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 10/31/2024

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 Investigations of Complaints IN00444496, IN00444566, IN00444931, IN00445377, IN00445562, IN00445563, and IN00446449. Complaint IN00444496 - No deficiencies related to the allegations are cited. Complaint IN00444566 - No deficiencies related to the allegations are cited. Complaint IN00444931 - No deficiencies related to the allegations are cited. Complaint IN00445377 - No deficiencies related to the allegations are cited. Complaint IN00445562 - No deficiencies related to the allegations are cited. Complaint IN00445563 - No deficiencies related to the allegations are cited. Complaint IN00446449 - No deficiencies related to the allegations are cited. Survey dates: October 30 and 31, 2024 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 110 Total: 110 Census Payor Type:	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 10/31/2024

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 Medicare: 5 Medicaid: 95 Other: 10 Total: 110 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 regard to the Investigation of Complaints IN00444496, IN00444566, IN00444931, IN00445377, IN00445562, IN00445563, and IN00446449. Quality review completed on November 4, 2024.	F 000		