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	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/18/25 Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130 At this 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. The facility has 159 certified beds. At the time of the survey, the census was 97. Quality Review completed on 02/21/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/18/25 Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130 At this Life Safety Code survey, Allison Pointe Healthcare Center was found not in compliance	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula E Carroll	HFA	03/06/2025

Any defiencystatement 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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ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

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	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. 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 97 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were each not sprinklered. Quality Review completed on 02/21/25			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 32 portable fire extinguishers in the facility were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could affect over 20 residents, staff and visitors.	K 0355	Corrective actions accomplished for those residents found to be affected by the alleged practice: The fire extinguisher was installed using the bracket supplied by the extinguisher manufacturer. It is secure to the wall. Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: The facility completed of an audit to ensure	03/21/2025

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	Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:30 p.m. to 3:35 p.m. on 02/18/25, the ABC portable fire extinguisher located in the mezzanine area above the Respiratory Therapy Director's Office in Cambridge Hall was not supported and was free standing on the floor of the mezzanine. A bracket to mount the fire extinguisher on the wall was on the floor near the fire extinguisher. Based on interview at the time of the observations, the Maintenance Assistant agreed the fire extinguisher was freestanding on the floor and secured the bracket to the wall of the mezzanine with a drill and mounted the fire extinguisher to it at the time of the observations. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		that all fire extinguishers are secure to the wall using a bracket or hanger intended for the extinguisher. Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to the Maintenance Director and Maintenance Assistant. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: The ED/ Designee will complete rounds 5 times per week for 4 weeks then 3 times per week for 4 weeks then 1 time per week for 4 weeks to ensure the discrepancies will be immediately corrected and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 60 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors.	K 0363	Corrective actions accomplished for those residents found to be affected by the alleged practice: The latching mechanism on each corridor door was adjusted to allow the door to properly close and latch.	03/21/2025

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:35 p.m. on 02/18/25, the corridor door to resident sleeping Room 138 and to resident sleeping Room 216 each had an impediment to latching into the door frame when tested to close multiple times. The latching mechanism on each corridor door failed to protrude into the latching plate on the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned two corridor doors each had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: The facility completed of an audit to ensure that all doors latch to the door frame properly. Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to the Maintenance Director and Maintenance Assistant. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: The ED/ Designee will complete rounds 5 times per week for 4 weeks then 3 times per week for 4 weeks then 1 time per week for 4 weeks to ensure the discrepancies will be immediately corrected and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of over 2 electrical junction boxes in the Cambridge mezzanine were maintained in a safe operating condition. LSC	K 0511	Corrective actions accomplished for those residents found to be affected by the alleged practice: The wall mounted electrical	03/21/2025

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	19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:30 p.m. to 3:35 p.m. on 02/18/25, the wall mounted electrical junction box in the Cambridge Hall mezzanine above the Respiratory Therapy Director's Office near the access door to the mezzanine was without a cover which exposed the electrical wiring in the junction box. The cover plate for the box was on the floor near the junction box. The Maintenance Assistant agreed the junction box was missing its cover and secured the cover plate to the junction box plate at the time of the observations. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		junction box was provided with a cover. The cover was secured by properly screwing it into the wall mounted box. Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: The facility completed of an audit to ensure that all junction boxes have covers. Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to the Maintenance Director and Maintenance Assistant. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: The ED/ Designee will complete rounds 5 times per week for 4 weeks then 3 times per week for 4 weeks then 1 time per week for 4 weeks to ensure the discrepancies will be immediately corrected and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	