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	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allison Pointe Healthcare Center	5226 E 82nd Street Indianapolis, IN 46250

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. The clinical record for Resident M was reviewed on 6/12/25 at 2:20 p.m. The diagnoses included, but were not limited to, anxiety disorder, fracture of the right upper humerus (arm bone). He was admitted to the facility on [DATE]. The acute care hospital discharge instructions, dated [DATE], indicated Resident M was to receive the following medications upon admission to the facility: 1. Aspirin 81 milligram (mg) two times daily, 2. gabapentin (anti-seizure medication) 400 mg three times daily, 3. levetiracetam (anti-seizure medication) 500 mg two times daily, 4. lorazepam (anti-anxiety medication) one mg once daily, 5. methocarbamol (muscle relaxer) 500 mg, two tablets every six hours, 6. oxycodone-acetaminophen (narcotic pain medication) 10 mg - 325 mg, two tablets every four hours as needed for pain, 7. clonazepam (anti-anxiety medication) one mg tablet two times daily, 8. losartan (high blood pressure medication) 50 mg once daily, and 9. paroxetine (anti-depressant) 40 mg once daily. The June 2025 Medication Administration Record (MAR) indicated Resident M received the following medications: The gabapentin, levetiracetam, methocarbamol, and losartan had been administered as ordered, starting on 6/6/25. He received aspirin 81 mg one tablet daily on 6/7/25, 6/8/25, and 6/9/25. On 6/10/25, Resident M began receiving 81 mg aspirin twice daily. He did not receive any doses of clonazepam, one mg. The paroxetine 40 mg one tablet daily did not start until 6/9/25. His lorazepam one mg daily was not started until 6/9/25. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/25 at 11:55 a.m., Resident M indicated he had a horrible time getting his medications when he first arrived at the facility on 6/6/25. He had been admitted over a weekend, and no one seemed to be able to get his medications for him. He had missed doses of several of his pills. He was discharging from the facility and was glad to be going home. An undated Physician Orders Policy was provided by the DDRM on 6/13/25 at 12:52 p.m. It indicated . Execution of Order and Notifications a. The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse i. Contact laboratory services, radiology services, pharmacy services, therapy or other outside vendors as required to execute the medical order . This citation relates to Complaint IN00461164. 3.1-37(a) Based on interview and record review, the facility failed to ensure admission orders for medications and treatments were entered timely and accurately for 2 of 4 residents reviewed for medication administration (Resident H and Resident M). Findings include: 1. The clinical record for Resident H was reviewed on 6/12/25 at 10:30 a.m. The diagnoses included, but were not limited to, perforation of intestine and peritoneal abscess. She was admitted to the facility on [DATE]. The on-boarding clinical evaluation provided by the discharging facility indicated Resident H's diagnoses and reason for admission included multiple bowel perforations, intra-abdominal abscess, candidemia (fungal infection of the bloodstream), wound care, total parenteral nutrition (artificial nutrition administered intravenously), intravenous (IV) antibiotics, and physical/occupational therapy. It also indicated Resident H was alert and oriented. Clinical needs included administration of Total Parenteral Nutrition (TPN), ordered as Clinimix 8/14 to run intravenously at a continuous rate of 65 milliliters (ml)/hour, Zosyn (antibiotic) 3.375 grams (gm), to be administered intravenously every 8 hours, Diflucan (antifungal) 400 milligrams (mg), to be administered intravenously once every 24 hours. Wound care was noted for an abdominal surgical wound with wound manager, accordion drain, and coccyx (tailbone) stage 1 pressure ulcer. The medication information included the resident was to continue receiving IV Zosyn and IV Diflucan until 06/11/25. The following medications were listed on the hospital medication list from the discharging facility: 1. Clinimix (artificial nutrition) 8/14, to run intravenously at a continuous rate of 65 milliliters (mL)/hour, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Clinolipid (fat emulsion supplement), to run intravenously at a rate of 21 mL/hour, 3. Buspirone (antianxiety) twice a day for anxiety, 4. Quetiapine (antipsychotic) 150 mg at bedtime for depression, 5. Scopolamine (medication for nausea) patch one mg every three days, 6. Hydroxyzine (medication used to treat anxiety) 10 mg needed every six hours for anxiety, 7. Simethicone (antiflatulent) 80 mg; one tablet as needed four times a day for gas, 8. Nicotine (nicotine replacement therapy) patch, to be applied once daily, old patch to be removed once daily, 9. Pantoprazole (medication used to reduce stomach acid) 40 mg twice daily, 10. Sucralfate (medication gastric protection) 1 gram (gm) tablet four times daily, 11. Trazodone (antidepressant) 50 mg at bedtime, 12. Bupropion Hydrochloride (antidepressant) 100 mg, two tablets twice a day, 13. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxycodone (opioid pain reliever) 10 mg, one tablet as needed every six hours for moderate to severe pain, 14. Naloxone Hydrochloride (opioid antagonist) 0.4 mg, for respiratory rate less than eight breaths per minute, 15. Calcium Carbonate (antacid) 500 mg, 1.5 tablets as needed twice a day, 16. Levetiracetam (antiseizure) 500 mg twice daily, 17. Methocarbamol (muscle relaxant) 500 mg, two tablets every eight hours, 18. Fentanyl Patch (opioid pain reliever) 25 micrograms (mcg), to be applied once every three days, 19. Lorazepam (antianxiety) 0.5 mg as needed for pain three times a day, and 20. Lovenox (blood thinner) 30 mg, inject 0.3 mL twice daily. Record review of the hospital medication list from the discharging facility revealed one page was missing. An interview was conducted with Resident H's family member on 6/12/25 at 12:20 p.m. She indicated when she arrived to the facility, on 6/7/25, she asked Registered Nurse (RN) 3 when Resident H's next dose of IV antibiotics was due. RN 3 indicated to her that there were none (IV antibiotics) ordered nor on the medication list. On 6/12/25 at 1:07 p.m., an interview was conducted with Resident H. She indicated nobody had done her admission evaluation, several times the resident asked staff about when she was going to get her medications and they kept telling her the pharmacy is on their way. Resident H indicated she was in pain and had been vomiting and crying. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Practical Nurse (LPN) 2 on 6/12/25 at 3:25 p.m., she indicated, on 6/6/25, she was the admitting nurse for Resident H and there were one or two other nurses assisting her with the admission. She indicated she entered all the medications and remembered there being three paper prescriptions that had to be faxed to the pharmacy for fulfillment. LPN 2 indicated she did not remember if IV antibiotics were included in the medications she entered. During an interview with RN 3 on 6/12/25 at 3:58 p.m., he indicated at around 10:00 a.m., he went through Resident H's medication lists and found she was supposed to have had IV antibiotics ordered and administered along with her TPN. Resident H's Order Summary Report was provided by the District Director of Risk Management (DDRM) on 6/12/25 at 2:32 p.m. The physician order for Zosyn and Diflucan were not entered until 6/7/25. An order for a wound care consult was entered on 6/6/25, however no orders for wound care treatment by facility staff were ever entered. During an interview with the Pharmacy Representative (PR) on 6/13/25 at 3:19 p.m., he indicated in their system Resident H was admitted on [DATE], at 3:19 p.m. The order for TPN was entered in as other instead of pharmacy as the source, and so the order was never transmitted to the pharmacy, and therefore never received. No notes could be found indicating communication from the facility to the pharmacy in regards to a STAT request for delivery on the evening of 6/6/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely obtain Total Parenteral Nutrition (TPN) for 1 of 4 residents reviewed for medication availability. (Resident H) Findings include: The clinical record for Resident H was reviewed on 6/12/25 at 10:30 a.m. The diagnoses included, but were not limited to, perforation of intestine and peritoneal abscess. She was admitted to the facility on [DATE]. The on-boarding clinical evaluation provided by the discharging facility indicated Resident H's diagnoses/reasons for admission included, but were not limited to, TPN (artificial nutrition to be administered intravenously). It also indicated Resident H was alert and oriented. An order for Clinimix (a variation of TPN) 8/14, and Clinolipid (fat emulsion supplement) were entered on 6/6/25. The Clinimix was to run intravenously at a continuous rate of 65 milliliters (mL)/hour, and the Clinolipid was to run intravenously at a rate of 21 mL/hour on the evenings of Monday, Wednesday, Friday, and Saturday. On 6/12/25 at 1:07 p.m., an interview was conducted with Resident H. She indicated she arrived at the facility around 1:00 p.m. on 6/6/25. Resident H indicated the day she arrived she had asked facility staff when she was going to get her medications, and they kept telling her the pharmacy is on their way. Resident H indicated she was in pain and had been vomiting and crying. An interview was conducted with Resident H's family member on 6/12/25 at 12:20 p.m. She indicated when she arrived to the facility, on 6/7/25, she asked Registered Nurse (RN) 3 when Resident H's next dose of IV antibiotics was due and why her TPN wasn't running. RN 3 indicated that there were no IV antibiotics ordered nor on the medication list. Resident H's family member indicated RN 3 administered a TPN solution along with one of Resident H's IV antibiotics a couple hours later. During an interview with RN 3 on 6/12/25 at 3:58 p.m., he indicated at around 10:00 a.m., on 6/7/25, he went through Resident H's medication lists and found she was supposed to have had IV antibiotics ordered and administered along with her TPN. RN 3 indicated he was able to get one of the IV antibiotics from the emergency drug kit that was due, and pharmacy brought the TPN via STAT delivery. The Medication Administration Record (MAR) indicated TPN was administered to Resident H on the day of 6/7/25. An interview was conducted, on 6/13/25 at 11:12 a.m., with the Unit Coordinator (UC). She indicated if we (facility staff) encounter a late admission, we can call the pharmacy to STAT order the Clinimix supplement, and then the pharmacy has a four-hour window to have it delivered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Pharmacy Representative (PR) on 6/13/25 at 3:19 p.m., he indicated in their system Resident H was admitted on [DATE]th, 2025, at 3:19 p.m. The pharmacy's cut off time for TPN orders was 2:00 p.m., Monday through Friday. The order for TPN was entered in as other instead of pharmacy as the source, and so the order was never transmitted to the pharmacy, and therefore never received. No notes could be found indicating communication from the facility to the pharmacy regarding a STAT request for delivery on the evening of 6/6/25. The PR indicated follow up communication from the facility staff would have prompted the pharmacy to process and deliver the order for TPN. The night shift nurse assigned to Resident H on 6/6/25 was unavailable for interview. During an interview on 6/13/25 at 1:54 p.m. with the Division Director of Risk Management (DDRM), she indicated the facility did not have a policy unique to TPN administration, it would fall under standard of practice. This citation relates to Complaint IN00461164. 3.1-46(a)(2)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely address a resident's pain for 1 of 5 residents reviewed for pain management. (Resident H) Findings include: The clinical record for Resident H was reviewed on 6/12/25 at 10:30 a.m. The diagnoses included, but were not limited to, perforation of intestine and peritoneal abscess. She was admitted to the facility on [DATE]. The on-boarding clinical evaluation provided by the discharging facility indicated Resident H was alert and oriented. An order was entered, on 6/6/25, for oxycodone immediate release (IR) 10 mg, one tablet as needed every six hours for moderate to severe pain. On 6/12/25 at 1:07 p.m., an interview was conducted with Resident H. She indicated on the day she arrived she asked staff several times about when she was going to get her medications and they kept telling her the pharmacy is on their way. Resident H indicated she was in pain and was vomiting and crying. She indicated Registered Nurse (RN) 3 had given her oxycodone the following day, on 6/7/25 at around 1:00 p.m. An interview was conducted with Resident H's family member on 6/12/25 at 12:20 p.m. She indicated Resident H had called her, on the evening of 6/6/25, crying saying the facility had not given her any of her medications, not even her pain medication. During an interview on 6/12/25 at 3:25 p.m. with Licensed Practical Nurse (LPN) 2, she indicated by the time she was leaving at the end of her shift, on 6/6/25, Resident H was asking about when her pain medication would be delivered. At 7:30 p.m., LPN 2 gave report and let the oncoming nurse know that the admission assessments needed to be completed and they needed to follow up with the pharmacy regarding her pain medication whether that be getting a STAT delivery or pulling it from the emergency drug kit. The Emergency Drug Kit (EDK) inventory log provided by the Division Director of Risk Management (DDRM), on 6/13/25 at 1:30 p.m., indicated five doses of oxycodone IR 10 mg were available on hand. The Medication Administration Record (MAR) did not contain documentation of oxycodone 10 mg being administered to Resident H on 6/6/25. The night shift nurse assigned to Resident H, on 6/6/25, was unavailable for interview. During an interview with RN 3 on 6/12/25 3:58 p.m., he indicated Resident H complained of pain during his shift on 6/7/25. The resident's order for oxycodone 10 mg had not been filled yet so he called the facility physician, and a STAT order was put in that the pharmacy delivered. RN 3 indicated he administered one dose of oxycodone 10 mg to Resident H on 6/7/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted, on 6/13/25 at 2:30 p.m., with the DDRM. She indicated if a resident had complained of pain, and had as needed pain medication ordered, she would have expected nursing staff to pull the ordered pain medication from the emergency drug kit if their routine medication had not yet been delivered. An undated Pain Management and Assessment Policy was provided by the DDRM on 6/13/25 at 1:54 p.m. It indicated .The facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management . This citation relates to Complaint IN00461164. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document controlled medications in sufficient detail to ensure an accurate reconciliation of the narcotic count for 4 of 5 residents reviewed for pain and ensure an intravenous (IV) antibiotic was administered timely for a newly admitted resident and completely for 2 of 4 residents reviewed for IV medications (Resident B, Resident L, Resident H, and Resident D). Findings include: 1. The clinical record for Resident L was reviewed on 6/12/25 at 3:10 p.m. The diagnoses included, but were not limited to, end stage renal disease, opioid dependence, low back pain, muscle weakness, and lumbago with sciatica (lower back pain accompanied by sciatic nerve pain). A care plan, revised 5/15/25, indicated Resident L was at risk for pain related to end stage renal disease. The goal was for Resident L to be able to verbalize relief of pain. The interventions included, but were not limited to, providing medication per physician's orders. A physician's order, dated 4/18/25 to 5/9/25, indicated the use of oxycodone 5 milligrams (mg) every four hours as needed for pain. A controlled drug administration record, dated 4/19/25 to 4/16/25, indicated one administration of the oxycodone 5 mg tablet was signed off without a date of when the medication was administered. The record consisted of handwritten dates and times the oxycodone was administered, and they were not legible to indicate the date or time of the administration of the oxycodone. It was not clear whether the time written on the controlled drug administration record indicated A.M. (before noon) or P.M. (after noon). A controlled drug administration record, dated 4/25/25 to 5/1/25, indicated one occasion where oxycodone 5 mg was signed off, as administered, but did not indicate the date or time the medication was given. The record consisted of handwritten dates and times the oxycodone was administered, and they were not legible to indicate the date or time the oxycodone was administered. The record indicated Resident L was given oxycodone 5 mg on 4/28/25 at 7:45 and the next administration was 4/28/25 at 8:00 a.m. There was no indication if the 4/28/25 at 7:45 was A.M. or P.M. A physician's order, dated 5/9/25 to 5/14/25, indicated the use of oxycodone 5 mg every four hours as needed for pain. A controlled drug administration record, dated 5/9/25 to 5/15/25, indicated Resident L was given oxycodone 5 mg on 5/10/25 at 4:00 a.m., 6:00 a.m., and 10:00 a.m. These administrations were inconsistent with the physician's order for as needed every four hours. The record also indicated Resident L was given oxycodone 5 mg on 5/10/25 at 10:00 p.m. and on 5/11/25 at 1:00 a.m. These administrations were inconsistent with the order for as needed every four hours. There was one administration, on 5/13/25, that did not indicate a time the oxycodone 5 mg was administered. The record indicated Resident L was given oxycodone 5 mg on 5/14/25 at 6:00 a.m., 8:00 a.m., 10:00 p.m., and 5/15/25 at midnight (12:00 a.m.). These administrations were inconsistent with the order for as needed every four hours. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 5/14/25 to 5/19/25, indicated the use of oxycodone 5 mg every four hours for pain. A controlled drug administration record, dated 5/16/25 to 5/17/25, indicated six oxycodone 5 mg tablets were located on that card of medication. The record indicated Resident L was administered oxycodone 5 mg on 5/16/25 at 4:00 p.m., 8:00 p.m., 5/17/25 at 12:00 a.m., and 4:00 a.m. There were two blank rows that didn't have a date or time of the administration for the oxycodone 5 mg tablet. The count of oxycodone 5 mg tablets went from five tablets to two tablets left remaining without indication as to why. The last three administrations of the oxycodone 5 mg did not contain a staff signature as to who administered the oxycodone 5 mg on 5/16/25 at 8:00 p.m., 5/17/25 at 12:00 a.m., and 5/17/25 at 4:00 a.m. A controlled drug administration record, dated 5/17/25 to 5/18/25, indicated the oxycodone 5 mg tablets were not administered consistently every 4 hours as ordered. The medication administration record (MAR), dated May 2025, indicated the oxycodone was signed off every four hours, as ordered, on 5/17/25 and 5/18/25. 2. The clinical record for Resident B was reviewed on 6/12/25 at 3:05 p.m. The diagnoses included, but were not limited to, hypertension and lymphedema. A physician's order, dated 3/15/25, indicated the use of ceftriaxone solium (antibiotic); administer one gram intravenously (IV) every 12 hours for infection for seven days to equal 14 administrations. The March 2025 MAR indicated on 3/20/25 at 9:00 p.m. and 3/21/25 at 9:00 p.m., the IV ceftriaxone was not signed off as administered. Resident B received 12 out of 14 administrations for the IV antibiotic. 4. The clinical record for Resident D was reviewed on 6/12/25 at 2:10 p.m. The diagnoses included, but were not limited to, epilepsy and end stage renal disease. A Quarterly Minimum Data Set (MDS) Assessment, completed 5/29/25, indicated he was cognitively intact. A physician's order, dated 3/31/25, indicated he was to receive oxycodone (narcotic pain medication) 20 mg one tablet every four hours as needed for pain. A Controlled Drug Administration Record indicated, on 5/29/25, 30 tablets of oxycodone 20 mg were delivered to the facility. The Controlled Drug Administration Record indicated Resident D had received one oxycodone 20 mg tablet on 5/31/25 at 8:00 a.m., and one tablet on 5/31/25 at 8:00 p.m. There were 28 pills left. There was a notation on the Controlled Drug Administration Record that the count was corrected, and 30 tablets were available for use. The count correction notation did not contain a time or date and contained no signatures of who corrected the drug count. The Controlled Drug Administration Record also contained illegible dates that had been crossed out and in the amount remaining column the number 29 which was circled. There were no legible dates or times to indicate when a dose of oxycodone 20 mg had been given to Resident D. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/13/25 at 11:10 a.m., the District Director of Risk Management (DDRM) provided the current Medication Controlled Drugs and Security Policy which indicated .The Narcotic Count and Inventory a. Controlled drugs as well as the controlled drug count sheets and cards, are counted every shift change by the nurse reporting on duty with the nurse reporting off duty .discrepancies in count a. In the event a discrepancy is found, check the resident's medication sheets and chart to see if a narcotic has been administered and not recorded. b. Check previous recordings on the control sheets for mistakes in arithmetic. c. If the cause of the discrepancy cannot be located and/or count does not balance, report the matter to the supervisor for immediate investigation . This citation relates to Complaint IN00461164. 3.1-25(a) 3.1-25(b)(3) 3.1-25(e)(3) 3a. The clinical record for Resident H was reviewed on 6/12/25 at 10:30 a.m. The diagnoses included, but were not limited to, perforation of intestine and peritoneal abscess. She was admitted to the facility on [DATE]. The on-boarding clinical evaluation provided by the discharging facility indicated Resident H's diagnoses and reason for admission included, but were not limited to, multiple bowel perforations, intra-abdominal abscess, candidemia (fungal infection of the bloodstream), intravenous (IV) antibiotics. It also indicated Resident H was alert and oriented. Clinical needs included administration of Zosyn (antibiotic) 3.375 grams (gm), to be administered intravenously every 8 hours, Diflucan (antifungal) 400 milligrams (mg), to be administered intravenously once every 24 hours. The medication information included the resident was to continue receiving IV Zosyn and Diflucan until 6/11/25. On 6/12/25 at 1:07 p.m. an interview was conducted with Resident H. She indicated she arrived at the facility around 1:00 p.m. on 6/6/25. Resident H indicated she had asked facility staff when she was going to get her medications, and they kept telling her the pharmacy is on their way. Resident H indicated she was in pain and was vomiting and crying. An interview was conducted with Resident H's family member on 6/12/25 at 12:20 p.m. She indicated when she arrived at the facility, on 6/7/25, she asked Registered Nurse (RN) 3 when Resident H's next dose of IV antibiotics was due. RN 3 indicated to her that there were none (IV antibiotics) ordered nor on the medication list. Resident H's Order Summary Report was provided by the District Director of Risk Management (DDRM) on 6/12/25 at 2:32 p.m. The physician order for Zosyn and Diflucan were not entered until 6/7/25. During an interview with the Pharmacy Representative (PR) on 6/13/25 at 3:19 p.m., he indicated in their system Resident H was admitted on [DATE]th, 2025, at 3:19 p.m. (continued on next page)

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	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allison Pointe Healthcare Center	5226 E 82nd Street Indianapolis, IN 46250

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with RN 3 on 6/12/25 at 3:58 p.m., he indicated, at around 10:00 a.m., he went through Resident H's medication lists and found she was supposed to have had IV antibiotics ordered and administered such along with her TPN. RN 3 indicated he was able to get the antibiotics [Zosyn] from the emergency drug kit that was due, and pharmacy brought the TPN via STAT delivery. Review of the Medication Administration Record (MAR) revealed Resident H received her IV Zosyn on 6/7/25 at 3:00 p.m., and did not receive the IV Diflucan. Resident H missed three doses of Zosyn and one dose of Diflucan while at the facility. The Emergency Drug Kit (EDK) inventory log provided by the DDRM, on 6/13/25 at 1:30 p.m., indicated two doses of IV Zosyn 3.375 gm were available on hand. 3b. A physician order for oxycodone hydrochloric acid (HCL) 10 (milligrams) mg was entered on 6/6/25 for Resident H. An additional order for Oxycodone HCL 10 mg was entered on 6/7/25. On 06/12/25 at 1:07 p.m., an interview was conducted with Resident H. She indicated she had asked facility staff when she was going to get her medications, and they kept telling her the pharmacy is on their way. Resident H indicated RN 3 had given her Oxycodone 20 mg on 6/7/25. During an interview with RN 3 on 6/12/25 3:58 p.m., he indicated Resident H complained of pain during his shift on 6/7/25. The resident's order for oxycodone 10 mg had not been filled yet so he called the facility physician, and a STAT order was put in that the pharmacy delivered. RN 3 indicated he administered one dose of oxycodone 10 mg to Resident H on 6/7/25. A delivery manifest from the pharmacy was provided by the DDRM on 6/12/25 at 4:32 p.m. It indicated lorazepam 0.5 mg (3 tablets), Fentanyl 25 micrograms (mcg) (1 patch), and oxycodone Immediate Release 10 mg (4 tablets) was delivered to the facility on 6/7/25 at 1:10 p.m. The Medication Administration Record (MAR) did not contain documentation of oxycodone 10 mg or lorazepam 0.5 mg being administered to Resident H. The MAR indicated one Fentanyl patch was applied to the resident on 6/7/25 at 2:00 p.m. The controlled drug administration record did not contain record of reconciliation of oxycodone 10 mg tablets or patches of Fentanyl 25 mcg. It did contain a reconciliation record for lorazepam 0.5 mg tablets indicating one tablet had been removed, and two tablets remained.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure a resident remained free from significant medication errors by receiving the incorrect narcotic pain medication on multiple occasions for 1 of 4 residents reviewed for medication administration. (Resident L) Findings include: The clinical record for Resident L was reviewed on 6/12/25 at 3:10 p.m. The diagnoses included, but were not limited to, end stage renal disease, opioid dependence, low back pain, muscle weakness, and lumbago with sciatica (lower back pain accompanied by sciatic nerve pain). A care plan, revised 5/15/25, indicated Resident L was at risk for pain related to end stage renal disease. The goal was for Resident L to be able to verbalize relief of pain. The interventions included, but were not limited to, providing medication per physician's orders. A physician order, dated 5/19/25 to 5/28/25, indicated the use of oxycodone 5 milligrams (mg); administer one tablet every four hours for pain. A physician order, dated 5/28/25 to 6/6/25, indicated the use of oxycodone-acetaminophen (narcotic pain medication; also known as Percocet) 5-325 (mg); administer one tablet every four hours for pain. The controlled drug administration record for Resident L's Percocet 5-325 mg tablets indicated the medication was not signed off, as ordered, every four hours per the physician's order. There were 12 administrations from 5/30/25 through 6/6/25. The controlled drug administration record for Resident L's oxycodone 5 mg tablets indicated the medication was signed off, as administered, 28 occasions from 5/29/25 to 6/6/25. Resident L had no active order for oxycodone 5 mg tablets from 5/29/25 to 6/6/25. A current physician order, dated 6/11/25, indicated the use of oxycodone 5 mg tablet; administer one tablet every four hours. The controlled drug administration record for Resident L's oxycodone 5 mg tablets indicated the medication was not consistently signed off, as administered, every four hours per the physician's order. The controlled drug administration record for Resident L's Percocet 5-325 mg tablets indicated the medication was signed off, as administered, on five occasions, from 6/11/25 to 6/12/25, when the order for oxycodone 5 mg was in place. A policy entitled Medication Controlled Drugs and Security, undated, was provided by the Divisional Director of Risk Management on 6/13/25 at 11:10 a.m. The policy indicated the following, .a. When the prescribed drug is discontinued, or the resident discharged , the container and control sheet must be removed for drug destruction . This citation is related to Complaint IN00461164. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-48(c)(2)