

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

PRINTED: 04/29/2024
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 C 04/25/2024
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND STREET 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	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00429426, IN00429578, IN00429790, IN00430310, IN00430494, IN00432094, and IN00432783. Complaint IN00429426 - No deficiencies related to the allegations are cited. Complaint IN00429578 - No deficiencies related to the allegations are cited. Complaint IN00429790 - No deficiencies related to the allegations are cited. Complaint IN00430310 - No deficiencies related to the allegations are cited. Complaint IN00430494 - No deficiencies related to the allegations are cited. Complaint IN00432094 - No deficiencies related to the allegations are cited. Complaint IN00432783 - No deficiencies related to the allegations are cited. Survey dates: April 25, 2024 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 126 Total: 126 Census Payor Type:	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.

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F 000	Continued From page 1 Medicare: 2 Medicaid: 101 Other: 23 Total: 126 Allison Pointe Healthcare Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the Investigation of Complaints IN00429426, IN00429578, IN00429790, IN00430310, IN00430494, IN00432094, and IN00432783. Quality review completed on April 25, 2024	F 000			