

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

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                      |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING | (X3) DATE SURVEY<br>COMPLETED<br><br>08/06/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>TANGLEWOOD TRACE                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>530 W TANGLEWOOD LN, MISHAWAKA,<br>, 46545 |                                  |                                                                 |                                                 |
| (X4) ID<br>PREFIX TAG                                                                                                                                                                                                                                   | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION... | (X5)<br>COMPLETION<br>DATE                                      |                                                 |
| R 0000                                                                                                                                                                                                                                                  | <p>INITIAL COMMENTS</p> <p>This visit was for the<br/>Investigation of Intake 470852.</p> <p>Intake 470852-No defociencies<br/>related to the allegations are<br/>cited.</p> <p>Survey date: 8/6/2026</p> <p>Facilty number: 009669</p> <p>Residential Cencus: 74</p> <p>Tanglewood Trace was found to<br/>be in compliance with 410<br/>Indiana Adminitrative Code<br/>16.2.5 in regards to the<br/>investigation of Intake 470852.</p> <p>Quality Review completed on<br/>8/10/2026</p> | R 0000                                                                                     |                                  |                                                                 |                                                 |
| Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from<br>correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See<br>instructions.) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                                  |                                                                 |                                                 |
| LABORATORY DIRECTOR'S OR<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                            | TITLE                            | (X6) DATE                                                       |                                                 |