STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF COLUMBUS	4300 WEST GOELLER BLVD, COLUMBUS, , 47201

(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 IN00463523 and IN00462206. Complaint IN00463523 - State deficiency related to the allegation is cited at R0052 Complaint IN00462206 - No deficiencies related to the allegations were cited. Survey date: August 5, 2025 Facility number: 015179 Residential Census: 90 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 7, 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. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **In response to R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights** **Deficiency:** **(V) Residents have the right to be free from:**	

			(1) Sexual Abuse; **(2) Physical Abuse;** **(3) Mental Abuse;** **(4) Corporal Punishment;** **(5) Neglect; and** **(6) Involuntary Seclusion.** **What corrective actions will be accomplished for those residents found to have been affected by the finding:** The employee in question was immediately suspended pending investigation and then terminated. The incident was reported to ISDH.	

			-Completed 7/18/25 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:** No residents were adversely affected though the potential for adverse outcome did exist. Resident Rights, Abuse and Reporting education was provided at staff meeting. -Completed 7/29/25, 8/28/25 and ongoing **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** **How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:**	

			We will continue to perform a background check and licensure verification on all new employees. -Completed 8/6/25 and ongoing monthly The Executive Director will conduct an Inservice for employees to review resident rights, abuse and reporting. The Executive Director will retain documentation of the Inservice. -Completed 7/29/25, 8/28/25 and ongoing Monthly resident review will be conducted during QA Meeting. -Completed 8/20/25 and ongoing monthly **What date the systemic changes will be completed:** 8/28/25 and ongoing	
R 0052	Residents' Rights - Offense	R 0052	The creation and submission of	08/28/2025

	410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure staff to resident physical abuse did not occur for 1 of 3 residents reviewed for abuse. (Resident C) Findings include: During an interview, on 8/5/2025 at 10:10 A.M., Home Health Aide (HHA) 5 indicated her and HH3 were getting Resident C ready for breakfast in his room. HH2 walked into the room and smacked the back of his head and started laughing. Resident C stated, "Ow, who did that". HHA3 stepped in front of the Resident after laughing and never responded to the resident. During an interview, on 8/5/2025 at 10:58 A.M., HHA 3 indicated she was helping HHA 5 transfer Resident C out of bed and into his wheelchair to go to breakfast		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. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **In response to R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights** **Deficiency:** **(V) Residents have the right to be free from:** **(1) Sexual Abuse;** **(2) Physical Abuse;** **(3) Mental Abuse;**	

	when HHA 2 walked into the room and slapped the back of his head. His head moved forward a little, but it wasn't a hard slap. It was enough to make the resident reply, "Ow who did that?". Resident C was upset after the slap to the back of his head and then grabbed the back of his head. Review of a facility incident report, dated 7/18/2025 at 10:30 A.M., indicated HHA 2 was observed, by HHA 3 and HHA 5, walking into Resident C's room and had hit the resident on the back of his head. An Incident Investigation Form, dated 7/18/2025, indicated HHA 2 reported she went into Resident C's room, and touched the back of his head to help motivate him to be strong and stand up. An Employee Termination Form, dated 7/22/2025, was provided by the Administrator on 8/5/25 at 2:20 P.M. The documented indicated HHA 2 was terminated by the facility due to unprofessional behavior. The clinical record for Resident C was reviewed on 8/5/2025 at 11:15 A.M. Resident C resided on the facilities Memory Care Unit. The resident's diagnoses included, but were not limited to, dementia with mood disturbance, hypothyroidism,		**(4) Corporal Punishment;** **(5) Neglect; and** **(6) Involuntary Seclusion.** **What corrective actions will be accomplished for those residents found to have been affected by the finding:** The employee in question was immediately suspended pending investigation and then terminated. The incident was reported to ISDH. -Completed 7/18/25	

	and anemia. The current facility policy titled, "Resident Neglect, Abuse, and Misappropriation of Property" with a revision date 3/2024, was provided by the Administrator on 8/5/2025 at 2:00 P.M. The policy indicated, "...Residents will be free from ... verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion...". The current facility policy titled, "Resident Rights" with a revision date 2/2022, was provided by the Administrator on 8/5/2025 at 2:00 P.M. The policy indicated, "... Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality ...". This citation relates to Complaint IN00463523. Based on interview and record review, the facility failed to ensure staff to resident physical abuse did not occur for 1 of 3 residents reviewed for abuse. (Resident C) Findings include: During an interview, on 8/5/2025 at 10:10 A.M., Home Health Aide (HHA) 5 indicated her and HH3 were getting Resident C ready for breakfast in his room. HH2 walked into the room and smacked the back of his head and started laughing. Resident		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:** No residents were adversely affected though the potential for adverse outcome did exist. Resident Rights, Abuse and Reporting education was provided at staff meeting. -Completed 7/29/25, 8/28/25 and ongoing **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** **How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:**	

C stated, "Ow, who did that". HHA3 stepped in front of the Resident after laughing and never responded to the resident.

During an interview, on 8/5/2025 at 10:58 A.M., HHA 3 indicated she was helping HHA 5 transfer Resident C out of bed and into his wheelchair to go to breakfast when HHA 2 walked into the room and slapped the back of his head. His head moved forward a little, but it wasn't a hard slap. It was enough to make the resident reply, "Ow who did that?". Resident C was upset after the slap to the back of his head and then grabbed the back of his head.

Review of a facility incident report, dated 7/18/2025 at 10:30 A.M., indicated HHA 2 was observed, by HHA 3 and HHA 5, walking into Resident C's room and had hit the resident on the back of his head.

An Incident Investigation Form, dated 7/18/2025, indicated HHA 2 reported she went into Resident C's room, and touched the back of his head to help motivate him to be strong and stand up.

An Employee Termination Form, dated 7/22/2025, was provided by the Administrator on 8/5/25 at 2:20 P.M. The documented indicated HHA 2 was terminated

We will continue to perform a background check and licensure verification on all new employees.

-Completed 8/6/25 and ongoing monthly

The Executive Director will conduct an Inservice for employees to review resident rights, abuse and reporting. The Executive Director will retain documentation of the Inservice.

-Completed 7/29/25, 8/28/25 and ongoing

Monthly resident review will be conducted during QA Meeting.

-Completed 8/20/25 and ongoing monthly

What date the systemic changes will be completed:

8/28/25 and ongoing

by the facility due to unprofessional behavior.

The clinical record for Resident C was reviewed on 8/5/2025 at 11:15 A.M. Resident C resided on the facilities Memory Care Unit. The resident's diagnoses included, but were not limited to, dementia with mood disturbance, hypothyroidism, and anemia.

The current facility policy titled, "Resident Neglect, Abuse, and Misappropriation of Property" with a revision date 3/2024, was provided by the Administrator on 8/5/2025 at 2:00 P.M. The policy indicated, "...Residents will be free from ... verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion...".

The current facility policy titled, "Resident Rights" with a revision date 2/2022, was provided by the Administrator on 8/5/2025 at 2:00 P.M. The policy indicated, "... Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality ...".

This citation relates to Complaint IN00463523.

SIGNATURE		