

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>015179</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/09/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TRADITIONS OF COLUMBUS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4300 WEST GOELLER BLVD</b> <b>COLUMBUS, IN 47201</b>
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(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
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00403502.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the PSR completed on December 21, 2022 to the Investigation of Complaint IN00391651 completed on February 3, 2023.</p> <p>Complaint IN00403052 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00391651 - Corrected</p> <p>Survey dates: March 8 and 9, 2023</p> <p>Facility number: 015179</p> <p>Residential Census: 63</p> <p>Traditions of Columbus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00403502.</p> <p>Quality review completed on March 12, 2023.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_