STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING _____ B. WING _____	C 02/08/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00391415, IN00393172, IN00394222, IN00394554, IN00394876, IN00397285, IN00397655, and IN00399926. Complaint IN00391415 - Unsubstantiated due to lack of evidence. Complaint IN00393172 - Unsubstantiated due to lack of evidence. Complaint IN00394222 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00394554 - Unsubstantiated due to lack of evidence. Complaint IN00394876 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00397285 - Unsubstantiated due to lack of evidence. Complaint IN00397655 - Unsubstantiated due to lack of evidence. Complaint IN00399926 - Unsubstantiated due to lack of evidence. Survey dates: February 7 and 8, 2023 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 117	F 000		

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 that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING _____ B. WING _____	C 02/08/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Total: 117 Census Payor Type: Medicare: 7 Medicaid: 99 Other: 11 Total: 117 Allison Pointe Healthcare Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the Investigation of Complaints IN00391415, IN00393172, IN00394222, IN00394554, IN00394876, IN00397285, IN00397655, and IN00399926. Quality review completed on February 9, 2023	F 000		