

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 01/23/2024	
NAME OF PROVIDER OR SUPPLIER TRADITIONS AT SOLANA		STREET ADDRESS, CITY, STATE, ZIP CODE 7721 BATTERY POINTE WAY, INDIANAPOLIS, , 46240					
(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 Complaints IN00415263, IN00419658 and IN00420371. Complaint IN00415263 - No deficiencies related to the allegations are cited. Complaint IN00419658 - No deficiencies related to the allegations are cited Complaint IN00420371 - No deficiencies related to the allegations are cited. Survey dates: January 22 and 23, 2024 Facility number: 013164 Residential Census: 82 Traditions At Solana was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00415263, IN00419658 and IN00420371.	R 0000					

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FORM APPROVED

OMB NO. 0938-0391

	Quality review was completed on January 31, 2024.			
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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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