

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 08/16/2024
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	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00440450. Complaint IN00440450 - No deficiencies related to the allegations are cited. Survey dates: August 15 & 16, 2024 Facility number: 012688 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 8/20/2024	R 0000			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear	R 0296	Staff was reeducated on the control substance policy and the sign in & out control book. A copy of the policy was disseminated amongst all applicable staff members. Acknowledgment forms	08/16/2024	

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written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff.

Based on observation, interview and record review the facility failed to ensure facility policies related to Controlled Substances were followed related to Narcotic Count/Change of Shift signatures and documentation on the Narcotic Count Records after administering for 1 of 1 narcotic log book reviewed. (Medication cart 1).

Finding includes:

A narcotic medication storage observation was completed, on 8/16/2024 at 8:55 A.M., with QMA 4. The Individual Resident Control Medication Record Sheet for Resident 16 indicated there were 27 pills left on the medication card in the narcotic lock box for Lorazepam 0.5 mg (milligram). The last dose was documented as given was on 8/15/2024 at 8:00 P.M. The order on the narcotic sheet indicated take 1 tablet by mouth three times daily. Observation of the card for Lorazepam indicated there were only 26 tablets left on the medication card.

In addition, QMA 4 had signed both the on and off times

were signed and placed in employee files.

An audit was conducted and the med count was found to be accurate, no residents were affected. Random audits will be conducted on a weekly basis for the following six months.

Date of final completion:
8/16/2024.

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signature page for 8/16/2024 on 8/16/2024 at 8:55 A.M.

During an interview, on 8/16/2024 at 8:56 A.M., QMA 4 indicated he had not signed out the medication after administering it to the resident earlier in the shift and should have and he should not have signed the Change of Shift sheet until the end of his shift, when the on coming staff member had assisted him in reconciling the narcotic counts.

On 8/16/2024 at 9:40 A.M., the ADON provided the policy titled, "Controlled Substance Record Form-Controlled Drug Shift Count Record Form, dated 2/2013, and indicated the policy was the one currently used by the facility. The policy indicated"...6. The licensed nurse or qualified medication aide who administers a Schedule II, III, or IV drug will document the date, time, number of tablets remove, and the remaining number of tables on the Controlled Substance Record along with legible initials...7. All Scheduled II, III, and IV drugs that require inventory monitoring will have the counts verified at the beginning off each shift. Shift counts must be completed by two authorized staff, i.e. licensed nurses or qualified medication aides... The count should included one authorized

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staff from the off-going shift, and one from the on-coming shift...."

Based on observation, interview and record review the facility failed to ensure facility policies related to Controlled Substances were followed related to Narcotic Count/Change of Shift signatures and documentation on the Narcotic Count Records after administering for 1 of 1 narcotic log book reviewed. (Medication cart 1).

Finding includes:

A narcotic medication storage observation was completed, on 8/16/2024 at 8:55 A.M., with QMA 4. The Individual Resident Control Medication Record Sheet for Resident 16 indicated there were 27 pills left on the medication card in the narcotic lock box for Lorazepam 0.5 mg (milligram). The last dose was documented as given was on 8/15/2024 at 8:00 P.M. The order on the narcotic sheet indicated take 1 tablet by mouth three times daily. Observation of the card for Lorazepam indicated there were only 26 tablets left on the medication card.

In addition, QMA 4 had signed both the on and off times signature page for 8/16/2024 on 8/16/2024 at 8:55 A.M.

During an interview, on

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8/16/2024 at 8:56 A.M., QMA 4 indicated he had not signed out the medication after administering it to the resident earlier in the shift and should have and he should not have signed the Change of Shift sheet until the end of his shift, when the on coming staff member had assisted him in reconciling the narcotic counts.

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R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview and record review, the facility failed to ensure a medication cart was free from loose pills and medications were labeled with resident identifiers for one of one medication carts reviewed. (Medication cart 1) Finding includes: During a medication storage observation for cart 1, on 8/16/2024 at 8:55 A.M., with QMA 4 the following was observed: -3 loose pills in one drawer. -2 boxes of Alendronate Sodium 35 mg (milligram) pills with no resident identifiers (pharmacy label) During an interview, on 8/16/2024 at 8:00 A.M., QMA 4 indicated there should be no loose pills in the medication cart and the medications should	R 0300	In-service was conducted with all nursing staff regarding "Medication Labeling" policy. A member of the nursing has been assigned to monitor medication carts for cleanliness and loose pills daily. An audit was conducted and the med count was found to be accurate, no residents were affected. Random audits will be conducted on a weekly basis for the following six months. Date of final completion: 08/16/2024	08/16/2024
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have a label on them.

On 8/16/2024 at 12:16 P.M., the ADON provided the policy titled," Medication Labeling", dated 11/2007, and indicated the policy is the one currently used by the facility. The policy indicated..." All medications must be labeled in a container that conforms to state regulations and should be consistent with physician's orders. 1. The Nurse, or designee, who receives a medication order from the pharmacy is responsible for verifying that the label is correct. Any item that is not properly labeled shall be returned to the pharmacy... Containers having no labels shall be returned to the pharmacy and destroyed in accordance with State and Federal laws...."

Based on observation, interview and record review, the facility failed to ensure a medication cart was free from loose pills and medications were labeled with resident identifiers for one of one medication carts reviewed. (Medication cart 1)

Finding includes:

During a medication storage observation for cart 1, on 8/16/2024 at 8:55 A.M.,with QMA 4 the following was observed:

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	-3 loose pills in one drawer. -2 boxes of Alendronate Sodium 35 mg (milligram) pills with no resident identifiers (pharmacy label) During an interview, on 8/16/2024 at 8:00 A.M., QMA 4 indicated there should be no loose pills in the medication cart and the medications should have a label on them. On 8/16/2024 at 12:16 P.M., the ADON provided the policy titled," Medication Labeling", dated 11/2007, and indicated the policy is the one currently used by the facility. The policy indicated..." All medications must be labeled in a container that conforms to state regulations and should be consistent with physician's orders. 1. The Nurse, or designee, who receives a medication order from the pharmacy is responsible for verifying that the label is correct. Any item that is not properly labeled shall be returned to the pharmacy... Containers having no labels shall be returned to the pharmacy and destroyed in accordance with State and Federal laws...."			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information	R 0356	All existing resident files were audited for state guidelines compliance and those found lacking were immediately	08/16/2024

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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, observation and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 9 of 44 residents. Finding includes: The Emergency Binder was		corrected. All new incoming resident files will be audited by the Director of Nursing within seven days of admission. Additional monthly audit will be conducted for a six month period. The additional audit will be conducted by the Dir. of Nursing on all resident files. Final date of completion: 08/16/2024	
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reviewed on 8/15/2024 at 2:49 P.M., and lacked the following:

Resident 2 had no hospital preference listed.

Resident 10 had no hospital preference listed.

Resident 11 had no hospital preference listed.

Resident 12 had no hospital preference listed.

Resident 13 had no hospital preference listed.

Resident 14 had no hospital preference listed.

Resident 15 had no hospital preference listed.

Resident 16 had no hospital preference listed.

Resident 17 had no hospital preference listed.

During an interview, on 8/16/2024 at 9:03 A.M., the Director of Nursing indicated the hospital preference should have been on the face sheets, but was not.

A policy on emergency resident information was requested on 8/16/2024 at 9:04 A.M.

On 8/16/2024 at 9:40 A.M., the Director of Nursing indicated the facility follows the State

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guidelines for documentation required in an emergency.

Based on record review, observation and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 9 of 44 residents.

Finding includes:

The Emergency Binder was reviewed on 8/15/2024 at 2:49 P.M., and lacked the following:

Resident 2 had no hospital preference listed.

Resident 10 had no hospital preference listed.

Resident 11 had no hospital preference listed.

Resident 12 had no hospital preference listed.

Resident 13 had no hospital preference listed.

Resident 14 had no hospital preference listed.

Resident 15 had no hospital preference listed.

Resident 16 had no hospital preference listed.

Resident 17 had no hospital preference listed.

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	During an interview, on 8/16/2024 at 9:03 A.M., the Director of Nursing indicated the hospital preference should have been on the face sheets, but was not. A policy on emergency resident information was requested on 8/16/2024 at 9:04 A.M. On 8/16/2024 at 9:40 A.M., the Director of Nursing indicated the facility follows the State guidelines for documentation required in an emergency.			
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (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	R 0383	Documented efforts to coordinate a comprehensive care plan with resident physicians diagnosed with MMI's will be made bi-weekly until such plan is signed by the physician. An audit will be conducted within fourteen days of all new move-in's to ensure continued compliance. All resident files were reviewed for deficiency, those found to be lacking/deficient will be reviewed and discussed with the provider for appropriate/agreeable resident care plans. Monthly audits will be conducted on a weekly basis for the following six months. Date of final completion: 8/16/2024	08/16/2024

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into less restrictive and more independent living arrangements.

2. A record review of Resident 7 was completed on 8/16/2024 at 10:14 A.M., Diagnoses included, but were not limited to: bipolar disorder, depression, anxiety and post-traumatic stress disorder.

A record review on 8/16/2024 at 10:31 A.M., indicated Resident 7 received Buspirone (an antianxiety medication) 30 milligrams, Chlordiazepoxide (an antianxiety medication) 10 milligrams and Duloxetine (an antidepressant medication) 60 milligrams daily and Quetiapine (an antipsychotic medication) 400 milligrams at bedtime.

A form titled, "Mental Health Screen", indicated Resident 7 had a diagnosis of bipolar disorder, depression, anxiety and post-traumatic stress disorder. The form indicated Resident 7 was being treated by her primary care physician for her mental illness.

There was no comprehensive care plan related to Resident 7's major mental illness completed.

During an interview on 8/16/2024 at 11:32 A.M., the Director of Nursing indicated a comprehensive care plan related to a major mental illness was not completed for Resident

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7 and should have been.

A current policy was provided on 8/16/2024 at 12:10 P.M., by the Director of Nursing. The policy titled, "Evaluation Process Policy", was revised on 7/15/2021. The policy indicated, "...Subsequent evaluations shall compare the resident's current status to his or her status on admission...."

Based on record review and interview, the facility failed to develop comprehensive service plans in coordination with mental health care providers for 2 of 3 residents reviewed for mental health service plans (Residents 3 and 7).

Findings include:

1. The record for Resident 3 was reviewed on 8/15/2024 at 1:30 P.M. Diagnosis, included but were not limited to: Bipolar Disorder. There was no service/care plan developed in coordination with the Resident 3's mental health provider.

During an interview, on 8/16/2024, at 10:10 A.M., the DON indicated Resident 3's psychiatric medications and care has been managed by the resident's primary care provider since admission. The DON indicated the resident did not see a mental health care provider and there had been no comprehensive care plan

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developed in cooperation with a mental health provider for Resident 3.

2. A record review of Resident 7 was completed on 8/16/2024 at 10:14 A.M., Diagnoses included, but were not limited to: bipolar disorder, depression, anxiety and post-traumatic stress disorder.

A record review on 8/16/2024 at 10:31 A.M., indicated Resident 7 received Buspirone (an antianxiety medication) 30 milligrams, Chlordiazepoxide (an antianxiety medication) 10 milligrams and Duloxetine (an antidepressant medication) 60 milligrams daily and Quetiapine (an antipsychotic medication) 400 milligrams at bedtime.

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A form titled, "Mental Health Screen", indicated Resident 7 had a diagnosis of bipolar disorder, depression, anxiety and post-traumatic stress disorder. The form indicated Resident 7 was being treated by her primary care physician for her mental illness.

There was no comprehensive care plan related to Resident 7's major mental illness completed.

During an interview on 8/16/2024 at 11:32 A.M., the Director of Nursing indicated a comprehensive care plan related to a major mental illness was not completed for Resident

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Based on record review and interview, the facility failed to develop comprehensive service plans in coordination with mental health care providers for 2 of 3 residents reviewed for mental health service plans (Residents 3 and 7).

Findings include:

1. The record for Resident 3 was reviewed on 8/15/2024 at 1:30 P.M. Diagnosis, included but were not limited to: Bipolar Disorder. There was no service/care plan developed in coordination with the Resident 3's mental health provider.

During an interview, on 8/16/2024, at 10:10 A.M., the DON indicated Resident 3's psychiatric medications and care has been managed by the resident's primary care provider since admission. The DON indicated the resident did not see a mental health care provider and there had been no comprehensive care plan

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developed in cooperation with a mental health provider for Resident 3.

2. A record review of Resident 7 was completed on 8/16/2024 at 10:14 A.M., Diagnoses included, but were not limited to: bipolar disorder, depression, anxiety and post-traumatic stress disorder.

A record review on 8/16/2024 at 10:31 A.M., indicated Resident 7 received Buspirone (an antianxiety medication) 30 milligrams, Chlordiazepoxide (an antianxiety medication) 10 milligrams and Duloxetine (an antidepressant medication) 60 milligrams daily and Quetiapine (an antipsychotic medication) 400 milligrams at bedtime.

A form titled, "Mental Health Screen", indicated Resident 7 had a diagnosis of bipolar disorder, depression, anxiety and post-traumatic stress disorder. The form indicated Resident 7 was being treated by her primary care physician for her mental illness.

There was no comprehensive care plan related to Resident 7's major mental illness completed.

During an interview on 8/16/2024 at 11:32 A.M., the Director of Nursing indicated a comprehensive care plan related to a major mental illness was not completed for Resident

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Based on record review and interview, the facility failed to develop comprehensive service plans in coordination with mental health care providers for 2 of 3 residents reviewed for mental health service plans (Residents 3 and 7).

Findings include:

1. The record for Resident 3 was reviewed on 8/15/2024 at 1:30 P.M. Diagnosis, included but were not limited to: Bipolar Disorder. There was no service/care plan developed in coordination with the Resident 3's mental health provider.

During an interview, on 8/16/2024, at 10:10 A.M., the DON indicated Resident 3's psychiatric medications and care has been managed by the resident's primary care provider since admission. The DON indicated the resident did not see a mental health care provider and there had been no comprehensive care plan

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	developed in cooperation with a mental health provider for Resident 3.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure an annual Health Statement was completed and signed by a physician for 1 of 9 residents reviewed. (Resident 6). Finding included: The record review for Resident 6 was completed on 8/16/2024 at 10:46 A.M. There was no Annual Health Statement for Resident 6. During an interview, on 8/16/2024, at 10:06 A.M., the ADON indicated she was unable to locate an Annual Health Statement for Resident 6. On 8/16/2024, at 12:13 P.M., during an interview, the DON indicated the facility had no	R 0409	Changes in the facility eMar system will be created triggering the requirement of an Annual Health Statement for all residents, existing and incoming. The Annual Health Statement has been included as a standard order upon move-in. All existing resident files have been audited and any found to be deficient were immediately corrected. Monthly audits will be conducted for a six month period to ensure compliance. Final date of completion: 08/16/2024	08/16/2024

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FORM APPROVED

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OMB NO. 0938-0391

policy regarding the Annual Health Statement for residents.

Based on interview and record review, the facility failed to ensure an annual Health Statement was completed and signed by a physician for 1 of 9 residents reviewed. (Resident 6).

Finding included:

The record review for Resident 6 was completed on 8/16/2024 at 10:46 A.M. There was no Annual Health Statement for Resident 6.

During an interview, on 8/16/2024, at 10:06 A.M., the ADON indicated she was unable to locate an Annual Health Statement for Resident 6.

On 8/16/2024, at 12:13 P.M., during an interview, the DON indicated the facility had no policy regarding the Annual Health Statement for residents.

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