

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 12/10/2025
NAME OF PROVIDER OR SUPPLIER Allison Pointe Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure a controlled substance medication received from the contracted pharmacy was properly processed and safely stored in the facility for 1 of 3 residents reviewed for pharmacy services. (Resident E) Findings include: A facility reported incident was received by the Indiana Department of Health's (IDOH) Long Term Care Division on 11-18-25 at 7:14 p.m. The report indicated the facility had received a delivery of a controlled medication, oxycodone, for Resident E on 11-15-25, but the medication was unable to be accounted for. It indicated notifications were made to the resident, resident representative, the Executive Director, the Director of Nursing, the attending physician, and the local law enforcement agency and an investigation was launched immediately. It indicated the nurse on duty for Resident E on the date of 11-15-25, was immediately suspended, pending results of the investigation. A medication reconciliation was initiated. Pain and skin assessments were initiated. Staff and resident interviews were initiated. A follow-up report was sent to the IDOH Long Term Care Division on 11-24-25, which indicated, the facility is unable to determine the disposition of the medication. It indicated the facility paid for a replacement of the identified missing controlled medication. It indicated, it was determined that the nurse [who] signed for the medication [receipt from the contracted pharmacy] and noted that it was for another unit and called the nurse over and the medication was released to [name of RN 6], who was the appropriate nurse. In an interview with the Director of Nursing (DON) on 12-10-25 at 12:20 p.m., she indicated the manner in which the facility became aware of the issue with Resident E's medications was one of the nurses had called the contracted pharmacy to request a refill of Resident E's oxycodone 20 milligrams (mg) on Monday, 11-17-25. The contracted pharmacy informed the staff member the controlled substance had been delivered on Saturday, 11-15-25. The nursing staff immediately notified the DON of the problem, because not only was there no medication, there was no record of the controlled substance in the facility's narcotic logbook. The pharmacy sent a copy of the contracted pharmacy's manifest documentation which indicated LPN 5, had signed for it on 11-15-25 between 11:00 a.m. and noon. The DON indicated a second staff signature was on the manifest documentation, but was illegible. We started an immediate investigation, in which it was learned the received medication of oxycodone 20 mg was given to RN 6 on 11-15-25 by LPN 5. To be honest, we don't know what happened to the meds once he received them. There were several issues that were not done according to our policies. First, the controlled substance was not delivered to us in a purple plastic bag, but in a white gift bag. Our narcotics, per our policies, are to be delivered in a purple plastic bag as a quick visual alert the medication is a controlled substance. That did not happen. Secondly, the narcotic was not processed by the nurses, two of them, by our policies, with the count and the paperwork being done. In our talking with [name of RN 6], he indicated around the time of this occurrence, he was in the process of sending a resident out to the hospital and was possibly distracted by those things. He could not specifically recall receiving any medication during that time. There were two staff members that recalled seeing [name of RN 6] receive the medication from [name of LPN 5]. In our interview with [name of RN 6], he indicated he had never had anything like this happen before and even offered to come in and help look for the medication and offered to take a drug test to prove he was not taking this medication. We wonder if the medication [and the associated paperwork] may have mistakenly been thrown away, thinking it was just extra papers or trash, since it did come in a gift bag, not the purple plastic bag, and would have been very lightweight, almost light enough you would have thought it was an empty bag. We ended up terminating [name of RN 6] due to this. The med has not been located. It was replaced by the facility. To the best of my knowledge, he [Resident E] did not miss any doses of his pain med. He ended up being sent out on the same afternoon, 11-17-25, due to hypotension and chest pain. [Name of RN 6], was a long time employee and did not have any type of write ups prior to this. I honestly do not think he did anything maliciously, but [there were] several failures of our policies that contributed to this situation. On 12-10-25 at 12:50 p.m., the DON provided copies of the facility's investigation for the unaccounted controlled substance for Resident E. The packet of information included, but was not limited to, facility policies regarding how staff are to handle the receipt of narcotic medications, but none of the policies provided addressed the contracted pharmacy is to deliver controlled substances in a purple plastic bag. On 12-10-25 at 12:50 p.m., the DON provided an undated copy of a policy entitled, Chain of Custody for Controlled Substances, This policy indicated, . . . Receiving a Pharmacy Delivery: Nurses will not accept delivery of controlled substances including, but not limited to the following circumstances or indications: Discrepancies in type or quantity; Tampered packages;</p>		