STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155236	A. BUILDING 00 B. WING	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVON HEALTH & REHABILITATION CENTER	4171 FOREST POINTE CIRCLE AVON, IN 46123

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00448672, IN00446400, and IN00447062. This visit included a State Residential Licensure Survey. Complaint IN00448672- No deficiencies related to the allegations are cited. Complaint IN00446400- No deficiencies related to the allegations are cited. Complaint IN00447062 -No deficiencies related to the allegations are cited. Survey dates: January 21, 22, 23, 24, 27, and 28, 2025 Facility number: 000141 Provider number: 155236 AIM number: 100283860 Census Bed Type: SNF/NF: 106 SNF: 2 Total: 108 Census Payor Type: Medicare: 9 Medicaid: 69 Other: 30 Total: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review copleted on February 4, 2025.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian P McKamie	Administrator	02/12/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments Based on record review and interviews, the facility failed to complete a new level of care Pre-admission screening and resident review (PASARR) for a resident when she had a diagnosis of psychosis added to her history for 1 of 1 resident reviewed (Resident 63). Findings include: On 1/22/25 at 12:22 p.m., a record review was completed for Resident 63. She had the following diagnoses which included but was not limited to hypertension, type 2 diabetes mellitus, generalized anxiety, and delusional disorders. She had a level 1 PASARR in her medical record. It did not include the diagnosis of delusional disorders. On 1/22/25 at 2:30 p.m., during an interview, the Minimum Data Set (MDS) Licensed Practical Nurse (LPN) indicated delusional disorders were on her list of diagnoses, therefore, he coded delusional disorders. On 1/23/25 at 9:30 a.m., the Director of Nursing (DON) indicated a new level of care was being completed for Resident 63 and she would provide the results. On 1/27/25 at 12:10 p.m., the DON provided a copy of Resident 63, new level of care dated 1/24/25, and it indicated to refer for a level 2 PASARR on site. A policy titled, "Level I and Level II process" was provided by the DON on 1/27/25 at 2:38 p.m. It	F 0644	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 63 was referred for a Level II. 2. All residents without a level II evaluation have the potential to be affected. An audit will be conducted on all Residents with only a PASARR Level 1 will be reviewed to determine if a Level II referral is indicated and, if so, the appropriate referrals will be made. 3. The Level I and Level II Process policy was reviewed and no changes were indicated. Social Services staff will be re-educated on this policy. The SSD or her designee will review 5 residents weekly for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be reviewed during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	02/18/2025

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	indicated " ...Social Service Director will notify refer residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition to the state mental health authority or the state intellectual authority. Documentation will be made in the progress notes ...."			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, interview, and record review, the facility failed to ensure a comprehensive resident centered care plan related to advanced directives was revised to reflect the wants and needs of a resident for 1 of 1 resident reviewed for advanced directives. (Resident 32) Findings include: On 1/21/25 at 10:21 a.m., Resident 32 was observed as she sat up in her bed. The Resident was in enhanced barrier precautions for her urostomy (an opening in the abdomen to allow urine to pass through) and gastrointestinal tube (Gtube), and she indicated she had recently tested positive for flu A. A urine drainage bag was observed as it hung on the side of the Residents bed frame covered with a dignity cover. Clear yellow urine was observed in the tubing and no dependent loops were noted. On 1/23/25 at 1:35 p.m., Resident 32's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to, post left wrist flap closure surgery, osteomyelitis (an infection of the bone that causes inflammation and damage to the bone tissue) of the hand and Methicillin Resistant Staphylococcus Aureus	F 0657	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 32 was not harmed. The care plan was revised during the survey. 2. All residents have the potential to be affected. An audit will be completed on all residents to ensure code status preference is accurately reflected in the plan of care. 3. The Comprehensive Care Plans policy was reviewed and no changes were indicated. Interdisciplinary Team Members (IDT) will be re-educated on this policy. The SSD or her designee will audit 5 residents weekly for 6 weeks and until 100% compliance is achieved, then 5 residents per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	02/18/2025

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	(MRSA) infection. Resident 32 had an active care plan, dated 5/17/23, for a Do Not Resuscitate (DNR) code status. Resident 32 had an active order, dated 12/13/24, for a full code status. On 1/24/25 at 10:06 a.m., the Director of Nursing (DON) provided documentation of the original DNR care plan and the updated Full Code care plan. She indicated that the DNR care plan was wrong and should have been a Full Code status care plan. On 1/28/25 at 10:50 a.m., the DON provided a copy of a current facility policy titled, "Comprehensive Care Plans," dated 9/18/24. The policy indicated " ...Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the care plan ....", " ...5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment ...." 3.1-35(c)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 70) who required the use of a suprapubic catheter (a thin, flexible tube inserted directly into the bladder through a small incision in the lower abdomen, just above the pubic bone) received treatment and services to prevent the potential for urinary tract infections (UTI) for 1 of 3 residents reviewed for catheters.	F 0690	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 70's catheter assessment has been updated. His orders we revised to include specifics. His care plan has been revised. 2. All residents with catheters	02/18/2025

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	Findings include: On 1/21/25 at 10:55 a.m., Resident 70 was observed in his room on the secured memory care unit. He was reclined in his bed and spoke out loud to anyone he saw. He repeatedly asked staff that passed by his room, where his watch was, and was told that it was, "being cleaned." His voice was raised, but he did not yell, as he continued to ask about his watch, and what he should do. An unidentified staff member who passed by his room indicated, "he always does this, he just gets so anxious about one thing after the other, sometimes its his watch, other times the catheter leg bag and he wants the water off his leg." On 1/27/25 at 12:39 p.m., Resident 70's medical record was reviewed. He was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, unspecified dementia (a degenerative brain disease which affects memory and cognitive function), anxiety and benign prostatic hyperplasia (BPH - a condition where the prostate gland, located at the base of the bladder in men, enlarges) with lower urinary tract symptoms (LUTS -symptoms that affect urination and can occur with BPH). There was an initial catheter assessment, dated 3/11/24, and a quarterly assessment, dated 5/27/24, but the record lacked further quarterly assessments. A urology physician's order, dated 12/16/24, indicated his catheter should be changed every 4 to 6 weeks. At the time of the initial record review, the facility's physician order list lacked a		have the potential to be affected. An audit will be completed on all residents with catheters to ensure a current assessment has been completed, specific orders are obtained, output is being recorded, and care plans are current. 3. The policies on Suprapubic catheters, Comprehensive Care Plans, and Bowel and Bladder Incontinence Management have been reviewed and no changes were indicated. Licensed and unlicensed staff will be re-educated on these policies. The DON or her designee will review 5 residents weekly for 6 weeks and until 100% compliance is achieved, then 5 residents per month for 6 months and until 100% compliance is maintained to ensure assessments remain current, orders are specific, output is being documented, and care plans remain current. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of correction adjusted accordingly.	

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	physician order with these specific instructions. An admission physician order, dated 3/11/24, indicated Resident 70's urine output should be recorded every shift. Resident 70's March 2024 Medication/Treatment Administration Records (MAR/TAR) was reviewed and revealed there was no output recorded for the following shifts: 3/17/24 night shift, 3/22/24 evening shift, 3/27/24 day shift and 3/31/24 night shift. A nursing progress note, dated 3/15/24 at 12:50 a.m., indicated, "hematuria [blood in the urine] continues, daughter aware." The record lacked documentation the physician had been notified. A nursing progress note, dated 3/19/24 at 8:59 p.m., indicated Resident 70 emptied the catheter bag but did not recall how much was in it. The record lacked notification the physician was notified. A nursing progress note, dated 3/20/24 at 7:52 p.m., indicated Resident 70 emptied his catheter bag into the toilet, but an amount of output was not recorded. A nursing progress note, dated 3/28/24 at 8:14 p.m., indicated Resident 70 emptied his bag and the output was not recorded. Resident 70's April 2024 MAR/TAR was reviewed and revealed no output was recorded for the following shifts: 4/9/24 night shift, 4/12/24 evening shift, 4/21/24 night shift and 4/25/24 day shift. A nursing progress note, dated 4/14/24 at 8:46			

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	p.m., indicated hematuria was "still noted" in his catheter drainage bag, but lacked documentation of physician notification. A nursing progress note, dated 4/18/24 at 9:17 p.m., indicated Resident 70 emptied his bag and no output was recorded. A nursing progress note, dated 4/22/24 at 8:49 p.m., indicated Resident 70 emptied his bag and no output was recorded. A nursing progress note, dated 4/26/24 at 9:45 p.m., indicated Resident 70's urine output was unable to be obtained because the bag was leaking and was replaced. The record lacked documentation the physician was notified. A nursing progress note, dated 4/29/24 at 8:41 p.m., indicated Resident 70 emptied his bag and no output was recorded. Resident 70's May 2024 MAR/TAR was reviewed and revealed no output was recorded for the following shifts: 5/1/24 day shift, 5/8/24 evening shift, 5/16/24 day shift, 5/17/24 day shift, and 5/20/24 day shift. A nursing progress note, dated 5/1/24 at 10:32 p.m., indicated Resident 70 emptied his bag and no output was recorded. A nursing progress note, dated 5/2/24 at 4:45 a.m., indicated no measurable output was obtained because Resident 70 emptied his own bag. A nursing progress not, dated 5/9/24 at 9:27 p.m., indicated his bag leaked but lacked documentation the physician was notified.			

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	The record lacked documentation of Interdisciplinary team (IDT) follow up and/or interventions to address Resident 70's behaviors of emptying his bag and not being able to recall the amounts. A change of condition progress note, dated 5/22/24 at 8:13 p.m., indicated Resident 70 had a fever of 100.6 degrees Fahrenheit. A nursing progress note, dated 5/22/24 at 9:19 p.m., indicated Resident 70 was sent to the hospital for catheter dysfunction, fever, and elevated blood pressure. A corresponding hospital summary, dated 5/22/24, indicated Resident 70 was admitted and had blood infection, UTI, and acute kidney injury. Resident 70 had a compressive care plan which was initiated on 3/13/24 which indicated, Resident 70 used a suprapubic catheter due to his obstructive uropathy. Interventions for this plan of care included: "Change catheter system when clinically indicated or ordered, I will have extra fluids offered with medications, I will receive fluid of my choice with meals, I will receive teaching on how to care for my catheter and personal hygiene needs, proper positioning of the drainage bag, I will report and you will observe for changes in the color, consistency, and odor of urine, changes in mental status, changes in amount of urine produced, and pain in lower back or lower abdomen, My catheter will be flushed as ordered and my treatment will be completed as ordered." The care plan lacked revision to address Resident 70's behavior of emptying his bag without letting staff know when, or how much.			

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	The care plan lacked revision of Resident 70's catheter specifications. The care plan lacked revision and specification of his urologist instructions and/or contact information, scheduled and/or as needed visits. On 1/28/24 at 10: 50 a.m., the Director of Nursing (DON) provided a copy of current facility policy titled, "Suprapubic Catheterization," reviewed 9/3/24. The policy indicated, "Suprapubic catheters will be changed in accordance with current standards of practice to minimize risk for bacterial contamination or failed insertions ...the care and maintenance of suprapubic catheters shall be in accordance with physician orders. The orders shall specify the type and size of catheter, and frequency of catheter changes ...." On 1/28/24 at 10: 50 a.m., the DON provided a copy of current facility policy titled, "Bowel and Bladder Incontinence Management," revised 5/2022. The policy indicated, " ... to ensure that a resident is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infection ... a resident requiring a catheter will have a catheter evaluation ... completed at the time of admission, new order for catheter, and quarterly ..." On 1/28/24 at 10: 50 a.m., the DON provided a copy of current facility policy titled, "Comprehensive Care Plans," reviewed 9/18/24. The policy indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the			

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	resident's comprehensive assessment ... the care planning process will include an assessment of the resident's strengths and needs ... resident specific interventions that reflect the resident's needs and preferences ... the physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods of refusal of treatment and services and document such attempts in the clinical record ...." 3.1-41(a)(2)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview, and record review, the facility failed to adequately implement care planned interventions, provide activities, and ensure proper dementia care was provided for a resident in the memory care unit who was in isolation for flu A for 1 of 3 residents reviewed for activities on dementia care (Resident 72). Findings include: On 1/23/25 at 10:15 a.m., Resident 72 was observed as she left her room to head to the common area. Resident 72 was on contact (a set of precautions that prevent the spread of disease by touching a resident or objects in their room.) and droplet (a set of precautions used to prevent the spread of respiratory infections from a resident to others.) precautions for flu A. Certified Nursing Assistant (CNA) 125 was observed as she redirected the Resident back to her room. CNA 125 came up to Resident 72 and told her she needed to go back to her room because she was	F 0744	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 72 is out of isolation and back to her normal activities. 2. Residents in isolation on the dementia care unit are at risk. All residents on isolation will be reviewed to ensure his/her activity/diversional needs are being met. 3. The policies on Resident Self-Determination and Participation (Activities), Dementia Care, and Activities were reviewed and no changes were indicated. Activities staff will be educated on the two activities policies, and nursing staff and activities on dementia care. The Activity Director or her designee will audit 5 residents weekly on Memory	02/18/2025

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	sick. Resident 72 indicated she was not sick, and CNA 125 indicated she may not feel sick, but she was. Resident 72 was assisted by CNA 125 back to her room where CNA 125 was observed as she helped settle Resident 72 for approximately 2 minutes. During an interview on 1/23/25 at 10:20 a.m., CNA 125 indicated Resident 72 had tried to come out of her room several times that day. CNA 125 indicated staff did not normally do anything special or different to engage or redirect residents who were in isolation. She indicated the activities staff usually did not go into the isolation rooms, but now that Resident 72 was feeling a little better the activity staff might go in there and do a one-on-one activity. On 1/23/25 at 10:24 a.m., 5 unknown staff members were observed talking amongst themselves at the nurse's station. On 1/27/25 at 11:41 a.m., Resident 72's record was reviewed. She was a long-term care resident who resided in the memory care unit. Her diagnoses included but were not limited to Cerebral infarction (stroke), history of falling, and influenza A. She had a comprehensive care plan, dated 7/26/22, which indicated Resident 72 should be offered snacks, drinks and conversation. She had a comprehensive care plan dated 7/26/22 which indicated, Staff should provide Resident 72 with 1 on 1 conversation and attention and should offer the resident diversional activities when voicing a desire to leave. She had a comprehensive care plan, dated 9/16/22,		Care in isolation (or less if less than 5 applicable) for 6 weeks and until 100% compliance is achieved, then 5 residents per month and until 100% compliance is maintained to ensure activities are provided to meet the needs of those in isolation. The Memory Care Coordinator or her designee will make rounds 5 times weekly to ensure staff are engaging with residents per plan of care for 6 weeks and until 100% compliance is achieved, then 5 times monthly and until 100% compliance is maintained. 4. The findings of these audits will be presented at the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	which indicated staff will give Resident 72 an activity of her choice if she wandered. She had a comprehensive care plan, dated 12/28/23, which indicated Resident 72 enjoyed interacting with her peers and staff. A fall Interdisciplinary Team (IDT) note, dated 2/19/24, indicated Resident 72 had a fall on 2/18/24 where she was found on the floor near her bathroom door. The intervention indicated the Resident will be toileted on the last round of night shift. A fall progress note, dated 3/2/24, indicated Resident 72 was found on the floor by the hallway. The immediate intervention indicated the Resident will participate in a toileting program. A fall progress note, dated 4/8/24, indicated, Resident 72 was found by an unknown CNA as she sat on the floor in the doorway to the resident's bathroom. The immediate intervention indicated staff will assist Resident 72 to the bathroom prior to lunch. A fall progress note, dated 7/15/24, indicated Resident 72 lost her balance in the dining room and fell, she had nonskid socks on, but they were twisted on her feet. A progress note, dated 1/19/25 at 9:00 a.m. indicated Resident 72 tested positive for flu A. A progress note, dated 1/19/25 at 11:27 a.m., indicated Resident 72 was placed in contact and droplet isolation. A fall progress note, dated 1/24/25, indicated at 12:25 a.m. Resident 72 was found on the floor at the foot of her roommate's bed. The immediate			

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	155236	A. BUILDING 00 B. WING	01/28/2025

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AVON HEALTH & REHABILITATION CENTER	4171 FOREST POINTE CIRCLE AVON, IN 46123

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	intervention indicated the resident would have her call light in reach at all times. A fall progress note, dated 1/24/25, indicated at 3:20 a.m. Resident 72 was found face down on the floor next to her bed. The intervention indicated the resident will have frequent checks throughout the night. Resident 72's activity logs were reviewed. Between the dates of 1/1/25 and 1/17/25 it was charted that Resident 72 was provided with an activity 18 times. On 1/19/25 Resident 72 was put in isolation for flu A until 1/27/25. Between the dates of 1/19/25 and 1/27/25 it was charted that Resident 72 was provided with an activity 4 times and it was charted that the resident was unavailable 5 times. During an interview on 1/27/25 at 1:45 p.m., the Activity Director indicated memory care activity participation fluctuates depending on the level each resident wass at on any given day. She indicated even when a resident was in isolation, they should still be able to receive one-on-one activities and visits with activity staff and other staff. On 1/28/25 at 2:30 p.m., the Director of Nursing (DON) provided a copy of a current facility policy titled, "Resident Self Determination and Participation (Activities)", dated 1/9/24. The policy indicated, " ...c. The right to interact with members of the community and participate in community activities both inside and outside of the facility ...." On 1/28/25 at 2:30 p.m., the Director of Nursing (DON) provided a copy of a current facility policy titled, "Dementia Care", dated 3/5/24. The policy			

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	indicated, " ...5. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being ...." On 1/28/25 at 2:30 p.m., the Director of Nursing (DON) provided a copy of a current facility policy titled, "Activities", dated 1/9/24. The policy indicated, " ...8. Activities will include individual, small and large group activities as well as: ...g. In-room activities...", " ...9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. These include, but are not limited to, considerations for: ...f. Residents who excessively seek attention from staff and/or peers ..." 3.1-37			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on observation, interview, and record review, the facility failed to manage a resident's medication regimen for unnecessary medications in the absence of a specific condition or behaviors in the medical record for 1 of 3 residents reviewed (Resident 265). Findings include: On 1/27/25 at 10:30 a.m., a record review was completed for Resident 265. She had the following diagnoses which included but were not limited to dementia with other behavioral disturbances, encounter for palliative care, and insomnia. Resident 265 had orders for the following medications. Trazodone (an antidepressant that	F 0758	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 265's medication regimen has been reviewed, along with her diagnosis list. Both have been revised. Her medication has been reduced. A consent has been obtained and family was educated. 2. All residents on psychoactive medication are at risk. All those residents will be audited to ensure an appropriate diagnosis is in place, consent is obtained and gradual dose reductions are completed in a timely manner. 3. The policy Gradual Dosage	02/18/2025

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	is used to treat insomnia) 100 milligrams (mg) at bedtime, melatonin (a supplement used to treat insomnia) 12 mg at bedtime, quetiapine (an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder) 100 mg at bedtime, hydrocodone-acetaminophen (It contains an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen) 7.5/325 mg two times daily, and gabapentin (works in the brain to prevent seizures and relieve pain for certain conditions in the nervous system) 300 mg two times daily. On 1/9/25 the pharmacist recommended adding a diagnosis for the use of quetiapine. The diagnosis in use was behaviors. The diagnosis was updated to psychosis. She was not seen by psychiatry prior to adding the diagnosis. The resident's medical record lacked documentation of behaviors associated with the use of quetiapine. On 1/21/25 at 10:30 a.m., observed Resident 265 lying in bed with her eyes closed. She did not respond when spoken to. On 1/27/25 at 12:45 p.m., during an interview with the son, he indicated that hospice had her on the medications and he did not know what the quetiapine was used for. He indicated he visited her on 1/26/25 and she appeared to be sleepy. On 1/27/25 at 1:00 p.m., during an interview with the Director of Nursing (DON), she indicated Resident 265 entered the facility on the medications and it was not time for a gradual dose reduction for Resident 265. She indicated there was no consent for antipsychotic usage in the		Reductions of Psychotropic Medications has been reviewed and no revisions were indicated. Licensed nursing staff and social services staff will be re-educated on this policy. The DON or her designee will audit 5 residents weekly for six weeks and until 100% compliance is achieved to ensure a diagnosis and consent or obtained prior to initiation of a psychoactive medication and that a GDR is completed when indicated, then 5 residents per month for 6 months and until 100% compliance is maintained. 4. Findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	medical record because they do not do consent to treat for antipsychotic medications. On 1/27/25 at 1:14 p.m. during an interview with the hospice nurse, he indicated resident medications were reviewed and her gabapentin was reduced. He indicated she had been on quetiapine for a long time, long before hospice began treating her. He was unsure of why she was on the medication. On 1/28/25 at 10:38 a.m., phoned Resident 265's physician to inquire about quetiapine usage and did not receive a return call. A policy titled "Gradual Dose Reduction of Psychotropic Drugs" was provided by the DON on 1/27/25 at 2:38 p.m. It indicated, " ...The timeframes and duration of attempts to taper any medication shall depend on factors including the coexisting medication regimen, the underlying causes of the symptoms, individual risk factors, and pharmacologic characteristics of the medication....". 3.1-48(b)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00448672, IN00446400, and IN00447062. Complaint IN00448672- No deficiencies related to the allegations are cited. Complaint IN00446400- No deficiencies related to	R 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk**	

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	the allegations are cited. Complaint IN00447062 -No deficiencies related to the allegations are cited. Survey dates: January 21, 22, 23, 24, 27, and 28, 2025 Facility number: 000141 Residential Census: 27 Avon Health and Rehabilitation Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on February 4, 2025.		**review for compliance.**	