STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155236		12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CTR	4171 FOREST POINTE CIR 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) COMPLETION DATE
F 0000 Bldg. 00	This visit was for an investigation of Complaint IN00188020. This visit was in conjunction with a Recertification and State Licensure Survey and the Investigation of Complaint IN00186985. Complaint IN00188020 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F309. Survey dates: November 30 and December 1, 2, 3, 4, & 7, 2015. Facility number: 000141 Provider number: 155236 AIM number: 100283860 Census bed type: SNF/NF: 111 Total: 111 Census payor type: Medicare: 14 Medicaid: 79 Other: 18 Total: 111 Sample: 4	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155236		12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CTR	4171 FOREST POINTE CIR 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) COMPLETION DATE
	These deficiencies reflect State findings in accordance with 410 IAC 16.2-3.1. Quality review completed December 13, 2015 by 29479.			
F 0157 SS=G Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155236		12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CTR	4171 FOREST POINTE CIR 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) COMPLETION DATE
	update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to assess and immediately notify a physician of a resident's change in condition related to concerns of lethargy and dehydration voiced by the family member, which resulted in hospitalization for dehydration. This deficient practice affected 1 of 3 residents reviewed for physician notification (Resident B). Findings include: Resident B's record was reviewed on 12/3/2015 at 3:45 p.m. Resident B had diagnoses which included, but were not limited to, dysphagia, vascular dementia, cognitive communication deficit, and hypernatremia (high concentration of sodium in the blood). The record lacked indication of a system for ensuring fluids were increased and the resident was monitored for signs of dehydration. A physician's progress report, dated 11/24/2015, indicated the Nurse Practitioner had evaluated Resident B for hypernatremia with regard to her sodium level of 150 drawn on 11/12/2015. The Nurse Practitioner indicated the facility was to encourage Resident B to drink	F 0157	Corrective action: Physician was notified of Resident B's change of condition and an assessment completed. Other residents with potential to be affected: Residents with a change of condition have the potential to be affected. Progress notes were reviewed from the past week to ensure any residents with a change of condition had been assessed and physicians had been notified. Systematic changes: 1:1 education was provided to staff member who failed to make appropriate notification. An in-service was presented to staff on the facility 'Physician/Family/Responsible Party Notification' policy and the e-interact Change of Condition Assessment. IDT will review progress notes during clinical meeting for changes of condition and audit for appropriate notification (no less than 5 days/week excluding holidays and weekends). Staff members who fail to comply will be subject to re-education and/or disciplinary action. Monitoring: Results of the audits will be forward to QA for review monthly X3 then quarterly. Date of completion: 1/6/16	01/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/04/2015
NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR 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) COMPLETION DATE
	oral fluids and recheck her BMP on 11/30/2015. A nurse's note, dated 11/25/2015 at 9:06 p.m., indicated Resident B's daughter called the facility twice during the shift and expressed concerns regarding her mother's lethargy during the afternoon and requested her anti-anxiety medication be placed on hold. This note indicated Resident B's anti-anxiety medication had been placed on hold and the resident had been put on the doctor's board for assessment during his next visit to the facility. A nurse's note, dated 11/26/2015 at 6:29 p.m., indicated Resident B's routine pain medication had not been administered because the resident appeared tired. A nurse's note, dated 11/26/2015 at 8:00 p.m., indicated Resident B's daughter arrived at the facility at 7 p.m. and expressed concern regarding her mother's lethargy, decreased responsiveness and lack of eating and drinking. She requested the facility transfer her mother to the Emergency Room for evaluation. This note indicated the ambulance transported Resident B to the Emergency Room at 7:50 p.m. A review of Resident B's November 2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155236		12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CTR	4171 FOREST POINTE CIR 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) COMPLETION DATE
	Vital Signs Report, dated 12/7/2015, indicated Resident B's blood pressure, temperature, pulse, respirations and oxygen level had not been assessed during the month of November until 11/26/2015 at 7 p.m. A Physician's Progress Note, dated 11/26/2015 at 11:29 p.m., indicated Resident B had a critically high sodium level of 182 and would be admitted to the hospital from the Emergency Department for further evaluation. An Admission History and Physical Note, dated 11/27/2015 at 2:58 a.m. indicated Resident B was admitted to the hospital with pronounced dehydration, severe hypernatremia and altered mental status. During an interview on 12/7/2015 at 11:23 a.m., the Director of Nursing (DON) indicated she could not provide documentation of a nursing assessment on Resident B after her family voiced concerns of the resident's condition. During an interview on 12/7/2015 at 12:07 p.m., the DON indicated Resident B had an order to encourage oral fluids due to her high sodium levels and to increase hydration. She indicated the facility encouraged and monitored oral			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/04/2015
NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR 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) COMPLETION DATE
	fluid intake with documentation. No other assessments were in place to assess hydration. During an interview on 12/7/2015 at 12:25 p.m., the DON indicated she expected her staff to perform an assessment of a resident when a family member voiced concerns regarding a change in the resident's condition. During an interview on 12/7/2015 at 2:49 p.m., Licensed Practical Nurse (LPN) #7 indicated non-emergent concerns regarding a resident are placed on the doctor's board. The physicians visit the facility at least twice a week and will review the doctor's board in the facility. Emergency concerns regarding a resident should be called into the physician. During an interview on 12/7/2015 at 3:55 p.m., the DON indicated an assessed change of condition should be reported to the physician immediately. A policy titled "Physician/Family/Responsible Party Notification for Change in Condition, dated 8/2013, and identified as current by the Nurse Consultant on 12/7/2015 at 3:35 p.m., indicated, ...Purpose: To ensure that medical care problems are communicated to the attending physician			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155236		12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CTR	4171 FOREST POINTE CIR 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) COMPLETION DATE
	and family/responsible party in a timely, efficient, and effective manner...Policy: Physician and family/responsible party notification is to include, but is not limited to: ...change in level of consciousness, change in condition that may warrant a change in current treatment...Physician and Family/Responsible Party notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained...." This Federal tag relates to Complaint IN00188020. 3.1-5(a)(1)			
F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to complete an immediate assessment of a resident following a family member's voiced	F 0309	Corrective action: Physician was notified of Resident B's change of condition and an assessment completed.Other residents having potential to be affected:	01/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/04/2015
NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR 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) COMPLETION DATE
	concerns of a change in condition, which resulted in a hospitalization of the resident due to critical sodium lab values and severe dehydration (Resident B). Findings include: Resident B's record was reviewed on 12/3/2015 at 3:45 p.m. Resident B had diagnoses which included, but were not limited to, dysphagia, vascular dementia, cognitive communication deficit, and hypernatremia (high concentration of sodium in the blood). The record lacked documentation of a nursing assessment performed for Resident B on 11/25/2015, following the concerns of the resident's family member. The record lacked indication of a system for ensuring fluids were increased and the resident was monitored for signs of dehydration. A Basic Metabolic Panel (BMP) lab report, dated 11/12/2015, indicated Resident B had a high sodium level of 150 milliequivalents per liter (mEq/L). The reference range for sodium levels is between 135- 145 mEq/L. A Basic Metabolic Panel (BMP) lab report, dated 11/12/2015, indicated Resident B had a high sodium level of 150 milliequivalents per liter (mEq/L). The reference range for sodium levels is		Residents with a change of condition have the potential to be affected. Progress notes were reviewed from the past week to ensure any residents with a change of condition had been assessed and physicians had been notified. Systematic changes: 1:1 education was provided to staff member who failed to make appropriate notification. An in-service was presented to staff on the facility 'Physician/Family/Responsible Party Notification' policy and the e-interact Change of Condition Assessment. IDT will review progress notes during clinical meeting for changes of condition and audit for appropriate notification and a completed assessment (no less than 5 days/week excluding holidays and weekends) . Staff members who fail to comply will be subject to re-education and/or disciplinary action. Monitoring: Results of the audits will be forward to QA for review monthly X3 then quarterly. Date of completion: 12/26/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/04/2015
NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR 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) COMPLETION DATE
	between 135- 145 mEq/L. A physician's progress report, dated 11/24/2015, indicated the Nurse Practitioner had evaluated Resident B for hypernatremia with regard to her sodium level of 150 drawn on 11/12/2015. The Nurse Practitioner indicated the facility was to encourage Resident B to drink oral fluids and recheck her BMP on 11/30/2015. A nurse's note, dated 11/25/2015 at 9:06 p.m., indicated Resident B's daughter called the facility twice during the shift and expressed concerns regarding her mother's lethargy during the afternoon and requested her anti-anxiety medication be placed on hold. This note indicated Resident B's anti-anxiety medication had been placed on hold and the resident had been put on the doctor's board for assessment during his next visit to the facility. A nurse's note, dated 11/26/2015 at 1:00 p.m., indicated Resident B's routine pain medication had not been administered per her daughter's request. A nurse's note, dated 11/26/2015 at 6:29 p.m., indicated Resident B's routine pain medication had not been administered because the resident appeared tired.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/04/2015
NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR 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) COMPLETION DATE
	A nurse's note, dated 11/26/2015 at 8:00 p.m., indicated Resident B's daughter arrived at the facility at 7 p.m. and expressed concern regarding her mother's lethargy, decreased responsiveness and lack of eating and drinking. She requested the facility transfer her mother to the Emergency Room for evaluation. This note indicated the ambulance transported Resident B to the Emergency Room at 7:50 p.m. A review of Resident B's November 2015 Vital Signs Report, dated 12/7/2015, indicated Resident B's blood pressure, temperature, pulse, respirations and oxygen level had not been assessed during the month of November until 11/26/2015 at 7 p.m. A Physician's Progress Note, dated 11/26/2015 at 11:29 p.m., indicated Resident B had a critically high sodium level of 182 and would be admitted to the hospital from the Emergency Department for further evaluation. An Admission History and Physical Note, dated 11/27/2015 at 2:58 a.m. indicated Resident B was admitted to the hospital with pronounced dehydration, severe hypernatremia and altered mental status.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/04/2015
NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR 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) COMPLETION DATE
	During an interview on 12/7/2015 at 11:23 a.m., the Director of Nursing (DON) indicated she could not provide documentation of a nursing assessment on Resident B after her family voiced concerns of the resident's condition. During an interview on 12/7/2015 at 12:07 p.m., the DON indicated Resident B had an order to encourage PO fluids due to her high sodium levels and to increase hydration. She indicated the facility encouraged and monitored oral fluid intake with documentation. No other assessments were in place to assess hydration. During an interview on 12/7/2015 at 12:25 p.m., the DON indicated she expected her staff to perform an assessment of a resident when a family member voiced concerns regarding a change in the resident's condition. During an interview on 12/7/2015 at 12:45 p.m., the DON indicated the facility had no numeric parameters for fluid to maintain Resident B's hydration. During an interview on 12/7/2015 at 2:49 p.m., Licensed Practical Nurse (LPN) #7 indicated non-emergent concerns regarding a resident are placed on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155236		12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CTR	4171 FOREST POINTE CIR 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) COMPLETION DATE
	doctor's board. The physicians visit the facility at least twice a week and will review the doctor's board in the facility. Emergency concerns regarding a resident should be called into the physician. During an interview on 12/7/2015 at 3:55 p.m., the DON indicated an assessed change of condition should be reported to the physician immediately. During an interview on 12/7/2015 at 4:00 p.m., the DON indicated she could not provide a facility policy regarding nursing assessments of a resident for a change in condition. A policy titled "Physician/Family/Responsible Party Notification for Change in Condition, dated 8/2013, and identified as current by the Nurse Consultant on 12/7/2015 at 3:35 p.m., indicated, ...Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner...Policy: Physician and family/responsible party notification is to include, but is not limited to: ...change in level of consciousness, change in condition that may warrant a change in current treatment...Physician and Family/Responsible Party notification			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155236		12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CTR	4171 FOREST POINTE CIR 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) COMPLETION DATE
	will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained...." This Federal tag relates to Complaint IN00188020. 3.1-37(a)			