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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			ETED
		155272	B. W	NG		06/22/	2022
				_	_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					82ND STREET		
ALLISON POINTE HEALTHCARE CENTER				INDIAN	IAPOLIS, IN 46250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
E 0000	REGUE/HORT OR	ESC IDENTIFICATION		1710			DATE
L 0000							
Bldg							
ычу	A E D			200	B		ı
		paredness Survey was	E 00	)00	Paper compliance requested.		
	•	diana Department of Health in					
	accordance with 42	CFR 483.73.					
		-					
	Survey Date: 06/22	/22					
	T 111, 37 1 0	00172					
	Facility Number: 00						
	Provider Number:						
	AIM Number: 1002	26/130					
		Preparedness survey, Allison					
		enter was found not in					
	-	nergency Preparedness					
		ledicare and Medicaid					
		ers and Suppliers, 42 CFR					
	483.73.						
	-	certified beds. At the time of					
	the survey, the censu	us was 129.					
	Quality Review com	npleted on 06/27/22					
E 0007							
E 0037	. , , ,	3.54(d)(1), 418.113(d)(1),					
SS=F		2.15(d)(1), 483.475(d)(1),					
Bldg		102(d)(1), 485.625(d)(1),					
		727(d)(1), 485.920(d)(1),					
	486.360(d)(1), 491						
	EP Training Progra	am					
		l16.54(d)(1), §418.113(d)(1),					
	§441.184(d)(1), §4	460.84(d)(1), §482.15(d)(1),					
	§483.73(d)(1), §48	33.475(d)(1), §484.102(d)(1),					
	§485.68(d)(1), §4	85.625(d)(1), §485.727(d)					
	(1), §485.920(d)(1	), §486.360(d)(1),					
	§491.12(d)(1).						
	. , . ,						
	*[For RNCHIs at §	403.748, ASCs at §416.54,					
		15, ICF/IIDs at §483.475,					

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

(X6) DATE

Any defiency statement 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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TITLE

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272			ILDING	NSTRUCTION	(X3) DATE COMPL <b>06/22</b> /	ETED
	PROVIDER OR SUPPLIEF		Ī	5226 E	DDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	HHAs at §484.102 §485.727, OPOs at §491.12:]  (1) Training prograll of the following (i) Initial training ir policies and proceexisting staff, indivender arrangement consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain docuexistent proceeding the emergency proceed (v) If the emergency proceed (v) Initial training ir policies and proceed existing hospice ex	e, "Organizations" under at §486.360, RHC/FQHCs  am. The [facility] must do : in emergency preparedness indures to all new and viduals providing services and, and volunteers, eit expected roles. It ency preparedness training ears. In ementation of all emergency in ency preparedness policies are significantly updated, the duct training on the end procedures.  §418.113(d):] (1) Training. It do all of the following: In emergency preparedness its redness plan with hospice in genomemployee staff), asis placed on carrying out in emergency in emergency in protect patients in ementation of all emergency					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155272		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/22/2022		
	PROVIDER OR SUPPLIE		5226 E	ADDRESS, CITY, STATE, ZIP COD E 82ND STREET NAPOLIS, IN 46250	•		
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	DATE		
	and procedures a	ncy preparedness policies are significantly updated, the aduct training on the and					
	-	441.184(d):] (1) Training TF must do all of the					
	(i) Initial training in	n emergency preparedness edures to all new and					
	existing staff, indi	viduals providing services nt, and volunteers,					
		eir expected roles. ining, provide emergency					
	preparedness trai	ining every 2 years.					
	emergency proce	staff knowledge of dures.					
	(iv) Maintain docu	ımentation of all emergency					
		ncy preparedness policies					
	•	re significantly updated, the					
	PRTF must condu policies and proce	uct training on the updated edures.					
	-	60.84(d):] (1) The PACE					
	_	t do all of the following: n emergency preparedness					
		edures to all new and					
		viduals providing on-site					
		rangement, contractors,					
	their expected rol	volunteers, consistent with es.					
		gency preparedness training					
	at least every 2 ye						
	, ,	staff knowledge of					
	1 .	dures, including informing					
		at to do, where to go, and					
		in case of an emergency.					
	I (IV) Maintain docu	imentation of all training.	1				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272	l í	JILDING	NSTRUCTION	(X3) DATE COMPI 06/22	
	PROVIDER OR SUPPLIER			5226 E	NDDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	and procedures a	ncy preparedness policies re significantly updated, the uct training on the updated edures.					
	Training Program of the following: (i) Initial training ir policies and proce existing staff, indirunder arrangement consistent with the (ii) Provide emergat least annually. (iii) Maintain docu preparedness trait (iv) Demonstrate emergency procestive CORF at § CORF must do all (i) Provide initial to preparedness policies.	mentation of all emergency ning. staff knowledge of dures.  485.68(d):](1) Training. The I of the following: raining in emergency icies and procedures to all					
	new and existing services under an consistent with the (ii) Provide emerg at least every 2 ye (iii) Maintain docu (iv) Demonstrate emergency process must be oriented responsibilities regemergency plan were serviced and services and services and services are services are services and services are services are services are services and services are services are services are services and services are service	staff, individuals providing rangement, and volunteers, eir expected roles. ency preparedness training					
	instruction in the l systems and sign equipment.	ocation and use of alarm als and firefighting ency preparedness policies					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155272	B. W	ING		06/22/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	ę.		5226 E	82ND STREET		
ALLISON	POINTE HEALTH	CARE CENTER		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		_	TAG	DEFICIENCY)		DATE
		re significantly updated, the					
	CORF must conduct training on the updated						
	policies and proce	edures.					
	*IFor CAHs at 848	35.625(d):] (1) Training					
		H must do all of the					
	following:						
	_	n emergency preparedness					
	. , ,	edures, including prompt					
	reporting and exti	nguishing of fires,					
	protection, and wh	nere necessary, evacuation					
	of patients, persor	nnel, and guests, fire					
	1 '	poperation with firefighting					
		orities, to all new and					
	_	viduals providing services					
	_	nt, and volunteers,					
		eir expected roles.					
	. , ,	ency preparedness training					
	at least every 2 ye	mentation of the training.					
	, ,	staff knowledge of					
	emergency proce	_					
		ncy preparedness policies					
		re significantly updated, the					
		ct training on the updated					
	policies and proce	-					
		485.920(d):] (1) Training.					
	1	provide initial training in					
		redness policies and					
	•	new and existing staff,					
	1	ng services under					
	_	volunteers, consistent with					
	their expected role						
		the training. The CMHC					
		e staff knowledge of					
	CMHC must provi	dures. Thereafter, the					
		ning at least every 2 years.					
		view and interview, the facility	E 00	037	Staff Training on Emergency		07/29/2022

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272		LDING	NSTRUCTION	COMI	E SURVEY PLETED 2/2022
	PROVIDER OR SUPPLIEF			5226 E	DDRESS, CITY, STATE, ZIP 82ND STREET APOLIS, IN 46250	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	training and testing program. The LTC following: (i) Initial preparedness policical and existing staff, in under arrangement, with their expected preparedness training Maintain document Demonstrate staff kerocedures in according the following include:  Based on review of Manual" documents Executive Director during record review on 06/22/22, documents and on interview the Executive Director documentation on the program conducted month period was not time of the survey.	emergency preparedness program includes a training facility must do all of the I training in emergency es and procedures to all new adividuals providing services and volunteers, consistent roles; (ii) Provide emergency at least annually; (iii) ation of the training; (iv) mowledge of emergency dance with 42 CFR 483.73(d) practice could affect all "Emergency Preparedness ation dated 06/08/22 with the and the Maintenance Director w from 9:20 a.m. to 12:50 p.m. mentation for staff training on dness within the most recent d was not available for review. At the time of record review, at the time of record review, at the time of record review at the emergency preparedness within the most recent twelve of available for review at the viewed with the Executive exit conference.			preparedness will be All residents have the be affected. Emergency prepared will be provided to sta and annually. Documentation of empreparedness training reviewed monthly by or designee and resuthrough QAPI for 6 mimmediate corrections necessary.	e potential to ness training aff upon hire nergency g will be administrator lts reported onths with	
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484 485.68(d)(2), 485	5.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IJI.TIPLE CO	NSTRUCTION		E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	ľ í	A. BUILDING			COMPLETED	
THILD TEAT	or coldination	155272	B. W				06/22/2022	
		100272	<i>5.</i>			00/22		
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
	ne (ibbit off boll bib			5226 E	82ND STREET			
ALLISON	N POINTE HEALTH	CARE CENTER		INDIAN	APOLIS, IN 46250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	§416.54(d)(2), §4	18.113(d)(2), §441.184(d)(2),						
	§460.84(d)(2), §48	82.15(d)(2), §483.73(d)(2),						
	- , , , -	484.102(d)(2), §485.68(d)(2),						
	. , , ,	485.727(d)(2), §485.920(d)						
	(2), §491.12(d)(2)							
	*[For ASCs at 8/1	6.54, CORFs at §485.68,						
		ons" under §485.727,						
		<u> </u>						
	CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:							
	9491.12, and ESP	ND Facilities at 9494.02].						
	(2) Testing. The [f	acility] must conduct						
	. ,	he emergency plan						
		ility] must do all of the						
	following:	,,						
	(i) Participate in a	full-scale exercise that is						
	community-based	every 2 years; or						
	(A) When a comm	nunity-based exercise is						
	not accessible, co	nduct a facility-based						
	functional exercise	e every 2 years; or						
	(B) If the [faci	lity] experiences an actual						
	natural or man-ma	ade emergency that requires						
	activation of the e	mergency plan, the [facility]						
	is exempt from en	gaging in its next required						
	community-based	or individual, facility-based						
	functional exercise	e following the onset of the						
	actual event.							
	(ii) Conduct an ad	ditional exercise at least						
	every 2 years, opp	posite the year the full-scale						
	or functional exerc	cise under paragraph (d)(2)						
	(i) of this section is	s conducted, that may						
	include, but is not	limited to the following:						
	(A) A second full-s	scale exercise that is						
	, ,	or individual, facility-based						
	functional exercise	-						
	(B) A mock disast							

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(C) A tabletop exercise or workshop that is led by a facilitator and includes a group

discussion using a narrated,

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272	A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/22/2022	
	PROVIDER OR SUPPLIER			5226 E	ADDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, IN 46250		
	SUMMARY (EACH DEFICIENT REGULATORY OF Clinically-relevant set of problem state messages, or preparent to challenge an erection (iii) Analyze the [famintain documer exercises, and enterection the [facility's] emee to challenge an erection (2) Testing for host the patient's home conduct exercises plan at least annut the following: (i) Participate in a community based (A) When a community based (A) When a community based functional erection (B) If the hospice man-made emerging of the emergency exempt from engals scale community-	CARE CENTER  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION emergency scenario, and a tements, directed pared questions designed mergency plan. acility's] response to and ntation of all drills, tabletop mergency events, and revise rgency plan, as needed.  418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do  a full-scale exercise that is every 2 years; or funity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual		5226 E	82ND STREET	BE	(X5) COMPLETION DATE
	onset of the emery (ii) Conduct an act years, opposite the functional exercise of this section is continued, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise (E)	ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: scale exercise that is or a facility based e; or					

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discussion using a narrated,

clinically-relevant emergency scenario, and a

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	OF CORRECTION	IDENTIFICATION NUMBER  155272		JILDING	nstruction 	COMPI 06/22	ETED
	PROVIDER OR SUPPLIER		•	5226 E	.DDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
	to challenge an en  (3) Testing for hos care directly. The exercises to test the per year. The hos (i) Participate in a that is community-	pared questions designed nergency plan.  pices that provide inpatient hospice must conduct ne emergency plan twice pice must do the following: n annual full-scale exercise					
	facility-based functions (B) If the hospice of man-made emergency exempt from engatill-scale communifunctional exercises emergency event.  (ii) Conduct an activate may include, I following:	ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the ditional annual exercise out is not limited to the scale exercise that is					
	community-based functional exercises (B) A mock disast (C) A tabletop exercise facilitator that inclusing a narrated, of emergency scenaristatements, direct questions designed emergency plan.  (iii) Analyze the himaintain document exercises, and emergency and emergency plan.	or a facility based e; or er drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING	COMPLETED
155272 B. WING	06/22/2022
STREET ADDRESS, CITY, STATE, Z	ZIP COD
NAME OF PROVIDER OR SUPPLIER  5226 E 82ND STREET	
ALLISON POINTE HEALTHCARE CENTER INDIANAPOLIS, IN 46250	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLANO	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE COMMENTER
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCE TO THE PROPERTY OF THE PROPERTY O	CY) DATE
*[For PRFTs at §441.184(d), Hospitals at	
§482.15(d), CAHs at §485.625(d):]	
(2) Testing. The [PRTF, Hospital, CAH] must	
conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital,	
CAH] must do the following:	
(i) Participate in an annual full-scale exercise	
that is community-based; or	
(A) When a community-based exercise is not	
accessible, conduct an annual individual,	
facility-based functional exercise; or	
(B) If the [PRTF, Hospital, CAH] experiences	
an actual natural or man-made emergency	
that requires activation of the emergency	
plan, the [facility] is exempt from engaging in	
its next required full-scale community based	
or individual, facility-based functional exercise	
following the onset of the emergency event.	
(ii) Conduct an [additional] annual	
exercise or and that may include, but is not	
limited to the following:	
(A) A second full-scale exercise that is	
community-based or individual, a	
facility-based functional exercise; or	
(B) A mock disaster drill; or	
(C) A tabletop exercise or workshop that	
is led by a facilitator and includes a group	
discussion, using a narrated,	
clinically-relevant emergency scenario, and a	
set of problem statements, directed	
messages, or prepared questions designed	
to challenge an emergency plan.	
(iii) Analyze the [facility's] response to	
and maintain documentation of all drills,	
tabletop exercises, and emergency events	
and revise the [facility's] emergency plan, as	
needed.	
*IF-" DACF -+ \$460 04/d)-1	
*[For PACE at §460.84(d):]	

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ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM:	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			l í	ULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155272	B. WI	NG		06/22	/2022
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
ALLISON	POINTE HEALTH	ICARE CENTER			82ND STREET APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOUL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s to test the emergency					
	plan at least annu	-					
	_	t do the following:					
		an annual full-scale exercise					
	that is community						
	, ,	nunity-based exercise is not					
		uct an annual individual, ctional exercise; or					
	_	experiences an actual natural					
	` '	ergency that requires					
		emergency plan, the PACE					
		ngaging in its next required					
	-	nity based or individual,					
		ctional exercise following the					
	onset of the emer	_					
		an additional exercise every					
		the year the full-scale or					
		se under paragraph (d)(2)(i)					
	of this section is	conducted that may include,					
	but is not limited	to the following:					
	(A) A second full	-scale exercise that is					
	community-based	d or individual, a facility					
	based functional	exercise; or					
	(B) A mock disas						1
	, ,	cercise or workshop that is					
	· ·	r and includes a group					
	discussion, using						
	1	emergency scenario, and a					
	-	atements, directed					
		epared questions designed					
	to challenge an e						
		PACE's response to and					
		ntation of all drills, tabletop					
		mergency events and revise					
	uie PACE'S emer	gency plan, as needed.					
	*IFor LTC Facilitie	es at §483.73(d):]					
	_	lity] must conduct exercises					
	, , ., <u>.</u>	/1	1				ì

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to test the emergency plan at least twice per year, including unannounced staff drills using

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155272	B. W	NG	_	06/22/	/2022
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			82ND STREET		
ALLISON	POINTE HEALTH	CARE CENTER		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ocedures. The [LTC facility,					
	ICF/IID] must do t						
	that is community	n annual full-scale exercise					
		nunity-based exercise is not					
	, ,	ct an annual individual,					
	facility-based fund						
	•	ility] facility experiences an					
	, , _	nan-made emergency that					
		of the emergency plan, the					
	•	mpt from engaging its next					
	-	le community-based or					
	•	based functional exercise					
	-	et of the emergency event.					
	-	dditional annual exercise					
	that may include,	but is not limited to the					
	following:						
	(A) A second full-	scale exercise that is					
	community-based	or an individual, facility					
	based functional e	exercise; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	<del>-</del> .					
	discussion, using						
	-	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		LTC facility] facility's					
	-	naintain documentation of					
	•	exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	• • •					
	. , -	CF/IID must conduct					
		he emergency plan at least					
	twice per year. Th following:	e ICF/IID must do the					
	_	n annual full scale evercise					

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ENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				ON	1B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMP	LETED
		155272	B. W	ING		06/22	2/2022
NAME OF 1	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CO	D	
				5226 E	82ND STREET		
ALLISON	N POINTE HEALTH	CARE CENTER		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
IAU				TAU			DATE
	that is community						
	1 ' '	nunity-based exercise is not					
		ict an annual individual,					
	1	ctional exercise; or.					
	(B) If the ICF/IID	experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the ICF/IID					
	is exempt from en	ngaging in its next required					
	full-scale commur	nity-based or individual,					
	facility-based fund	ctional exercise following the					
	onset of the emer	gency event.					
		Iditional annual exercise					
	1 ' '	but is not limited to the					
	following:						
	1	scale exercise that is					
	community-based						
	1	ctional exercise; or					
	1						
	(B) A mock disast						
		ercise or workshop that is					
	1	and includes a group					
	discussion, using						
	1	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	· · · · · · · · · · · · · · · · · · ·					
	(iii) Analyze the IC	CF/IID's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and en	nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	34.102]					
	(d)(2) Testing. The	e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						
	1	community-based exercise					
	, ,	conduct an annual					
	I is not accessible,	CONTROL AN ANNUAL					1

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individual, facility-based functional exercise

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155272	B. W	ING		06/22/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	R			82ND STREET		
ALLISON	I POINTE HEALTH	CARE CENTER			APOLIS, IN 46250		
/\LLIOOI\		ONITE OF ITTER		II VIDI/ II V	711 OLIO, 11 <b>1</b> 40200		_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	every 2 years; or.						
	` '	A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
	•	tional exercise following the					
	onset of the emer	•					
	` '	ditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c						
	· ·	limited to the following:					
	, ,	full-scale exercise that is					
	community-based						
	facility-based fund	isaster drill; or					
	• •	exercise or workshop that					
		or and includes a group					
	discussion, using	- ·					
	-	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	•					
	_	HA's response to and					
	. ,	ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	*[For OPOs at §48	36.360]					
	(d)(2) Testing. The	e OPO must conduct					
	exercises to test the	he emergency plan. The					
	OPO must do the	following:					
	(i) Conduct a pape	er-based, tabletop exercise					
	or workshop at lea	ast annually. A tabletop					
	exercise is led by	a facilitator and includes a					
	group discussion,	using a narrated, clinically					
	relevant emergen	cy scenario, and a set of					
	problem statemen	its, directed messages, or					
	prepared question	ns designed to challenge an					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155272	B. WING		06/22/2022	
	PROVIDER OR SUPPLIER		5226	T ADDRESS, CITY, STATE, ZIP COD E 82ND STREET ANAPOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		f the OPO experiences an				
		nan-made emergency that				
	-	n of the emergency plan, the				
		om engaging in its next				
		xercise following the onset				
	of the emergency					
	. ,	PO's response to and				
		ntation of all tabletop				
		nergency events, and revise				
	_	OPO's] emergency plan, as				
	needed.					
	*[ RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct					
		he emergency plan. The				
	RNHCI must do th	- · · ·				
		er-based, tabletop exercise				
		A tabletop exercise is a				
		led by a facilitator, using a				
		r-relevant emergency				
	-	et of problem statements,				
		s, or prepared questions				
	designed to challe	enge an emergency plan.				
	(ii) Analyze the RI	NHCI's response to and				
	maintain documer	ntation of all tabletop				
	exercises, and em	nergency events, and revise				
		rgency plan, as needed.				
		view and interview, the facility	E 0039	A table top exercise will be	07/08/2022	
		tercises to test the emergency		conducted to test the emerge	ncy	
	plan at least twice p	-		plan.		
		drills using the emergency		All resident have the potentia	l to	
	_	C facility must do the		be affected.		
	following:	1011		the maintenance director or		
		annual full-scale exercise that		designee will conduct a quart	-	
	is community-based			review of Fullscale drills, mod		
		ity-based exercise is not		disaster drills, and/ or table to	•	
		an annual individual,		exercises or workshops to en	sure	
	facility-based funct			compliance.		
		y experiences an actual natural		Results of the quarterly review		
	or man-made emerg	gency that requires activation	1	be submitted through QAPI a	nd	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155272		î ´	UILDING	ONSTRUCTION	(X3) DATE COMPI 06/22	LETED	
NAME OF I	PROVIDER OR SUPPLIEI	3	•		ADDRESS, CITY, STATE, ZIP COD 82ND STREET		
ALLISON	POINTE HEALTH	CARE CENTER		INDIAN	APOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION lan, the LTC facility is exempt		TAG	any concerns addressed		DATE
		ext required full-scale			immediately.		
	000	or individual, facility-based			ininiculately.		
	1	l exercise for 1 year following					
	the onset of the act	· · · · · · · · · · · · · · · · · · ·					
	(ii) Conduct an add	itional exercise that may					
	include, but is not l	imited to the following:					
	a. A second full-sca	ale exercise that is					
	community-based of	or an individual, facility-based					
	functional exercise						
	b. A mock disaster drill; or						
	c. A tabletop exercise or workshop that is led by a						
	facilitator that includes a group discussion, using						
	a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed						
	^						
	challenge an emerg	red questions designed to					
		ΓC facility's response to and					
		ation of all drills, tabletop					
		rgency events, and revise the					
		gency plan, as needed in					
		CFR 483.73(d)(2). This					
	deficient practice c	ould affect all occupants.					
	Findings include:						
		"Emergency Preparedness					
		ation dated 06/08/22 with the					
		and the Maintenance Director					
		w from 9:20 a.m. to 12:50 p.m.					
		cility has not documented an					
		e drill, mock disaster drill, or					
		or workshop to test the					
		required. Based on interview d review, the Executive Director					
		s currently experiencing the					
		it agreed documentation for an					
	additional exercise						
		es and procedures within the					
		month period was not					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155272		 JILDING	NSTRUCTION	COMPL 06/22/	ETED	
	PROVIDER OR SUPPLIER		5226 E	.ddress, city, state, zip cod 82ND STREET APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0041	Director during the 482.15(e), 483.73	viewed with the Executive exit conference.  (e), 485.625(e)				
SS=F Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in	et forth in paragraphs (b)(1)				
	The [LTC facility a implement emerge	d standby power systems.  Ind the CAH] must  Ency and standby power  the emergency plan set				
	Emergency generator must be the location requirement Care Facilities Control Interim Amendment 12-4, TIA 12-5, and Code (NFPA 101 and Amendments TIA	e located in accordance with ements found in the Health de (NFPA 99 and Tentative nts TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing				
	Emergency general The [hospital, CAF	3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272	ľ	UILDING	NSTRUCTION		LETED 1/2022	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		D BE	(X5) COMPLETION DATE	
	requirements four	i, and [maintenance] nd in the Health Care FPA 110, and Life Safety						
	Emergency generand LTC facilities source to power enhance a plan for home	3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs I that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the s it evacuates.						
	§483.73(g), and O The standards inc this section are appreference by the I Federal Register 552(a) and 1 CFF the material from You may inspect and Information Reson Boulevard, Baltim Archives and Rec (NARA). For inforthis material at NA go to:	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in opproved for incorporation by Director of the Office of the n accordance with 5 U.S.C. a part 51. You may obtain the sources listed below. a copy at the CMS curce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code						
	_of_federal_regul If any changes in incorporated by re document in the F announce the cha (1) National Fire F Batterymarch Par Quincy, MA 0216 1.617.770.3000. (i) NFPA 99, Heal	ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a federal Register to inges. Protection Association, 1 k,						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		155272	B. WING		06/22/2022
NAME OF F	PROVIDER OR SUPPLIER	3		ET ADDRESS, CITY, STATE, ZIP COD	<u> </u>
				S E 82ND STREET	
ALLISON	I POINTE HEALTH	CARE CENTER	INDI	ANAPOLIS, IN 46250	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROP	RIATE
TAG		R LSC IDENTIFYING INFORMATION im amendment (TIA) 12-2 to	TAG	DELICE ACT 1	DATE
	NFPA 99, issued	` ,			
	(iii) TIA 12-3 to NFPA 99, issued August 9,				
	2012.	3 -,			
	(iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1,				
	' '	FPA 99, issued March 3,			
	2014.	f- 0-f-h- 0-d- 0040			
	<ul><li>(vii) NFPA 101, Life Safety Code, 2012</li><li>edition, issued August 11, 2011.</li><li>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</li><li>(ix) TIA 12-2 to NFPA 101, issued October</li></ul>				
	30, 2012.	,			
	(x) TIA 12-3 to NF	PA 101, issued October			
	22, 2013.				
	` '	FPA 101, issued October			
	22, 2013.				
	, ,	standard for Emergency and			
		ystems, 2010 edition,			
	2009	chapter 7, issued August 6,			
		view and interview, the facility	E 0041	The current Maintenance di	rector 07/29/2022
		the emergency power system	1 0041	has been operating within	01/2/1/2022
	_	and maintenance requirements		compliance of this preventat	tive
	-	Care Facilities Code, NFPA		measure since his hire date	
		y Code in accordance with 42		All residents have the poten	tial to
		This deficient practice could		be affected.	
	affect all occupants			The Current maintenance di	rector
				will continue to conduct the	
	Findings include:			monthly load test and mainted	
	Based on review of	Direct Supply TELS Logbook		within Direct Supply TELS	
		nergency Power Generators:		Logbook documentation	
	Monthly Generator	Exercise and Inspection		"Emergency Generators: We	eekly
		mentation for the most recent		Generator Exercise and Insp	pection
	_	d with the Executive Director		(no load)"	
	and the Maintenance	ee Director during record	1	The documentation of the m	onthly

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/22/2022	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD 82ND STREET		
ALLISON	POINTE HEALTH	CARE CENTER		NAPOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		m. to 12:50 p.m. on 06/22/22,	TAG	load test will be reviewed mon	DATE this	
		g documentation for the		for 6 months by the Administra	•	
	•	l emergency generator for the		or designee to ensure complia	<b>I</b>	
	three month period	of March 2022 through May		and reported through QAPI.		
		ble for review. In addition,				
		Direct Supply TELS Logbook				
		nergency Generators: Weekly and Inspection (no load)"				
		he most recent twelve month				
		cutive Director and the				
	-	or during record review from				
		o.m. on 06/22/22, weekly				
	-	tation for the facility's diesel				
		nerator for the 13 week period 06/21/22 was not available for				
		nterview at the time of record				
		ance Director stated he				
		he facility 3 to 4 weeks ago				
	-	esting documentation and				
		spection documentation				
	lapsed because of st	aff turnover.				
		viewed with the Executive				
	Director during the	exit conference.				
K 0000						
Bldg. 01						
	•	Recertification and State	K 0000	Paper compliance requested.		
	•	as conducted by the Indiana				
	-	th in accordance with 42 CFR				
	483.90(a).					
	Survey Date: 06/22	2/22				
	Facility Number: 0					
	Provider Number:					
	AIM Number: 1002	267130				
	At this Life Safety (	Code survey, Allison Pointe				

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	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	` ′	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE COMPL	
		155272	B. WI	ING		06/22/	
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD 82ND STREET		
ALLISON	I POINTE HEALTH	CARE CENTER		INDIAN	IAPOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1710		was found not in compliance		1110			DATE
	with Requirements	-					
	Medicare/Medicaid	l, 42 CFR Subpart 483.90(a),					
		re 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 fa	ncility has a fire alarm system					
		on in the corridors and in all					
	-	orridor. The facility has smoke					
		d to the fire alarm system in all					
		ooms. The facility has a					
	time of this survey.	I had a census of 129 at the					
	time of this survey.						
	All areas where res	idents have customary access					
	were sprinklered.	The facility has two detached					
		g facility storage services					
	which were each no	ot sprinklered.					
	Quality Review con	mpleted on 06/27/22					
K 0100	NFPA 101						
SS=E	General Requiren	nents - Other					
Bldg. 01	General Requiren						
		RKS section any LSC					
		19.1 General Requirements					
		essed by the provided					
	-	eficient. This information,					
		olicable Life Safety Code or itation, should be included					
	on Form CMS-25	•					
		ation and interview, the facility	K 0	100	The latching hardware was		07/29/2022
		atching hardware on 2 of 10		100	corrected in the corridor door	set	0112312022
		er doors and 1 of 2 doors to the			by the payroll office		
	kitchen in accordan	nce with 4.6.12.3. LSC 4.6.12.3			The latching hardware was		
	requires existing lif	fe safety features obvious to			corrected in the corridor door	set	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155272	B. W	ING		06/22	/2022
				_			
NAME OF I	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
					82ND STREET		
ALLISON	I POINTE HEALTH	CARE CENTER		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the public if not rec	quired by the Code, shall be			by room 132.		
	either maintained o	r removed. This deficient			The corridor door to the kitche	n	
	practice could affect over 30 residents, staff and				nearest the kitchen rolling fire		
	visitors.				was corrected so that it closed		
					and latched properly.		
	Findings include:				All residents have the potentia	al to	
					be affected.		
	Based on observation	ons with the Executive			The maintenance director will		
	Director and the Ma	aintenance Director during a			conduct weekly rounds to ens	ure	
		from 1:30 p.m. to 5:00 p.m. on			all appropriate doors close an		
		ing hardware at the top of the			latch properly within the facility		
		orridor door set by the Payroll			and document the results.	,	
		ch into the door frame when			The administrator or designee	will	
	tested to close multiple times. The latching				review the results monthly and		
		of the east door in the corridor		results will be reported through			
	_	132 also failed to latch into the			QAPI.		
	-	ested to close multiple times. In			The fire resistance rating labe	ls	
		or door to the kitchen nearest			affixed to the top of each door		
	the kitchen rolling	fire door was equipped with a			the corridor door set by the Pa		
		but the self closing device			Office were made unobscured	-	
	_	latch the door into the door			paint so that they are now leg		
	frame when tested t	to close multiple times. Based			All residents have the potentia		
		time of the observations, the			be affected.		
		and the Maintenance Director			The fire resistance rating labe	ls on	
	agreed the aforeme	ntioned doors failed to latch			doors that require them will be		
	into the door frame	when tested to close multiple			monitored and documented		
	times.				monthly by the Maintenance		
					Director or designee and kept	with	
	This finding was re	eviewed with the Executive			preventative maintenance		
	Director during the				documentation TELS log boo	k to	
					ensure the fire resistance ratir		
	3.1-19(b)				labels are legible	-	
					The results of the monthly		
	2. Based on observa	ation and interview, the facility			monitoring will be reviewed by	the	
	failed to maintain f	ire resistance rating label			administrator or designee mor		
		1 of 10 sets of smoke barrier			for 6 months and reported thro	-	
	doors in accordance	e with 4.6.12.3. LSC 4.6.12.3			QAPI	Ü	
	requires existing lif	fe safety features obvious to					
		quired by the Code, shall be					
	_	r removed. This deficient					

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155272	B. WING		06/22/2022	
	PROVIDER OR SUPPLIER		5226 E	ADDRESS, CITY, STATE, ZIP COD 8 82ND STREET NAPOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	``	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		t over 20 residents, staff and				
	Findings include:					
	Director and the Matour of the facility for 06/22/22, the fire rethe top of each door the Payroll Office wilegible. Based on in observations, the Examintenance Direct fire resistance rating not legible.	ons with the Executive aintenance Director during a from 1:30 p.m. to 5:00 p.m. on esistance rating labels affixed to e in the corridor door set by were painted and were not interview at the time of the executive Director and the for agreed the aforementioned g labels were painted and were				
	This finding was red Director during the 3.1-19(b)	viewed with the Executive exit conference.				
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - Means of Egress - Aisles, passagewardischarges, exit lo in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1	- General ays, corridors, exit cations, and accesses are n Chapter 7, and the means accussly maintained free of full use in case of s modified by 18/19.2.2 110.1				
	failed to ensure 5 of continuously mainta or impediments to f fire or other emerge	on and interview, the facility f 9 means of egress was ained free of all obstructions full instant use in the case of ency. This deficient practice of residents, staff and visitors if facility.	K 0211	The two pallets of large boxes stacked on the pallets and wrapped with plastic were morprior to the end of the survey. Staff education to be provided The wooden chair in the corridoutside of room 203 was removed.	ved I. dor	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/22/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
	Findings include:  Based on observation Director during the facility from 8:45 at following was noted at two pallets and with stored in the corridor the path of egress for the path of egress for the ambulance entrated boxes on the pallets the floor or to the winder the entrance to the sambulance entrance fully open position and a wedge was used the breakroom in the position.  e. a wooden chair woutside resident sleet was not affixed to the facility of the fa	ons with the Maintenance initial walk through of the m. to 9:05 a.m. on 06/16/22, the diage boxes which were stacked rapped with plastic were or outside the service hall in or the ambulance entrance/exit. The chair was not affixed to all. The chair was not affixed to all. The corridor door set serving as service hall from the corridor was propped in the with a cardboard box. The the corridor door to be service hall in the fully open as stored in the corridor door to be service hall in the fully open was stored in the corridor door to be service hall in the fully open as stored in the corridor at the exit outside resident sleeping was stored in the corridor at the exit outside resident sleeping air was not affixed to the floor or to was stored in the corridor at facility outside resident		PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDERICIENCY)  The hoyer lift in the corridor a exit door to the facility outside room 205.  The box propping open the widoor in the corridor in the corridor was immediately removed.  The large wheelchair in the corridor at the exit door to the facility outside room 232 was immediately removed.  The fan plugged into the wall mounted electrical receptacle the corridor outside room 112 removed.  The small waste basket outsi the payroll office was removed All residents have the potentiable affected.  The Maintenance Director or designee will inspect the corriweekly to ensure all means of egress are maintained free or obstructions and document the results.  The results of the weekly inspection will be reviewed monthly be the Adminstrator designee for 12 months with results reported through QAF	est ridor lance iately  e in 2 was de ed. all to idors of fine		
	outside the Payroll	Office.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155272		r í	UILDING	01	COMPL 06/22/	ETED	
	PROVIDER OR SUPPLIER			5226 E	DDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0222	Director and the Matour of the facility for 106/22/22, the pallets wooden chair were entrance corridor. The wall mounted electroutside Room 112 as still stored in the corroller. Based on interview observations, the Expandintenance Direct means of egress were maintained free of a to full instant use in emergency.	recutive Director and the or agreed the aforementioned re not continuously all obstructions or impediments the case of fire or other					
SS=E Bldg. 01	Egress Doors Egress Doors Doors in a required be equipped with a requires the use of egress side unless special locking arm CLINICAL NEEDS LOCKING Where special lock clinical security ne used, only one lock permitted on each be made for the ra by: remote control	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements:  OR SECURITY THREAT king arrangements for the leds of the patient are king device shall be door and provisions shall upid removal of occupants of locks; keying of all led by staff at all times; or					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  06/22/2022	
	PROVIDER OR SUPPLIER			5226 E 8	DDRESS, CITY, STATE, ZIP COD 32ND STREET APOLIS, IN 46250		
	1						
(X4) ID		STATEMENT OF DEFICIENCIE	D.	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		REFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG			+	TAG	DA ICIANO.		DATE
	staff at all times.	e means available to the					
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6	.2.2.0, 19.2.2.2.3.1,					
	SPECIAL NEEDS	LOCKING					
	ARRANGEMENT						
		king arrangements for the					
		e patient are used, all of					
	1	curity Locking requirements					
		addition, the locks must be					
	electrical locks that fail safely so as to						
	release upon loss of power to the device; the						
	building is protected by a supervised						
	automatic sprinkler system and the locked						
	space is protected	d by a complete smoke					
	detection system	(or is constantly monitored					
		ation within the locked					
		the sprinkler and detection					
	1 -	iged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2						
	DELAYED-EGRE						
	ARRANGEMENT						
	1	lelayed-egress locking					
	1 -	in accordance with					
		permitted on door					
		g low and ordinary hazard lgs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2	•					
	ACCESS-CONTR						
	LOCKING ARRAN						
		d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	.2.4					
		BY EXIT ACCESS					
	LOCKING ARRAN						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPI	LETED
		155272	B. W	ING		06/22	/2022
NAME OF B	DDOLUDED OD GUDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIER	C			82ND STREET		
ALLISON	I POINTE HEALTH	CARE CENTER		INDIAN	IAPOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	t access door locking in					
		7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
	1 ' '	sed automatic sprinkler					
	system. 18.2.2.2.4, 19.2.2.	2.4					
		on and interview, the facility	V O	222	The exit door to the outside of	the	07/29/2022
		means of egress through 1 of			facility by room 205 was equip		01/29/2022
		ocks were readily accessible			with delayed egress signage.	pou	
		ff and visitors. LSC 7.2.1.6.1,			Education provided to		
		cks allows approved, listed,			Maintenance Director		
		s shall be permitted to be			All residents seeking to exit to	the	
		erving low and ordinary			outside of the facility through		
	hazard contents in b	-			exit door by room 205 have th		
	throughout by an ap	oproved, supervised automatic			potential to be affected.		
	fire detection syster	m installed in accordance with			The maintenance director or		
	Section 9.6, or an ap	pproved, supervised automatic			designee will make weekly rou	unds	
	sprinkler system ins	stalled in accordance with			to ensure all delayed egress of	loors	
	Section 9.7, and wh	ere permitted in Chapters 12			are equipped with the proper		
	through 42, provide				delayed egress signage and		
	1 1	k upon actuation of an			document the result		
		ed automatic sprinkler system			The results will be monitored	-	
		nce with Section 9.7, or upon			the administrator or designee		
		heat detector or not more			months and the results report	ed	
		ectors of an approved,			through QAPI		
	_	ic fire detection system					
		nce with Section 9.6.					
	1 1	ek upon loss of power					
		or locking mechanism.					
		process shall release the lock					
		upon application of a force to equired in 7.2.1.5.4 that shall					
		xceed 15 lbf nor required to be					
	_	ed for more than 3 seconds.					
		e release process shall activate					
		the vicinity of the door. Once					
	_	een released by the application					
		sing device, relocking shall be					
	or rorce to the relea	onig device, relocking shall be	1		i		1

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	TATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA  ND PLAN OF CORRECTION IDENTIFICATION NUMBER  155272		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/22/2022	
	PROVIDER OR SUPPLIER		5226 E	ADDRESS, CITY, STATE, ZIP COD 82ND STREET IAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
	having jurisdiction, seconds shall be per (d) On the door adjathere shall be a read letters not less than inch in stroke width that reads: "PUSH UNTIL AL DOOR CAN BE Of This deficient pract residents if needing 205.  Findings include:  Based on observation Director during the facility from 8:45 a exit door to the outs was magnetically leentering a four digit posted to release the was not equipped w Based on observation Director and the Matour of the facility for 6/22/22, the exit doy Room 205 was released by enter code was still not propen. When the exithe door did not ope at the keypad which delayed egress door after pushing for 15 equipped with the n signage. Based on signage.	pproved by the authority a delay not exceeding 30 mitted. acent to the release device, lily visible, durable sign in 1 inch high and at least 1/8 on a contrasting background				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272		X2) MULTIPLE CONSTRUCTION   X3) DATE SU     A. BUILDING   01   COMPLET     B. WING   06/22/20			,	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMP	X5) LETION ATE
K 0271 SS=E Bldg. 01	residents in the 200 diagnosis to be in a exit door was not endelayed egress sign.  This finding was re Director during the 3.1-19(b)  NFPA 101  Discharge from E. Exit discharge is a 7.7, provides a level the provisions of the charge in elevate free of obstruction discharge shall be travel surface.  18.2.7, 19.2.7  Based on observation of impediments to fire or other emerged could affect over 30 needing to exit the the Therapy Room facility by the exit of Eased on observation.  Findings include:  Based on observation of the provision of the exit of the the Therapy Room facility by the exit of the Eased on observation.	viewed with the Executive exit conference.  Exits exit exit exit exit exit exit exit exit	K 0271		de of the groom the room neans of west exit re the or or kly rounds ensure all ress to lity are	9/2022
	06/22/22, overgrow means of egress in exit by the Therapy	rn bushes on each side of the the exit discharge for the west Room and the exit discharge Room 232 was noted which		results.  The administrator or des review the documentation for 6 months and the res	signee will on monthly	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 06/22/2022			ETED		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0291 SS=F Bldg. 01	restricted the path of bushes were near the discharge. Based of observations, the Exovergrown bushes is provide an impediment case of fire or other.  This finding was resulted bushes in the Director during the second se	f egress. The overgrown e Ambulance entrance exit in interview at the time of the executive Director agreed the in the exit discharge would ment to full instant use in the emergency.  viewed with the Executive exit conference.			be reviewed in QAPI.		
	interview; the facilitesting for 3 of 4 bath accordance with LS testing of emergence permitted to be concerned (1) Functional testing with a minimum of weeks between tests seconds, except as of 7.9.3.1.1(2).  (2) The test interval extended beyond 30 authority having jur (3) Functional testing for a minimum of 1 lighting system is b (4) The emergency	riew, observation and ty failed to document monthly ttery backup lights in C 7.9. Section 7.9.3.1.1 states y lighting systems shall be ducted as follows: ng shall be conducted monthly, 3 weeks and a maximum of 5 s, for not less than 30 otherwise permitted by shall be permitted by shall be permitted to be 0 days with the approval of the risdiction. ng shall be conducted annually 1/2 hours if the emergency attery powered. lighting equipment shall be referenced to the risdiction of the risdiction.	K 02	291	The current Maintenance Dire does conduct monthly testing all battery backup lights in accordance with LSC 7.9 All residents have the potentiable affected.  The Maintenance Director will conduct monthly testing of all batter back lights and record to results in Direct Supply TELS under "Emergency Lighting: Conduct a 30 second monthly functional test"  The administrator or designeed review the results monthly for months and the results will be reported thru QAPI.	of al to he will 12	07/29/2022

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155272	B. WI	NG		06/22/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			82ND STREET		
ΔΙΙΙΔΟΝ	I POINTE HEALTH	CARE CENTER			APOLIS, IN 46250		
ALLIOON	IT OINTE HEALTH	CARE CENTER		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	* *	of visual inspections and tests					
		owner for inspection by the					
	authority having jur						
	This deficient practice could affect all residents,						
	staff and visitors.						
	Findings include:						
	Based on review of	Direct Supply TELS					
		ng: Conduct a 30 second					
		test" documentation with the					
	•	and the Maintenance Director					
		w from 9:20 a.m. to 12:50 p.m.					
	_	ly functional testing					
		three of four battery operated					
		after 02/11/22 was not					
		. Based on interview at the					
		ew, the Maintenance Director					
		orking at the facility 3 to 4					
		ery operated light testing for					
	_	iod of March 2022 through					
	-	ecause of staff turnover.					
		ons with the Executive					
	Director and the Ma	aintenance Director during a					
	tour of the facility f	From 1:30 p.m. to 5:00 p.m. on					
	06/22/22, two batte	ry operated lights were noted					
	at the generator loca	ation outside the facility and					
	one battery operated	d light was noted in the main					
	Mechanical Room i	in the service hall by the					
	Maintenance Office	e. Each battery operated light					
	operated when its re	espective test button was					
	pushed. One additi	onal battery operated lighting					
	system was noted o	n the exit sign in the new					
	dialysis room which	n illuminated when its					
	respective test butto	on was pushed. Interview					
	with dialysis staff in	ndicated the new dialysis wing					
	became operational	in early June 2022.					
	This finding	vious d with the Eventi					
	Director during the	viewed with the Executive					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		, ,	A. BUILDING <u>01</u>			SURVEY ETED	
		155272	B. WING			06/22/	2022
	PROVIDER OR SUPPLIER		52	226 E 8	DDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0321 SS=D Bldg. 01	3.1-19(b)  NFPA 101  Hazardous Areas  Hazardous Areas  Hazardous areas  barrier having 1-he (with 3/4 hour fire automatic fire exti accordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door.  Describe the floor hazardous areas t REMARKS.  19.3.2.1, 19.3.5.9  Area Separation	- Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system a areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in	TA	AG	DEFICIENCY)		DATE
	b. Laundries (large c. Repair, Mainter d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square for g. Laboratories (if Hazard - see K32: Based on observation	er than 100 square feet) nance, and Paint Shops noms (exceeding 64  n Rooms lons) prage Rooms/Spaces eet) classified as Severe 2) on and interview, the facility	K 0321		The active leaf door in the cor		07/29/2022
	failed to ensure 1 of	f over 9 hazardous areas such			door set to the washing machi	ne	

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ENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155272	B. W	ING		06/22	/2022
	PROVIDER OR SUPPLIE			5226 E	ADDRESS, CITY, STATE, ZIP COD 82ND STREET IAPOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		r than 100 square feet) were			room in the Laundry was close	∍d.	
	_	er spaces by smoke resistant			Staff training provided.		
	_	s. Doors shall be self closing			All residents have the potentia	ıl to	
		g in accordance with 7.2.1.8.			be affected		
	This deficient practice could affect over 2 staff				The maintenance director will		
	and visitors.				make rounds weekly to ensure		
					hazardous areas are separate	:d	
	Findings include:				from other spaces by smoke		
				resistant partitions and doors	and		
		ons with the Executive			document the results.		
		aintenance Director during a			The Administrator will review t		
		from 1:30 p.m. to 5:00 p.m. on			results monthly for 12 months	and	
		e leaf door in the corridor door			report through QAPI.		
	_	nachine room in the Laundry					
		fully open position by					
		e side of the door up against a					
		Based on interview at the time					
		, the Executive Director and					
		irector agreed propping the					
	_	eparate this hazardous areas					
	_	with smoke resistant partitions					
	and doors.						
	This Co. 1:	ori consideration Decreasions					
	_	eviewed with the Executive					
	Director during the	exit conference.					
	3.1-19(b)						
K 0351	NFPA 101						
SS=D	Sprinkler System	- Installation					
Bldg. 01	Spinkler System -						
J	2012 EXISTING						
		nd hospitals where required					
	by construction ty						
	1 -	approved automatic					
		n accordance with NFPA					
	1 '	he Installation of Sprinkler					
	Systems.	no motalication of Opinino					
		onstruction, alternative					
	I I PO I GITG II OC		1		Ī		1

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protection measures are permitted to be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SO			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155272	B. W	ING		06/22	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			82ND STREET		
ALLISON	I POINTE HEALTH	CARE CENTER			IAPOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		inkler protection in specific					
		or local regulations prohibit					
	sprinklers.	klers are not required in					
		patient sleeping rooms					
		the closet does not exceed					
		sprinkler coverage covers					
	•	t as required by NFPA 13,					
		Illation of Sprinkler					
	Systems.						
	19.3.5.1, 19.3.5.2	, 19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 0	351	The box on the shelving in the		07/29/2022
		spray pattern for sprinkler			storage room by the mechanic	cal	
		tructed in 1 of 1 storage rooms			room in the service hall was		
		LSC 19.3.5.1. NFPA 13, 2010			moved to a distance greater th	nan	
		.5.1 states sprinklers shall be			18" from the ceiling. Staff		
		nimize obstructions to			education to be provided.		
	-	d in Section 8.5.5.2 and Section l sprinklers shall be provided to			All residents have the potentia	II TO	
		verage of the hazard. Sections			be affected. The maintenance director or		
	-	do not permit continuous or			designee will make weekly rou	ınde	
		ructions less than or equal to			to ensure sprinkler head spray		
		e sprinkler deflector or in a			patterns remain unobstructed		
		ore than 18 inches below the			document the results.		1
	-	that prevent the spray pattern					
	-	ng. This deficient practice					
	could affect staff or	nly.					
	Eindings in the d						
	Findings include:						
	Based on observation	ons with the Executive					
	Director and the Ma	aintenance Director during a					
	tour of the facility f	From 1:30 p.m. to 5:00 p.m. on					
		ge on shelving in the storage					
	-	nical Room in the service hall					
		ix inches of the ceiling which					
		spray pattern obstruction for					
	_	l sprinkler in the room. Based					
1	I on interview at the i	time of the observations the	1		I		1

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/22/2022	
	PROVIDER OR SUPPLIER		5226	ET ADDRESS, CITY, STATE, ZIP COD B E 82ND STREET ANAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
	Executive Director had an obstructed spremove the box store 18 inches below the This finding was re	agreed the sprinkler in the room pray pattern and had staffing rage in the room to greater than e ceiling.				
	Director during the 3.1-19(b)	exit conference.				
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar	- Maintenance and Testing - Maintenance and Testing er and standpipe systems sted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a and readily available. It system last checked				
	c) Water system	supply source				
	coverage for any is automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on record interview; the facility system inspections NFPA 25, Standard and Maintenance of Systems, 2011 Edit and fire department	, and NFPA 25 review, observation and ity failed to document sprinkler in accordance with NFPA 25. If for the Inspection, Testing, If Water-Based Fire Protection ion, Section 5.1.2 states valves t connections shall be	K 0353	The current maintenance direcurrently conducts the month sprinkler system valve inspected and documents in Direct Sup TELS "Fire Sprinkler System Monthly Fire Sprinkler Control Valve Visual Inspection"	ortion opply :	
	_	nd maintained in accordance ection 13.3.2.1 states all valves		The current maintenance dire		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (		ONSTRUCTION (X3) DATE		URVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		<u>01</u>	COMPLETED		
		155272	B. WING			06/22/2022		
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD			
ALLICON POINTE LIEAL THOADE OFNITED				5226 E 82ND STREET				
ALLISON POINTE HEALTHCARE CENTER			INDIANAPOLIS, IN 46250					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG				TAG DEFICIENCY)			DATE	
	shall be inspected weekly. Section 13.3.2.1.1				sprinkler system valve inspection			
	states valves secured with locks or supervised in			and document results in Direct Supply TELS "Fire Sprinkler				
	accordance with applicable NFPA standards shall							
	be permitted to be inspected monthly. Section			System: Monthly Fire Sprinkler				
	13.3.2.2 states the valve inspection shall verify			Control Valve Visual Inspection"				
	that the valves are in the following condition:				All residents have the potential to			
	(1) In the normal open or closed position				be affected.			
	(2) *Sealed, locked or supervised				The administrator or designee will			
	(3) Accessible				review the documentation monthly			
	(4) Provided with correct wrenches				for 12 months and report the			
	(5) Free from external leaks				results through QAPI.			
	(6) Provided with applicable identification				The current maintenance director			
	Section 4.3.1 states records shall be made for all				conducts the In house fire			
	inspections, tests, and maintenance of the system				sprinkler visual inspection weekly			
	and its components and shall be made available to				and records the results in Direct			
	the authority having jurisdiction upon request.				Supply TELS "Fire Sprinkler			
	This deficient practice could affect all residents,				Visual Inspection – Weekly"			
	staff and visitors.				All residents have the potential to			
					be affected.			
	Findings include:				The maintenance director will			
					conduct in house fire sprinkler			
	Based on review of Direct Supply TELS "Fire				visual inspection weekly and			
	Sprinkler System: Monthly Fire Sprinkler Control				record the results in Direct Supply			
	Valve Visual Inspection" documentation with the				TELS " Fire Sprinkler Visual			
	Executive Director and the Maintenance Director			Inspection – Weekly"				
	during record review from 9:20 a.m. to 12:50 p.m.				The results will be reviewed			
	on 06/22/22, monthly sprinkler system valve				monthly by the Administrator or			
	inspection documentation after 03/07/22 was not			designee Monthly for 12 months				
	available for review. Monthly sprinkler system				and the results reported through			
	valve inspection documentation for the two				QAPI.			
	month period of April 2022 through May 2002 was				The two conduits penetrating the			
	not available for review. Based on interview at the				suspended ceiling tile next to the			
	time of record review, the Maintenance Director				range hood in the kitchen will be			
	stated he started working at the facility 3 to 4			corrected to be within compliance.				
	weeks ago and monthly sprinkler system valve			The ceiling tile in the corridor				
	inspection documentation for the two month			outside room 207 was replaced.				
	period of April 2022 through May 2022 lapsed				All residents have the potential to			
	because of staff turnover. Based on observations				be affected.			
	with the Executive Director and the Maintenance			The maintenance				
	Director during a tour of the facility from 1:30 p.m.			director/designee will perform				
Entered and a sear of the memory from 1.50 p.m.			1		1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272		(X2) MULTII A. BUILDI B. WING		nstruction <u>01</u>	(X3) DATE COMPI <b>06/22</b>		
	PROVIDER OR SUPPLIER		52	26 E	DDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		22/22, the facility has	TA	.G		v io	DATE
	supervised dry sprii				weekly audits to ensure facilit in compliance.	y 15	
		viewed with the Executive			The Maintenance		
	Director during the	exit conference.			Director/Designee will bring re	esults	
	3.1-19(b)				of the audits to QAPI for six months or until 100% complia	nce	
	2.1 15(0)				is achieved and address any	1100	
	2. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25.				concerns immediately.		
	NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection				<del></del>		
	Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be				The ceiling mounted sprinkler the 200 hall housekeeping clo		
					will be replaced.	set	
		ensure that normal air and			All residents have the potentia	al to	
		being maintained. Section			be affected.	ai to	
	_	shall be made for all			The maintenance		
		nd maintenance of the system			director/designee will perform		
	-	and shall be made available to			weekly audits to ensure facilit		
		g jurisdiction upon request.			in compliance.		
	_	ice could affect all residents,					
	staff, and visitors.				The Maintenance		
	T' 1' ' 1 1				Director/Designee will bring re	esults	
	Findings include:				of the audits to QAPI for six	noo	
	Based on review of	Direct Supply TELS "Fire			months or until 100% complia is achieved and address any	nc <del>e</del>	
		n-House Fire Sprinkler Visual			concerns immediately.		
		y" documentation with the			concomo inimodiatory.		
		and the Maintenance Director					
	during record review	w from 9:20 a.m. to 12:50 p.m.					
	on 06/22/22, weekl	y sprinkler gauge inspection					
		he facility's dry sprinkler					
	-	week period of 03/14/22					
	~	as not available for review.					
		at the time of record review,					
		rector stated he started					
	_	ity 3 to 4 weeks ago and					
		stem gauge inspection					
	uocumentation for t	the 13 week period of 03/14/22					I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272		X2) MULTIPLE CONSTRUCTION A. BUILDING D1 COMPLETED 06/22/2022				
	PROVIDER OR SUPPLIEF		5226 E	ADDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	through 06/21/22 la Based on observation Director and the Matour of the facility of 16/22/22, the facility systems.  This finding was reduced by the facility of 16/22/22, the facility systems.  This finding was reduced by the facility of 16/22/22, the facility systems.  This finding was reduced by the facility of 16/22/22, the facility systems.  This finding was reduced by the facility of 16/22/22, the fa	e LSC IDENTIFYING INFORMATION appeal because of staff turnover. cons with the Executive aintenance Director during a from 1:30 p.m. to 5:00 p.m. on by has supervised dry sprinkler eviewed with the Executive			IIE	
	construction. This over 15 residents, s Findings include:	deficient practice could affect taff, and visitors.				
	Director and the Matour of the facility for 06/22/22, two conditions to the ceiling tile next to the In addition, two hole in the corridor outsing 207. The holes wou which would delay	ons with the Executive aintenance Director during a from 1:30 p.m. to 5:00 p.m. on uits penetrated the suspended he range hood in the kitchen. les were noted in a ceiling tile ide resident sleeping Room ald not trap hot air and gases sprinkler activation. Based on e of the observations, the				

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Executive Director agreed the holes in the ceiling

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STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272	(X2) MULTIPLE CO A. BUILDING B. WING	nstruction <u>01</u>	(X3) DAT COMI	E SURVEY PLETED 2/2022	
	PROVIDER OR SUPPLIER		5226 E	NDDRESS, CITY, STATE, ZIP COE 82ND STREET APOLIS, IN 46250	)		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETION DATE	
	This finding was re Director during the 3.1-19(b)  4. Based on observation failed to ensure 1 of the facility were free accordance with NI the Inspection, Test Water-Based Fire F. Edition, Section 5.2 show signs of leakat foreign materials, p. shall be installed in up-right, pendent, c. 5.2.1.1.2 any sprink the following shall (1) Leakage (2) Corrosion (3) Physical Damag (4) Loss of fluid in element (5) Loading (6) Painting unless manufacturer. In lieu of replacing dust, it is permitted compressed air or be equipment does not This deficient pract	prinkler activation.  viewed with the Executive exit conference.  ation and interview, the facility fover 100 sprinkler heads in see of corrosion were replaced in FPA 25. NFPA 25, Standard for ting, and Maintenance of Protection Systems, 2011 2.1.1.1 states sprinklers shall not age; shall be free of corrosion, aint, and physical damage; and the correct orientation (e.g., or sidewall). Furthermore, at caller that shows signs of any of be replaced:  gethe glass bulb heat responsive  painted by the sprinkler  sprinklers that are loaded with to clean sprinklers with to clean sprinklers with to clean sprinkler. it is could affect over 15 visitors in the vicinity of the					
	Findings include:  Based on observation	ons with the Executive					

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Director and the Maintenance Director during a

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155272	B. W	ING		06/22/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				82ND STREET		
ALLISON	POINTE HEALTH	CARE CENTER			APOLIS, IN 46250		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	rom 1:30 p.m. to 5:00 p.m. on					
		g mounted sprinkler in the 200					
		closet was green with					
		n interview at the time of the					
	observations, the Executive Director and the Maintenance Director agreed the aforementioned automatic sprinkler location was not free of						
	corrosion.						
	This finding was rev	viewed with the Executive					
	Director during the						
	Director during the exit conference.						
	3.1-19(b)						
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
-	Doors protecting of	corridor openings in other					
		osures of vertical openings,					
	exits, or hazardou	s areas resist the passage					
	of smoke and are	made of 1 3/4 inch					
	solid-bonded core	wood or other material					
	capable of resistin	g fire for at least 20					
		fully sprinklered smoke					
	•	only required to resist the					
		e. Corridor doors and doors					
	to rooms containing						
		rials have positive latching					
		atches are prohibited by					
	-	hese requirements do not					
		spaces that do not contain					
	flammable or com						
		n bottom of door and floor					
	-	ceeding 1 inch. Powered					
		vith 7.2.1.9 are permissible					
	-	device capable of keeping					
		hen a force of 5 lbf is					
		no impediment to the					
	-	rs. Hold open devices that					
	release when the	door is pushed or pulled are					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/22/2022 155272 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5226 E 82ND STREET INDIANAPOLIS, IN 46250 ALLISON POINTE HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3. unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility K 0363 The wedge used to prop the 07/29/2022 failed to ensure 5 of over 50 corridor doors to corridor to the breakroom in the resident sleeping rooms had no impediment to service hall was removed. closing and latching into the door frame and The door to room 101 will be would resist the passage of smoke. This deficient adjusted to reduce the gap when practice could affect over 50 residents, staff and closed. visitors. The Brookshire nurses station supply closet corridor door Findings include: latching mechanism will be adjusted, allowing it to latch and Based on observations with the Maintenance close properly Director during the initial walk through of the The wooden chair against the facility from 8:45 a.m. to 9:05 a.m. on 06/16/22, a corridor door to room 201 was wedge was used to prop the corridor door to the removed. breakroom in the service hall in the fully open The cardboard box against the position. Based on observations with the corridor door to the respiratory Executive Director and the Maintenance Director office was removed. during a tour of the facility from 1:30 p.m. to 5:00 Residents residing in the corridor p.m. on 06/22/22, a one inch gap was noted in where room 201 is located have between the door and the door stop near the the potential to be affected. latching mechanism for the corridor door to Room Residents residing in the corridor 101 when the door was in the fully closed and where room 101 is located have latched position. The Brookshire nurse's station the potential to be affected.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/22/2022
	PROVIDER OR SUPPLIER		5226 E	ADDRESS, CITY, STATE, ZIP COD E 82ND STREET NAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	failed to latch into the frame when tested the wooden chair was shoot to Room 201. On the floor up again	or door latching mechanism he latching plate on the door o close multiple times. A tored up against the corridor A cardboard box was placed nst the corridor door to the Based on interview at the time		The maintenance director/designee will perform weekly audits to ensure facil is in compliance.  The Maintenance Director/Designee will bring	<b>I</b>
	the Maintenance Di aforementioned con to closing and latch would not resist the	ridor doors had an impediment ing into the door frame or passage of smoke.		results of the audits to QAPI six months or until 100% compliance is achieved and address any concerns immediately.	for
	This finding was red Director during the 3.1-19(b)	viewed with the Executive exit conference.			
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers shall be postriers shall be postrium wall. Smoke in duct penetration systems where and is installed for smoth to the smoke barriers and to the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any medical system in REMAR	all be constructed to a ance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er. ) hanical smoke control	W 0272	The emple beginning well need	07/20/2022
	interview; the facili smoke barrier walls fire resistance of the	riew, observation and ty failed to ensure 1 of 10 were protected to maintain the e smoke barrier. LSC Section noke barriers to be constructed	K 0372	The smoke barrier wall near the payroll door will have the smoke barrier restored by removing the fusible link to the fire damper. Training will be	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155272	B. W	ING		06/22/	2022
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	in accordance with	LSC Section 8.5 and shall have			provide to maintenance on		
	a minimum ½ hour	fire resistive rating. This			inspection of fire/smoke		
	deficient practice co	ould affect over 20 residents,			barriers for smoke resistance	е	
	staff and visitors in	the vicinity of the corridor			All residents have the potent	ial	
	door set by the Pay	roll Office.			to be affected		
	Findings include:				The maintenance director or designee will perform month		
	Based on review of	floor plan documentation with			audits to ensure the facility is	-	
	the Executive Direc	ctor and the Maintenance			in compliance.		
	Director during rec	ord review from 9:20 a.m. to					
	_	2/22, an existing smoke barrier			The Maintenance		
	wall is near the Payroll Office. Based on observations with the Executive Director and the				Director/Designee will bring		
					results of the audits to QAPI	for	
		tor during a tour of the facility			six months or until 100%		
	_	:00 p.m. on 06/22/22, one fire			compliance is achieved and		
		n the smoke barrier wall above			address any concerns		
	_	ng above the corridor door set			immediately.		
	1 -	ce. The fire damper shutter was					
		en position with a fusible link.					
		smoke barrier wall caused by er would not resist the passage					
		n interview at the time of the					
		xecutive Director contacted					
		er's office by telephone to					
		mper was in a smoke barrier wall					
		non-rated assembly. The					
		stated the Corporate owner's					
		ll was a fire barrier wall but the					
		agreed the open fire damper					
	would not resist the						
		viewed with the Executive					
	Director during the	exit conference.					
	3.1-19(b)						
K 0374	NFPA 101						
SS=E		ilding Spaces - Smoke					
Bldg. 01	Barrie	Ų i					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u>01</u>	COMPL	ETED
		155272	B. W	ING		06/22/	2022
				CTDEET /	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD 82ND STREET		
ALLISON	N POINTE HEALTH	CARE CENTER			APOLIS, IN 46250		
ALLISON	I POINTE HEALTH	CARE CENTER		INDIAN	APOLIS, IN 40250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Subdivision of Bui	ilding Spaces - Smoke					
	Barrier Doors						
	2012 EXISTING						
	Doors in smoke ba	arriers are 1-3/4-inch thick					
	solid bonded woo	d-core doors or of					
	construction that r	esists fire for 20 minutes.					
	Nonrated protective	ve plates of unlimited height					
		ors are permitted to have					
	fixed fire window a	assemblies per 8.5. Doors					
	are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches						
	for swinging or ho						
	19.3.7.6, 19.3.7.8						
		on and interview, the facility	K C	374	The therapy office door insid	de	07/29/2022
		f 1 Therapy Room smoke			the therapy room was		
		restrict the movement of			equipped with a self closing		
		0 minutes. LSC, Section			device. Training provided to		
	_	at doors in smoke barriers shall			maintenance staff on		
		Section 8.5.4. LSC, Section			importance of door closers a	and	
	_	ors in smoke barriers to close			smoke barrier wall doors.		
		only the minimum clearance			Residents utilizing the therapy		
		r operation which is defined			gym have the potential to be	!	
		ct the movement of smoke.			affected.		
	^	ice could affect over 10			l		
	·	visitors in the vicinity of the			The maintenance		
	Therapy Room.				director/designee will perfor	m	
	F. 1				Monthly audits to ensure		
	Findings include:				facility is in compliance.		
	Događen st	ons with the Executive			The Maintenance		
		ons with the Executive aintenance Director during a			The Maintenance		
		From 1:30 p.m. to 5:00 p.m. on			Director/Designee will bring	for	
	-	py Office door inside the			results of the audits to QAPI	IOF	
		a smoke barrier wall which			six months or until 100%		
		vall to outside wall and was			compliance is achieved and		
		self closing device. Based on			address any concerns		
		e of the observations, the			immediately.		
		and the Maintenance Director					
	Executive Director	and the Maintenance Director					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	01	COMPL	
		155272	B. WIN	NG		06/22/	2022
	PROVIDER OR SUPPLIER			5226 E	ADDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	•	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	agreed the Therapy with a self closing of	Office door was not equipped levice.					
	This finding was reviewed with the Executive Director during the exit conference.						
	3.1-19(b)						
K 0511 SS=E Bldg. 01	Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2		K 05	11	A cover plate was installed on electrical junction box mounter above the suspended ceiling of the smoke barrier wall by room 228 All residents residing in the corridor where room 228 is loo have the potential to be	d on n	07/08/2022
	suitable for the cond metal covers shall c requirements of 250 could affect over 12 the vicinity of Room Findings include:	ons with the Executive			affected. The maintenance director/designee will perform weekly audits to ensure facilis in compliance. The Maintenance Director/Design will bring results of the audit to QAPI for six months or un 100% compliance is achieved and address any concerns immediately.	ity nee s til	
	tour of the facility for 06/22/22, the electric	nintenance Director during a from 1:30 p.m. to 5:00 p.m. on ical junction box mounted d ceiling on the smoke barrier					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY  COMPLETED  06/22/2022		
	PROVIDER OR SUPPLIER		5226 E	ADDRESS, CITY, STATE, ZIP COD E 82ND STREET NAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
K 0711 SS=F Bldg. 01	exposed the spliced junction box. Based the observations, the aforementioned did not have its covexposed the spliced junction box.  This finding was reducted junction box.  There is a uritten patients and for the fire is a written patients and for the with telephone opplan addresses the staff per 18/19.2 of the fire safety per 18/19.2.2 in 18.7.2.1 through 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2. Based on record reverties interview; the facility written emergency incorporated all item 19.7.2.2.  1. Use of alarms.  2. Transmission of	elocation Plan elocation Plan plan for the protection of all eir evacuation in the event riodically instructed and their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all lan components per 8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 2, 19.7.2.3 riew, observation and ty failed to provide 1 of 1 fire safety plan that as listed in NFPA 101, Section alarms to fire department. the call to fire department	K 0711	The written fire safety plan floor plan documentation w updated to identify the loca of fire doors, fire barrier wa smoke doors, or smoke bar walls in the facility. All residents have the poter to be affected.	tion IIs, rier

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155272	B. W	NG		06/22/	2022
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			82ND STREET		
ALLISON	I POINTE HEALTH	CARE CENTER			APOLIS, IN 46250		
ALLISON		CARE CENTER		INDIAN	AFOLIS, IN 40230		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	5. Isolation of fire.				The fire safety plan will be		
	6. Evacuation of in	mmediate area.			updated to include all 9 item	ıs	
	7. Evacuation of si	moke compartment.			listed in NFPA 101 section		
	8. Preparation of fl	loors and building for			19.7.2.2.		
	evacuation.						
	9. Extinguishment				The fire safety plan will be		
	This deficient pract	tice affects all residents, staff			reviewed, approved and		
	and visitors.				updated as necessary by		
		T. I			members of the QAA		
	Findings include:				committee annually.		
		E"Emergency Preparedness					
	Policy Manual" documentation dated 06/08/22						
		Director during the exit					
		00 p.m. to 6:00 p.m. on 06/22/22,					
	the written fire safe						
		not consistently identify the					
		rs, fire barrier walls, smoke					
		rier walls in the facility. The					
		ergency preparedness					
		tained multiple floor plans					
	_	locations of smoke barrier					
	I	. Based on interview at the time					
		ice, the Executive Director					
	_	t floor plans for the facility did					
	I	te a smoke barrier wall was or					
		the Payroll Office. In addition,					
		ctor could not locate all 9 items					
		, Section 19.7.2.2 in the written					
		he emergency preparedness					
	documentation for	the facility.					
	7E1 ' C' 1'						
	_	eviewed with the Executive					
	Director during the	exit conference.					
	3.1-19(b)						
						İ	
K 0741							
SS=D	Smoking Regulati						
Bldg. 01	Smoking Regulati	ions					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155272	B. WING		06/22/2022
	PROVIDER OR SUPPLIER		5226 1	ADDRESS, CITY, STATE, ZIP COD E 82ND STREET NAPOLIS, IN 46250	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	Smoking regulation shall include not be provisions:  (1) Smoking shall ward, or comparted liquids, combustibe used or stored and location, and such signs that read NC posted with the interest smoking.  (2) In health care a smoking is prohibit prominently placed secondary signs we smoking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the properties of the posted with the provided with	be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ted and signs are d at all major entrances, with language that prohibits be required. Attents classified as not be prohibited. Int of 18.7.4(3) shall not attent is under direct moombustible material and the provided in all areas permitted. The sign of the sign o	TAG	DEFICIENCY	DATE
		view, observation and	K 0741	All cigarette butts were	07/22/2022
	materials were depo containers with self which ashtrays can material and safe de where smoking was practice could affect the vicinity of the o	ty failed to ensure smoking osited into ashtrays and metal c-closing cover devices into be emptied of noncombustible esign in 1 of 3 outdoor areas taking place. This deficient t over 5 staff and visitors in utdoor staff smoking area at ance on the northwest side of		removed from the ambulance entrance and along the concrete path and mulch as well as outside the ambulancentrance doors. Staff education to be provided.  All residents have the potento be affected.	ce

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272		l í	JILDING	onstruction 01	(X3) DATE S COMPL <b>06/22</b> /	ETED	
	ROVIDER OR SUPPLIER			5226 E	ADDRESS, CITY, STATE, ZIP COD 82ND STREET APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	Based on review of documentation with the Maintenance Diffrom 9:20 a.m. to 1 residents and staff a designated outdoor interview at the tim Maintenance Direct and staff are allowed outdoor areas. Base Executive Director during a tour of the p.m. on 06/22/22, v. strewn on the ground the concrete path of well as in the mulch ambulance entrance containers with self which ashtrays can material and safe do outdoor location why place but extinguish consistently deposite containers. Based of observations, the Emaintenance Direct deposited on the green trance path outside mulch area and were into the ashtrays an self-closing cover deprovided at this out smoking was taking	"Smoking Policy" In the Executive Director and arector during record review 2:50 p.m. on 06/22/22, assessed are allowed to smoke in smoking areas. Based on e of record review, the tor stated assessed residents and to smoke only in designated ed on observations with the and the Maintenance Director facility from 1:30 p.m. to 5:00 well over 50 cigarette butts were and outside the facility all along if the ambulance entrance as an area just outside the edoors. Ashtrays and metal acclosing cover devices into be emptied of noncombustible esign were provided at this mere staff smoking was taking and cigarette butts were not ted into the designated on interview at the time of the executive Director and the tor agreed cigarette butts were bound all along the ambulance de the building and in the re not consistently deposited d metal containers with devices into which were door location where staff is place.			director/designee will perform daily audit to ensure facility in compliance and that all cigarette butts are disposed properly.  Results of the audits will be brought to QAPI monthly for months or until 100% compliance is achieved and address any concerns immediately.	is of	

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STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155272	B. WI			06/22/	
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0911 SS=E Bldg. 01	Chapter 6 Electric that are not addre K-Tags, but are do along with the app NFPA standard ciron Form CMS-256 Chapter 6 (NFPA Based on observation failed to ensure accommaintained in enclous apparatus in 2 of ov 99, Health Care Face Section 6.3.2.1 state in accordance with Code. NFPA 70, 20 states working space 600 volts, nominal, examination, adjust maintenance while dimensions of 110.2 shall be measured for are exposed or from opening if such are states the working shall not be used for practice could affect Findings include:  Based on observation Director and the Matour of the facility for 06/22/22, soiled line	S - Other RKS section any NFPA 99 al Systems requirements ssed by the provided eficient. This information, blicable Life Safety Code or tation, should be included of. 99) on and interview, the facility ess and working space was sures housing electrical ter 2 electrical rooms. NFPA cilities Code, 2012 Edition, es electrical installation shall be NFPA 70, National Electric 011 Edition, Article 110.26 e for equipment operating at or less and likely to require	K 0	911	All obstructions were remove from under the wall mounted electrical panel identified as EMEQ-L-2 in the Brookshire soiled linen room with the at access door across from the nurse's station. Staff education to be provided.  All residents have the potent to be affected.  The maintenance director/designee will perform weekly audits to ensure facilis in compliance.  The Maintenance Director/Designee will bring results of the audits to QAPI six months or until 100% compliance is achieved and address any concerns immediately.	tic ion tial m	07/15/2022

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155272	B. WI	NG		06/22/	/2022
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
			5226 E 82ND STREET				
ALLISON POINTE HEALTHCARE CENTER			INDIANAPOLIS, IN 46250				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	CCP-4" in the soiled linen					
	•	Concentrators and soiled					
		were stored directly mounted electrical panel					
		Q-L2" in the Brookshire soiled					
		attic access door across from					
		Each electrical panel was					
		e stating not to store items in					
		th each panel and each					
		tained isolated circuit breakers					
		bed locations. Based on					
		e of the observations, the					
	Executive Director agreed access and working space was not maintained in front of the two wall						
	mounted electrical p	panels at the aforementioned					
	locations.						
	This finding was rev	viewed with the Executive					
	Director during the						
	3.1-19(b)						
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01	-	s - Essential Electric					
	System Maintenar	nce and Testing					
	The generator or	other alternate power					
	source and associ	ated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
	•	ocess shall be provided to					
	-	nis capability for the life					
	•	branches. Maintenance					
	-	generator and transfer					
	· · · · · · · · · · · · · · · · · · ·	rmed in accordance with					
	NFPA 110.	inapacted weekly					
		e inspected weekly, and 30 minutes 12 times a					
		intervals, and exercised					
		nths for 4 continuous hours.					
	Shoc Gvery 50 mio	nano non 4 domandous mours.					

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING	01	COMPLETED				
		155272	B. WING		06/22/2022				
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD					
				E 82ND STREET					
ALLISON POINTE HEALTHCARE CENTER			INDIA	INDIANAPOLIS, IN 46250					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION				
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE				
		nder load conditions include							
		ated cold start and							
		ual transfer of all EES							
		nducted by competent							
	-	enance and testing of stored							
		ırces (Type 3 EES) are in							
		NFPA 111. Main and feeder							
		re inspected annually, and a							
		dically exercising the							
	•	tablished according to							
		uirements. Written records							
		nd testing are maintained							
		ble. EES electrical panels							
		narked, readily identifiable,							
		n normal power circuits.							
		ssibility of damage of the							
		r source is a design							
	consideration for								
		(NFPA 99), NFPA 110,							
	NFPA 111, 700.1		17.0010	The second state and a discrete	07/20/2022				
		review, observation and	K 0918	The new maintenance direct	or 07/29/2022				
		ity failed to document		does conduct monthly load					
		or monthly load testing for 3 recent 12 month period to		testing of the generatorAll	- h -				
		_		residents have the potential to					
	_	ents of NFPA 110, 2010 Edition, nergency and Standby Powers		affected.The maintenance dire					
		3.4.2. Section 8.4.2 states diesel		will conduct monthly load test	·				
		rvice shall be exercised at least		of the generator and record the					
	-	a minimum of 30 minutes, using		results in TELS.The Maintena Director/Designee will bring re					
	one of the followin			of the audits to QAPI for six	Julio				
		aintains the minimum exhaust		months or until 100% complia	ince				
		s recommended by the		is achieved and address any					
	manufacturer	. 1000mmenada oy me		concerns immediately.					
		g temperature conditions and at		Buckeye Power Sales, our ve	ndor				
		reent of the EPS (Emergency		will run a 4hr load test above					
	Power Supply) nan			on our generator	1070				
	* * * * *	es diesel-powered EPS		Annual load bank testing will l	he				
		o not meet the requirements of		documented as being conduc					
		rised monthly with the available		pursuant to NFPA 110.					
1	1		1	P=104411 to 141 1 / 1 1 10.	I				

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EPSS (Emergency Power Supply System) load and

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This could affect all residents, staff

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/22/2022 155272 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5226 E 82ND STREET INDIANAPOLIS, IN 46250 ALLISON POINTE HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE shall be exercised annually with supplemental and visitors. loads at not less than 50 percent of the EPS The maintenance nameplate kW rating for 30 continuous minutes director/designee will complete and at not less than 75 percent of the EPS monthly audits to ensure annual nameplate kW rating for 1 continuous hour for a supplemental load testing was total test duration of not less than 1.5 continuous conducted pursuant to NFPA 110 hours. This deficient practice could affect all by Buckeye. residents, staff and visitors. The maintenance director or designee, after completing Findings include: monthly audits will report to the QAPI committee on a quarterly Based on review of Direct Supply TELS Logbook basis to ensure total run time for Documentation "Emergency Power Generators: the test at greater than 75% load Monthly Generator Exercise and Inspection was greater than one hour. (under load)" documentation for the most recent The current maintenance director twelve month period with the Executive Director does conduct weekly generator and the Maintenance Director during record exercise and inspection (no load) review from 9:20 a.m. to 12:50 p.m. on 06/22/22, and records the results. monthly load testing documentation for the All residents have the potential to facility's diesel fired emergency generator for the be affected. three month period of March 2022 through May This could affect all residents, staff 2022 was not available for review. Based on and visitors. interview at the time of record review, the The maintenance director will Maintenance Director stated he started working at conduct weekly generator the facility 3 to 4 weeks ago and monthly load exercise and inspection (noload) testing documentation for the three month period and record the results of March 2022 through May 2022 lapsed because The results will be reviewed by the of staff turnover. Based on observations with the Administrator monthly for 6 Executive Director and the Maintenance Director months or until compliant and the during a tour of the facility from 1:30 p.m. to 5:00 results reported through QAPI. p.m. on 06/22/22, the facility has a diesel fired emergency generator located outside of the building on the northwest side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 110

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This finding was reviewed with the Executive

Director during the exit conference.

kW.

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3BXA21

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
155272		B. W	ING		06/22/	2022		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					82ND STREET			
ALLISON POINTE HEALTHCARE CENTER				INDIANAPOLIS, IN 46250				
					,			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE!		DATE	
	3.1-19(b)							
	2 Based on record	review, observation and						
		ity failed to exercise the						
		to meet the requirements of						
	-	dition, the Standard for						
		ndby Powers Systems, Chapter						
		2 states diesel generator sets in						
		recised at least once monthly,						
	for a minimum of 3	0 minutes, using one of the						
	following methods:							
	(1) Loading that ma	aintains the minimum exhaust						
	gas temperatures as recommended by the							
	manufacturer							
		g temperature conditions and at						
	_	cent of the EPS (Emergency						
	Power Supply) nam	-						
		es diesel-powered EPS						
		not meet the requirements of						
		ised monthly with the available						
		Power Supply System) load and						
		nnually with supplemental						
	`	Test) at not less than 50 percent						
	_	ate kW rating for 30 continuous						
		less than 75 percent of the EPS ag for 1 continuous hour for a						
	_	f not less than 1.5 continuous						
		nt practice could affect all						
	residents, staff and	•						
	residents, starr and	visitors.						
	Findings include:							
	i manigs merade.							
	Based on review of	Direct Supply TELS Logbook						
		nergency Power Generators:						
	Monthly Generator Exercise and Inspection							
	(under load)" documentation for the most recent							
	twelve month period with the Executive Director							
	_	ee Director during record						
	review from 9:20 a.	.m. to 12:50 p.m. on 06/22/22,						
	monthly load testing documentation for the							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155272		A. BUILDING <u>01</u> B. WING			COMPLETED 06/22/2022			
NAME OF PROVIDER OR SUPPLIER  ALLISON POINTE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
IAU	facility's diesel fired March 2022 indicated achieved during any Monthly load testing facility's diesel fired three month period 2022 was not availareview of the generation o	d emergency generator prior to ed the lowest load kW monthly load test was 34%. g documentation for the demergency generator for the of March 2022 through May lible for review. Based on attor contractor's "3 Phase documentation dated 09/15/21 Director and the Maintenance ord review from 9:20 a.m. to 2/22, annual supplemental load on indicated supplemental d not exceed 70 percent of the rating for any amount of time the annual load bank test. Based time of record review, the for stated additional annual commentation was not attended to the facility from 1:30 p.m. 22/22, the facility has a diesel merator located outside of the hwest side of the property. nameplate rating for the the generator was rated at 110 viewed with the Executive		IAG			DATE	
	practice could affec	t all residents, staff and						

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/22/2022	
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	'S PLAN OF CORRECTION	
TAG	· ·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
mo	visitors.	ESC ISENTI TING IN CREATION		1110			DittE
	Documentation "En Generator Exercise documentation for t period with the Exe	Direct Supply TELS Logbook nergency Generators: Weekly and Inspection (no load)" he most recent twelve month cutive Director and the					
		or during record review from o.m. on 06/22/22, weekly					
	-	tation for the facility's diesel					
		nerator for the 13 week period 06/21/22 was not available for					
	review. Based on it	nterview at the time of record					
	· ·	ance Director stated he he facility 3 to 4 weeks ago					
		or inspection documentation					
		iod of 03/17/22 through					
	_	ause of staff turnover. Based					
		h the Executive Director and rector during a tour of the					
		.m. to 5:00 p.m. on 06/22/22, the					
		fired emergency generator					
		ne building on the northwest					
		. The manufacturer's					
		r the generator indicated the					
	generator was rated	at 110 KW.					
	This finding was red Director during the	viewed with the Executive exit conference.					
	3.1-19(b)						

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