

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014959</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>01/03/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HARMONY AT AVON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2141 NORTH DAN JONES ROAD AVON, IN 46123</b>
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(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) COMPLETE DATE
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on October 4, 2023. This visit included a PSR to the Investigation of Complaint IN00417879 completed on October 4, 2023.</p> <p>Complaint IN00417879: corrected.</p> <p>Survey dates: January 2 and 3, 2024</p> <p>Facility number: 014959</p> <p>Residential Census: 69</p> <p>Harmony at Avon was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey and the Investigation of Complaint IN00417879</p> <p>Quality review completed on January 12, 2024.</p>	{R 000}		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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