

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 11/26/2025
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 IN00465793 and IN00466193. Intake IN00465793 - No deficiencies related to the allegations are cited. Intake IN00466193- No deficiencies related to the allegations are cited. Survey date: 11/25 & 11/26/2025 Facility number: 009669 Residential Census: 80 Tanglewood Trace was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intakes IN00465793 and IN00466193. Quality Review completed on 12/01/2025	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