STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155272	A. BUILDING -- B. WING	12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/05/23 Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130 At this Emergency Preparedness survey, Allison Pointe Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 159 certified beds. At the time of the survey, the census was 117. Quality Review completed on 12/07/23	E 0000	Preparation and execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed soley because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of non-compliance cited during the survey process. Please accept this plan of correction as the provider’s credible allegation of compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/05/23 Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130 At this Life Safety Code survey, Allison Pointe Healthcare Center was found not in compliance	K 0000	Preparation and execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed soley because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of non-compliance cited during the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula E. Carroll	Executive Director	12/14/2023

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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	with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has vent unit beds in Rooms 210, 211, 212, 213, 214, 215, 216, 217, 218, 220, 221, 222, 223, 224 & 225 for a total of 15 vent unit beds. The facility has a capacity of 159 and had a census of 117 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were each not sprinklered. Quality Review completed on 12/07/23		survey process. Please accept this plan of correction as the provider's credible allegation of compliance.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure continuity of egress lighting for 1 of 12 exits. For the purposes of this requirement, exit access shall include only designated stairs,	K 0281	F281- Illumination of Means of Egress A No resident was harmed by	12/19/2023

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	aisle, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility from the main dining room. Finding include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:35 p.m. on 12/05/23, the exit discharge for the main dining room exit at the south side of the dining room did not have egress lighting from the exit to the public way. The south side exit door for the main dining room was marked as a facility exit with an exit sign. An exterior wall for the new dialysis area abuts the exit discharge. Based on interview at the time of the observations, the Maintenance Director stated an exit door was taken out of the exterior wall for the new dialysis area within the last couple of years, egress lighting for the exit discharge area was probably taken out at that time and agreed the exit discharge for the main dining room exit at the south side of the dining room did not have egress lighting from the exit to the public way. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		the facility's alleged deficient practice. B All residents have the potential to be affected. The facility ensured continuity of egress lighting from the exit to the public way at the south side exit door for the main dining room. Permanent lighting was installed to illuminate the path of egress. C Education was provided to the Maintenance Director and Assistant regarding the importance of ensuring the continuity of egress lighting at exits. D The ED/Designee will conduct random audits 1 time/ weekly for 1 month; then, monthly for 4 months. Any discrepancies will be corrected immediately and education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities			

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	Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect over three kitchen staff and visitors. Findings include:	K 0324	F324- Cooking Facilities A No resident was harmed by the facility's alleged deficient practice. B The facility ensured that kitchen range hood system filters were equipped with drip trays beneath their lower edges. C Education was provided to dietary and maintenance staff regarding the importance of ensuring that a drip tray be in place beneath the lower edge of the range hood to collect grease. D The ED/Designee will conduct random audits 1 time/ weekly for 1 month; then, monthly	12/19/2023

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	Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:35 p.m. on 12/05/23, two of two designated locations underneath the kitchen range hood system drip tray were missing an enclosed metal container for grease to drain into. The designated locations for a grease container each had a one inch in diameter hole in the drip tray beneath the system filters and had an affixed bracket for holding a container but no container was present. Based on interview at the time of observation, the Maintenance Director agreed the designated locations underneath the kitchen range hood system drip tray were missing an enclosed metal container for grease to drain into. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		for 4 months. Any discrepancies will be corrected immediately and education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads in the facility were not painted in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 111. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:35 p.m. on 12/05/23, the deflector for the ceiling mounted sprinkler in the closet for Room 111 had beige colored paint on the deflector.	K 0353	F353- Sprinkler System- Maintenance and Testing A No resident was harmed by the facility's alleged deficient practice. B All residents have the potential to be affected. The facility ensured that sprinkler heads were not painted. The sprinkler was replaced by Safe Care. C Education was provided to Maintenance on the importance of ensuring that sprinkler heads were not painted. D The ED/Designee will conduct random audits 1 time/ weekly for 1 month; then, monthly for 4 months. Any discrepancies will be corrected immediately and education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved.	12/19/2023

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	Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned automatic sprinkler location had paint on the deflector. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 34 portable fire extinguishers had pressure gauge readings in the acceptable range in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.2 requires periodic inspection of fire extinguishers shall include pressure gauge reading or indicator in the operable range or position. When an inspection of any rechargeable dry chemical fire extinguisher reveals a deficiency in Section 7.2.2(3) or 7.2.2(4), the extinguisher shall be subjected to applicable maintenance procedures. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the main entrance lobby. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:35 p.m. on 12/05/23, the pressure gauge on	K 0355	F355- Portable Fire Extinguisher A No resident was harmed by the facility's alleged deficient practice. B All residents have the potential to be affected. The facility completed an audit of all portable fire extinguishers to ensure that they had pressure gauge readings in the acceptable range in accordance with NFPA 10. The portable fire extinguisher was replaced by Safe Care. C Education was provided to all Maintenance staff on the importance of ensuring that portable fire extinguisher had the correct pressure gauge reading. D The ED/Designee will conduct random audits 1 time/	12/19/2023

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	the wall mounted portable ABC type fire extinguisher behind the reception desk in the main entrance lobby showed the extinguisher was undercharged. The portable fire extinguisher inspection contractor had an affixed maintenance tag indicating the annual maintenance for the fire extinguisher was performed in September 2023. The affixed maintenance tag also indicated monthly inspections by facility staff had been documented through December of 2023. Based on interview at the time of the observations, the Maintenance Director stated he was unaware if the fire extinguisher had been used recently and agreed the pressure gauge on the portable fire extinguisher in the reception area of the main entrance lobby indicated the fire extinguisher was undercharged. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		weekly for 1 month; then, monthly for 4 months. Any discrepancies will be corrected immediately and education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are			

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	prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on record review, observation and interview; the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 2 outdoor areas where smoking was taking place. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the Brookshire outdoor smoking area. Findings include: Based on review of "Smoking Policy" documentation with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 12:30 p.m. on 12/05/23, assessed residents and staff are allowed to smoke in designated outdoor smoking areas. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:35 p.m. on 12/05/23, well over 100 cigarette butts were strewn on the ground outside the facility at the Brookshire outdoor smoking area. Ashtrays	K 0741	F741- Smoking Regulations A No resident was harmed by the facility's alleged deficient practice. B All residents have the potential to be affected. The facility completed an audit in the resident smoking areas to ensure that smoking materials are deposited into ashtrays and metal containers. C Education was provided to all Maintenance staff on the importance of ensuring that smoking materials are deposited into ashtrays and metal containers. D The ED/Designee will conduct random audits 1 time/ weekly for 1 month; then, monthly for 4 months. Any discrepancies will be corrected immediately and education will be provided. Results	12/19/2023

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	and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design were provided at this outdoor location where resident smoking was currently taking place but extinguished cigarette butts were not consistently deposited into the designated containers. Based on interview at the time of the observations, the Maintenance Director stated residents who smoke at the outdoor smoking area are instructed to use the ashtrays and metal containers but staff have to clean up the strewn cigarette butts regularly and agreed cigarette butts were deposited on the ground at the Brookshire outdoor smoking area and were not consistently deposited into the ashtrays and metal containers with self-closing cover devices into which were provided at this outdoor location where resident smoking was taking place. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		of the audit will be brought to QAPI for six months or until 100% compliance is achieved.	