STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY DEVELOPMENT CORPORATION OF MISHAWAKA, IN	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 the Investigation of Complaints IN00463837, IN00464223, IN00464437 and IN00464714. Complaint IN00463837 - No deficiencies related to the allegations are cited. Complaint IN00464223 - State deficiencies related to the allegations are cited at R0216. Complaint IN00464437 - State deficiencies related to the allegations are cited at R0064 and R0090. Complaint IN00464714 - No deficiencies related to the allegations are cited. Survey date: 9/30/2025 Facility number: 012688 Residential Census: 36	R 0000	Thanks for the Visit. The following tags have Plan of corrections.	

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 10/02/2025			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on record review and interview, the facility failed to ensure the resident's medication was protected from theft for 1 of 1 residents reviewed for misappropriation of property. (Resident E) Finding included: The clinical record of Resident E was reviewed on 9/30/2025 at 11:10 A.M. The resident's diagnoses included, but were not limited to: alcohol dependence, cirrhosis of the liver, schizoaffective disorder, cannabis abuse, cerebral infarction, primary hypertension, anxiety and depression. A current Physician's order	R 0064	1. Corrective Action for the Affected Resident Resident E’s Ozempic medication was replaced by the facility’s pharmacy. The resident was informed of the resolution and the replacement medication was securely stored according to facility policy. 2. Identification of Other Residents Potentially Affected One other incident was found and reported to ISDH via Gateway. 3. Systemic Changes to Prevent Recurrence	10/30/2025

	included Ozempic (an injectable prescription medication containing semaglutide, approved for use alongside diet and exercise to manage blood sugar in adults with type 2 diabetes) 2 milligrams (mg) per 3 milliliters (mg) give 0.5 mg subcutaneously every week. A Nursing Progress Note, dated 8/22/2025, indicated Resident E reported his Ozempic injections had not been initiated. Resident E reported to the documenting nurse that he had brought the Ozempic medication down to the nurses station the week prior. The nurse documented she had seen "boxes of Ozempic medication" in the nurses' station but could not recall where the medication had been placed. During an interview, on 9/30/2025 at 1:40 P.M., the Administrator indicated he was notified of Resident E's missing Ozempic from the facility's nursing station but he was unsure who had notified him or on what specific day he had been notified. The Administrator indicated it was reported to him that an agency QMA had gone to Resident E's apartment and had received 3 boxes of his Ozempic medication. The agency QMA then took Resident E's Ozempic to the nurses station and other staff had recalled seeing it lying on a		In-service was conducted for the policy “Receiving and Documenting Medications Other than ITP” with Nursing Department The Director of Nursing will ensure that agency hand-off binder includes a review of medication handling procedures. 4. Monitoring and Quality Assurance The Director of Nursing (DON) or designee will complete weekly audits for 4 weeks and bi-weekly for 5 months to verify that all medications brought in from outside sources are properly logged and secured. 5. Date of Completion Target Completion Date: October 30th, 2025	

	desk in the nursing station. Later, Resident E's Ozempic medication could not be located. The Administrator indicated he had contacted InTouch pharmacy to have the medication replaced, including all 3 boxes of the injection the administration pen. The Administrator indicated he did not investigate the missing medication but had just had the pharmacy replace the medication that was lost. He indicated the facility did have a process in which residents were to turn in their medications when they ordered them from an outside pharmacy The Administrator indicated the facility process was not followed for Resident E's Ozempic medication and his medication had not been protected from loss and/or theft. On 9/30/2025 at 2:15 P.M., the Administrator provided a policy titled, "Receiving and Documenting Medications Other than ITP," dated 3/25/2025, indicated the policy was the one currently used by the facility. The policy indicated, "...Medications brought in by residents (or their families/representatives) must be safely received, properly documented, and stored according to the established procedures. All staff members are responsible for ensuring that			

	medications are accurately recorded, securely stored..." This citation relates to complaint IN00464437. Based on record review and interview, the facility failed to ensure the resident's medication was protected from theft for 1 of 1 residents reviewed for misappropriation of property. (Resident E) Finding included: The clinical record of Resident E was reviewed on 9/30/2025 at 11:10 A.M. The resident's diagnoses included, but were not limited to: alcohol dependence, cirrhosis of the liver, schizoaffective disorder, cannabis abuse, cerebral infarction, primary hypertension, anxiety and depression. A current Physician's order included Ozempic (an injectable prescription medication containing semaglutide, approved for use alongside diet and exercise to manage blood sugar in adults with type 2 diabetes) 2 milligrams (mg) per 3 milliliters (mg) give 0.5 mg subcutaneously every week. A Nursing Progress Note, dated 8/22/2025, indicated Resident E reported his Ozempic injections had not been initiated. Resident E reported to the documenting nurse that he had brought the			

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R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:	R 0090	1. Corrective Action for the Affected Resident Resident E’s Ozempic medication was replaced by the facility’s pharmacy.	10/30/2025

	(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and		Resident E was notified of the resolution. 2. Identification of Other Residents Potentially Affected No other unreported incidents were found. 3. Systemic Changes to Prevent Recurrence The policy titled “State Reportable Unusual Occurrences – Investigation and Reporting” was reviewed and we rewrote policy to include incidents that need to be reported. The Administrator, Director of Nursing (DON), and department heads were re-educated on reporting requirements on October 10th, 2025.	

	(B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure a theft of a resident's medications was reported to the State Survey Agency for 1 of 3 residents reviewed for medications. (Resident E) Finding included: The clinical record of Resident E was reviewed on 9/30/2025 at 11:10 A.M. The resident's diagnoses included, but were not limited to: alcohol dependence, cirrhosis of the liver, schizoaffective disorder, cannabis abuse, cerebral infarction, primary hypertension, anxiety and depression. A current Physician's order included Ozempic (an injectable prescription medication		All licensed nurses, QMAs, and administrative staff will receive education on identifying and reporting unusual occurrences within 24 hours of awareness. Agency staff orientation now includes a review of this policy. 4. Monitoring and Quality Assurance The Administrator or designee will review all incident reports daily for 2 weeks, Weekly for 2 weeks, and Monthly for 5 Months to ensure reportable events are sent to the State within 24 hours. 5. Date of Completion Target Completion Date: October 30th, 2025.	

	containing semaglutide, approved for use alongside diet and exercise to manage blood sugar in adults with type 2 diabetes) 2 milligrams (mg) per 3 milliliters (mg) give 0.5 mg subcutaneously every week. A Nursing Progress Note, dated 8/22/2025, indicated Resident E reported his Ozempic injections had not been initiated. Resident E reported to the documenting nurse that he had brought the Ozempic medication down to the nurses station the week prior. The nurse documented she had seen "boxes of Ozempic medication" in the nurses' station but could not recall where the medication had been placed. During an interview, on 9/30/2025 at 1:40 P.M., the Administrator indicated he was notified of Resident E's missing Ozempic from the facility's nursing station but he was unsure who had notified him or on what specific day he had been notified. The Administrator indicated it was reported to him that an agency QMA had gone to Resident E's apartment and had received 3 boxes of Ozempic medication. The agency QMA then took Resident E's Ozempic to the nurses station and other staff had recalled seeing it lying on a desk in the nursing station. Later, Resident E's Ozempic			

	medication could not be located. The Administrator indicated he had contacted the facility's pharmacy to have the medication replaced, including all 3 boxes of the injection the administration pen. The Administrator indicated he had not reported the missing medication to the state as a reportable. He indicated the facility did have a process in which residents were to turn in their medications when they ordered them from an outside pharmacy The Administrator indicated the facility process was not followed for Resident E's Ozempic medication. On 9/30/2025 at 1:43 P.M., the Administrator provided a policy titled, "State Reportable Unusual Occurrences - Investigation and Reporting, ", dated 10/15/2015, and indicated the policy was the one currently used by the facility. The policy indicated, "alleged violations involving...misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law...the Administrator...will be responsible for notification...including the Indiana State Department of Health Long Term Care Division, all unusual occurrences..."			

This citation relates to complaint IN00464437.

Based on record review and interview, the facility failed to ensure a theft of a resident's medications was reported to the State Survey Agency for 1 of 3 residents reviewed for medications. (Resident E)

Finding included:

The clinical record of Resident E was reviewed on 9/30/2025 at 11:10 A.M. The resident's diagnoses included, but were not limited to: alcohol dependence, cirrhosis of the liver, schizoaffective disorder, cannabis abuse, cerebral infarction, primary hypertension, anxiety and depression.

A current Physician's order included Ozempic (an injectable prescription medication containing semaglutide, approved for use alongside diet and exercise to manage blood sugar in adults with type 2 diabetes) 2 milligrams (mg) per 3 milliliters (mg) give 0.5 mg subcutaneously every week.

A Nursing Progress Note, dated 8/22/2025, indicated Resident E reported his Ozempic injections had not been initiated. Resident E reported to the documenting nurse that he had brought the Ozempic medication down to the nurses station the week prior. The nurse documented

	she had seen "boxes of Ozempic medication" in the nurses' station but could not recall where the medication had been placed. During an interview, on 9/30/2025 at 1:40 P.M., the Administrator indicated he was notified of Resident E's missing Ozempic from the facility's nursing station but he was unsure who had notified him or on what specific day he had been notified. The Administrator indicated it was reported to him that an agency QMA had gone to Resident E's apartment and had received 3 boxes of Ozempic medication. The agency QMA then took Resident E's Ozempic to the nurses station and other staff had recalled seeing it lying on a desk in the nursing station. Later, Resident E's Ozempic medication could not be located. The Administrator indicated he had contacted the facility's pharmacy to have the medication replaced, including all 3 boxes of the injection the administration pen. The Administrator indicated he had not reported the missing medication to the state as a reportable. He indicated the facility did have a process in which residents were to turn in their medications when they ordered them from an outside pharmacy The Administrator indicated the facility process			

	was not followed for Resident E's Ozempic medication. On 9/30/2025 at 1:43 P.M., the Administrator provided a policy titled, "State Reportable Unusual Occurrences - Investigation and Reporting, ", dated 10/15/2015, and indicated the policy was the one currently used by the facility. The policy indicated, "alleged violations involving...misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law...the Administrator...will be responsible for notification...including the Indiana State Department of Health Long Term Care Division, all unusual occurrences..." This citation relates to complaint IN00464437.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status.	R 0216	1. Corrective Action for the Affected Resident Resident G's ability to self-administer medications was immediately reassessed by October 14th, 2025.	10/30/2025

	(2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview the facility failed to assess a resident's ability to self administer medications safely for 1 of 2 residents reviewed for medication self administration. (Resident G) Finding includes: On 9/30/2025 at 10:30 A.M. the DON provided a list of residents who self administered their medications, which included Resident G. During an interview on 9/30/2025 at 2:02 P.M., Resident G indicated she handled and administered her own medications. A record review for Resident G was completed on 9/30/2025 at 2:32 P.M. The most recent Self Administration Assessment had been completed on 12/4/2024. During an interview on 9/30/2025 at 2:51 P.M., the		The updated Self-Administration Assessment was placed in the resident’s record. Resident G continues to safely self-administer medications with no negative outcome. 2. Identification of Other Residents Potentially Affected A full review was completed of all residents who self-administer medications to ensure current assessments are on file. Any missing or outdated assessments were completed by October 17th, 2025. 3. Systemic Changes to Prevent Recurrence A new policy titled “Self-Administration of Medications” was developed	

	DON indicated the last Self Administration Assessment was completed on 12/4/2025 and she did not know how often the assessment should be completed. She also indicated there was not a policy addressing self administration of oral medications. The only one she had was for injectable medications. This citation relates to complaint IN00464223. Based on record review and interview the facility failed to assess a resident's ability to self administer medications safely for 1 of 2 residents reviewed for medication self administration. (Resident G) Finding includes: On 9/30/2025 at 10:30 A.M. the DON provided a list of residents who self administered their medications, which included Resident G. During an interview on 9/30/2025 at 2:02 P.M., Resident G indicated she handled and administered her own medications. A record review for Resident G was completed on 9/30/2025 at 2:32 P.M. The most recent Self Administration Assessment had been completed on 12/4/2024. During an interview on		and implemented on October 7th, 2025. The policy includes requirements that all residents approved to self-administer medications must have a written assessment on admission and reviewed at least every six (6) months or with any significant change in condition. The DON and licensed nursing staff were re-educated on completing and updating self-administration assessments and documenting them in the resident’s record. 4. Monitoring and Quality Assurance The DON or designee will review the list of residents who self-administer medications weekly for 4 weeks, and monthly for 5 months to verify current assessments are completed and documented.	

	9/30/2025 at 2:51 P.M., the DON indicated the last Self Administration Assessment was completed on 12/4/2025 and she did not know how often the assessment should be completed. She also indicated there was not a policy addressing self administration of oral medications. The only one she had was for injectable medications. This citation relates to complaint IN00464223.		5. Date of Completion Target Completion Date: October 30th, 2025.	

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 SIGNATUREThomas Klempay Sr.	TITLEAdministrator	(X6) DATE10/20/2025