

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/21/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRADITIONS OF COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4300 WEST GOELLER BLVD COLUMBUS, IN 47201
---	---

(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 Complaints IN00452478 and IN00453872.</p> <p>Complaint IN00452478 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00453872 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 20, and 21, 2025</p> <p>Facility number: 015179</p> <p>Residential Census: 90</p> <p>Traditions of Columbus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00452478 and IN00453872.</p> <p>Quality review completed on February 26, 2025.</p>	R 000		

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