

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/28/2022
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 the Investigation of Complaint IN00398037. Complaint IN00398037 - Unsubstantiated due to lack of evidence. Survey date: December 27 and 28, 2022 Facility number: 012688 Residential Census: 45 Community Development Corporation of Mishawaka was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00398037. Quality review completed 1/3/23.	R 0000			
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			TITLE	(X6) DATE	

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SIGNATURE		
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