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 _____	R-C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISON POINTE HEALTHCARE CENTER	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 a Post Survey Revisit (PSR) to the Investigation of Complaints IN00422861, IN00423058, and IN00423382 completed on 12/6/23. This visit was in conjunction with the PSR to the Annual/Recertification and State Licensure survey conducted on 11/3/23. This visit included the PSR to the Investigation of Complaints IN00419584, IN00420370, IN00420188, IN00420302 and IN00420629 completed on 11/3/2023. This visit was in conjunction with the PSR to Complaint IN00420629 conducted on 11/3/23. This visit was in conjunction with the Investigation of Complaints IN00424489 and IN00425553 completed on January 17, 2024 Complaint IN00422861 - Corrected Complaint IN00423058 - Corrected Complaint IN00423382 - Corrected Complaint IN00419584 - Corrected Complaint IN00420370 - Corrected Complaint IN00420188 - Corrected Complaint IN00420302 - Corrected Complaint IN00420629 - Corrected Complaint IN00424489 - No deficiencies related to the allegations are cited Complaint IN00425553 - No deficiencies related to the allegations are cited Survey dates: January 16 and 17, 2024 Facility number: 000172 Provider number: 155272 AIM number: 100267130	{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.

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 _____	R-C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISON POINTE HEALTHCARE CENTER	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}	Continued From page 1 Census Bed Type: SNF/NF:110 Total: 110 Census Payor Type: Medicare: 5 Medicaid: 90 Other: 15 Total: 110 Allison Pointe Health Care was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00422861, IN00423058, and IN00423382. Quality review completed on January 22, 2024	{F 000}		