

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013264	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/21/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRADITIONS AT REAGAN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1176 KINGWOOD DRIVE AVON, IN 46123
--	--

(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 IN00449886.</p> <p>Complaint IN00449886 - No deficiencies related to the allegations are cited.</p> <p>Survey date: February 21, 2025</p> <p>Facility number: 013264</p> <p>Residential Census: 79</p> <p>Traditions at Reagan Park was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00449886.</p> <p>Quality review completed on February 21, 2025.</p>	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE