

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER TANGLEWOOD TRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 530 W TANGLEWOOD LN, MISHAWAKA, , 46545			
(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 IN00470037 and IN00470345. Intake IN00470037 - No deficiencies related to the allegations are cited. Intake IN00470345 - No deficiencies related to the allegations are cited. Survey date: July 8 & 9, 2026 Facility number: 009669 Residential Census: 79 Tanglewood Trace was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intakes IN00470037 and IN00470345. Quality Review completed on 7/10/2026	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					

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instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE