STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/09/2024

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 was an offsite Licensure Investigation Survey Survey Date: May 9, 2024 Facility: #015486 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed May 9, 2024	R 0000	Submission of this plan of correction shall serve as credible evidence of substantial compliance with the alleged deficiency. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 9999	FINAL OBSERVATIONS 16.2-5-1.1 Licenses (1) The facility shall submit a renewal application to the director at least forty-five (45) days prior to the expiration of the license. This state rule was not met as evidenced by: Based on document review, the facility failed to ensure it had timely renewed their license to	R 9999	1. No residents were affected by the alleged deficiency. 2. Business Office Manager or designee will mark calendar with a weekly reminder 60 days prior to license expiration to submit license renewal application. 3. Business Office Manager or designee will monitor incoming mail for license renewal packet beginning 60 days prior to license expiration.	05/13/2024

	operate as a residential care facility before their current license expired on March 31, 2024. The agency received the facility's renewal application post marked April 23, 2024, which was not at least 45 days of the current license expiration date of Maqrch 31, 2024.		4. Business Office Manager or designee will submit renewal application in a timely fashion. 5. Change will be completed on or before May 13, 2024.	

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 SIGNATURE	TITLE	(X6) DATE