

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 08/14/2026
NAME OF PROVIDER OR SUPPLIER TRADITIONS OF COLUMBUS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Intake 470553. This visit was in conjuncture with a Post Survey Revisit (PSR) to the investigation of Intakes 470243 and 470248 completed on 06/16/2026. Intake 470553 - State deficiency related to the allegation is cited at R0036. Intake 470243 - Corrected Intake 470248 - Corrected Survey date: August 14, 2026 Facility number: 015179 Residential Census: 90 This State Residential Finding is cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5.	R 0000			

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	Quality review completed on August 25, 2026.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview, observation, and record review, the facility failed to update a resident's Service Plan following an elopement (when a resident leaves a safe care area or facility unsupervised, unnoticed, and without staff knowledge or permission) to ensure the resident's safety for 1 of 3 residents reviewed for Service Plans. (Resident C) Findings include: During an interview on 08/14/2026 at 10:07 A.M., the Memory Care Director indicated Resident C had exited (eloped)	R 0036	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 029 410 IAC 16.2-5-1.2(k)(1-2)Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. What corrective actions will be accomplished for those	09/01/2026

from the Memory Care Unit several weeks ago. The resident was found near the dumpsters in the back of the building. She had exited through a back door immediately next to the dumpsters. Once the code to exit the unit was entered into the keypad and you went through the door, it would not lock immediately. The resident lived on the locked dementia unit and had gotten out through a different set of doors and into the Main Lobby again, within the last week. Per the fire safety code, if you held the door handle in for 30 seconds, the lock would release and the door would open. The resident did that. When pushing on the door for 30 seconds, the alarm would go off the entire time. The staff were doing other things at that time, and it took longer than 30 seconds to respond. The resident got out into the Main Lobby but did not exit the building. This had happened around 8:00 P.M. The resident was constantly exit seeking and always pushing on the doors.

The door to the dumpster area in the Memory Care Unit was observed on 08/14/2026 at 10:26 A.M., with the Director of Wellness and the Memory Care Director. The staff members indicated the kitchen staff had exited the Memory Care Unit through a door at the end of a

residents found to have been affected by the deficient practice:

No residents were affected by the deficient practice, though the potential for adverse outcome did exist.

-Completed 9/1/26

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

No residents were adversely affected though the potential for adverse outcome did exist.

Elopement education was provided to staff with documentation kept in the ED office/ Inservice Binder

-Completed 9/1/26 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.

We will continue to educate employees on elopement procedures during monthly staff in-services.

-Completed 9/1/26 and ongoing

New employees will be

hallway. The resident caught the door before it latched. One of the resident assistants saw the resident outside through a window of another resident's room. The resident got out of the building without anyone knowing because the alarm did not go off due to her pushing the door along with the kitchen staff. The elopement had happened on a weekend, but the staff could not remember at what time. The resident had an increase in memory issues in the afternoon and evening and her exit seeking behaviors increased during that time. The two staff had not seen the camera footage to know how long the resident was outside. The exit door from the unit led to a short hallway with a locked door to the kitchen and an exit door to the parking lot and dumpster area. The staff indicated the door to the parking lot was not locked.

During an interview, on 08/14/2026 at 12:14 P.M., Licensed Practical Nurse (LPN) 2 indicated the resident had been exit seeking the night before and was trying to look for her deceased husband.

The clinical record for Resident C was reviewed on 08/14/2026 at 11:38 A.M. The resident's admission date was 06/11/2026. The resident's diagnosis

educated on elopement protocols as part of their new hire process, with documentation kept in the employee file.

-Completed 9/1/26 and ongoing

Monthly resident review will be conducted during QA Meeting to review any elopements and to ensure care plans are updated accordingly

-Completed 9/1/26 and ongoing

How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:

ED will audit care plans for updates and accuracy weekly x4 weeks, monthly x4 weeks and PRN thereafter. Documentation of this to be kept in ED office.

-Completed 9/1/26 and ongoing

Monthly resident review will be conducted during QA Meeting.

-Completed 9/1/26 and ongoing monthly

What date the systemic changes will be completed:

9/1/26 and ongoing

included, but were not limited to, dementia (an umbrella term for a decline in memory, language, problem-solving, and other thinking skills that affect a person's ability to perform everyday activities).

A Nurse's Note, dated 06/27/2026 at 2:01 P.M., indicated that during the morning hours, the resident was wandering on the unit, difficult to redirect, and kept repeating that she needed to go see her mother in (another State). She needed to leave and stated that if she could not leave, she would bust out the windows. The resident needed to be redirected every 15 to 20 minutes.

A Nurse's Note, dated 06/27/2026 at 6:56 P.M., indicated staff had reported to the nurse the resident had eloped from the unit and was found nearby on the sidewalk outdoors. A staff member saw the resident through the window in another resident's room and went outside to redirect her. The resident stated that she was searching for her husband and was easily redirected back inside. This resident was frequently exit seeking and staff members have been educated on ensuring that all doors shut and lock behind them when leaving the unit.

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

The resident's current Service Plan indicated it was last updated, on 06/24/2026, prior to the resident's elopement. The Service Plan lacked an updated intervention after the resident left the locked unit on two separate occasions.

The current facility policy, titled "Resident Service Plan", reviewed on 10/22, was provided by the Administrator on 08/14/2026 at 2:20 P.M. The policy indicated " ...The community utilizes an individualized service plan for each resident that includes assessments important in meeting the needs of the resident ...Service plans shall be reviewed and revised as appropriate ..."

This citation relates to Intake 470553.

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
SIGNATUREStacey Gallardo

TITLEExecutive Director

(X6) DATE09/08/2026