

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

PRINTED: 12/01/2021
FORM APPROVED
OMB NO. 0938-0391

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 R-C 11/29/2021
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST 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}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00365917 completed on November 8, 2021.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaints IN00365380 and IN00365813 completed on 10/28/2021.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00364264 completed on 10/21/2021.</p> <p>Complaint IN00364264 - Corrected. Complaint IN00365380 - Corrected Complaint IN00365813 - Corrected Complaint IN00365917 - Corrected</p> <p>Survey date: November 29, 2021</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Census Bed Type: SNF/NF: 130 Total: 130</p> <p>Census Payor Type: Medicare: 10 Medicaid: 86 Other: 34 Total: 130</p> <p>Allison Pointe Healthcare was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the</p>	{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.

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

PRINTED: 12/01/2021
FORM APPROVED
OMB NO. 0938-0391

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 R-C 11/29/2021
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST 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 Investigation of Complaint IN00365917. Quality review completed on November 30, 2021	{F 000}		