| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 08/20/2025 |

| 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<br><br>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 6/19/25. This visit included a PSR to the Investigation of Complaint IN00458166 completed on 6/19/25.<br><br>This visit was in conjunction with the PSR to the Investigation of Complaint IN00461959 completed on 7/7/25.<br><br>Complaint IN00458166- Corrected.<br><br>Survey dates: August 19 & 20, 2025<br><br>Facility number: 012688<br><br>Residential Census: 37<br><br>Community Development Corporation of Mishawaka was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR State Licensure | R 0000 | | |

Survey and the PSR to the Investigation of Complaint IN00458166.

Quality Review completed on 8/26/2025

This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 6/19/25. This visit included a PSR to the Investigation of Complaint IN00458166 completed on 6/19/25.

This visit was in conjunction with the PSR to the Investigation of Complaint IN00461959 completed on 7/7/25.

Complaint IN00458166-Corrected.

Survey dates: August 19 & 20, 2025

Facility number: 012688

Residential Census: 37

Community Development Corporation of Mishawaka was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR State Licensure Survey and the PSR to the Investigation of Complaint IN00458166.

Quality Review completed on 8/26/2025

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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 |
|---|---|---|
| | | |