

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2026
NAME OF PROVIDER OR SUPPLIER HELLENIC SENIOR LIVING OF MISHAWAKA		STREET ADDRESS, CITY, STATE, ZIP CODE 1540 SOUTH LOGAN STREET, 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 470457, 470729, and 471247. Intake 470457- No deficiencies related to the allegations are cited. Intake 470729- No deficiencies related to the allegations are cited. Intake 471247- No deficiencies related to the allegations are cited. Survey dates: August 6 and 7, 2026 Facility number: 014224 Residential Census: 117 Hellenic Senior Living of Mishawaka was found to be in compliance with 410 IAC 16.2-3.1.in regards to the Intake Investigation. Quality Review completed on	R 0000			

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FORM APPROVED

OMB NO. 0938-0391

	August 10, 2026.			
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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
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