STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SENIOR LIVING	6021 S ARLINGTON AVENUE, INDIANAPOLIS, , 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake IN00465520. Intake IN00465520 - State deficiencies related to the allegations are cited at R53. Survey date: November 6, 2025 Facility number: 015486 Residential Census: 122 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed November 7, 2025.	R 0000	Submission of this plan of correction shall serve as credible evidence of substantial compliance with the alleged deficiency.	
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on interview and record	R 0053	1. There was no negative outcome for the resident involved. No other residents were identified as having been affected by the alleged deficient practice.	11/26/2025

	review, the facility failed to protect the resident's right to be free from verbal abuse from a staff member for 1 of 3 residents reviewed for abuse. (Resident B, CNA 1) Finding includes: The clinical record for Resident B was reviewed on 11/6/25 at 9:14 a.m. The diagnosis included, but was not limited to, dementia. On 11/6/25 at 9:15 a.m., the Administrator provided a copy of a facility reportable incident, dated 10/17/25. A review of the reportable incident indicated CNA 1 had been terminated because she used inappropriate language when providing care to Resident B. On 11/6/25 at 9:32 a.m., the Administrator provided a copy of a hand written transcript of a phone conversation between CNA 1, the Administrator, and the Director of Nursing, dated 10/17/25, and indicated the transcription was a part of the abuse investigation regarding Resident B and CNA 1. A review of the document indicated CNA 1 told Resident B that he was one of her least favorite residents, that Resident B had s*** on himself, and Resident B appeared to be uncomfortable when CNA 1 provided the care. CNA 1 also		2. CNA 1 was terminated based on investigation; therefore, no other residents will be affected by the alleged deficient practice of CNA 1. 3.Director of Nursing or designee will audit at least three random staff interactions with residents weekly for one month and monthly for five months to ensure the regulation is met. Any noncompliance will be addressed immediately. 4.Audit results will be reviewed by the Executive Director or designee for compliance. Any noncompliance will be addressed immediately. 5. Changes will be completed on or before November 26, 2025.	

indicated that she would not have made those statement to Resident B if management were there or Resident B's wife.

During an interview on 11/6/25 at 10:21 a.m., the Administrator indicated CNA 1 admitted that she told Resident B that he had s*** on himself and that Resident B appeared to be uncomfortable while CNA 1 was providing care. CNA 1 was terminated for violating the facility's standards of conduct.

On 11/6/25 at 9:11 a.m., the Administrator provided a copy of an undated facility policy, titled Abuse Registry, and indicated this was the current policy used by the facility. A review of the policy indicated the facility would not condone abuse.

This citation relates to Intake IN00465520.

Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse from a staff member for 1 of 3 residents reviewed for abuse. (Resident B, CNA 1)

Finding includes:

The clinical record for Resident B was reviewed on 11/6/25 at 9:14 a.m. The diagnosis included, but was not limited to, dementia.

	On 11/6/25 at 9:15 a.m., the Administrator provided a copy of a facility reportable incident, dated 10/17/25. A review of the reportable incident indicated CNA 1 had been terminated because she used inappropriate language when providing care to Resident B. On 11/6/25 at 9:32 a.m., the Administrator provided a copy of a hand written transcript of a phone conversation between CNA 1, the Administrator, and the Director of Nursing, dated 10/17/25, and indicated the transcription was a part of the abuse investigation regarding Resident B and CNA 1. A review of the document indicated CNA 1 told Resident B that he was one of her least favorite residents, that Resident B had s*** on himself, and Resident B appeared to be uncomfortable when CNA 1 provided the care. CNA 1 also indicated that she would not have made those statement to Resident B if management were there or Resident B's wife.			

	During an interview on 11/6/25 at 10:21 a.m., the Administrator indicated CNA 1 admitted that she told Resident B that he had s*** on himself and that Resident B appeared to be uncomfortable while CNA 1 was providing care. CNA 1 was terminated for violating the facility's standards of conduct. On 11/6/25 at 9:11 a.m., the Administrator provided a copy of an undated facility policy, titled Abuse Registry, and indicated this was the current policy used by the facility. A review of the policy indicated the facility would not condone abuse. This citation relates to Intake IN00465520.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREJerrilynn Morehous	TITLEExecutive Director	(X6) DATE11/25/2025