STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	04/04/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00455778 and IN00456573 Complaint IN00455778 - No deficiencies related to the allegations are cited. Complaint IN00456573- Federal/state deficiencies related to the allegations are cited at F0697 and F0880. Survey dates: April 3 and 4, 2025 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 98 Total: 98 Census Payor Type: Medicare: 3 Medicaid: 82 Other: 13 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 7, 2025.	F 0000	/p>	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, interview, and record	F 0697	**Corrective actions accomplished for those**	05/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sydnie Reed	Executive Director	04/23/2025

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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	review, the facility failed to attempt non-pharmacological interventions for pain, to assess pain levels prior to administering an as needed pain medication, and to assess the effectiveness of as needed pain medication for 1 of 3 residents reviewed for pain (Resident C). Findings include: The clinical record for Resident C was reviewed on 4/3/25 at 11:00 a.m. The diagnoses included, but were not limited to, cerebral infarction (disrupted blood flow to the brain), aphasia (inability to swallow), and hemiplegia (inability to move one side of the body). He was admitted to the facility on 2/10/25. A physician's order, dated 2/10/25, indicated to monitor pain every shift. A physician's order, dated 2/10/25, indicated to administer oxycodone (narcotic pain medication) immediate release (IR) 5 milligram (mg); give one tablet every six hours as needed for moderate to severe pain. A care plan, last revised on 2/11/25, indicated he was at risk for pain related to stroke, hemiplegia, and tracheostomy status. The goal was for him not to exhibit nonverbal signs or symptoms of pain such as grimacing, groaning, agitation, yelling, moaning, resisting care, crying, and refusal to eat. The interventions included administering non-pharmacological interventions such as repositioning, diversional activities, snacks and fluids, ice, heat, music therapy, relaxation techniques, and imagery. The care plan reflected the need to complete a pain assessment upon admission, quarterly, with significant changes and as needed, follow physician orders		**residents founds to be affected by the alleged practice:** Resident C is the only resident found to be potentially affected by the alleged practice. Education was provided to all nursing staff to ensure documenting when attempting non-pharmacological interventions for pain, to assess pain levels prior to administering an as needed pain medication, and to assess the effectiveness of as needed pain medication **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents with orders for pain medications have the potential to be affected. Education was provided to all nursing staff to ensure documenting when attempting non-pharmacological interventions for pain, to assess pain levels prior to administering an as needed pain medication, and to assess the effectiveness of as needed pain medication. Facility completed pain assessments on all residents with pain medication orders to ensure residents with pain medication orders have documentation of pain assessment prior to administering, non-pharmacological interventions attempted, and/or effectiveness of administered medication. There were no other residents harmed by the alleged practice.	

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	for complaints of pain, and observe for pain every shift. A physician's order, dated 2/12/25, indicated to administer acetaminophen (Tylenol) tablets 325 mg; give two tablets via gastric tube (G-tube) every four hours as needed for mild pain. The February and March 2025 Medication Administration Records (MAR) indicated Resident C's pain had been assessed each shift, but it did not include the level of pain assessed. The February 2025 MAR indicated oxycodone IR 5 mg had been administered on 2/11/25. The pain level was not recorded on the MAR. The MAR indicated the dose of pain medication had been effective. There were no doses of acetaminophen documented as received. The 2/10/25 Controlled Drug Administration Record for Resident C's oxycodone IR 5 mg indicated he had received one dose on 2/11/25, three doses on 2/12/25, one dose on 2/13/25, two doses on 2/15/25, and one dose 2/16/25. The 2/13/25 Controlled Drug Administration Record for Resident C's oxycodone IR 5 mg indicated he had received one dose on 2/20/25, two doses on 2/26/25, one dose on 2/27/25, and one dose on 2/28/25. The March 2025 MAR indicated oxycodone IR 5 mg had been administered on 3/10/25, 3/11/25, 3/16/25, and 3/20/25. The pain levels were not recorded on the MAR and the doses were documented as effective. There were no doses of acetaminophen documented as received. The 2/13/25 Controlled Drug Administration		**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with all nursing staff to ensure documentation occurs when attempting non-pharmacological interventions for pain, to assess pain levels prior to administering an as needed pain medication, and to assess the effectiveness of as needed pain medication. Pain assessments with pain levels, non-pharmacological interventions, and effectiveness have been added to all residents with PRN pain medications. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/designee will conduct audits of 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks, and then 4 residents per month for 4 months to ensure residents with pain medication orders have documentation of pain assessment prior to administering, non-pharmalogical interventions attempted, and/or effectiveness of administered medication. Any discrepancies will be corrected immediately and education will be provided. The results of the audit observations will be reported, reviewed, and trended for	

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	Record for Resident C's oxycodone IR 5 mg indicated he had received two doses on 3/1/25, and one dose on 3/2/25. The 3/1/25 Controlled Drug Administration Record for Resident C's oxycodone IR 5 mg indicated he had received one dose on 3/7/25, one dose on 3/8/25, and one dose on 3/11/25. The 3/10/25 Controlled Drug Administration Record for Resident C's oxycodone IR 5 mg indicated he had received one dose on 3/15/25, one dose on 3/16/25 and 3/18/25. The 3/26/25 Controlled Drug Administration Record for Resident C's oxycodone IR 5 mg indicated he had received one dose on 3/26/25, one dose on 3/27/25, one dose on 3/28/25, one dose on 3/29/25, two doses on 3/30/25, and one dose on 3/31/25. A Care Conference Note, dated 3/21/25, indicated a care planning meeting had been held with Resident C's family member, who would like to have Resident C's pain medication scheduled to be administered routinely instead of as needed. The pain management physician was to be notified. The clinical record did not contain the non-pharmacological pain interventions that had been attempted or the assessment of pain levels prior to administration of the oxycodone IR doses given. There was no documentation of the effectiveness of the doses received, with the exception on 2/11/25, 3/10/25, 3/11/25, 3/16/25, and 3/20/25. On 4/3/25 at 11:47 a.m., Resident C was observed lying in bed with his eyes closed. Family Member		compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	(FM) 5 was present at the bedside. During an interview on 4/3/25 at 11:47 a.m., FM 5 indicated she had requested the pain medication be scheduled instead of as needed due to Resident C not being able to verbalize his pain. FM 5 had informed the staff that when Resident C was in pain he would bite on his lip, grimace, tear up, shake his foot and tense up. She had requested the as needed oxycodone IR 5 mg to be given at least twice daily, however had been told by the facility nursing staff that Resident C would have to request the medication since the physician's order indicated it was "as needed". FM 5 did not understand how he was to ask for the medication since he was not verbal. FM 5 had visited Resident C, on 4/2/25, and found that his top lip had dried blood on it from him biting down on it. FM 5 felt he was in pain when this happened and requested the oxycodone to be given, which had helped Resident C stop biting his lip. During an interview on 4/4/25 at 10:18 a.m., Licensed Practical Nurse (LPN) 4 indicated she monitored Resident C for pain using facial expressions and grimaces. Resident C had family that often visited and would inform the staff if Resident C appeared to be in pain. On 4/4/25 at 4:56 p.m., the Clinical Nurse Consultant provided the current Pain Management and Assessment which indicated "...based on the comprehensive assessment of the resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management...Pain Management Considerations a. To the extent possible and in consideration of cognitive			

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	abilities, the nurse will provide a thorough assessment by observation of activities and treatment/ relief for detection of pain and to attempt to identify location and limitations imposed by the pain...c. The use of the appropriated Pain Management Scale for the resident's ability to express pain...Documentation a. Medication pain relief and response b. non-pharmacological measures attempted, and the resident response c. care plan updated as needed...." This citation is related to Complaint IN00456573. 3.1-37(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to maintain infection control by staff not donning a gown when providing personal care for a resident in enhanced barrier precautions (EBP) and not ensuring soiled linen was not placed directly on the floor for 1 of 3 residents reviewed for Activities of Daily Living (ADLs). (Resident C) Findings include: The clinical record for Resident C was reviewed on 4/3/25 at 11:00 a.m. The diagnoses included, but were not limited to, cerebral infarction (disrupted blood flow to the brain), aphasia (inability to swallow), and hemiplegia (inability to move one side of the body), and tracheostomy. A physician's order, dated 2/12/25, indicated Resident C was receiving enhanced barrier	F 0880	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** Resident C is the only resident found to be potentially affected by the alleged practice. The soiled linen was immediately removed from the resident's room and CNA was educated on Enhanced Barrier Precaution policy. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents who in Enhanced Barrier Precautions have the potential to be affected. There were no other residents harmed by the alleged practice.	05/14/2025

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	precautions related to having a tracheostomy, gastric tube, and wounds. It was to occur when dressing, bathing, showering, transferring, changing linen, providing hygiene, changing briefs, or assisting with toileting. An Admission Minimum Data Set (MDS) assessment, completed 2/17/25, indicated Resident C was non- verbal and could not make his needs or wants known. He was dependent on staff for bed mobility and toileting. On 4/4/25 at 10:23 a.m., Certified Nurse Aide (CNA) 6 was observed providing perineal care for Resident C. CNA 6 was wearing disposable gloves. She was providing perineal care using a soapy washcloth. CNA 6 did not have a disposable gown on while providing care. There was a pile of feces soiled linen lying directly on the floor in the middle of the room. During an interview on 4/4/25 at 10:25 a.m., CNA 6 indicated she was unaware that she needed to wear a gown while providing incontinent care for Resident C. During an interview on 4/4/25 at 10:37 a.m., Licensed Practical Nurse 4 indicated that soiled linen should be bagged. On 4/4/25 at 1:07 p.m., the Clinical Nurse Consultant provided the current Enhanced Barrier Precautions policy which indicated "... Policy: Enhanced Barrier Precautions [EBP] refer to an infection control intervention designed to reduce transmission of multi-drug organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include; Dressing, Bathing/ showering, Transferring, Providing hygiene, Changing		Facility completed a whole house audit of resident rooms to ensure there were no other linens on the floor. Facility completed education with all direct care nursing staff on Enhanced Barrier Precautions with an emphasis on donning gowns and changing linens. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with all direct care nursing staff on Enhanced Barrier Precautions with an emphasis on donning gowns and changing linens. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/designee will conduct skill check offs 5 direct care nursing staff employees per week for 4 weeks, then 3 direct care nursing staff employees per week for 4 weeks, and then 4 direct care nursing staff employees per month for 4 months to ensure all don PPE appropriately for residents in EBP. The ED/designee will conduct audits of 5 resident rooms per week for 4 weeks, then 3 residents per week for 4 weeks, and then 4 residents per month for 4 months to ensure there are no soiled linens on the floor. Any	

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	Linens, Changing Briefs or assisting with toileting... EBP are indicated for residents with any of the following...Wounds and/or indwelling medical devices..." On 4/4/25 at 1:07 p.m., the Clinical Nurse Consultant provided the current Infection Control Practices for Laundry/ Linens which indicated "...Provide the storage, handling and processing of linen activities following practices to decrease the risk of spreading infection and exposure to bloodborne pathogens..." This citation is related to Complaint IN00456573. 3.1-18(b)(1) 3.1-18(b)(2)		discrepancies will be corrected immediately and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	