STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/26/2026

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 Intake 469434. Intake 469434- State deficiencies related to the allegations are cited at R0241. Survey dates: May 26, 2026 Facility number: 012688 Residential Census: 41 This deficiency reflects State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1. Quality Review completed on 5/28/2026	R 0000		
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s	R 0241		06/16/2026

	physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure medications were administered by licensed personnel. (QMA 2) Finding includes: Review of a facility reported incident, dated 2/22/2026, indicated QMA 2 had brought her minor child to work with her and had allowed the child to handle resident medication, including passing the medication to residents. The investigation alleged in one instance, the child handed a resident medications to the resident, without any oversight by QMA 2 who had left the area. The facility's investigation included video recording, which had confirmed the allegations as having happened.			

During an interview, on 5/26/2026 at 1:27 P.M., alert and oriented Resident D indicated he had observed QMA 2's child handing medications to some of the residents. He indicated that QMA 2 had handed him his medications.

A review of the investigation documents on 5/26/2026 at 1:30 P.M., indicated the videotape showed QMA 2 leaving the area and her child handing medications to Resident B.

A record review for Resident B was completed on 5/26/2026 at 9:45 A.M. Diagnoses included, but were not limited to, glaucoma, chronic obstructive pulmonary disease, and depression.

Physician Orders for Resident B included, but were not limited to:

-8/19/2025 acetaminophen 325 milligrams (mg) 2 tablets by mouth every 4 hours as needed for pain.

-5/18/2026 amlodipine 5 mg 1 tablet by mouth daily.

-5/18/2026 atorvastatin 20 mg 1 tablet by mouth every evening.

-3/11/2024 docusate sodium 100 mg 1 capsule by mouth at bedtime as needed.

-5/18/2026 Eliquis 5 mg 1 tablet

by mouth twice daily.

-5/18/2026 levothyroxin 75 micrograms (mcg) 1 tablet by mouth daily at A.M.

-5/18/2026 lisinopril 20 mg 1 tablet by mouth twice daily.

-5/18/2026 Nebivolol 5 mg 1 tablet daily.

-5/182026 sotalol hcl 80 mg 1 tablet by mouth every 12 hours.

A current Care Plan indicated Resident B was able to understand directions but had some difficulty expressing needs or preferences.

Medication management for Resident B indicated staff ordered and prepared all medications. Staff was allowed to leave medication at the bedside for resident to take independently.

During the survey process, on 5/26/2026 at 1:19 P.M., Resident B was unavailable for an interview.

During an interview on 5/26/2026 at 1:38 P.M., the DON indicated QMA 2 was not supposed to brng her child to work with her. The DON indicated documentation in the investigation was incorrect. She indicated on a previous occasion, she had consented to

	allowing QMA 2 to bringing her child to work with her if she received permission from the Administrator. However, the QMA had informed the DON she had found someone to keep her daughter and no longer needed to bring her to work with her. However, for incident that had occurred on 2/22/2026 the QMA 2 had not asked anyone about bringing her daughter to work for the day and had just brought her without permission.. A current policy, dated 6/19/2025 and titled, "Medication Administration Policy Standards" was provided by the Administrator on 5/26/2026 at 10:07 A.M. The policy indicated, "...All medications, including oral, topical, and injectable medications, shall be administered safely and accurately by trained and authorized personnel, in accordance with state regulations, physician orders, and resident rights...."			

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