STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/23/2025

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 IN00465439 and IN00463467. Intake IN00465439-No deficiencies related to the allegations are cited. Intake IN00463467-State deficiencies related to the allegations are cited at R29. Survey dates: October 22 and 23, 2025. Facility number: 013164 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 27, 2025.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.	
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d)	R 0029	What corrective action(s) will be accomplished for those residents found to have been	11/12/2025

	(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 for 1 of 6 residents reviewed for quality of care. (Resident 2) Findings include: During an interview, on 10/23/25 at 10:30 a.m., Resident 2's Power of Attorney (POA) indicated she had concerns with the care provided to Resident 2. Resident 2 moved into the facility approximately 8 weeks ago and had several falls since admission. The staff were to complete 2-hour checks on Resident 2 throughout the night and several checks throughout the day. Resident 2 had a camera in her room and the POA would receive a notification on her cell phone of any movement in the room. The staff did not complete the 2-hour checks on Resident 2 at night. She had contacted the facility and asked if staff would be sure to check on her mother throughout the night. The following night, on 9/30/25 at 10:30 p.m., Home Health Aide (HHA) 7 and HHA 8 entered Resident 2's room, turned on the overhead light, and woke Resident 2 up by getting close		affected by the deficient practice Inservice completed on Residents Rights for Employee 7 & 8 by Wellness Director or Designee Employee 8 – Disciplinary action for Standard of Resident Care Employee 7 – Disciplinary action for Standard of Resident Care and education for Fall Procedures by Wellness Director or Designee 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 provided care by Employee 7 or 8 have potential to be impacted by alleged deficient practice	

	to the resident's face, speaking loudly, and telling Resident 2 it was 10:30 p.m. and goodnight. The POA indicated Resident 2 was asleep at the time the staff members entered the room but was awake and talking when they shut the light off and left the room. Resident 2 had dementia and was a fall risk. The POA believed the behavior by the two staff members was not appropriate and increased her mother's risk of falling by waking her up and then leaving her alone. The POA indicated she showed management the video and was told the two staff members did nothing wrong. The Area Vice President of Operations refused to watch the video and indicated HHA 8 was an exceptional care giver. The POA indicated a different video had shown where HHA 7 attempted to get Resident 2 off the floor after a fall without being assessed by a nurse and another instance where HHA 8 had recorded a video on her personal cell phone of Resident 2's behaviors and sent the video to her boss's personal phone. During an observation of a video recording with the POA, on 10/23/25 at 10:35 a.m., Resident 2, on 9/30/25 at 10:30 p.m., was quietly lying on her left side in her bed, facing the wall, and not moving. The room was dark and the door was shut. The door to the room was		Disciplinary action for employees 7 & 8, Reeducation on Resident Rights, Standard of Care, Fall Procedures by Wellness Director or Designee What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Education provided to Employee 7 by Wellness Director or Designee – Resident Rights and Standard of Care Education provided to Employee 8 by Wellness Director or Designee– Resident Rights, Standard of Care, Fall Procedures Staff educated on Resident Rights, Standard of Resident Care, Fall Procedures by Wellness Director or designee, and Executive Director or designee (Resident rights)	

	adjacent to the foot of the bed. HHA 8 opened the door and walked into the dark room with a cell phone in her hand. HHA 7 turned on the overhead light as she entered the room behind HHA 8. HHA 8 leaned over Resident 2's bed next to Resident 2's head and said "Goodnight, it's 10:30, have a goodnight." Resident 2 started speaking at this time and HHA 8 turned to leave the room. HHA 7 followed HHA 8 out of the room, turned the overhead light off, and closed the door. Resident 2 was still speaking at the time the two staff members exited the room. During an observation of a video recording with the POA, on 10/23/25 at 10:40 a.m., Resident 2 was lying on the floor in her room. The room was dark and the door was closed. HHA 7 entered the room, walked over to Resident 2 on the floor, and removed the blankets off Resident 2. HHA 7 then repositioned Resident 2's right leg, so her knee was bent, and her foot was flat on the floor. Resident 2 groaned in discomfort when her leg was moved. HHA 7 held out her hands for Resident 2 to grab and assisted Resident 2 into a seated position. Once Resident 2 was in a seated position, HHA 7 stood behind Resident 2, placed her arms under Resident 2's armpits and attempted to lift		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. Audits to be conducted by Wellness Director or Designee Observing Employee 7 & 8 provide patient care - Daily x3 days, Twice weekly for 4 weeks, Weekly X4, Twice monthly X1 Month, monthly for 3 months Random audit of resident care covering variety of employees, shifts, hallways – - Daily x3 days, Twice weekly for 4 weeks, Weekly X4, Twice monthly X1 Month, monthly for 3 months	

her off the floor. A licensed staff member was not observed to have entered Resident 2's room to assess the resident for injuries prior to HHA 7 repositioning or moving the resident.

During an interview, on 10/23/25 at 11:08 a.m., the Memory Care Director indicated HHA 8 took a video of Resident 2 on her personal phone and sent the video to her (the Memory Care Director) which was against the facility media policy. Staff should not have their cell phones out, take pictures, or record videos of a resident. After reviewing the video recording from the POA, the Memory Care Director indicated the manor of the bed check for Resident 2 was not acceptable. The staff should not turn on the overhead light or wake the residents up unless needed. The Memory Care Director indicated "That is not the quality of care expected from the employees." A resident would not be moved after a fall until the resident had been assessed for injuries by a nurse and HHA 7 should not have moved Resident 2 after she fell.

The clinical record for Resident 2 was reviewed on 10/23/25 at 11:40 a.m. The diagnoses included, but were not limited to, dementia and depression.

	A service plan, dated 8/27/25, indicated Resident 2 was a fall risk related to confusion, disorientation, and impulsivity. She required safety checks eight (8) times a day and safety checks throughout the night every two (2) hours. During an interview, on 10/23/25 at 11:08 a.m., the Director of Nursing (DON) indicated she and the Executive Director had watched the video recordings with Resident 2's POA and indicated it was not the quality of care the facility wanted their employees to provide. A staff member should not record any resident with a personal cell phone. A resident who had fallen would not be moved until a nurse had assessed the resident for injuries. When HHA 7 attempted to move Resident 2 after the fall, the resident had not been assessed by a nurse. During an interview, on 10/23/25 at 11:27 a.m., HHA 7 indicated during a bed check, the overhead light would not be turned on, and the resident would not be woken unless resident care needed to be completed. She did not turn the light on, on 9/30/25, and did not wake Resident 2 up. Resident 2 had woken up during the bed check. HHA 7 indicated she would not move a resident who had fallen until a nurse had assessed the resident for			

	injuries. She had panicked when she noticed Resident 2 on the floor and immediately wanted to get Resident 2 into a comfortable position. During an interview, on 10/23/25 at 11:58 a.m., HHA 8 indicated she checked residents every 2 hours. She flipped on the lights to see if the residents were "alive and not on the floor". She told Resident 2 the time that night because "they all want to know the time, like if it is breakfast" and Resident 2 had asked what time it was. HHA 8 indicated Resident 2 was awake when they entered the room and she had not "done anything wrong". She used her personal phone to make a video of Resident 2's behaviors and sent the video to her supervisor. HHA 8 indicated "what other phone was I supposed to use?" and she did not know what the facility media policy was.			

A current facility policy, titled "Social Media," undated and received from the Area Vice President of Operations on 10/23/25 at 11:16 a.m., indicated "...Using social media poses a potential for risks such as invasion of privacy...Do not take photos, videos, or audio recordings of residents or in the work place...The only employees that should take photos of residents are those whose job requires it...."

A current facility policy, titled "Residents' Rights," dated 2/22 and received from the Area Vice President of Operations on 10/22/25 at 2:26 p.m., indicated "...Residents have the right to a dignified existence...Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality...Residents have the right to confidentiality...Residents have the rights to be treated as individuals with consideration and respect for their privacy...."

This citation relates to Intake IN00463467.

Based on observation, interview and record review, the facility failed to ensure a resident was treated with respect and dignity for 1 of 6 residents reviewed for quality of care. (Resident 2)

Findings include:

	During an interview, on 10/23/25 at 10:30 a.m., Resident 2's Power of Attorney (POA) indicated she had concerns with the care provided to Resident 2. Resident 2 moved into the facility approximately 8 weeks ago and had several falls since admission. The staff were to complete 2-hour checks on Resident 2 throughout the night and several checks throughout the day. Resident 2 had a camera in her room and the POA would receive a notification on her cell phone of any movement in the room. The staff did not complete the 2-hour checks on Resident 2 at night. She had contacted the facility and asked if staff would be sure to check on her mother throughout the night. The following night, on 9/30/25 at 10:30 p.m., Home Health Aide (HHA) 7 and HHA 8 entered Resident 2's room, turned on the overhead light, and woke Resident 2 up by getting close to the resident's face, speaking loudly, and telling Resident 2 it was 10:30 p.m. and goodnight. The POA indicated Resident 2 was asleep at the time the staff members entered the room but was awake and talking when they shut the light off and left the room. Resident 2 had dementia and was a fall risk. The POA believed the behavior by the two staff members was not appropriate and increased her mother's risk of falling by			

	waking her up and then leaving her alone. The POA indicated she showed management the video and was told the two staff members did nothing wrong. The Area Vice President of Operations refused to watch the video and indicated HHA 8 was an exceptional care giver. The POA indicated a different video had shown where HHA 7 attempted to get Resident 2 off the floor after a fall without being assessed by a nurse and another instance where HHA 8 had recorded a video on her personal cell phone of Resident 2's behaviors and sent the video to her boss's personal phone. During an observation of a video recording with the POA, on 10/23/25 at 10:35 a.m., Resident 2, on 9/30/25 at 10:30 p.m., was quietly lying on her left side in her bed, facing the wall, and not moving. The room was dark and the door was shut. The door to the room was adjacent to the foot of the bed. HHA 8 opened the door and walked into the dark room with a cell phone in her hand. HHA 7 turned on the overhead light as she entered the room behind HHA 8. HHA 8 leaned over Resident 2's bed next to Resident 2's head and said "Goodnight, it's 10:30, have a goodnight." Resident 2 started speaking at this time and HHA 8 turned to leave the room. HHA 7 followed HHA 8 out of the room,			

	turned the overhead light off, and closed the door. Resident 2 was still speaking at the time the two staff members exited the room. During an observation of a video recording with the POA, on 10/23/25 at 10:40 a.m., Resident 2 was lying on the floor in her room. The room was dark and the door was closed. HHA 7 entered the room, walked over to Resident 2 on the floor, and removed the blankets off Resident 2. HHA 7 then repositioned Resident 2's right leg, so her knee was bent, and her foot was flat on the floor. Resident 2 groaned in discomfort when her leg was moved. HHA 7 held out her hands for Resident 2 to grab and assisted Resident 2 into a seated position. Once Resident 2 was in a seated position, HHA 7 stood behind Resident 2, placed her arms under Resident 2's armpits and attempted to lift her off the floor. A licensed staff member was not observed to have entered Resident 2's room to assess the resident for injuries prior to HHA 7 repositioning or moving the resident. During an interview, on 10/23/25 at 11:08 a.m., the Memory Care Director indicated HHA 8 took a video of Resident 2 on her personal phone and sent the video to her (the Memory Care			

	Director) which was against the facility media policy. Staff should not have their cell phones out, take pictures, or record videos of a resident. After reviewing the video recording from the POA, the Memory Care Director indicated the manor of the bed check for Resident 2 was not acceptable. The staff should not turn on the overhead light or wake the residents up unless needed. The Memory Care Director indicated "That is not the quality of care expected from the employees." A resident would not be moved after a fall until the resident had been assessed for injuries by a nurse and HHA 7 should not have moved Resident 2 after she fell. The clinical record for Resident 2 was reviewed on 10/23/25 at 11:40 a.m. The diagnoses included, but were not limited to, dementia and depression. A service plan, dated 8/27/25, indicated Resident 2 was a fall risk related to confusion, disorientation, and impulsivity. She required safety checks eight (8) times a day and safety checks throughout the night every two (2) hours. During an interview, on 10/23/25 at 11:08 a.m., the Director of Nursing (DON) indicated she and the Executive Director had watched the video recordings			

	with Resident 2's POA and indicated it was not the quality of care the facility wanted their employees to provide. A staff member should not record any resident with a personal cell phone. A resident who had fallen would not be moved until a nurse had assessed the resident for injuries. When HHA 7 attempted to move Resident 2 after the fall, the resident had not been assessed by a nurse. During an interview, on 10/23/25 at 11:27 a.m., HHA 7 indicated during a bed check, the overhead light would not be turned on, and the resident would not be woken unless resident care needed to be completed. She did not turn the light on, on 9/30/25, and did not wake Resident 2 up. Resident 2 had woken up during the bed check. HHA 7 indicated she would not move a resident who had fallen until a nurse had assessed the resident for injuries. She had panicked when she noticed Resident 2 on the floor and immediately wanted to get Resident 2 into a comfortable position. During an interview, on 10/23/25 at 11:58 a.m., HHA 8 indicated she checked residents every 2 hours. She flipped on the lights to see if the residents were "alive and not on the floor". She told Resident 2 the time that night because "they all want to			

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	the rights to be treated as individuals with consideration and respect for their privacy...." This citation relates to Intake IN00463467.			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure a resident was free from misappropriation of property of a narcotic medication for 1 of 3 residents reviewed for	R 0298	Not identified as a deficiency on the 2567.	10/29/2025

misappropriation of property. (Resident B)

Findings include:

A facility reported incident, dated 10/10/25, indicated hydrocodone (a narcotic pain medication) was found missing during the morning shift change.

During a telephone interview, on 10/22/25 at 10:07 a.m., Resident B's family member indicated she was not notified of missing narcotics.

The clinical record for Resident B was reviewed on 10/22/25 at 10:02 a.m. The diagnoses included, but were not limited to, dementia with agitation, scoliosis with deformity, and anxiety.

A physician's order, dated 9/8/25, indicated to administer one tablet of hydrocodone with acetaminophen 5/325 milligrams as needed.

A facility document, titled "Disciplinary Action Form," undated, indicated a verbal warning was given to LPN 2 for the inability to perform job responsibilities.

During an interview, on 10/22/25 at 10:26 a.m., the Area Vice President of Operations indicated the missing narcotic medication was not found.

During an interview, on 10/23/35 at 9:07 a.m., QMA 4 indicated the medications were to be counted and the narcotic sign out sheet was to be signed every shift change.

During an interview, on 10/23/35 at 9:22 a.m., QMA 5 indicated the narcotics needed to be counted and checked with the narcotic count sheets to determine the remaining balance. The narcotic book needed to be signed every shift when the medication cart keys changed hands.

During a telephone interview, on 10/22/25 at 1:37 p.m., LPN 3 indicated when the night shift staff member arrived and was taking over the medication cart, LPN 2 took the keys, and they counted the cart together. A pill was missing the next day. He indicated he had been educated to observe both the count sheet and the amount of medication left.

During a telephone interview, on 10/23/25 at 5:41 a.m., LPN 2 indicated during the shift change it was busy. She had three carts to count, and the pharmacy was waiting for her. LPN 3 had the narcotic count book, and she was counting the narcotic medications. LPN 3 read the balance of narcotics left as she checked the narcotic medications. She took LPN 3's

word as to what each balance was left on the narcotic count sheet.

A current facility policy, titled "...Resident Neglect, Abuse and Misappropriation of Property," dated March 2024 and received from the Area Vice President of Operations on 10/22/25 at 2:26 p.m., indicated "...Residents will be free from misappropriation of resident property...."

This citation relates to Intake IN00465439.

Based on interview and record review, the facility failed to ensure a resident was free from misappropriation of property of a narcotic medication for 1 of 3 residents reviewed for misappropriation of property. (Resident B)

Findings include:

A facility reported incident, dated 10/10/25, indicated hydrocodone (a narcotic pain medication) was found missing during the morning shift change.

During a telephone interview, on 10/22/25 at 10:07 a.m., Resident B's family member indicated she was not notified of missing narcotics.

The clinical record for Resident B was reviewed on 10/22/25 at 10:02 a.m. The diagnoses included, but were not limited to,

dementia with agitation, scoliosis with deformity, and anxiety.

A physician's order, dated 9/8/25, indicated to administer one tablet of hydrocodone with acetaminophen 5/325 milligrams as needed.

A facility document, titled "Disciplinary Action Form," undated, indicated a verbal warning was given to LPN 2 for the inability to perform job responsibilities.

During an interview, on 10/22/25 at 10:26 a.m., the Area Vice President of Operations indicated the missing narcotic medication was not found.

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PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETy Warner		