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	02/04/2025

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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 34850 Based on interview and record review, the facility failed to address grievances that were reported in resident council meetings for 9 of 9 residents that attended a resident council meeting. (Residents' 1, 8, 12, 28, 39, 63, 67, 71, and 73) Findings include: The November 2024, December 2024, and January 2025 resident council minutes did not indicate any concerns that were discussed with the following departments: nursing, housekeeping, laundry, business office, activities, and maintenance. A resident council meeting was conducted on 1/29/25 at 2:00 p.m. The resident attendees were Residents' 1, 8, 12, 28, 39, 63, 67, 71, and 73. During the meeting, the resident council indicated the staff do not answer the call lights timely. This had been ongoing for a while and had not improved. It was not discussed at previous resident council meetings. An interview was conducted with the Activities Director on 2/3/25 at 8:58 a.m. She indicated grievances discussed in the resident council meetings were only recorded in the meeting minutes if the entire group had reported a concern. The facility encouraged individual residents that have concerns/grievances in the meetings to fill out grievance forms that were posted throughout the facility. Their concerns can be addressed sooner versus having to wait three weeks for the next resident council meeting. A resident council policy was provided by the Regional [NAME] President of Risk Management on 2/3/25 at 2:15 p.m. It indicated, .1. It is the expectation of [name of corporation] that all Administrators offer to attend the Resident Council Group meeting. While it is the residents' choice to have staff in attendance, Administration should ask permission to attend (even for a short appearance) to assure residents that all grievances and concerns are as important to the management team as they are to the residents .4. Document the Resident Council Meeting on the Resident Council Minutes Form. Any concerns voiced at the meeting should be documented on the Concern Form and distributed to the appropriate Department Head. 5. Facility should follow the 'Resident Grievance Procedure' for any concerns identified. 3.1-3(k) 3.1-3(l) (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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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-7(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 40287 Based on observation, interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for a resident's ability to communicate and regarding Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for communication and 1 of 1 resident reviewed for PASRR (Resident E and Resident 28). Findings include: 1. The clinical record for Resident E was reviewed on 1/29/25 at 11:27 a.m. The diagnoses included, but were not limited to, diabetes and malnutrition. An Annual MDS assessment, completed 1/2/25, indicated Resident E had clear speech. He was rarely or never able to understand what was said to him or to make himself understood. During an interview on 1/31/25 at 11:37 a.m., Unit Manager 4 indicated Resident E was able to speak and understand English enough to communicate his needs. During an interview on 2/3/25 at 11:20 a.m., Resident E indicated the facility staff treated him well. During an interview on 2/3/25 at 11:31 a.m., the Social Service Assistant indicated Resident E could make his needs known, but at times he would not answer questions. During an interview on 2/3/25 at 4:05 p.m., the Float Minimum Data Set Coordinator indicated that the Annual MDS assessment could have been coded as sometimes able to make his needs known and to understand others. 51750 2. The clinical record for Resident 28 was reviewed on 01/29/25 at 3:43 p.m. The diagnoses included, but were not limited to, paranoid schizophrenia, major depressive disorder, and congestive heart failure. A PASRR Level II, conducted on 1/13/20, indicated the resident did not require specialized services. Important information .Since this evaluation has determined that you have a PASRR condition., If you admit to a Medicaid-certified nursing facility, or if you are currently in a Medicaid-certified nursing facility, the facility will need to document your PASRR condition in the Minimum Data Set (MDS) assessment record. The facility should mark yes to question A1500 on the MDS, 'Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?' Also, your specific PASRR condition(s) should be checked in question A1510, 'Level II Preadmission Screening and Resident Review (PASRR) Conditions. The Admission MDS assessment, dated 10/04/24, indicated the resident had not been evaluated by PASRR level II and did not identify level II PASRR conditions. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Corporate MDS Coordinator on 01/31/25 at 2:48 p.m., she indicated that question A1500 on the MDS, completed on 10/04/24, had been answered inaccurately. On 2/04/25 at 10:15 a.m. the [NAME] President of Risk Management confirmed the facility uses the Resident Assessment Instrument (RAI) as the facility's policy for completing MDS assessments.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 34850 Based on observation, interview, and record review, the facility failed to ensure nail care was provided and to ensure lotion was applied with personal hygiene for 2 of 6 residents reviewed for activities of daily living (ADLs). (Resident B and Resident E) Findings include: 1. The clinical record for Resident B was reviewed on 1/28/25 at 3:30 p.m. The diagnoses included, but were not limited to, respiratory failure. An 11/25/24 Quarterly Minimum Data Set (MDS) assessment indicated Resident B was cognitively impaired. The staff was to provide substantial/maximal assistance with bathing. An ADL care plan, dated 10/10/24, indicated .offer shower evening shift, Tuesday and Friday . Observations were conducted of Resident B on 1/28/25 at 3:32 p.m., 1/31/25 at 10:52 a.m., and 2/3/25 at 11:25 a.m. Resident B's nails were observed long in length. An interview was conducted with Resident B's Representative on 1/30/25 at 3:48 p.m. She indicated Resident B was not provided with good hygiene care. An interview was conducted with Licensed Practical Nurse (LPN) 1 on 2/3/25 at 11:34 a.m. She indicated nail care should be provided on shower days. She would trim Resident B's fingernails. 40287 2. The clinical record for Resident E was reviewed on 1/29/25 at 11:27 a.m. The diagnoses included, but were not limited to, diabetes and malnutrition. A care plan, last revised on 1/6/25, indicated Resident E required assistance with ADL care. The goal was for him to maintain his current level of function. The interventions included, but were not limited to, provide maximum assistance with personal hygiene and offer showers on the night shift twice weekly. A Skin and Wound Note, dated 1/21/25, indicated his skin was dry and he had a history of chronic wounds. The physical examination indicated his skin was thin, fragile, dry, and flaky. The preventative measures were to use emollient (moisturizing lotion) as needed for skin dryness over his entire body. On 1/31/25 at 2:28 p.m., Resident E was observed lying in bed. His legs had dry, flaky patches on them. During an interview on 1/31/25 at 2:30 p.m., Certified Nurse Aide (CNA) 5 indicated Resident E required total assistance with ADL care, and did not refuse care when offered. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 11:20 a.m., Resident E was observed in his bed. He had dry, flaky patches of skin on both of his arms and legs. Resident E indicated he would like lotion for his skin. He did not think he had any lotion in his room. The clinical record did not contain a physician's order for lotion application to the skin. During an interview on 2/3/25 at 1:45 p.m., Registered Nurse (RN) 6 indicated lotion was applied to Resident E's skin, but he may need a different type of lotion. A bathing-shower policy was provided by the Regional [NAME] President of Risk Management on 2/3/25 at 2:15 p.m. It indicated .This checklist identifies the steps needed to assist an individual with a shower. It also provides rationales to explain why these steps are performed .Hygiene: Help the individual dry their body, apply desired toiletries, dress, and complete other personal hygiene needs. Promotes comfort and cleanliness This citation is related to Complaint IN00449389. 3.1-38(a)(3)(A) 3.1-38(a)(3)(E)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 30344 Based on observation, interview, and record review, the facility failed to timely provide foot care to 1 of 2 residents reviewed for skin conditions. (Resident 7) Findings include: The clinical record for Resident 7 was reviewed on 1/30/25 at 10:33 a.m. His diagnoses included, but were not limited to, traumatic brain injury, dementia, chronic pain, and chronic obstructive pulmonary disease. The 12/12/24 Quarterly MDS (Minimum Data Set) assessment indicated he required substantial/maximal assistance for putting on and taking off footwear. The ADL (activities of daily living) self-care performance deficit care plan, revised 5/28/24, indicated he required assistance with ADLs, due to a functional deficit related to traumatic brain injury. The physician's orders indicated podiatry, as needed, effective 4/1/24. The 5/11/23 podiatry consent form indicated he requested to be seen for podiatry services, and to please have the podiatrist examine him for thickened, dystrophic (deformed, discolored, or thickened,) and/or painful nails with increased risk of infection. An observation and interview were conducted with Resident 7 in his room on 1/30/25 at 10:36 a.m. He was lying in bed with his feet exposed, not wearing any socks. Both feet had several extremely thick, long, yellowish toenails, that curved around the end of his toes. The toenail on his right big toe was thick and raised a quarter inch from the base. Resident 7 indicated he wanted to see a podiatrist, but every time he discussed it with staff, it never happened. Resident 7's electronic health record did not include any documented podiatry consultations. An interview was conducted with the SSA (Social Services Assistant) on 1/31/25 at 2:09 p.m. He indicated when a resident signed their consent form to be seen for podiatry services, the facility faxed the consent form to the podiatry provider, who then sent the facility a schedule for when the resident could be seen for an initial visit. Then the resident was seen every sixty days thereafter. The SSA reviewed Resident 7's clinical record at this time, and indicated he did not see any podiatry consults for him. The podiatrist was most recently at the facility earlier this week. An observation of Resident 7's feet was made with UM (Unit Manager) 4 on 1/31/25 at 2:22 p.m. UM 4 removed both socks from Resident 7's feet. Both feet appeared the same as during the, 1/30/25 10:36 a.m., observation with several extremely thick, long, yellowish toenails, that curved around the end of his toes, and his right big toenail was thick and raised a quarter inch from the base. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident 7, on 1/31/25 at 2:22 p.m., during the above observation. He indicated he talked to staff about podiatry services, but nothing ever happened, and he never saw the podiatrist. An interview was conducted with UM 4, on 1/31/25 at 2:22 p.m., just after observation of Resident 7's feet. She indicated she was unaware of the condition of Resident 7's feet. His big toe needed referred to podiatry, and the other toenails were pretty long, but she thought nursing may be able to cut them. An interview was conducted with the RVPRM (Regional [NAME] President of Risk Management) on 2/4/25 at 3:00 p.m. She indicated the facility was unable to locate any verification Resident 7 was seen by podiatry after signing his 5/11/23 podiatry consent form. The Foot Care policy was provided by the RVPRM on 1/31/25 at 3:07 p.m. It read, Foot care is often performed in conjunction with shower/bathing. However, some residents may require additional care or be unable to perform this care while showering or is unsafe to do so. Foot care will be provided by nursing personnel for those residents unable to perform this task. Foot care is considered bathing of feet and regular trimming of toenails . In some residents, foot care including trimming of nails should only be performed by a professional. 3.1-47(a)(7)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51750 Based on observation, interview, and record review, the facility failed to ensure care planned fall interventions were implemented timely for 1 of 2 residents reviewed for positioning (Resident 63). Findings include: The clinical record for Resident 63 was reviewed on 01/28/25 at 1:50 p.m. The diagnoses included, but were not limited to, personal history of transient ischemic attack, muscle weakness, and abnormal posture. A care plan, dated 04/04/24, indicated Resident 63 was at risk for falls. The goal was for the resident not to sustain major injury related to falls. The interventions included, but were not limited to, a mat to be placed on the floor at bedside, bed in lowest position, and ensure that bed locks are engaged, initiated on 07/25/22. On 01/28/25 at 11:43 a.m., Resident 63 was observed lying in bed with no mat on the floor at bedside. On 01/31/25 at 09:27 a.m., Resident 63 was observed lying in bed eating breakfast with no mat on the floor at bedside. On 02/03/25 02:09 p.m., Resident 63 was observed lying in bed with no mat on the floor at bedside. On 02/03/25 02:11 p.m., an interview was conducted with Certified Nurse Aide (CNA) 3. When asked why Resident 63 did not have a mat on the floor at bedside she indicated she was unsure. CNA 3 indicated if the use of a mat on the floor at the bedside was included in a resident's care plan, then it should be in use at bedside. A Fall Prevention and Management Policy was provided by the Regional [NAME] President of Risk Management on 02/04/25 at 11:25 a.m. It indicated, .If the resident is identified to be at risk for falls, a care plan should be initiated that includes a plan to potentially diminish the risk for falls. The care plan can include interventions that address environmental factors, ADL [activities of daily living] factors, risk factors that result from dementia and other mental diagnoses, medical diagnosis that put the resident at higher risk . 3.1-45(a)(2)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40287 Based on observation, interview, and record review, the facility failed to serve food at palatable temperatures for 4 of 4 residents reviewed for food (Resident 24, Resident 14, Resident C, and Resident 44). Findings include: 1 a. The clinical record for Resident 24 was reviewed on 1/30/25. The diagnoses included, but were not limited to, heart failure. A Quarterly Minimum Data Set (MDS) assessment, completed 11/1/24, indicated he was cognitively intact. During an interview on 1/30/25 at 10:04 a.m., Resident 24 indicated his food was not always hot when he received it. 51750 1 b. The clinical record for Resident 14 was reviewed on 1/29/25 at 10:20 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease. A Quarterly MDS assessment, completed 11/06/24, indicated he was cognitively intact. During an interview on 1/29/25 at 10:29 a.m., Resident 14 indicated when food was delivered the hot items were not hot and the cold items were not cold. 34850 1 c. The clinical record for Resident 44 was reviewed on 1/29/25 at 10:00 a.m. The diagnoses included, but were not limited to, anxiety disorder. An Admission MDS assessment indicated Resident 44 was cognitively intact. An interview was conducted with Resident 44 on 1/29/25 at 10:13 a.m. He indicated his meal trays that were delivered to his room; the food was always cold. 1 d. The clinical record for Resident C was reviewed on 1/29/25 at 1:00 p.m. The diagnoses included, but were not limited to, anxiety disorder. A Quarterly MDS assessment, dated 12/24/24, indicated Resident C was cognitively intact. An interview was conducted with Resident C on 1/29/25 at 2:22 p.m. She indicated she received meals delivered to her room. The food items were delivered cold when they should be hot, and the cold food items are warm when they should be cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/3/25 at 12:35 p.m., a test tray was observed on the Cambridge Hall food cart. The test tray was removed from the cart, leaving two more room trays to be passed to residents. The temperatures of the food items on the test tray were obtained by the Dietary Manager (DM). The pork roast was 112 degrees Fahrenheit (F), the seasoned rice was 123 degrees F, and the mixed vegetables were 135 degrees F. During an interview on 2/3/25 at 12:35 p.m., the DM indicated that food was served from the steam table at a minimum of 135 degrees F. During an interview on 2/3/25 at 12:54 p.m., the DM indicated residents had the option of having food warmed up if it was cold. She was unaware that food should be held at 135 degrees F until delivered to the residents' room. A food quality and palatability policy were provided by the Regional [NAME] President of Risk Management on 2/3/25 at 2:08 p.m. It indicated, .Policy Statement. Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs .Procedures .2. The Cook(s) prepare food in a sanitary manner utilizing the principles of Hazard Analysis Critical Control Pointe (HACCP) and time and temperature guidelines as outlined in the Federal Food Code. 3. Food and liquids/beverages are prepared in a manner, form and texture that meets each resident's needs . 3.1-21(a)(2) 3.1-21(i)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34850 Based on observation, interview, and record review, the facility failed to maintain infection control by not donning on personal protective equipment (PPE) while providing respiratory care for 1 of 2 random observations of respiratory care. (Resident 75) Findings include: The clinical record for Resident 75 was reviewed on 1/28/25 at 11:00 a.m. The diagnoses included, but were not limited to, acute respiratory distress syndrome, tracheostomy, and acute respiratory failure. A physician order, dated 10/22/24, indicated the resident was in enhanced barrier precautions every shift. An observation was made of Resident 75 in his room with Respiratory Therapist (RT) 2 on 1/28/25 at 11:49 a. m. RT 2 was observed at Resident 75's bedside providing respiratory care to the resident. At that time, RT 2 was not observed wearing a gown while providing respiratory care. An interview was conducted with the Regional [NAME] President of Risk Management on 1/28/25 at 3:42 p. m. She indicated RT 2 should have been wearing PPE while providing respiratory care. An Enhanced Barrier Precaution policy was provided by the Regional [NAME] President of Risk Management on 2/3/25 at 2:08 p.m. It indicated, .Policy: Enhanced Barrier Precautions (EBP) refer to an infection control interventions designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include . device care or use: .tracheostomy/ventilator . 3.1-18(b)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 30344 Based on observation, interview, and record review, the facility failed to maintain residents' room in a clean manner and good repair for 2 of 10 residents reviewed for environmental concerns. (Resident 47 and 60) Findings include: 1. An observation of Resident 60's room was made on 1/29/25 at 1:34 p.m. The restroom floor had no tile or flooring. There were a significant number of small, brownish spots on the ceiling above her bed. The ceiling vent cover between her bed and restroom was pulling away from the ceiling. An environmental tour was conducted with the Maintenance Director and Administrator on 2/4/25 at 2:40 p. m. During the tour, Resident 60's room was observed. An interview was conducted with Resident 60 at that time. The small, brownish spots on the ceiling above her bed remained, and the ceiling vent cover between her bed and restroom remained pulled away from the ceiling. There was a screw on one side of the vent that was no longer affixed to the drywall above it. The restroom flooring was now placed, but there was a puddle of water built up in the back left corner of the restroom, next to the commode. Resident 60 indicated the commode leaked every time you flushed it. She spoke with Maintenance Technician 5 and another staff member about the leaky commode. It was supposed to be fixed prior to the placement of the new flooring, but it wasn't. The puddle of water had been there all week, since the new flooring was placed. The brownish spots on the ceiling above her bed and ceiling vent pulling away from the ceiling were both like that when she moved into the room a couple of years ago. An interview was conducted with the Maintenance Director on 2/4/25 at 2:40 p.m., during and after observation of Resident 60's room. He indicated he was unaware of the brownish spots above her bed, the leaky commode, and the ceiling vent pulling away from the ceiling. The spots on the ceiling looked like some sort of spill to him. As far as the leaky commode, there must have been some sort of miscommunication with the staff who laid the flooring. No one informed him of the leaky commode, and he would have needed to know about it for it to be fixed. 40287 2. The clinical record for Resident 47 was reviewed on 1/30/25 at 11:00 a.m. The diagnoses included, but were not limited to, dementia. On 1/30/25 at 11:00 a.m., Resident 47 was observed lying in bed. The grab bar on the left side of her bed had a dried tan substance on the bar. On 2/4/25 at 12:10 p.m., Resident 47 was observed with Certified Nurse Aide (CNA) 7. The grab bar on the left side of her bed had a tan dried substance present on it. CNA 7 indicated it was most likely dried food and attempted to wipe it off with a paper towel. The tan substance was not able to be wiped off with a paper towel. CNA 7 indicated the grab bar needed cleaned. (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	02/04/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Rights policy was provided by the RDCO (Regional Director of Clinical Operations) on 2/4/25 at 3:13 p.m. It read, Definitions: Dignity: a state worthy of honor or respect; includes but not limited to speaking respectfully to resident, providing privacy for care and treatment, providing safe and secure housing, sanitary food and hydration; respecting resident choice and attending to needs in a timely fashion. Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. 3.1-19(f)(5)