

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/28/2025
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NAME OF PROVIDER OR SUPPLIER TRADITIONS AT SOLANA	STREET ADDRESS, CITY, STATE, ZIP CODE 7721 BATTERY POINTE WAY INDIANAPOLIS, IN 46240
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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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00450389.</p> <p>Complaint IN00450389-No deficiencies related to the allegations were cited.</p> <p>Survey dates: January 27 and 28, 2025</p> <p>Facility number: 013164</p> <p>Residential census: 87</p> <p>Traditions at Solana was found to be in compliance with 42 CFR 483, Subpart B and 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00450389.</p> <p>Quality review was completed February 3, 2025.</p>	R 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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