04/18/2025

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155786	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/31/2025	
		133760			03/31/	2023	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS				RS, IN 46038		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
L 0000							
Bldg							
· ·		paredness Survey was diana Department of Health in CFR 483.73.	E 00	000			
	Survey Date: 03/31/	/25					
	Facility Number: 01	2466					
	Provider Number: 1						
	AIM Number: 2010	114060					
		Preparedness survey,					
		ws was found in compliance					
		eparedness Requirements for caid Participating Providers					
	and Suppliers, 42 C						
	The facility has 161 the survey, the cens	certified beds. At the time of us was 132.					
	Quality Review con	npleted on 04/04/25					
K 0000							1
Bldg. 01							
-	Licensure Survey w	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0	000			
	Survey Date: 03/31/	/25					
	Facility Number: 01 Provider Number: 1 AIM Number: 2010	55786					
		Code survey, Allisonville d not in compliance with					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN					TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Justin Sims

Executive Director

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 disclodays 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155786			A. BUILDING B. WING	01	COMPLETED 03/31/2025				
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			10312	STREET ADDRESS, CITY, STATE, ZIP COD 10312 ALLISONVILLE RD FISHERS, IN 46038					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
K 0232	Requirements for Pa Medicare/Medicaid, Life Safety From Fi National Fire Protect Life Safety Code (L Health Care Occupa This one-story facility Type V (111) constr The facility has a fir detection in the corr the corridor. The fact wired to the fire alar resident sleeping roc capacity of 161 and time of this visit. All areas where the access were sprinkle facility services were Quality Review com	articipation , 42 CFR Subpart 483.90(a), re and the 2012 Edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. Aty was determined to be of ruction and fully sprinklered. The alarm system with smoke fidor and in all areas open to ceility has smoke detectors hard arm system installed in all toms. The facility has a had a census of 132 at the are identification of the residents have customary ared and all areas providing the sprinklered. The pletted on 04/04/25							
SS=E Bldg. 01	failed to meet clear	Ramp Width on and interview, the facility width requirement exceptions for 2 of 7 corridors. LSC	K 0232	/p>	04/18/2025				
	19.2.3.4(1) requires adjunct areas not int treatment, or use of than 44 inches in cle This deficient practistaff. Findings include: Based on observation	aisles, corridors, and ramps in tended for the housing, inpatients shall not be less ear and unobstructed width. ce could affect as many as 10		What corrective action(s) w taken for those residents foun have been affected by the def practice? Items that obstructed the width to less than 44 inches w removed. How will you identify other residents having the potential	ill be d to icient vere				

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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 COMPLETED 01 B. WING 03/31/2025 155786 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10312 ALLISONVILLE RD ALLISONVILLE MEADOWS FISHERS, IN 46038 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the facility, the following was noted: be affected by the same deficient 1) at 12:01 p.m., several food transport carts were practice and what corrective action lined up on one side of the service hall corridor. will be taken? Immediately outside of the laundry room a broken No residents were affected wash machine was also sitting in the service hall by the alleged deficient practice. across from the food transport carts obstructing All residents have the the clear width of the service hall to approximately potential to be affected by the 34 inches. Based on interview on 03/31/25 at 12:03 alleged deficient practice. p.m., the Maintenance Director acknowledged the All corridors were inspected service hall had less than 44 inches of clear and to ensure all widths were unobstructed width and provided the unobstructed toat least 44 inches. aforementioned measurement. ·What measures will be put into 2) at 1:48 p.m., it was noted that a large "milk place or what systemic changes cooler" was being stored in the service hall will you make to ensure that located off the kitchen area. This milk cooler was deficient practice does not recur? very large and took obstructed most of the food The Maintenance Director service hall leaving only 40 inches of clear and educated IDT regarding corridors unobstructed width to reach the exit at the end of being maintained free of the hall. Based on interview on 03/31/25 at 1:50 obstructions to lessen width to p.m., the Maintenance Director acknowledged this less than 44 inches. service hall had less than 44 inches of clear and A maintenance audit tool will unobstructed width and provided the be completed to ensure corridors aforementioned measurement. maintained free of obstructions to Based on a final interview at the end of the tour of lessen width to less than 44 the facility, these items were again discussed. inches. This finding was reviewed with the Maintenance ·How the corrective action(s) will Director and the facility Administrator at the exit be monitored to ensure the conference held on 03/31/25. deficient practice will not recur, i.e. what quality assurance 3.1-19(b)program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved,

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COMP.		
155786 B. WING 03/31	1/2025	
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS STREET ADDRESS, CITY, STATE, ZIP COD 10312 ALLISONVILLE RD FISHERS, IN 46038		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROJUBERS IN AN OF CORRECTION	(X5)	
PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
an action plan will be developed to ensure compliance.		
K 0324 NFPA 101		
SS=E Cooking Facilities		
Bldg. 01 Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 32 residents, 6 staff, and 2 visitors in the facility. K 0324 The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be closed the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. K 0324 The creation and submission by this provider of any violation of fegulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. K 324 Cooking Facilities What corrective action(s) will be taken for	04/18/2025	
Findings include: No residents were affected by the alleged deficient practice. Based on observations made during a tour of the All residents have the		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155786		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/31/2025			
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 10312 ALLISONVILLE RD FISHERS, IN 46038				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE ((X5) COMPLETION DATE	
	grill which was locathe hood in the kitch approved method the appliance was return location after it had and/or cleaning. Bast 1:21 p.m., the Main was not aware an approvided to ensure the returned to an appromaintenance or cleas something done to the soon as possible.	ar (4) burner stove and the flat atted on the cooking line under then was not provided with an att would ensure that the med to an approved design been moved for maintenance sed on interview on 03/31/25 at tenance Director stated that he approved method should be that the appliance was aved design location after ming and that he would have the kitchen stove or floor as wiewed with the Maintenance ility Administrator at the exit 03/31/25.		alleged deficient practice. 'What measures will be puinto place or what systemic changes will you make to ensure that deficient practice does not recur? 'The Maintenance Director educated kitchen staff on retukitchen equipment to the secupositioning system. 'A maintenance audit tool woompleted to ensure the cook appliances are secured in the positioning system. 'How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be pinto place? 'The POC QAPI Tool will be utilized by ED/designee week 4 weeks, monthly x 6 months, quarterly thereafter for one ye with results reported to the Quasturance and Performance Improvement Committee over by the Executive Director. If a threshold of 95% is not achieved an action plan will be develop ensure compliance.	rning ired ill be ing ir (s) the ut ly x and ar uality seen		
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System	· Maintenance and Testing					
	failed to ensure 9 of were replaced every tested every 5 years	on and interview, the facility F9 sprinkler system gauges F9 years or documented as by comparison with a FPA 25, Standard for the	K 0353	The creation and submission this plan of correction does not constitute an admission by thi provider of any conclusion set in the statement of deficiencies	ot s : forth	04/18/2025	

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	l ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ILDING	01	COMPLETED		
		155786	B. WING 03/31/2025			03/31/2025	
NAME OF F	PROVIDER OR SUPPLIER	•			ADDRESS, CITY, STATE, ZIP COD	•	
					ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS			FISHEF	RS, IN 46038		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		, and Maintenance of			of any violation of regulation.		
		rotection Systems, 2011			provider respectfully requests	I	
		3.2.1 states gauges shall be			the 2567 Plan of Correction be		
		ars or tested every 5 years by			considered the letter of credib		
		calibrated gauge. Gauges not			allegation and requests a desl	I	
		percent of the full scale shall			review in lieu of a Post Compl	aint	
		eplaced. This deficient practice			Survey Revisit on or after.		
		dents, staff, and visitors in the			K 353 Sprinkler System -		
	facility.				Maintenance and Testing		
	Findings include:				·What corrective action(s)	will	
					be taken for those residents		
	Based on observation	ons made during a tour of the			found to have been affected	by	
	facility with the Ma	intenance Director on 03/31/25			the deficient practice?		
	at 12:31 p.m., the fa	acility has supervised wet and			All 9 sprinkler system gau	iges	
	dry sprinkler systen	ns and had a total of nine			were replaced		
	pressure gauges. T	he manufacture date of 2019			·How will you identify othe	r	
	was listed on the fa-	ce of each of the nine sprinkler			residents having the potentia	al	
	1	recalibration date information			to be affected by the same		
		prinkler system gauges either.			deficient practice and what		
		on 03/31/25 at 12:33 p.m., the			corrective action will be		
		for stated he did not believe			taken?		
	, , ,	uges had been recalibrated			No residents were affecte	d by	
		ent five-year period and			the alleged deficient practice.		
		mentation of sprinkler system			All residents have the		
		or recalibration was not			potential to be affected by the		
		for each of nine sprinkler than five years			alleged deficient practice.		
	old.	more more man five years			·What measures will be put		
	J				into place or what systemic	•	
	This finding was re	viewed with the Maintenance			changes will you make to		
		cility Administrator at the exit			ensure that deficient practice	e	
	conference held on	-			does not recur?		
		 -			The Maintenance Director	r	
	3.1-19(b)				was educated that the sprinkle		
					gauges are replaced or calibra		
					with the 5 year period.		
					·A maintenance audit tool w	ill be	
					completed to ensure the sprin		
					gauges are replaced or calibra		

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CENTERS FOI	OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155786	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/31/2025
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			10312	ADDRESS, CITY, STATE, ZIP COD ALLISONVILLE RD RS, IN 46038	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
		REGULATORY OR LSC IDENTIFYING INFORMATION		with the 5 year period. ·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be purinto place? ·The POC QAPI Tool will be utilized by ED/designee weekly 4 weeks, monthly x 6 months, quarterly thereafter for one year with results reported to the Quarterly the ensure and Performance Improvement Committee overse by the Executive Director. If a threshold of 95% is not achieve an action plan will be developed ensure compliance.	he ut y x and ar ality seen
K 0363 SS=E Bldg. 01	failed to ensure 1 or doors to the corrido latch into the door to could affect approx and 2 visitors. Findings include: Based on observation facility with the Market at 1:57 p.m., the consumptions of the country of	on and interview, the facility f 81 sets of resident room or would close completely and frame. This deficient practice imately 38 residents, 4 staff, ons made during a tour of the aintenance Director on 03/31/25 rridor door to resident room # and latch into the frame when	K 0363	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. The provider respectfully requests the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complet Survey Revisit on or after.	t s forth s, or This that e

tested on three separate occasions. Based on

Maintenance Director attempted to close the door

interview on 03/31/25 at 1:58 p.m., the

What corrective action(s)

will be accomplished for those

residents found to have been

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
155786					03/31/	03/31/2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS				RS, IN 46038		
712210011	TVILLE IVIE, IDOVIO			1101121			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		agreed that the door failed to			affected by the deficient		
	· ·	pletely latch into the			practice		
	_	nat he would have the door			The door on room 526 ha	IS	
	looked at as soon as	s possible.			been adjusted to latch when		
	TT1 : C 1:	1 14 4 36 4			closed.		
	_	viewed with the Maintenance			How other residents		
	conference held on	cility Administrator at the exit			having the potential to be		
	conference neid on	U3/31/23.			affected by the same deficier		
	3.1-19(b)				practice will be identified and what corrective action(s) will		
	J.1 17(0)				be taken		
					No residents were affecte	d hy	
					the alleged deficient practice.	ару	
					34 residents, 2 visitors an	d 4	
					staff have the potential to be	u .	
					affected by the alleged deficie	nt	
					practice.		
					What measures will be p	ut	
					into place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur		
					The Maintenance Director	-	
					educated all corridor doors to	have	
					no impediment to closing and		
					latching into the door frame ar	nd	
					would resist the passage of		
					smoke.		
					A maintenance audit tool		
					be completed to ensure reside	nt	
					room doors latch.		
					How the corrective		
					action(s) will be monitored to)	
					ensure the deficient practice will not recur, ie., what qualit	.,	
					assurance program will be p	-	
					into place	ut	
					The POC QAPI Tool will b	ne.	
					utilized by ED/designee weekl		
					4 weeks, monthly x 6 months,	-	

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/31/2025		
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 10312 ALLISONVILLE RD FISHERS, IN 46038				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					quarterly thereafter for one ye with results reported to the Quassurance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant	uality seen ot ee	

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