

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 009669	(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, IN 46545		
(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>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00389168, IN00384825 and IN00391838.</p> <p>Complaint IN00389168 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00384825 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00391838 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: November 21 & 22, 2022</p> <p>Facility number: 009669</p> <p>Residential Census: 75</p> <p>Tanglewood Trace was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaints IN00389168, IN00384825 and IN00391838.</p> <p>Quality review completed 11/29/22.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE