STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT SOLANA	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 Intakes 469327, 469776 and 469848. Intake 469327-State deficiencies related to the allegations are cited at R29. Intake 469776-State deficiencies related to the allegations are cited at R51 and R214. Intake 469848-State deficiencies related to the allegations are cited at R51 and R214. Survey dates: May 20, 21 and 22, 2026 Facility number: 013164 Residential: 92 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed	R 0000		

	on June 2, 2026.			
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review, the facility failed to ensure a resident was treated with respect and dignity during an episode of aggressive behavior toward a staff member for 1 of 5 residents reviewed for respect and dignity. (Resident B) Findings include: During an observation, on 5/20/26 at 2:34 p.m., Resident B was ambulating throughout the memory care hallway talking to herself in nonsensical words. The facility staff attempted to get Resident B to go to an activity, but she would not stay for the activity. During an interview, on 5/22/26 at 11:20 a.m., the Executive Director (ED) indicated the Memory Care Activity Director did not use appropriate interventions to redirect Resident B from grabbing clean dishes. The Memory Care Activity Director put her arm out	R 0029	What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice • Resident monitored for psychosocial distress • Resident care plan updated with interventions for aggressive behaviors • Memory Care Activity Coordinator Terminated How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken • Residents with aggressive behaviors have the potential to be affected by the same alleged deficient practice • Review Medical charts of residents on Memory Care to identify residents with history of aggressive behaviors • Service plans for residents exhibiting aggressive behaviors will be reviewed and will be updated with appropriate interventions as indicated	06/21/2026

	to try to stop Resident B from getting the clean dishes and Resident B fell. The Memory Care Activity Director was terminated because of previous performance issues, she did not redirect a dementia resident appropriately, and she had been trained on how to handle the situation. The clinical record for Resident B was reviewed on 5/22/26 at 4:02 p.m. The diagnoses included, but were not limited to, dementia and hypertension. Resident B's service plan, dated 4/24/26, indicated she required daily interventions to manage episodic behaviors such as agitation, refusing to put on pull ups, refusing to change clothes, her mood changing easily, and she threw dishes and puzzles on the floor when she was agitated. The interventions staff were to use to intervene when the resident had these behaviors were to provide personal space, make little eye contact with the resident while she was upset, staff were not to take items away from her, allow her to become disinterested on her own, and offer her a sucker to assist in redirecting her behavior. During a telephone interview, on 5/21/26 at 10:15 a.m., the previous Memory Care Activity		What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not occur • Educate staff on the following topics: Resident Rights, Abuse, De-escalation, and Aging Sensitivity: Delivering Care with Empathy and Respect by Executive Director or designee How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place • Observation of care to be completed by Wellness Director or designee, alternating shifts daily x3 days, Bi-Weekly x4 weeks, Weekly x4 weeks, Twice Monthly x1 Month, Monthly x3 Months	

	Director indicated Resident B was "getting into everything all over the kitchen." She tried to redirect her, but nothing was working, then Resident B got into the refrigerator, took a cream pie out of the refrigerator, and threw it on the floor. Resident B was headed to the clean dishes and her hands had cream pie all over them. The Memory Care Activity Director indicated she did not want Resident B to get the clean dishes, so she moved the cart with the clean dishes which infuriated Resident B. Resident B then went to the table and "swiped" a pitcher of lemonade off the table onto the floor. The Memory Care Activity Director indicated she put her arm out to try to stop Resident B from knocking the pitcher of lemonade off the table, but it did not help. Resident B grabbed a hold of her left forearm, and they both ended up over by the dining room table in front of the steam table. Resident B started to fall and was trying to pull the Memory Care Activity Director down with her. The Memory Care Activity Director stiffened her left forearm and tried to stop Resident B from falling, but it was impossible. The incident happened on 4/17/26. She was terminated on 4/22/26. A resident right and a behavior policy was requested on 5/22/26			

	at 3:05 p.m. The Regional Director of Clinical Services indicated the facility followed the Indiana State Regulations. This citation relates to Intake 469327.			
R 0051	Residents' Rights - Offense 410 IAC 16.2-5-1.2(u) (u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident ' s medical symptoms. Based on interview and record review, the facility failed to ensure a resident was free from chemical restraints when a resident was administered a medication to decrease his sex drive without documentation of sexual behaviors for 1 of 1 resident reviewed for chemical restraints. (Resident C) Findings include: During an interview, a confidential interviewee indicated Resident C liked to invite female residents into his room and this was the reason he received a Depo-Provera shot (an injectable hormone used for female contraception with an off-label use in men to suppress testosterone, reduce	R 0051	What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice • Resident C no longer resides in community How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken • Any resident receiving medication for behavior management had the potential to be affected by alleged deficient practice • Review Memory Care residents' med lists for residents receiving medication for behavior management • Confirm documented medical reason for medication, if not indicated physician med review will be requested. What measures will be put into	06/21/2026

	libido, and control hypersexuality) on 4/24/26. An order for Depo-Provera 150 mg (milligrams)/ml(milliliters) intramuscularly was to be administered on the 24th of each month. He received his first dose on 4/24/26. The clinical record for Resident C was reviewed on 5/21/26 at 12:20 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, depression, anxiety, and chronic alcoholism in remission. A physician's order, dated April 2026, indicated to administer Depo-Provera 150 mg/ml intramuscularly monthly on the 24th of every month to reduce sexual drive. The order was signed off as administered, on 4/24/26 at 6:08 p.m., in the right hip. A progress note, dated 2/10/26 at 3:40 p.m., indicated Resident C wandered into another resident's room. A progress note, dated 2/14/26 at 3:06 p.m., indicated Resident C attempted to invite another resident into his room multiple times during the shift.		place or what systemic changes the facility will make to ensure that the deficient practice does not occur • Clinical meeting following morning meeting to review Memory Care resident behaviors to ensure appropriate interventions are in place and medications for behaviors are indicated. To be completed by WD or designee How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Regional Nurse or designee to audit clinical meeting weekly x4 weeks, monthly x5 months	

	A progress note, dated 2/28/26 at 9:12 p.m., indicated Resident C attempted to provide assistance to another resident who was using a walker. A progress note, dated 3/1/26 at 12:40 p.m., indicated Resident C began an inappropriate conversation with the QMA. A progress note, dated 3/2/26 at 8:06 a.m., indicated Resident C continued to be monitored for behavioral problems and touching other residents. The progress note did not include information related to where Resident C was touching other residents, how many residents Resident C touched, any interventions implemented, the effectiveness, and if Resident C was redirected and the results of the redirection. A progress note, dated 3/3/26 at 7:15 p.m., indicated Resident C had been asked several times not to try and pick up a resident out of her chair. He was redirected three times. He went into the nurse's station and took the staff's snacks and ate them. A progress note, dated 3/6/26 at 4:49 p.m., indicated Resident C was attempting to assist a female resident out of her wheelchair. After being redirected, he attempted to take another female resident down to			

	his room, but staff redirected. He continued to require redirection to leave other residents alone. A progress note, dated 3/6/26 at 10:21 p.m., indicated Resident C was observed talking very close to women's faces in an aggressive manner and taking their silverware during dinner. Resident C yelled at a staff member and was in his face when he redirected him and helped him to his room. A progress note, dated 3/7/26 at 7:08 p.m., indicated Resident C walked around the dayroom and the kitchen trying to "force" female residents to come to his room. He was redirected four times. He tried to grab the activities assistant by the neck when he was redirected. The progress note did not include information related to why Resident C was trying to "force" female residents to his room, how many residents Resident C tried to "force", any interventions implemented, or the effectiveness. A progress note, dated 3/7/26 at 10:15 p.m., indicated Resident C was found in another resident's room in bed with another resident who was also in the wrong room. Resident C was prompted five times to exit the room and to return to his			

	own room. He was placed on hourly checks. The progress note did not include information related to what Resident C was wearing, the other resident was wearing, or what the residents were observed to be doing when they were found. A progress note, dated 3/8/26 at 6:13 a.m., indicated Resident C went from door to door and attempted to enter resident rooms. A progress note, dated 3/10/26 at 5:06 p.m., indicated Resident C came out of his room wearing his boxer underwear. He indicated he had shorts on. He was easily redirected to put pants on. Resident C was educated on wearing appropriate clothing in the common area. A progress note, dated 3/14/26 at 7:30 a.m., indicated a CNA on the memory care unit was assisting another resident when Resident C kept trying to "barge" his way into the room. Resident C was redirected; he walked off and came right back again. He was redirected again and walked to his room.			

	A progress note, dated 3/15/26 at 3:41 p.m., indicated Resident C continued to invite residents into his room. The progress note did not include information related to why Resident C was trying to invite residents to his room, how many residents Resident C tried to invite to his room, any interventions implemented, or the effectiveness. A progress note, dated 4/9/26 at 8:15 p.m., indicated staff had alerted the nurse Resident C had a female resident in his room. The nurse observed the female fully clothed lying next to him in his bed. The female was removed from the room, and Resident C was instructed to keep his door locked to prevent other residents from wandering into his room. A progress note, dated 4/10/26 at 3:17 p.m., indicated Resident C was in room with his door open inviting others into his room. A female resident was asked to come out of his room and return to the common area.			

	The progress note did not include information related to why Resident C was trying to invite residents to his room, how many residents Resident C tried to invite to his room, any interventions implemented, or the effectiveness. A progress note, dated 4/10/26 at 8:58 p.m., indicated Resident C was very restless and wandering in and out of other residents' room, exit seeking, most of the evening. As needed (PRN) medication was administered. A progress note, dated 4/17/26 at 3:41 p.m., indicated Resident C attempted to get a female resident to go into his room. Staff redirected his behavior. Staff continued to keep all the residents' room doors locked, so staff were aware of who was in their rooms alone. A progress note, dated 4/23/26 at 9:04 p.m., indicated Resident C had to be redirected away from a female resident several times during this shift. He was very anxious at times. As needed (PRN) medication was administered. A progress note, dated 4/24/26 at 5:54 p.m., indicated the LPN on the evening shift administered the Depo-Provera 150 mg.			

	A progress note, dated 4/24/26 at 10:05 p.m., indicated Resident C required redirection several times during this shift. He became restless/anxious, which upset female residents on the unit. As needed (PRN) medication was administered. A progress note, dated 4/25/26 at 1:57 p.m., indicated Resident C continued to invite other residents into his room. The progress note did not include information related to why Resident C was trying to invite residents to his room, how many residents Resident C tried to invite to his room, any interventions implemented, or the effectiveness. A progress note, dated 4/27/26 at 7:47 p.m., indicated Resident C was agitated with other residents and required redirection multiple times during the shift. As needed (PRN) medication was administered. A progress note, dated 5/12/26 at 12:57 a.m., indicated Resident C was inappropriate and aggressive towards staff and residents. He yelled and swung at the staff. He indicated he had "needs" when redirected to stop touching a resident. Resident C had his hand under another resident's clothes. A progress note, dated 5/17/26			

	at 6:06 p.m., indicated Resident C showed aggressive behavior towards the Qualified Medication Aide this evening. He pointed and yelled at the QMA's face. Resident C's individual service plan, dated 2/20/26, did not include interventions on how the staff were to address Resident C's aggressive behaviors towards staff and other residents, when he invited female residents into his room, when he wandered in and out of other residents' rooms, when he had female residents in bed with him, when he came into the hallway dressed in only boxer shorts, when he attempted to "force" female residents into his room, or when he attempted to assist other residents and touch female residents even though he had been instructed not to. During an interview, a confidential interviewee indicated Resident C sat on his bed and a female resident was standing by his door. The confidential interviewee did not witness anything sexual happening between the two residents. He did try to touch the female residents. During an interview, a confidential interviewee indicated Resident C invited female residents to his room			

	especially the severely cognitively impaired residents. One female resident was in his room one day sitting on one end of his couch and he was sitting on the other end of his couch. The Memory Care Director knew Resident C invited female residents into his room. This confidential interviewee had been told to keep Resident C away from the female residents. During an interview, a confidential interviewee indicated Resident C invited female residents to his room, but they had never saw any sexually inappropriate behaviors from him. During an interview, a confidential interviewee indicated Resident C had been aggressive with female residents and had pulled on them trying to take them to the dining room or his room. They went into his room when the door was closed before and found a particular female who Resident C generally invited into his room asleep in one of his recliners. Resident C was asleep in the other recliner. Resident C thought the female residents on the unit were his friends and he liked the companionship. During an interview, on 5/20/26 at 3:40 p.m., CNA 11 indicated			

	she had not seen any sexually inappropriate behaviors from Resident C. During an interview, on 5/20/26 at 11:54 p.m., LPN 13 indicated she had not witnessed any inappropriate sexual behaviors from Resident C. During an interview, on 5/20/26 at 11:59 p.m., CNA 14 indicated she had not witnessed any inappropriate sexual behaviors from Resident C. During an interview, on 5/21/26 at 9:55 a.m., the Regional Director of Clinical Services indicated Resident C invited other residents into his room and the Depo-Provera was ordered as a preventative intervention because they did not know what kind of behaviors he was going to display. During an interview, on 5/21/26 at 11:01 a.m., the Nurse Practitioner indicated she ordered the Depo-Provera for Resident C because the facility had informed her female residents went into Resident C's room and he had inappropriate sexual behaviors. During an interview, on 5/22/26 at 12:25 p.m., the Regional Director of Clinical Services indicated Resident C did not have a service plan for inappropriate sexual behaviors			

	because he did not have any inappropriate sexual behaviors. The staff have been instructed to redirect residents when they were having behaviors, so they would redirect Resident C. The staff were also keeping all the residents' doors locked when the residents were inside their rooms, so the staff knew Resident C could not get inside the other residents' rooms. Resident C's door was kept closed and locked as well to keep wanderers out of his room. Resident C was monitored more frequently when he was out of his room to ensure he was not touching other residents or trying to invite residents into his room. A resident right and a behavior policy was requested on 5/22/26 at 3:05 p.m. The Regional Director of Clinical Services indicated the facility followed the Indiana State Regulations.			

	The University of San Diego website https://digital.sandiego.edu indicated Depo-Provera was used to lower sex drive and manage severe inappropriate sexual behaviors. The use of Depo-Provera for this purpose came with significant debate and was typically reserved for highly specific clinical programs or court-mandated treatment rather than general medical use. This citation relates to Intakes 469776 and 469848.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate the individual needs of a resident related to a change in behavior and to update the service plan for 1 of 2 residents reviewed for service plans. (Resident C)	R 0214	What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice • Resident discharged from facility and no longer resides on premises How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken • Any resident with significant change in behavior has the potential to be affected by the same alleged deficient practice. • Service plans for residents exhibiting	06/21/2026

	Findings include: The clinical record for Resident C was reviewed on 5/21/26 at 12:20 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, depression, anxiety, and chronic alcoholism in remission. A progress note, dated 2/10/26 at 3:40 p.m., indicated Resident C wandered into another resident's room. A progress note, dated 2/14/26 at 3:06 p.m., indicated Resident C attempted to invite another resident into his room multiple times during the shift. A progress note, dated 2/28/26 at 9:12 p.m., indicated Resident C attempted to provide assistance to another resident who was using a walker. A progress note, dated 3/1/26 at 12:40 p.m., indicated Resident C began an inappropriate conversation with the QMA. A progress note, dated 3/2/26 at 8:06 a.m., indicated Resident C continued to be monitored for behavioral problems and touching other residents. A progress note, dated 3/3/26 at 7:15 p.m., indicated Resident C had been asked several times not to try and pick up a resident out of her chair. He went into		significant change in behaviors will be reviewed and will be updated with appropriate interventions as indicated What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not occur • Clinical meeting following morning meeting to review significant behavior change and ensure service plan is updated with appropriate intervention(s) • In-service to be completed on Reporting/Notification of significant behavior changes with nursing staff. To be completed by Wellness Director or designee • In-service to be completed with nursing staff on Change in Condition. To be completed by Wellness Director or designee How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Wellness Director or designee to audit service plans with significant	

	the nurse's station and took the staff's snacks and ate them. A progress note, dated 3/6/26 at 4:49 p.m., indicated Resident C was attempting to assist a female resident out of her wheelchair. He attempted to take another female resident down to his room. He continued to require redirection to leave other residents alone. A progress note, dated 3/6/26 at 10:21 p.m., indicated Resident C was observed talking very close to women's faces in an aggressive manner and taking their silverware during dinner. Resident C yelled at a staff member and was in his face when he redirected him and helped him to his room. A progress note, dated 3/7/26 at 7:08 p.m., indicated Resident C walked around the dayroom and the kitchen trying to "force" female residents to come to his room. He tried to grab the activities assistant by the neck when he was redirected. A progress note, dated 3/7/26 at 10:15 p.m., indicated Resident C was found in another resident's room in bed with another resident who was also in the wrong room. A progress note, dated 3/8/26 at 6:13 a.m., indicated Resident C went from door to door and		behavior changes to be completed Bi-Weekly x4 weeks, Weekly x5 weeks, Twice Monthly x1 Month, Monthly x3 Months	

attempted to enter resident rooms.

A progress note, dated 3/10/26 at 5:06 p.m., indicated Resident C came out of his room wearing his boxer underwear.

A progress note, dated 3/14/26 at 7:30 a.m., indicated a CNA on the memory care unit was assisting another resident when Resident C kept trying to "barge" his way into the room.

A progress note, dated 3/15/26 at 3:41 p.m., indicated Resident C continued to invite residents into his room.

A progress note, dated 4/9/26 at 8:15 p.m., indicated staff had alerted the nurse Resident C had a female resident in his room. The nurse observed the female fully clothed lying next to him in his bed.

A progress note, dated 4/10/26 at 3:17 p.m., indicated Resident C was in room with his door open inviting others into his room. A female resident was asked to come out of his room and return to the common area.

A progress note, dated 4/10/26 at 8:58 p.m., indicated Resident C was very restless and wandering in and out of other residents' room, exit seeking, most of the evening. As needed (PRN) medication was

administered.

A progress note, dated 4/17/26 at 3:41 p.m., indicated Resident C attempted to get a female resident to go into his room. Staff continued to keep all the residents' room doors locked, so staff were aware of who was in their rooms alone.

A progress note, dated 4/23/26 at 9:04 p.m., indicated Resident C had to be redirected away from a female resident several times during this shift. He was very anxious at times. As needed (PRN) medication was administered.

A progress note, dated 4/24/26 at 5:54 p.m., indicated the LPN on the evening shift administered the Depo-Provera 150 mg.

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redirection multiple times during the shift. As needed (PRN) medication was administered.

A progress note, dated 5/12/26 at 12:57 a.m., indicated Resident C was inappropriate and aggressive towards staff and residents. He yelled and swung at the staff. He indicated he had "needs" when redirected to stop touching a resident. Resident C had his hand under another resident's clothes.

A progress note, dated 5/17/26 at 6:06 p.m., indicated Resident C showed aggressive behavior towards the Qualified Medication Aide this evening. He pointed and yelled at the QMA's face.

Resident C's individual service plan, dated 2/20/26, did not include interventions on how the staff were to address Resident C's aggressive behaviors towards staff and other residents, when he invited female residents into his room, when he wandered in and out of other residents' rooms, when he had female residents in bed with him, when he came into the hallway dressed in only boxer shorts, when he attempted to "force" female residents into his room, or when he attempted to assist other residents and touch female residents even though he had been instructed not to.

During an interview, on 5/22/26 at 12:25 p.m., the Regional Director of Clinical Services indicated Resident C did not have a service plan for inappropriate sexual behaviors because he did not have any inappropriate sexual behaviors. The staff have been instructed to redirect residents when they were having behaviors, so they would redirect Resident C. The staff were also keeping all the residents' doors locked when the residents were inside their rooms, so the staff knew Resident C could not get inside the other residents' rooms. Resident C's door was kept closed and locked as well to keep wanderers out of his room. Resident C was monitored more frequently when he was out of his room to ensure he was not touching other residents or trying to invite residents into his room.

A service plan policy was requested on 5/22/26 at 3:05 p.m. The Regional Director of Clinical Services indicated the facility followed the Indiana State Regulations.

This citation relates to Intakes 469776 and 469848.

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	TITLEExecutive Director	(X6) DATE06/12/2026

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETy Warner		