STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING -- B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/31/25 Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060 At this Emergency Preparedness survey, Allisonville Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 161 certified beds. At the time of the survey, the census was 132. Quality Review completed on 04/04/25	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: 03/31/25 Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060 At this Life Safety Code survey, Allisonville Meadows was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Sims	Executive Director	04/18/2025

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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	Requirements for Participation 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 161 and had a census of 132 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 04/04/25			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Based on observation and interview, the facility failed to meet clear width requirement exceptions per LSC 19.2.3.4(1) for 2 of 7 corridors. LSC 19.2.3.4(1) requires aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall not be less than 44 inches in clear and unobstructed width. This deficient practice could affect as many as 10 staff. Findings include: Based on observations made with the Maintenance Director on 03/31/25 during a tour of	K 0232	/p> K 232 Aisle, Corridor or Ramp ·What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? Items that obstructed the width to less than 44 inches were removed. ·How will you identify other residents having the potential to	04/18/2025

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	the facility, the following was noted: 1) at 12:01 p.m., several food transport carts were lined up on one side of the service hall corridor. Immediately outside of the laundry room a broken wash machine was also sitting in the service hall across from the food transport carts obstructing the clear width of the service hall to approximately 34 inches. Based on interview on 03/31/25 at 12:03 p.m., the Maintenance Director acknowledged the service hall had less than 44 inches of clear and unobstructed width and provided the aforementioned measurement. 2) at 1:48 p.m., it was noted that a large "milk cooler" was being stored in the service hall located off the kitchen area. This milk cooler was very large and took obstructed most of the food service hall leaving only 40 inches of clear and unobstructed width to reach the exit at the end of the hall. Based on interview on 03/31/25 at 1:50 p.m., the Maintenance Director acknowledged this service hall had less than 44 inches of clear and unobstructed width and provided the aforementioned measurement. Based on a final interview at the end of the tour of the facility, these items were again discussed. This finding was reviewed with the Maintenance Director and the facility Administrator at the exit conference held on 03/31/25. 3.1-19(b)		be affected by the same deficient practice and what corrective action will be taken? No residents were affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All corridors were inspected to ensure all widths were unobstructed toat least 44 inches. ·What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur? The Maintenance Director educated IDT regarding corridors being maintained free of obstructions to lessen width to less than 44 inches. A maintenance audit tool will be completed to ensure corridors maintained free of obstructions to lessen width to less than 44 inches. ·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance 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,	

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			an action plan will be developed to ensure compliance.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 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. Section 12.1.2.3 states 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. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 03/31/25	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 considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. K324 Cooking Facilities **·What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The facility installed a method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed. **·How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents have the potential to be affected by the	04/18/2025

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	at 1:18 a.m., the four (4) burner stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and/or cleaning. Based on interview on 03/31/25 at 1:21 p.m., the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would have something done to the kitchen stove or floor as soon as possible. This finding was reviewed with the Maintenance Director and the facility Administrator at the exit conference held on 03/31/25. 3.1-19(b)		alleged deficient practice. **·What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** ·The Maintenance Director educated kitchen staff on returning kitchen equipment to the secured positioning system. ·A maintenance audit tool will be completed to ensure the cooking appliances are secured in their positioning system. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance 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, an action plan will be developed to ensure compliance.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 9 of 9 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the	K 0353	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	04/18/2025

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	Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 03/31/25 at 12:31 p.m., the facility has supervised wet and dry sprinkler systems and had a total of nine pressure gauges. The manufacture date of 2019 was listed on the face of each of the nine sprinkler system gauges. No recalibration date information was affixed to the sprinkler system gauges either. Based on interview on 03/31/25 at 12:33 p.m., the Maintenance Director stated he did not believe sprinkler system gauges had been recalibrated within the most recent five-year period and acknowledged documentation of sprinkler system gauge replacement or recalibration was not available for review for each of nine sprinkler system gauges which were more than five years old. This finding was reviewed with the Maintenance Director and the facility Administrator at the exit conference held on 03/31/25. 3.1-19(b)		of any violation of regulation. 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 353 Sprinkler System - Maintenance and Testing **·What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** All 9 sprinkler system gauges were replaced **·How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. **·What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** The Maintenance Director was educated that the sprinklers gauges are replaced or calibrated with the 5 year period. ·A maintenance audit tool will be completed to ensure the sprinklers gauges are replaced or calibrated	

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			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 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, an action plan will be developed to ensure compliance.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 81 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately 38 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 03/31/25 at 1:57 p.m., the corridor door to resident room # 526 failed to close and latch into the frame when tested on three separate occasions. Based on interview on 03/31/25 at 1:58 p.m., the Maintenance Director attempted to close the door	K 0363	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 considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. K363 – Corridor Doors **What corrective action(s) will be accomplished for those residents found to have been**	04/18/2025

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	several times, then agreed that the door failed to fully close and completely latch into the doorframe adding that he would have the door looked at as soon as possible. This finding was reviewed with the Maintenance Director and the facility Administrator at the exit conference held on 03/31/25. 3.1-19(b)		**affected by the deficient practice** The door on room 526 has been adjusted to latch when closed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** No residents were affected by the alleged deficient practice. 34 residents, 2 visitors and 4 staff have the potential to be affected by the alleged deficient practice. **What measures will be put 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 and would resist the passage of smoke. A maintenance audit tool will be completed to ensure resident room doors latch. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance 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	

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			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, an action plan will be developed to ensure compliance.	