STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00422409, IN00422777, IN00422861, IN00422908, IN00423058, IN00423061, and IN00423382. Complaint IN00422409 - No deficiencies related to the allegations are cited. Complaint IN00422777 - No deficiencies related to the allegations are cited. Complaint IN00422861 - Federal/state deficiencies related to the allegations are cited at F814. Complaint IN00422908 - No deficiencies related to the allegations are cited. Complaint IN00423058 - Federal/state deficiencies related to the allegations are cited at F694. Complaint IN00423061 - No deficiencies related to the allegations are cited. Complaint IN00423382 - Federal/state deficiencies related to the allegations are cited at F694 and F921. Survey dates: December 5 and 6, 2023 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 117 Total: 117	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of non-compliance cited during the survey process. Please accept this plan of correction as the provider's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lenore Williams	RN	12/22/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Census Payor Type: Medicare: 3 Medicaid: 92 Other: 22 Total: 117 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 12, 2023			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to ensure a physicians' order was in place for the use of total parenteral nutrition (TPN) and clarify physicians; order upon readmission for the utilization of TPN for 1 of 3 residents reviewed for intravenous (IV) therapy. (Resident H) Findings include: The clinical record for Resident H was reviewed on 12/6/23 at 1:38 p.m. The diagnoses included, but were not limited to, tracheostomy status, diabetes mellitus, muscle weakness, and history of infectious and parasitic diseases. Resident H was readmitted to the facility from the hospital on 11/30/23. An observation conducted on 12/5/23 at 12:52	F 0694	Resident H was not harmed by the deficient practice. Resident H's TPN orders were reviewed with the NP and transcribed into the medical record per physician order. Resident H no longer resides in the facility. All residents receiving TPN have the potential to be affected. An audit of residents receiving TPN has been conducted to ensure that appropriate physician orders for TPN are in place. Any resident found with incorrect orders or omissions had their physician and family notified and the orders were immediately clarified and transcribed appropriately. Licensed Nursing staff was educated on facility policy	12/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	p.m. of Resident H lying in her bed with an IV device to her right chest. It was connected to a bag that contained TPN running at 75 milliliters (mL) an hour. Licensed Practical Nurse (LPN) 2 was present and indicated the TPN was connected by night shift, and she monitors the site and administration of TPN during her shift. Upon review of Resident H's clinical record, there were no current physician orders for the utilization of TPN. A "parenteral nutrition order", dated 11/27/23, indicated 2000 mL of total volume to be administered per day continuously. This order was from the hospital that Resident H resided at prior to being readmitted on 11/30/23. A physician order, dated 12/6/23, was noted for TPN at 83 mL/hour intravenously every shift for nutritional electrolytes. An interview conducted with the Director of Nursing (DON), on 12/6/23 at 1:55 p.m., indicated there were no current physicians' orders for TPN for Resident H. Resident H was previously on TPN with a rate of 83 mL/hour. The DON indicated she observed the TPN hanging for Resident H. She stated the expectations are for the admitting nurse to clarify any orders and follow up if no orders are noted for items such as TPN. The night shift staff hangs the bag for TPN. It appeared that Admissions Staff had the TPN order from the hospital and they faxed it to the pharmacy so they can compile such orders. The nursing staff had the supply of TPN, but no order was inputted into the electronic medical record. A policy titled "Parenteral Nutrition", revised 12/2019, was provided by the DON on 12/6/23 at		identified as, “Parenteral Nutrition” with an emphasis on appropriate physician orders for TPN. The DON or Designee will audit and observe all residents receiving TPN weekly x 3 months to ensure TPN residents have appropriate physician orders. All new orders are reviewed in the clinical morning meeting Monday through Friday, this is an ongoing facility practice. The results of the audit or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations. **span="">** ="" span="">**b="">** ="" b="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	2:58 p.m. The policy indicated the following, " ...3. Total Parenteral Nutrition (TPN) - Final dextrose concentration greater than 10% to 70%, and protein greater than 5%...1. Upon receiving the physician's order, the nurse shall fax a completed Pharmscript TPN Order Form, which may be requested through PharmScript Medical Records Department ...I. Procedure for Ordering a New TPN ...1. The TPN Order Form must be completed by the prescriber or facility designee and faxed to the pharmacy ...I. Preparation ...1. A physician's order is necessary for this treatment ...." This citation relates to Complaints IN00423058 and IN00423382. 3.1-47(a)(1) 3.1-47(a)(2)			
F 0814 SS=D Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure the trash compactor did not have trash items located outside of the unit for 1 of 2 trash disposal items observed. Findings include: An observation was conducted, on 12/5/23 at 10:50 a.m., of the outside of the kitchen to where a trash compactor and a trash receptacle adjacent to the trash compactor. The trash compactor had bags of trash and other numerous items of trash located on the ground, beside the trash compactor. Another observation was conducted, on 12/5/23	F 0814	A No resident was harmed by the facility's alleged deficient practice. B The facility ensured that the trash compactor did not have trash items located outside of the unit. C Education was provided to the Maintenance, Dietary, Nursing and Housekeeping Managers regarding ensuring that trash bags are not spilled or may possibly spilled outside of the compactor. The facility had the waste disposal company add another pick-up day. This increase pick-up days from 3-days to 4-days per week.	12/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	at 12:10 p.m., of the trash compactor. It contained 2 trash bags and other random items of trash located right outside of the trash compactor. An interview conducted with the District Dietary Manager, on 12/5/23 at 2:05 p.m., indicated she noticed writer was observing the outside trash receptacles. She then noticed the trash located outside of the trash compactor. She went to get staff assistance and they proceeded to clean up the trash that was located outside of the trash compactor. She wasn't sure how often the trash is picked up but sometimes, if the trash compactor is too full, it would cause some trash to spill out when the trash is picked up. This citation relates to Complaint IN00422861. 3.1-21(i)(5)		D The ED/Designee will conduct random audits of the trash disposal area 3 time/weekly for 1 month; then, monthly for 2 months. Any discrepancies will be corrected immediately and education will be provided. Results of the audit will be brought to QAPI for 6 months or until 100% compliance is achieved.	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain the tile walls in a cleanly manner in the kitchen. This had the potential to affect all 117 residents in the facility. Findings include: An observation was conducted of the kitchen with the District Dietary Manager (DDM), on 12/5/23 at 10:50 a.m. There was a dark substance that appeared liked caked dirt, debris, and/or grease located on the tile behind the double oven along the top part of the preparation area adjacent	F 0921	A No resident was harmed by the facility's alleged deficient practice. B All residents have the potential to be affected. The facility ensured that the tile walls were maintained in a clean manner. They were scrubbed clean. The dietary manager ensured that that task was a part of the cleaning schedule. C Education was provided to the Dietary Manager and Staff regarding the importance of	12/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	to the double oven. The DDM indicated they had rented a pressure washer to clean parts of the kitchen but that had not be utilized for the wall tile. They have attempted to scrub parts of the tile wall but not all of such. An observation was conducted of the kitchen with the DDM, on 12/5/23 at 12:05 p.m. There was a dark substance that appeared like caked dirt, debris, and/or grease located on the tile behind the double oven, the top part of the preparation area adjacent to the double oven, and along the tile located behind the pre rinse area in the dish room towards the floor. An interview conducted with the DDM, on 12/5/23 at 2:05 p.m., indicated they were in the process of developing a deep cleaning schedule to enforce. That would include the cleaning of the tiles in the kitchen. This citation relates to Complaint IN00423382. 3.1-19(f)		maintaining a clean environment per facility policy. The ED/Designee will conduct random audits ensuring that the tile walls are maintained in a clean manner 1 time/weekly for 1 month; then, monthly for 2 months. Any discrepancies will be corrected immediately and education will be provided. Results of the audit will be brought to QAPI for 6 months or until 100% compliance is achieved.	