STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012203	A. BUILDING: _____ B. WING _____	C 08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS HEALTH	7215 E 21ST STREET, SUITE A INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a Federal and State complaint survey of a hospice agency. The investigation was initiated by the Indiana Department of Health. Survey Dates: 8-15-22 and 8-16-22 Complaint Number: IN 00387600: Unsubstantiated: No deficiencies were cited. Facility Number: 012203 CCN: 151606 Medicaid Number: 201179100 Traditions Health was found to have been IN COMPLIANCE with the state licensure requirements 410 IAC Article 17 et seq. in relation to the complaint allegations. QR by Area 3 on 8-22-2022	S 000		