

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 11/22/2022
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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00389168, IN00384825 and IN00391838. Complaint IN00389168 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00384825 - Unsubstantiated due to lack of evidence. Complaint IN00391838 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 21 & 22, 2022 Facility number: 009669 Residential Census: 75 Tanglewood Trace was found to be in compliance with 410 IAC 16.2-5 in regard to the State	R 0000			

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Residential Licensure Survey and the Investigation of Complaints IN00389168, IN00384825 and IN00391838. Quality review completed 11/29/22.			
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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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