PRINTED: 03/07/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/18/2025			
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	•		
ALLISON	I POINTE HEALTH	CARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0000							
Bldg	conducted by the Ir accordance with 42 Survey Date: 02/13 Facility Number: (Provider Number: AIM Number: 100 At this Emergency Pointe Healthcare (with Emergency Pr	8/25 000172 155272 1267130 Preparedness survey, Allison Center was found in compliance reparedness Requirements for icaid Participating Providers	E 0000				
K 0000	the survey, the cens	9 certified beds. At the time of sus was 97. mpleted on 02/21/25					
11 0000							
Bldg. 01	Licensure Survey v Department of Hea 483.90(a). Survey Date: 02/13 Facility Number: (Provider Number: AIM Number: 100 At this Life Safety	000172 155272	K 0000				
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE		
Paula E Ca	arroll		HFA		03/06/2025		

Any defiency statement 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
155272		B. WING	02/18/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa	the and the 2012 Edition of the etion Association (NFPA) 101, asc), Chapter 19, Existing ancies and 410 IAC 16.2.				
	Type V (111) constructions sprinklered. The far with smoke detection areas open to the condetectors hard wired resident sleeping rocapacity of 159 and of this survey. All areas where resident sprinklered. The far with sprinklered areas were sprinklered.	ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors and in all rridor. The facility has smoke it to the fire alarm system in all toms. The facility has a had a census of 97 at the time dents have customary access the facility has two detached facility storage services				
	Quality Review con	-				
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extir	nguishers				
	failed to ensure 1 of in the facility were in NFPA 10, Standard 2010 Edition. Section extinguishers other shall be installed us means. (1) Securely extinguishers. (2) In extinguisher manufacture approved for such p	on and interview, the facility 32 portable fire extinguishers installed in accordance with for Portable Fire Extinguishers, on 6.1.3.4 states portable fire than wheeled extinguishers ing any of the following on a hanger intended for the acture. (3) In a listed bracket purpose. (3) In a cabinet or wall int practice could affect over and visitors.	K 0355	Corrective actions accomplish for those residents found to be affected by the alleged practic. The fire extinguisher was instausing the bracket supplied by extinguisher manufacturer. It secure to the wall. Identification of other resident having the potential to be affe by the same alleged practice accorrective action taken: The facompleted of an audit to ensure	e ee: alled the is s cted and acility	

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Facility ID: 000172

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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 02/18/2025	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0363	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.		
SS=E Bldg. 01	failed to ensure 2 or resident sleeping reclosing and latching would resist the pas	on and interview, the facility f over 60 corridor doors to oms had no impediment to g into the door frame and ssage of smoke. This deficient at over 20 residents, staff and	K 036.	3	Corrective actions accomplish for those residents found to be affected by the alleged practic. The latching mechanism on eacorridor door was adjusted to a the door to properly close and latch.	e: e: ach allow	03/21/2025

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JENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING 01		COMPLETED	
1		155272	B W	B. WING		02/18/	
		100272	D			02/10/	72020
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	X.		5226 E	82ND STREET		
ALLISON	I POINTE HEALTH	CARE CENTER		INDIAN	IAPOLIS, IN 46250		
	ı				1		1
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Identification of other residents	3	
	Findings include:				having the potential to be affect	cted	
					by the same alleged practice a		
	Based on observation	ons with the Maintenance			corrective action taken: The fa		
		our of the facility from 1:30 p.m.			completed of an audit to ensur	-	
		18/25, the corridor door to			1		
	_				that all doors latch to the door		
		oom 138 and to resident			frame properly.		
		each had an impediment to			Measures put in place and		
	_	or frame when tested to close			systemic changes made to en		
		e latching mechanism on each			the alleged deficit practice doe		
		to protrude into the latching			not recur: Education was prov	rided .	
	plate on the door fra	ame when tested to close			to the Maintenance Director ar	nd	
	multiple times. Bas	sed on interview at the time of			Maintenance Assistant.		
	the observations, th	e Maintenance Director			How the corrective measures	will	
	agreed the aforemen	ntioned two corridor doors			be monitored to ensure the alle	eged	
	-	ment to latching into the door			deficit practice does not recur:	-	
		ot resist the passage of smoke.			The ED/ Designee will comple		
		versus me pussage or smone.			rounds 5 times per week for 4		
	These findings were	e reviewed with the			weeks then 3 times per week to	for 1	
	_	he Maintenance Director					
					weeks then 1 time per week fo	л 4	
	during the exit conf	erence.			weeks to ensure the		
					discrepancies will be immedia		
	3.1-19(b)				corrected and education will be	Э	
					provided.		
					The results of the audit		
					observations will be reported,		
					reviewed, and trended for		
					compliance through the facility	,	
					Quality Assurance Committee		
					a minimum of six months and		
					randomly thereafter for further		
					_		
					recommendation.		
V 0511	NEDA 404						
K 0511	NFPA 101						
SS=E	Utilities - Gas and	Electric					
Bldg. 01							
		on and interview, the facility	K 0	511	Corrective actions accomplish		03/21/2025
		f over 2 electrical junction			for those residents found to be	<u>;</u>	
	boxes in the Cambr	idge mezzanine were			affected by the alleged practic	e:	

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maintained in a safe operating condition. LSC

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The wall mounted electrical

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
1		155272	B. WING		02/18/2025			
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER			5226 E	STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND STREET INDIANAPOLIS, IN 46250				
(X4) ID	CLIMMADY	STATEMENT OF DEFICIENCIE	ID		(V5)			
PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
1110		tilities comply with Section 9.1.		junction box was provided wit				
	•	electrical wiring and equipment		cover. The cover was secure				
	_	PA 70, National Electrical Code.		properly screwing it into the w	,			
		lition, Article 314.28(3) (c) states		mounted box.				
		ll be provided with covers		Identification of other resident	s			
	-	e box and suitable for the		having the potential to be affe	cted			
	conditions of use.	Where used, metal covers shall		by the same alleged practice				
	comply with the gr	ounding requirements of		corrective action taken: The fa				
	250.110. This defi	cient practice could affect over		completed of an audit to ensu	•			
	20 residents, staff and visitors.			that all junction boxes have				
				covers.				
	Findings include:			Measures put in place and				
				systemic changes made to en	sure			
	Based on observati	ons with the Maintenance		the alleged deficit practice do	es			
	Director and the M	aintenance Assistant during a		not recur: Education was pro-	vided			
	tour of the facility	from 1:30 p.m. to 3:35 p.m. on		to the Maintenance Director a	nd			
	02/18/25, the wall	mounted electrical junction box		Maintenance Assistant.				
	in the Cambridge I	Hall mezzanine above the		How the corrective measures	will			
	Respiratory Therap	by Director's Office near the		be monitored to ensure the all	leged			
	access door to the	mezzanine was without a cover		deficit practice does not recur	:			
	which exposed the	electrical wiring in the junction		The ED/ Designee will comple	ete			
	_	ate for the box was on the floor		rounds 5 times per week for 4				
	-	ox. The Maintenance		weeks then 3 times per week	for 4			
		e junction box was missing its		weeks then 1 time per week for	or 4			
		the cover plate to the junction		weeks to ensure the				
	box plate at the tim	ne of the observations.		discrepancies will be immedia	-			
				corrected and education will b	e			
	_	re reviewed with the		provided.				
		the Maintenance Director		The results of the audit				
	during the exit con	ference.		observations will be reported,				
				reviewed, and trended for				
	3.1-19(b)			compliance through the facility	•			
				Quality Assurance Committee				
				a minimum of six months and				
				randomly thereafter for further	1			
				recommendation.				

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