STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/21/2026

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 Intakes 471984 and 471652. Intake 471652 - State deficiencies related to the allegations are cited at R0241. Intake 471984 - State deficiencies related to the allegations are cited at R0241. Survey date: 9/21/2026 Facility number: 012688 Residential Census: 39 These State Residential Findings are cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-5. Quality Review completed on 9/23/2026	R 0000	N/A	

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 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 record review and interview, the facility failed to administer medications timely for 2 of 5 residents reviewed. (Resident B and C) Findings include: 1. Resident B's record review was completed at 10:20 A.M. Diagnoses included, but were not limited to: anxiety disorder, restless legs syndrome, mood disorder and abdominal hernia. Resident B had the following Physician's orders: -8/24/2026 5 milligram (mg) of buspirone (anti-anxiety medication) once a day at 6:00 A.M. -5/21/2026 500 mg of metformin (antihyperglycemic) twice a day at 6:00 A.M. and 6:00 P.M.	R 0241	1. Corrective action for residents identified as affected The medication administration records for Residents B and C were reviewed by the Director of Nursing/designee for medication administration and documentation concerns identified during the survey. Current physician medication orders for Residents B and C were reviewed and compared with the medication administration records to verify the accuracy of medication schedules. Licensed nurses and Qualified Medication Aides responsible for medication administration were re-educated regarding timely medication administration according to physician orders and facility policy and the requirement to document medication administration in the resident's medication administration record at the time the medication is administered. Residents B and C will continue to be monitored for medication administration concerns. Any identified medication variance or medication error will be addressed according to facility policy, including physician notification when indicated. 2. Identification of other residents who have the potential	10/21/2026

	A review of Resident B's Medication Administration Record (MAR), dated 8/21-9/21/2026, indicated the resident's morning medications (6:00 A.M. to 10:00 A.M.) had been administered late on: -8/22/2026 500 mg of metformin and 5 mg of buspirone were administered at 10:36 A.M. -8/24/2026 500 mg of metformin and 5 mg of buspirone were administered at 10:23 A.M. -8/27/2026 500 mg of metformin and 5 mg of buspirone were administered at 10:29 A.M. -8/28/2026 500 mg of metformin and 5 mg of buspirone were administered at 1:43 P.M. -8/31/2026 500 mg of metformin and 5 mg of buspirone were administered at 1:32 P.M. -9/2/2026 500 mg of metformin and 5 mg of buspirone were administered at 10:40 A.M. -9/6/2026 500 mg of metformin and 5 mg of buspirone were administered at 4:51 P.M. -9/9/2026 500 mg of metformin and 5 mg of buspirone were administered at 11:45 A.M.		to be affected All residents receiving facility-administered medications have the potential to be affected by this deficient practice. The Director of Nursing/designee will complete an audit of current residents receiving medication administration services. Current physician orders will be compared with the medication administration record to identify medication administration documented outside of the ordered or established administration time. Any discrepancies identified during the audit will be reviewed to determine whether the medication was administered outside the appropriate administration time or whether documentation was not entered at the time of administration. Identified concerns will be addressed immediately and appropriate follow-up completed. 3. Measures/systemic changes implemented to prevent recurrence All licensed nursing personnel and Qualified Medication Aides who administer medications will receive education regarding:	

	-9/10/2026 500 mg of metformin and 5 mg of buspirone were administered at 10:52 A.M. -9/11/2026 500 mg of metformin and 5 mg of buspirone were administered at 2:40 P.M. -9/11/2026 500 mg of metformin and 5 mg of buspirone were administered at 11:22 A.M. -9/14/2026 500 mg of metformin and 5 mg of buspirone were administered at 2:34 P.M. -9/16/2026 500 mg of metformin and 5 mg of buspirone were administered late at 10:20 A.M. During an interview on 9/21/2026 at 12:00 P.M., Resident B indicated she had sometimes received her morning medications late. 2. Resident C's record review was completed, on 9/21/2026 at 11:00 A.M. Diagnoses included, but were not limited to: peripheral neuropathy, benign prostatic hyperplasia (BPH) and congestive heart failure. Resident C had the following Physician's orders: -8/26/2026 150 mg of clindamycin hydrochloride (antibiotic) three times a day for seven days at 6 A.M., 2 P.M. and 10 P.M.		• Administration of medications in accordance with current physician orders and facility medication administration policy; • Reviewing the MAR and scheduled medication times before and during each medication pass; • Completing medication administration within the appropriate administration time; • Documenting medication administration in the MAR immediately following administration and not delaying documentation until later in the shift; • Reporting medications that cannot be administered within the appropriate time to the licensed nurse/DON according to facility procedure; and • Following facility medication-error procedures when a medication is omitted, administered outside the appropriate administration time, or otherwise administered contrary to the physician's order. Medication administration staff will be instructed that the medication administration task is not complete until the medication has been administrated and the	

	-8/26/2026 0.5 mg dutasteride (treats BPH) once a day at 6 A.M. -8/26/2026 0.5 mg tamsulosin (treats BPH) once a day at 6 A.M. A review of Resident C's Medication Administration Record (MAR), dated 8/21-9/21/2026, indicated the resident's morning medications (6:00 A.M. to 10:00 A.M.) had been administered late on: -8/22/2026 150 mg of clindamycin hydrochloride had been administered at 1:49 P.M. -8/31/2026 150 mg of clindamycin hydrochloride, 0.5 mg of dutasteride and 0.4 mg of tamsulosin were administered at 1:35 P.M. -9/1/2026 150 mg of clindamycin hydrochloride, 0.5 mg of dutasteride and 0.4 mg of tamsulosin were administered at 10:43 A.M. -9/5/2026 0.5 mg of dutasteride and 0.4 mg of tamsulosin were administered at 2:34 P.M. -9/6/2026 0.5 mg of dutasteride and 0.4 mg of tamsulosin were administered at 4:53 P.M.		administration has been appropriately documented in the resident's MAR. The Director of Nursing/designee will review medication administration practices and MAR documentation with medication administration staff and provide additional education or corrective action as indicated by audit findings. 4. Monitoring / Quality Assurance The Director of Nursing/designee will conduct medication administration/MAR audits to monitor compliance with timely medication administration and documentation. Audits will include a sample of residents receiving facility-administered medications and will compare physician orders, scheduled administration times, and documented medication administration times. Audits will be completed as follows: • 5 residents weekly for 4 weeks; • 5 residents every two weeks for the following 2 months; and	

	-9/9/2026 0.5 mg of dutasteride and 0.4 mg of tamsulosin were administered at 1:18 P.M. -9/11/2026 0.5 mg of dutasteride and 0.4 mg of tamsulosin were administered at 2:34 P.M. -9/13/2026 0.5 mg of dutasteride and 0.4 mg of tamsulosin were administered at 11:23 A.M. -9/14/2026 0.5 mg of dutasteride and 0.4 mg of tamsulosin were administered at 2:38 P.M. -9/15/2026 0.5 mg of dutasteride and 0.4 mg of tamsulosin were administered at 10:51 A.M. During an interview with Resident C, on 9/21/2026 at 12:10 P.M., the resident indicated his medications were late a lot and he had complained multiple times, but nothing had changed. During an interview, on 9/21/2026 at 1:30 P.M., the Director of Nursing indicated if the medication had been scheduled for 6:00 A.M., the facility had between 6:00 A.M. and 10:00 A.M. to administer the medications. If a medication had been administered after 10:00 A.M., that medication would have been considered		• 5 residents monthly for 3 additional months. Audit results will be reviewed by the Director of Nursing/Administrator and incorporated into the facility's Quality Assurance process. Any identified noncompliance will result in immediate corrective action, which may include additional staff education, counseling, competency review, or other corrective action as appropriate. The monitoring process will continue until the facility demonstrates sustained compliance. The Administrator/Director of Nursing is responsible for ensuring implementation and continued compliance with this Plan of Correction. 5. Date of Compliance The facility will complete the systemic corrective actions identified in this Plan of Correction by October 21, 2026.	

	late. The DON indicated she believed all medications had been passed timely, but had not been charted as administered in the resident's record. The DON indicated the medication should have been signed off in the record as soon as the medication had been administered. On 9/21/2026 at 1:45 P.M., the DON provided an undated policy title, "Medication Management Program", and identified it as the policy currently used by the facility. The policy indicated, "... C. Medications are accurately administered in accordance with prescribed route, dosage, and frequency by trained and authorized health services staff...."			

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) DATE10/02/2026