

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/22/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155811</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>12/17/2022</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WELLBROOKE OF AVON</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>10307 EAST COUNTY ROAD 100 NORTH</b> <b>INDIANAPOLIS, IN 46234</b>			
(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 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on October 25, 2022. This visit included a PSR to the Investigation of Complaints IN00392899 and IN00390209 completed on October 25, 2022. This visit included a PSR to the State Residential Licensure Survey completed on October 25, 2022.</p> <p>Complaint IN00392899 - Corrected.</p> <p>Complaint IN00390209 - Corrected.</p> <p>Survey dates: December 16 and 17, 2022.</p> <p>Facility number: 013085 Provider number: 155811 AIM number: 201279600</p> <p>Census Bed Type: SNF/NF: 27 SNF: 21 Residential: 35 Total: 83</p> <p>Census Payor Type: Medicare: 21 Medicaid: 17 Other: 10 Total: 48</p> <p>Wellbrooke of Avon was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaints IN00392899 and IN00390209.</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/22/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>12/17/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>WELLBROOKE OF AVON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10307 EAST COUNTY ROAD 100 NORTH</b> <b>INDIANAPOLIS, IN 46234</b>		
(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 000}	Continued From page 1  Quality review completed on December 21, 2022.	{F 000}			