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 _____	11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND ST 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 a Covid-19 Focused Infection Control Survey. Survey date: November 18, 2021 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census bed type: SNF/NF: 133 Total: 133 Census payor type: Medicare: 6 Medicaid: 96 Other: 31 Total: 133 Allison Pointe Healthcare Center was found to be in substantial compliance with 42 CFR Part 483, Subpart B in regards to the Covid-19 Focused Infection Control Survey. Quality review completed on November 22, 2021	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE