Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 04/08/2026
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)
F 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed ensure a resident received timely foot care related to a referral for a vascular specialist and treatment for osteomyelitis, resulting in a hospitalization for intravenous antibiotics and subsequent toe removal for 1 of 3 residents reviewed for foot care. (Resident E) Findings include:The clinical record for Resident E was reviewed on 4/7/26 at 10:00 a.m. The resident's diagnosis included, but was not limited to, peripheral artery disease (circulatory condition caused by plaque buildup, narrowing arteries, and reduces blood flow to the limbs). The impaired skin integrity care plan, revised 3/31/26, indicated the resident had areas to his left fourth and fifth toes. A goal was for him to not exhibit complications from altered skin integrity. An intervention was to administer treatments as ordered by the medical provider. The progress note, dated 2/12/26 and written by Nurse Practitioner (NP) 5, indicated the resident had a wound to his left toe, fifth digit. The interpretation of a left arterial doppler of the lower extremity indicated the impression was mild trifurcation/outflow disease. The assessment and plan section of the note indicated, the resident had mild trifurcation/outflow disease on arterial Doppler, dated 2/10/2026. The NP ordered a referral for the resident to see a vascular specialist. The NP would continue to monitor, and the resident was to continue on the current antihypertensive medication and statin therapy. An interview was conducted with NP 5 on 4/8/26 at 12:07 p.m. She indicated she referred Resident E to a vascular specialist due to his Doppler results on his 2/10/26. The results indicated remote outflow disease, which were abnormal results. The facility needed to make the vascular appointment as soon as possible, within a week or so. The nursing note, dated 3/26/26, indicated Resident E had a follow-up vascular appointment scheduled for 4/7/26. There were no other progress notes that referenced a scheduled vascular appointment after the 2/12/26 progress note by NP 5. An interview was conducted with the Director of Nursing (DON) on 4/7/26 at 2:58 p.m. She indicated there was no verification they attempted to make a vascular appointment for Resident E after NP 5's referral on 2/12/26 until 3/25/26. On 4/7/26 at 2:58 p.m., the DON provided a faxed confirmation, dated 3/25/26, from a vascular surgery provider confirming a radiology appointment for 3/30/26 and office visit for 4/7/26. On 4/7/26 at 3:01 p.m., an interview was conducted with the Administrative Assistant for the above referenced vascular surgery provider. She indicated that their office received the referral from the facility on 3/24/26. Their office scheduled the appointment the next day, on 3/25/26; and the appointment was scheduled for 4/7/26 for a new patient exam, an ultrasound of the lower left extremity, and follow-up discussion of the 3/30/26 CT scan results. During an interview with NP 5, on 4/8/26 at 12:07 p.m., she indicated she was not aware of an issue with Resident E's fourth left toe until after the fact, but was unsure of when she was made aware. She never saw his left foot after the issue with his fourth toe was found. Her understanding was that the fifth toe was healed, but the fourth toe was necrotic. The Wound Nurse Practitioner was who would have been informed of any condition changes and responsible for treatment changes. An interview was conducted with the NP 7 from the facility's wound care provider on 4/8/26 at 12:28 p.m. She indicated she was notified on 3/26/26 of an injury of some sort to Resident E's left foot, so she saw Resident E in the facility on 3/31/26 to assess him. At that time, he had an open wound to his left fourth toe, (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

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