

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

PRINTED: 09/12/2022

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2022
--	---	--	---

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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	<p>A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 06/22/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 08/18/22</p> <p>Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130</p> <p>At this PSR survey to the Emergency Preparedness survey, Allison Pointe Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 159 certified beds. At the time of the survey, the census was 134.</p> <p>Quality Review completed on 08/22/22</p>	E 0000	Allison Pointe Healthcare requests a desk review for this plan of correction.	
K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/22/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 08/18/22</p> <p>Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130</p>	K 0000	Allison Pointe Healthcare requests a desk review for this plan of correction.	

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2022
--	---	--	---

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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0100 SS=E Bldg. 01	<p>At this PSR survey, Allison Pointe Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 159 and had a census of 134 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were each not sprinklered.</p> <p>Quality Review completed on 08/22/22</p> <p>NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on record review, observation and interview; the facility failed to maintain fire resistance rating label documentation for 1 of 10</p>	K 0100	Guardian Fire Testing Laboratories, Inc. was contacted and did visit the facility , inspect	08/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2022
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>sets of smoke barrier doors in accordance with 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of facility floor plan documentation with the Executive Director during record review from 9:30 a.m. to 10:25 a.m. on 08/18/22, each door in the corridor door set by the Payroll Office was identified as a fire door. Based on interview at the time of record review, the Executive Director stated the floor plan documentation was updated following the most recent Life Safety Code survey in June 2022 and agreed the updated floor plan documentation identified the corridor door set by the Payroll Office as fire doors. Based on observations with the Executive Director during a tour of the facility from 10:25 a.m. to 11:00 a.m. on 06/22/22, the fire resistance rating label affixed to the top of each door in the corridor door set by the Payroll Office was not legible. It appeared the paint that had covered the labels on the 06/22/22 Life Safety Code survey had been removed but any fire resistance rating documentation on the labels was not legible. Based on interview at the time of the observations, the Executive Director agreed the aforementioned fire resistance rating labels were not legible.</p> <p>This deficiency was cited on 06/22/22. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This finding was reviewed with the Executive Director during the exit conference.</p>		<p>the corridor door set by the Payroll Office and affix new, legible fire resistance rating labels to the corridor door set.</p> <p>All residents have the potential to be affected.</p> <p>The facility will ensure doors that have been identified with labels have not been removed, defaced, or made illegible while the doors are in service. If the label on an existing fire door has been removed or is no longer legible, it is acceptable to verify the rating of the fire door through other means acceptable to the authority having jurisdiction such as an inspection or certification service that provides acceptable documentation or the doors may be replaced. Ongoing, the Administrator or designee will monitor monthly labeled doors to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.</p>	

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

PRINTED: 09/12/2022
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/18/2022
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-19(b)				