

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012688</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/28/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY DEVELOPMENT CORPORATION OF MIS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 LINCOLNWAY EAST MISHAWAKA, IN 46544</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00398037.</p> <p>Complaint IN00398037 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: December 27 and 28, 2022</p> <p>Facility number: 012688</p> <p>Residential Census: 45</p> <p>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.</p> <p>Quality review completed 1/3/23.</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------