health provider. This checklist will be uniform for all residents, regardless of their diagnosis at pre-admission.

an audit checklist to ensure the proper procedure has been followed. The Administrator, Director of Nursing, or designated staff member will alternate auditing charts monthly for a period of six months and will continue quarterly thereafter. Changes and findings will be noted in monthly quality assurance meeting minutes.

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milligrams, two capsules daily, and on 6/29/2023 an order for Vraylar 4.5 milligrams at bedtime.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated specific care plans for mental illness were not available.

On 9/18/2023 at 2:53 P.M., the Wellness Director indicated she did not care plan for any of the residents who have major mental illness.

2. A record review was completed on 9/18/2023 at 11:37 A.M. Diagnoses included, but were not limited to: paranoid schizophrenia, major depression, and generalized anxiety.

A Physician's Order, dated 3/7/2023, indicated Resident 6 received citalopram 20 milligrams daily, and starting 3/8/2023, Resident 6 received Vraylar 1.5 milligrams daily.

A mental health screening form was not found in the clinical record.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated specific care plans for mental illness were not available.

3. A clinical record review of Resident 5 was completed on

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9/18/2023 at 2:22 P.M.
Diagnoses included, but were not limited to: bipolar, anxiety and major depressive disorder.

A record review was completed on 9/18/2023 at 2:31 P.M., and indicated Resident received Duloxetine 30 milligrams daily and Quetiapine 300 milligrams at bedtime.

A form titled, "Mental Health Screen", indicated Resident 5 had a diagnosis of bipolar, anxiety and major depressive disorder. The form indicated Resident 5 was being treated by her primary care physician for her mental illnesses.

A mental health care plan could not be found in the medical record.

During an interview, on 9/18/2023 at 2:52 P.M., the Director of Nursing indicated the comprehensive care plan related to a major mental illness was not completed for Resident 5 and should have been.

Based on record review and interview, the facility failed to complete a comprehensive care plan within 30 days for 3 of 3 residents reviewed for major mental illness. (Residents D, 6, and 5)

On 9/18/2023 at 2:53 P.M., the Wellness Director indicated she did not a care plan for any of the

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residents who have major mental illness.

A current policy was provided on 9/18/2023 at 2:45 P.M., by the Wellness Director. The policy titled, "Admission Health Assessment", was revised on 9/18/2023. The policy indicated, " ...Admission: Within thirty (30) days after the resident with mental illness is placed, a comprehensive care plan shall be developed for the individual and shall be reviewed every 6 months and with the change in condition"

Based on record review and interview, the facility failed to complete a comprehensive care plan within 30 days for 3 of 3 residents reviewed for major mental illness. (Residents D, 6, and 5)

Findings include:

1. A record review of Resident D was completed on 9/18/2023 at 10:54 A.M. Diagnoses included, but were not limited to: depression, anxiety, bipolar disorder, and post-traumatic stress disorder.

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A form titled, "Mental Health Screen", indicated Resident D had a diagnosis of bipolar disorder and anxiety disorder. The form indicated Resident D was being treated by her primary care physician for her mental illnesses.

A review of the current Physician's Orders dated 9/1/2023-9/30/2023, indicated Resident D had an order on 1/12/2023 for quetiapine 300 milligrams at bedtime. On 6/1/2023, Resident D had an order for buspirone 30 milligrams twice a day. On 6/2/2023 resident D had an order for duloxetine 60 milligrams, two capsules daily, and on 6/29/2023 an order for Vraylar 4.5 milligrams at bedtime.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated specific care plans for mental illness were not available.

On 9/18/2023 at 2:53 P.M., the Wellness Director indicated she did not care plan for any of the residents who have major mental illness.

2. A record review was completed on 9/18/2023 at 11:37 A.M. Diagnoses included, but were not limited to: paranoid schizophrenia, major depression, and generalized

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anxiety.

A Physician's Order, dated 3/7/2023, indicated Resident 6 received citalopram 20 milligrams daily, and starting 3/8/2023, Resident 6 received Vraylar 1.5 milligrams daily.

A mental health screening form was not found in the clinical record.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated specific care plans for mental illness were not available.

3. A clinical record review of Resident 5 was completed on 9/18/2023 at 2:22 P.M. Diagnoses included, but were not limited to: bipolar, anxiety and major depressive disorder.

A record review was completed on 9/18/2023 at 2:31 P.M., and indicated Resident received Duloxetine 30 milligrams daily and Quetiapine 300 milligrams at bedtime.

A form titled, "Mental Health Screen", indicated Resident 5 had a diagnosis of bipolar, anxiety and major depressive disorder. The form indicated Resident 5 was being treated by her primary care physician for her mental illnesses.

A mental health care plan could not be found in the medical

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record.

During an interview, on 9/18/2023 at 2:52 P.M., the Director of Nursing indicated the comprehensive care plan related to a major mental illness was not completed for Resident 5 and should have been.

Based on record review and interview, the facility failed to complete a comprehensive care plan within 30 days for 3 of 3 residents reviewed for major mental illness. (Residents D, 6, and 5)

On 9/18/2023 at 2:53 P.M., the Wellness Director indicated she did not a care plan for any of the residents who have major mental illness.

A current policy was provided on 9/18/2023 at 2:45 P.M., by the Wellness Director. The policy titled, "Admission Health Assessment", was revised on 9/18/2023. The policy indicated, " ...Admission: Within thirty (30) days after the resident with mental illness is placed, a comprehensive care plan shall be developed for the individual and shall be reviewed every 6 months and with the change in condition"

R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2)	R 0383	Mental health care plans for all existing residents diagnosed with major mental illness will be	10/18/2023
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(g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on record review and interview, the facility failed to develop a mental health care plan in collaboration with a mental health provider for 3 of 3 residents reviewed for major mental illness. (Resident D, 6, and 5) Findings include: 1. A record review of Resident D was completed on 9/18/2023 at 10:54 A.M. Diagnoses included, but were not limited to: depression, anxiety, bipolar disorder, and post-traumatic stress disorder.	reviewed to ensure the current care plan includes appropriate and updated to include the following: Psychosocial rehabilitation services that are to be provided within the community. A comprehensive range of activities to meet multiple levels of need, including the following Recreational and socialization activities. Social Skills. Training, occupational, and work programs. Opportunities for progression into less restrictive and more independent living arrangements.	
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A form titled, "Mental Health Screen", indicated Resident D had a diagnosis of bipolar disorder and anxiety disorder. The form indicated Resident D was being treated by her primary care physician for her mental illnesses.

A review of the current Physician's Orders dated 9/1/2023-9/30/2023, indicated Resident D had an order on 1/12/2023 for quetiapine 300 milligrams at bedtime. On 6/1/2023, Resident D had an order for buspirone 30 milligrams twice a day. On 6/2/2023 resident D had an order for duloxetine 60 milligrams, two capsules daily, and on 6/29/2023 an order for Vraylar 4.5 milligrams at bedtime.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated specific care plans for mental illness were not available. She indicated if a resident had a major mental illness, a psych doctor or the primary care physician would manage the resident, and a request would be made for a letter that stated the resident was stable with their medications.

On 9/18/2023 at 2:53 P.M., the Wellness Director indicated she did not a care plan for any of the residents who have major

An updated chart audit checklist will be developed by 10/16/2023 to ensure all residents with major mental illness will be assessed and will have a mental health care plan in place within 30 days in conjunction with the mental health provider. This checklist will be uniform for all residents, regardless of their diagnosis at pre-admission.

an audit checklist to ensure the proper procedure has been followed. The Administrator, Director of Nursing, or designated staff member will alternate auditing charts monthly for a period of six months and will continue quarterly thereafter. Changes and findings will be noted in monthly quality assurance meeting minutes.

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mental illness.

2. A record review was completed on 9/18/2023 at 11:37 A.M. Diagnoses included, but were not limited to: paranoid schizophrenia, major depression, and generalized anxiety.

A Physician's Order, dated 3/7/2023, indicated Resident 6 received citalopram 20 milligrams daily, and starting 3/8/2023, Resident 6 received Vraylar 1.5 milligrams daily.

A mental health screening form was not found in the clinical record.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated specific care plans for mental illness were not available. She indicated if a resident had a major mental illness, a psych doctor or the primary care physician would manage the resident, and a request would be made for a letter that stated the resident was stable with their medications.

On 9/18/2023 at 2:53 P.M., the Wellness Director indicated she did not a care plan for any of the residents who have major mental illness.

3. A clinical record review of Resident 5 was completed on 9/18/2023 at 2:22 P.M.,

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Diagnoses included, but were not limited to: bipolar, anxiety and major depressive disorder.

A record review was completed on 9/18/2023 at 2:31 P.M., and indicated Resident received Duloxetine 30 milligrams daily and Quetiapine 300 milligrams at bedtime.

A form titled, "Mental Health Screen", indicated Resident 5 had a diagnosis of bipolar, anxiety and major depressive disorder. The form indicated Resident 5 was being treated by her primary care physician for her mental illnesses.

A mental health care plan could not be found in the medical record.

During an interview, on 9/18/2023 at 2:52 P.M., the Director of Nursing indicated the comprehensive care plan related to a major mental illness was not completed for Resident 5 and should have been.

A current policy was provided on 9/18/2023 at 2:45 P.M., by the Wellness Director. The policy titled, "Admission Health Assessment", was revised on 9/18/2023. The policy indicated, " ...Admission: Within thirty (30) days after the resident with mental illness is placed, a comprehensive care plan shall be developed for the individual and shall be reviewed every 6

months and with the change in condition ...The facility in cooperation with the community mental health center/professional or an individual's managed care provider (as defined in IC 12-7-2-127(b)) serving the area shall develop a comprehensive care plan for the individual"

Based on record review and interview, the facility failed to develop a mental health care plan in collaboration with a mental health provider for 3 of 3 residents reviewed for major mental illness. (Resident D, 6, and 5)

Findings include:

1. A record review of Resident D was completed on 9/18/2023 at 10:54 A.M. Diagnoses included, but were not limited to: depression, anxiety, bipolar disorder, and post-traumatic stress disorder.

A form titled, "Mental Health Screen", indicated Resident D had a diagnosis of bipolar disorder and anxiety disorder. The form indicated Resident D was being treated by her primary care physician for her mental illnesses.

A review of the current Physician's Orders dated 9/1/2023-9/30/2023, indicated Resident D had an order on 1/12/2023 for quetiapine 300

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milligrams at bedtime. On 6/1/2023, Resident D had an order for buspirone 30 milligrams twice a day. On 6/2/2023 resident D had an order for duloxetine 60 milligrams, two capsules daily, and on 6/29/2023 an order for Vraylar 4.5 milligrams at bedtime.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated specific care plans for mental illness were not available. She indicated if a resident had a major mental illness, a psych doctor or the primary care physician would manage the resident, and a request would be made for a letter that stated the resident was stable with their medications.

On 9/18/2023 at 2:53 P.M., the Wellness Director indicated she did not a care plan for any of the residents who have major mental illness.

2. A record review was completed on 9/18/2023 at 11:37 A.M. Diagnoses included, but were not limited to: paranoid schizophrenia, major depression, and generalized anxiety.

A Physician's Order, dated 3/7/2023, indicated Resident 6 received citalopram 20 milligrams daily, and starting

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3/8/2023, Resident 6 received Vraylar 1.5 milligrams daily.

A mental health screening form was not found in the clinical record.

During an interview on 9/18/2023 at 2:03 P.M., the Wellness Director indicated specific care plans for mental illness were not available. She indicated if a resident had a major mental illness, a psych doctor or the primary care physician would manage the resident, and a request would be made for a letter that stated the resident was stable with their medications.

On 9/18/2023 at 2:53 P.M., the Wellness Director indicated she did not a care plan for any of the residents who have major mental illness.

3. A clinical record review of Resident 5 was completed on 9/18/2023 at 2:22 P.M., Diagnoses included, but were not limited to: bipolar, anxiety and major depressive disorder.

A record review was completed on 9/18/2023 at 2:31 P.M., and indicated Resident received Duloxetine 30 milligrams daily and Quetiapine 300 milligrams at bedtime.

A form titled, "Mental Health Screen", indicated Resident 5 had a diagnosis of bipolar,

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anxiety and major depressive disorder. The form indicated Resident 5 was being treated by her primary care physician for her mental illnesses.

A mental health care plan could not be found in the medical record.

During an interview, on 9/18/2023 at 2:52 P.M., the Director of Nursing indicated the comprehensive care plan related to a major mental illness was not completed for Resident 5 and should have been.

A current policy was provided on 9/18/2023 at 2:45 P.M., by the Wellness Director. The policy titled, "Admission Health Assessment", was revised on 9/18/2023. The policy indicated, "...Admission: Within thirty (30) days after the resident with mental illness is placed, a comprehensive care plan shall be developed for the individual and shall be reviewed every 6 months and with the change in condition ...The facility in cooperation with the community mental health center/professional or an individual's managed care provider (as defined in IC 12-7-2-127(b)) serving the area shall develop a comprehensive care plan for the individual"

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from

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correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE