STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allisonville Meadows	10312 Allisonville Rd Fishers, IN 46038

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure the dignity of residents was maintained and respected for 3 of 4 resident reviewed for dignity and 16 of 134 residents reviewed in resident council. (Residents' B, E, F, G, H, J, K, L, M, N, O, P, Q, R, S, T, V, Y, and Z).Findings include: 1. The clinical record for Resident B was reviewed on 4/9/25 at 3:27 p.m. The resident's diagnoses included, but were not limited to, dementia (progressive decline in cognitive function) and deafness. A care plan, initiated 1/29/26, indicated Resident B required assistance with Activities of Daily Living (ADL) care including bed mobility, transfers, eating, and toileting. An admission Minimum Data Set (MDS) Assessment, completed 2/4/26, indicated Resident B had no useful hearing and no speech. She was sometimes able to make herself understood and sometimes able to understand what was said. She was dependent on staff for toileting. An intervention indicated to assist with toileting and/ or incontinent care as needed. A care plan, initiated 3/13/26, indicated the resident had a communication deficit related to being deaf. The goal was for the resident to understand and make herself understood by answering simple yes and no questions. The approaches included, but were not limited to, use hand gestures as necessary and use simple communication. On 3/30/26, Resident B's family member filed a Grievance Form. The grievance form indicated that on 3/30/26 a Certified Nursing Assistant (CNA) had an attitude with Resident B. An Incident Report, filed with the Indiana Department of Health on 4/1/26, indicated Resident B's family member had reported concerns that CNA 7 had made inappropriate comment made in the presence of Resident B. During an interview on 4/14/26 at 2:20 p.m., Family Member (FM) 9 indicated he had been present on 3/30/26 when CNA 7 went off on Resident B. FM 9 felt CNA 7 had mocked Resident B. Resident B used American Sign Language (ASL) to communicate. An ASL interpreter was present during the interaction between Resident B and CNA 7. FM 9 had informed the nurse on duty about the interaction and was very upset about the situation, and requested that CNA 7 not care for Resident B again. During an interview on 4/14/2026 at 3:21 p.m., CNA 7 indicated she had cared for Resident B on 3/30/26. CNA 7 provided incontinence care for Resident B prior to therapy. The therapist had brought Resident B back from therapy because she needed to use the bathroom. CNA 7 could not speak American Sign Language. CNA 7 had seen Resident B use the gesture of pinching her nose frequently. CNA 7 had imitated the gesture and asked the interpreter who was with Resident B what that gesture (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meant. CNA 7 had not cared for Resident B since 3/30/26. During an interview on 4/13/26 at 3:30 p.m., Interpreter (INT) 10 indicated she had been present during the incident between Resident B and CNA 7 on 3/30/26. Resident B needed to have a bowel movement while participating in therapy. The therapists had taken Resident B back to her room and requested CNA 7 to assist her back to bed. INT 10 had stayed in the room with Resident B. CNA 7 had come into the room and began using the sign for poop and said, it's always poop, poop, poop. INT 10 had tried to intervene and felt that CNA 7 was mocking Resident B. CNA 7 had not asked INT 10 what the sign she was making meant. Resident B had asked INT 10 if there was anything wrong during the interaction. INT 10 had informed FM 9 about the incident. 2. The clinical record for Resident E was reviewed on 4/10/26 at 1:44 p.m. The resident's diagnosis included, but was not limited to, diabetes. A Quarterly Minimum Data Set (MDS) Assessment, completed 1/22/26, indicated Resident E was cognitively intact. During an interview on 4/10/26 at 1:44 p.m., Resident E indicated some of the Certified Nursing Assistances (CNA) had attitudes when they come in to work. They appear angry about something, and complain about their shifts and the people they work with. Resident E would prefer not to have to deal with those attitudes at this stage in his life. 3. The clinical record for Resident F was reviewed on 4/10/26 at 1:20 p.m. The resident's diagnosis included, but was not limited to, lung cancer. During an interview on 4/14/26 at 10:23 a.m., FM 11 indicated she had visit Resident F over the past weekend. When FM 11 entered Resident F's room she found a urinal full of urine on the bedside table and a styrofoam cup with urine in it. The bedside commode had not been emptied from the day before. Resident F's room had a foul smell. FM 11 had asked the staff to empty the bedside commode, and no one came for quite a while. FM 11 felt the care that Resident F had received over the weekend was not appropriate or respectful. 4. The January 2026, February 2026, and March 2026 resident council minutes were provided by the Executive Director on 4/13/26 at 11:16 a.m. The meeting minutes indicated the following: The resident council meeting minutes, dated 1/14/26, indicated the staff were putting residents in bed in the evenings too early resulting in residents unable to attend evening bingo. The resident council meeting minutes, dated 2/26/26, indicated the residents had concerns with being put in bed too early. The resident council meeting minutes, dated 3/12/26, indicated Certified Medications Aides (CNA) staff are talking on cell phones while providing care. A resident council meeting was conducted on 4/13/26 at 1:53 p.m. The attendees in the meeting were Residents' G, H, J, K, L, M, N, O, P, Q, R, S, T, V, Y, and Z. During the meeting, the council indicated the staff are not respectful. The residents are put in bed too early with no choice. The residents had requested to be placed in bed after activities. The staff had provided excuses; they have too many (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	people to bathe at that hour or too many residents already in that time frame to add someone else to be placed in bed when residents requested to be placed after evening activities. That resulted in residents missing evening activities. The staff were often on their cell phones while providing care. During that time, the staff were speaking in a language other than English on their phones and with each other if there were more than one person providing care. The residents had asked, what are you saying? The staff's response, we are not talking about you. The residents want the staff to speak English while in their presence. The council had reported the concerns, and it continues to not get better. An interview was conducted with the Executive Director on 4/13/26 at 2:56 p.m. He indicated the resident council had reported concerns with staff placing them in bed too early. Education was provided to staff. The residents had reported concerns several months ago about phone usage, and the staff speaking in a language other than English. He was unaware the residents still had concerns with the staff speaking in a different language. The residents had care companions that check on them routinely, and the residents had not reported recently any concerns with the staff speaking in a language other than English. This citation is related to Intake 2964009. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(t)

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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. Based on interview and record review, the facility failed to ensure follow-up with resolutions to concerns brought up in resident council meetings were reported back to the resident council members. This had the potential to effect 16 of 134 residents that attended resident council meeting. (Residents' G, H, J, K, L, M, N, O, P, Q, R, S, T, V, Y, and Z) Findings include:The January 2026, February 2026, and March 2026 resident council minutes were provided by the Executive Director on 4/13/26 at 11:16 a.m. The meeting minutes indicated the following: The resident council meeting minutes, dated 1/14/26, indicated the staff were putting residents in bed in the evenings too early resulting in residents unable to attend evening bingo. The Resident Council President had signed she had received follow up with resolutions of the concerns reported in the meeting that day. There were no documentation there was discussion with the resident council members of resolutions with the concerns reported in the previous month. The resident council meeting minutes, dated 2/26/26, indicated the residents had concerns with being put in bed too early and missing evening bingo, staff were dropping off medications in the residents' rooms and not waiting for residents to take them prior to leaving and late food services. The Resident Council President had signed she had received follow-up with resolutions of the concerns reported in the meeting that day. There were no documentation, there was discussion with the resident council members of resolutions of concerns reported in the previous month. The resident council meeting minutes, dated 3/12/26, indicated medications are left in the resident rooms without waiting for residents to taking them and Certified Medications Aides (CNA) staff were talking on cell phones while providing care. The Resident Council President had signed she had received follow-up with resolutions of the concerns reported in the meeting that day. There were no documentation, there was discussion with the resident council members of resolutions with concerns reported in the previous month. A resident council meeting was conducted on 4/13/26 at 1:53 p.m. The attendees in the meeting were Residents' G, H, J, K, L, M, N, O, P, Q, R, S, T, V, Y, and Z. During the meeting, the council indicated they had file grievances during the resident council meetings, but they never heard back with resolutions to their concerns. The Resident Council President indicated there were no discussions or communication provided by the staff with how the facility had addressed concerns that had been reported in the resident council meetings.An interview was conducted with Executive Director on 4/13/26 at 2:56 p.m. He indicated the Resident Council President did get informed of the resolutions to the concerns brought up in the resident council meetings that day of the reporting. She would sign off as she had been informed of the resolution. A grievance policy was provided by the Executive Director on 4/14/26 at 1:55 p.m. It indicated, .The Executive Director/Grievance Official will sign off on all completed concerns/grievances forms, ensuring resident and/or family satisfaction. A resident council policy was provided by the Executive Director on 4/14/26 at 1:55 p.m. It indicated, .Procedure: 7. The facility responses to concerns/suggestions will be reviewed by the Resident Council President and the resident council on their next meeting. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(l)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to ensure residents were able to file grievances anonymously for 16 of 134 residents reviewed during resident council. (Residents' G, H, J, K, L, M, N, O, P, Q, R, S, T, V, Y, and Z) Findings include:A resident council meeting was conducted on 4/13/26 at 1:53 p.m. The attendees in the meeting were Residents' G, H, J, K, L, M, N, O, P, Q, R, S, T, V, Y, and Z . During the meeting, the council indicated they were unable to file a grievance anonymously. If there was a location to anonymously report a grievance, they were unaware. The residents requested a grievance form from the staff at the nurse's station. The grievance forms were kept there. The forms were not in reach for residents to take without anyone knowing. There was no privacy to report a grievance without staff knowing what you put on the form. An observation was made of the 500 Hall nurses' station on 4/13/26 at 2:48 p.m. There were orange forms sitting in a tray in the corner of the nurse's station. The forms were not accessible to anyone standing outside of the nurse's station.An interview was conducted with License Practical Nurse (LPN) 2 at the nurses' station on 4/13/26 at 2:49 p.m. The LPN indicated the orange sheets were grievance forms to be filled out if someone had a grievance they would like to report. The residents did have to ask for the grievance forms if they would like to fill one out. The staff would assist with filling the form out if residents requested or the residents could fill out the forms themselves. The residents would turn the forms back into the staff at the desk after they filled them out. The staff would turn the forms in for the residents. There used to be places around the facility to anonymously turn a grievance form in, but now the residents had to ask for the forms. An interview was conducted with the Activities Assistant on 4/13/26 at 2:51 p.m. She indicated the activities staff did not have grievance forms the residents could take and fill out. If the residents had concerns the activity staff directed the residents to go to the social service's office. An interview was conducted with the Executive Director/Grievance Official on 4/13/26 at 2:56 p.m. He indicated the residents all have care companions that check on their assigned residents. The resident was able to address concerns to their care companion. The residents can also go to the nurse's station and get grievance forms to fill out to report grievances. A grievance policy was provided by the Executive Director on 4/14/26 at 1:55 p.m. It indicated, .Each resident has the right to file grievances orally or in writing; file a grievance anonymously, and to obtain a written decision regarding his or her grievance. Grievances may be submitted anonymously as preferred by a resident, representative and/or family member. Anonymity will be maintained by the Grievance Official throughout the resolution process. 410 IAC (Indiana Administrative Code) 16.2-3.1-7(a)(1)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview and record review, the facility failed to ensure meal services were provided timely for 19 of 134 residents that eat food served from the kitchen. (Residents' G, H, J, K, L, M, N, O, P, Q, R, S, T, V, Y, Z, BB, CC and DD) Findings include:The meals service schedule was provided by the Executive Director on 4/9/26 at 12:24 p.m. The serving schedule indicated the following breakfast, lunch and dinner scheduled times at each serving areas:Breakfast meal - the start time to prepare meal trays = 6:55 a.m.100 Hall serving time = 7:15 a.m.,200 Hall serving time = 7:30 a.m.,Main dining room = 7:45 a.m.,300 Hall serving time = 8:10 a.m.,400 Hall serving time = 8:20 a.m., and500 Hall serving time = 8:55 a.m. Lunch meal - the start time to prepare meal trays = 11:25 a.m.100 Hall serving time = 11:45 a.m.,200 Hall serving time = 12:00 p.m.,Main dining room serving time = 12:15 p.m.,300 Hall serving time = 12:35 p.m.,400 Hall serving time = 12:45 p.m., and500 Hall serving time = 1:05 p.m. Dinner meal - - the start time to prepare meal trays = 4:55 p.m.100 Hall serving time = 5:15 p.m.,200 Hall serving time = 5:30 p.m.,Main dining room serving time = 5:45 p.m.300 Hall serving time = 6:10 p.m.,400 Hall serving time = 6:20 p.m., and500 Hall serving time = 6:35 p.m. An interview was conducted with Resident CC on 4/9/26 at 11:20 a.m. She indicated the meals were served late on the 500 Hall. She preferred to eat earlier. The breakfast meals were served after 10:00 a.m., lunch normally was served at around 2:00 p.m., and dinner was served at 7:00 p.m.An interview was conducted with Resident N on 4/9/26 at 11:35 a.m. She indicated the dinner meal was often served later than it was supposed to. She lived in the 500 Hall. The staff would deliver her dinner meal trays to her room at 7:00 p.m., and at times later than that. An observation was made of breakfast room trays on the 400 Hall delivered on 4/10/26 at 9:55 a.m. A staff member indicated breakfast room trays were normally served around 8:15 a.m. to 8:30 a.m.An observation was made of Resident BB on 4/10/26 at 10:33 a.m. The resident was observed uncovering her breakfast tray. She indicated she had just received her breakfast tray at 10:30 a.m. It was always late. The staff woke her up at 5:00 a.m. to take her morning mediations, but she did not receive her breakfast until late morning.An interview was conducted with Resident G on 4/10/26 at 10:46 a.m. She indicated the meals were served late in the 500 Hall. She received her breakfast meal at 10:30 a.m. that morning.An interview was conducted with Resident DD on 4/10/26 at 11:00 a.m. He indicated all the meals were served late all the time.A resident council meeting was conducted on 4/13/26 at 1:53 p.m. The attendees in the meeting were Residents' G, H, J, K, L, M, N, O, P, Q, R, S, T, V, Y, and Z. During the meeting, the council indicated the meals were often provided late. The evenings were the worst. The dinner meals were provided at times between 7:00 p.m. and 8:00 p.m.During a kitchen tour with the Dietary Manger on 4/14/26 at 11:43 a.m. She indicated the lunch meal normally would be served at 11:30 a.m. The order of serving area from the kitchen was the following: 300 Hall, 100 Hall, 200 Hall, 400 Hall, the main dining room and the 500 Hall. The dinner meals recently had been provided late at times. The latest meals had been served were 6:30 p.m. She has had some staffing concerns on 3rd shift with vacations and call-ins, which had caused dinner meals to be served a little late at times.This citation was related to Intake 2682125. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(c)

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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. Based on interview and record review, the facility failed to timely document meal consumption for 1 of 3 residents reviewed for nutrition (Resident B). Findings include: The clinical record for Resident B was reviewed on 4/9/25 at 3:27 p.m. The resident's diagnoses included, but were not limited to, seizure disorder and dementia (progressive decline in cognitive function). A care plan, initiated 1/30/26, indicated Resident B required assistance and/or monitoring of AM/PM care, nutrition, hydration, and elimination. The goal was that her Activities of Daily Living (ADL) needs would be met. The approaches included, but were not limited to, breakfast intake percentage and fluid consumption, lunch intake percentage and fluid consumption, dinner intake percentage and fluid consumption.An admission Minimum Data Set (MDS) Assessment, completed 2/4/26, indicated Resident B had no useful hearing and no speech. She was sometimes able to make herself understood and sometimes able to understand what was said. She required supervision with eating and her weight was 172 pounds.A care plan, initiated 2/4/26, indicated Resident B was at risk for altered nutritional status related to a history of impaired skin integrity which may have resulted in increased protein needs. Other nutritional concerns of dementia and diabetes. She had poor appetite. Her family member brought in food from outside. She has had a change in environment, decreased social interaction, weight loss and poor oral intake. The goal was for her to maintain her current weight with no significant changes. The approaches included, but were not limited to, notify physician and family of significant weight changes, and offer substitutes if 50 percent or less of meal is consumed. Meal consumption amounts had not been documented on the followings days and meal:-1/31/26, dinner not documented,-2/6/26, breakfast and lunch not documented,-2/12/26, breakfast not documented,-2/16/26, breakfast not documented,-2/21/26, breakfast and dinner not documented,-2/24/26, at breakfast not documented,-2/26/26, breakfast not documented,-3/1/26, lunch and dinner not documented,-3/3/26, lunch not documented,-3/10/26, lunch not documented,-3/11/26, lunch not documented,-3/12/26, lunch not documented,-3/14/26, breakfast not documented,-3/16/26, lunch not documented,-3/17/26, breakfast and lunch not documented,-3/19/26, lunch not documented,-3/21/26, breakfast not documented,-3/25/26, lunch not documented, -3/27/26, lunch not documented,-3/29/26, lunch not documented,-3/30/26, breakfast not documented,-4/1/26, breakfast and dinner not documented,-4/3/26, breakfast and lunch not documented,-4/5/26, dinner not documented,-4/8/26, breakfast and lunch not documented,-4/10/26, breakfast, lunch and dinner not documented, -4/11/26, lunch not documented, and-4/12/26, breakfast and lunch not documented. On 2/26/26, Resident B's weight was recorded as being 161 pounds, indicating a 6% weight loss since admission. On 3/2/26, Resident B's weight was recorded at 161 pounds.On 3/17/26, Resident B's weight was recorded at 154 pounds. On 4/2/26, Resident B's weight was 157 pounds. During an interview on 4/15/26 at 11:24 a.m., the Regional Dietician (RD) indicated Resident B had a poor appetite when she first admitted to the facility. Several interventions were attempted and her appetite was improving. Staff should document consumption of all meals. This citation relates to Intake 2964009. 410 IAC (Indiana Administrative Code) 16.3.146(a)(1)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and record review, the facility failed to address a resident lying in another resident's bed, as care planned, for 1 of 2 residents reviewed for dementia care. (Resident 4)Findings include: The clinical record for Resident 4 was reviewed on 4/10/26 at 1:50 p.m. Her diagnosis included, but were not limited to, dementia. The behavior care plan, initiated on 10/17/25 and last revised on 2/11/26, indicated the resident expressed physical aggression without provocation while intrusively wandering. An approach was to redirect her to her room and/or quiet area away from other residents and offer calm reassurance. The behavior care plan, initiated on 5/1/25 and last revised on 2/11/26, indicated the resident had episodes of agitation directed toward others. She could become verbally and physically aggressive. An approach was to calmy redirect her away from other residents and offer to have her lay down. The behavior care plan, initiated on 1/31/24 and last revised on 2/11/26, indicated the resident would intrusively wander in and out of other residents' rooms. Approaches were to redirect her to her own room or to the dining room for mealtime or activity. An observation of Resident 4 on 4/10/26 at 1:58 p.m., indicated Resident 4 was located inside Resident 75's and Resident 124's room on the memory care unit of the facility. Resident 4 was lying down in Resident 75's bed with her eyes closed. Resident 124 was lying down in her own bed. The door to the room was open. Resident 75 entered the room and walked around a bit, while Resident 4 remained lying in Resident 75's bed. Resident 75 then shut the door to the room with Resident 4 still in Resident 75's bed. Laundry Aide 3, who was putting away clothes in the room next door, came to Resident 75's and 124's room and clarified who all three residents in the room were and whose room was whose. Resident 4 remained lying in bed at this time. Laundry Aide 3 indicated Resident 4's room was next door. Laundry Aide 3 did not redirect Resident 4 from the room or inform any of the nursing staff Resident 4 was in Resident 75's bed. Laundry Aide 3 left the room and proceeded to pass clothes to other rooms. The Memory Care Support Specialist (MCSS) came down the hallway, knocked on Resident 75's and 124's door, opened the door slightly, peaked inside, and shut the door. Resident 4 remained in the room. The MCSS was informed Resident 4 was in the room. After having been informed, the MCSS went into the room to address Resident 4 lying in Resident 75's bed. Resident 75 could be heard saying ?She doesn't belong in here,' in a raised, irritated voice, multiple times, while the MCSS was in the room. An interview was conducted with the Memory Care Unit Manger on 4/14/26 at 2:20 p.m. in the hallway, after Resident 4 was observed to be lying down in bed in Resident 117's room (not Resident 4's own room) with the door shut. She indicated when Resident 4 was found lying in another resident's bed, they would normally redirect her to her own room. After having been informed of the above occurrence on 4/10/26 at 1:58 p.m., when Resident 4 was found lying in Resident 75's bed, she indicated she thought the laundry aide should have redirected her out of the room or told another staff member she was in there. They could do an in-service to educate staff, because she was unsure the laundry aide knew what to do at that time. It was a constant thing for staff having to redirect Resident 4 out of other residents' rooms. The Behavior Management policy was provided by the Regional Director of Clinical Services on 4/14/26 at 5:45 p.m. It indicated, It is the policy of [name of facility] to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non-pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expressions. Procedure: 1. Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other resident or caregivers. Care plan interventions should include individualized and non-pharmacological interventions which address both proactive and responsive interventions.3. When a behavioral expression occurs, the staff communicates to the nurse what behavior occurred. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure medication was available for administration for 1 of 2 residents reviewed for hospitalization (Resident E).Findings include: The clinical record for Resident E was reviewed on 4/10/26 at 1:44 p.m. The resident's diagnosis included, but was not limited to, diabetes. A Quarterly Minimum Data Set (MDS) Assessment, completed 1/22/26, indicated Resident E was cognitively intact. A nursing progress note, dated 3/26/26 at 2:44 p.m., indicated the resident was scheduled for a colonoscopy on 3/30/26 at 2:45 p.m. The March Medication Administration Record (MAR) indicated Resident E received bisacodyl (laxative given as colonoscopy preparation) 20 milligrams on 3/29/26 at 8:00 p.m. He had not received colyte (medication used for cleansing bowel prior to colonoscopy) due to the medication being unavailable. A nursing progress note, dated 3/30/26 at 8:39 a.m., indicated the resident did not complete the colonoscopy preparation and the appointment needed to be rescheduled. The colyte had been out of stock at the pharmacy. During an interview on 4/10/26 at 1:44 p.m., Resident E indicated the continuity of care at the facility was poor. The facility had not ensured all the medication was available for his colonoscopy prep. He had received one of the medications, but the other medication had not come in from the pharmacy. He had to deal with the results of receiving the first medications. The colonoscopy had to be rescheduled. Appointments dealing with his health were very important to him and he would have liked to have the colonoscopy done when it was scheduled. During an interview on 4/14/2026 at 9:58 a.m., the Director of Nursing indicated the colyte for Resident E had been on backorder. The pharmacy did not normally inform the facility of medications that are on backorder. The physician was contacted and did not want an alternative treatment and the procedure was rescheduled. On 4/15/26 at 3:05 p.m., the Executive Director provided the Long-Term Care Facilities Receiving Products and Services from Pharmacy policy, last revised 8/1/24, that read .Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. 1.1 If the medication shortage is discovered at the time of medication administration, Facility staff should immediately notify the Pharmacy . 410 IAC (Indiana Administrative Code) 16.3.1-25(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allisonville Meadows	10312 Allisonville Rd Fishers, IN 46038

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to timely complete a physician's ordered STAT (immediate) laboratory test as ordered, for 1 of 2 residents reviewed for laboratory services. (Resident 15)Findings include:The clinical record for Resident 15 was reviewed on 04/13/26 at 1:54 p.m. His diagnoses included, but were not limited to, chronic kidney disease. The nursing note, dated 4/6/26 at 6:51 a.m., indicated Resident 15 had an extra large amount of liquid greenish stool that night. The resident's ostomy bag was changed three times and the resident had emesis (vomiting) one time at 6:00 a.m. of a small amount of thick, clear, emesis with some undigested food present. The progress note, dated 4/6/26 and written by Nurse Practitioner (NP) 5, indicated Resident 15's chief complaint was nausea, vomiting, and diarrhea. The Assessment and Plan Diagnoses and associated orders for the visit section indicated staff were to obtain a CBC (complete blood count) and BMP (basic metabolic panel) STAT (immediate labs that prioritize emergency, urgent, procedures to ensure quick descision-making). The resident's clinical record lacked the CBC and BMP laboratory results for 4/6/26 or 4/7/26. There were results for a CBC and a BMP on 4/8/26. The nursing note, dated 4/7/26 at 12:37 p.m. and recorded as a late entry on 4/8/26 at 12:38 p.m., indicated the laboratory failed to draw the resident's labs ordered on 4/6/26. The provider was notified to request new orders to obtain the labs. The nursing note, dated 4/8/26 at 12:47 p.m., indicated Resident 15 was noted with two episodes of emesis that shift. Zofran (medication used to prevent nausea and vomiting) per standing orders with good tolerance. The NP was notified, and a verbal order was received to obtain a KUB (diagnostic evaluation of the urinary system and surrounding organs to check for kidney stones, infections, tumors, or obstruction.) The nursing note, dated 4/8/26 at 10:03 p.m., indicated a critical lab was received that indicated a BUN level of 61 and Creatinine level of 10.7. Resident 15 was assessed and no acute distress was noted at this time. The writer notified the After Hours On Call, and the NP gave a verbal order to send to the emergency room. The Director of Nursing (DON,) family were notified. The Emergency Medical Technician (EMT) was notified that the family requested he be transported to a specific hospital. An interview was conducted with the DON on 4/13/26 at 2:22 p.m. He indicated the used a specific lab provider to complete obtain labs at the facility. They came to the facility daily, Monday through Friday. For STAT labs, they entered the order into their electronic health record (EHR) and verified they received the order. The lab provider was supposed to come the same day for STAT labs, so long as there was a technician in the area. That was the process that was supposed to be followed on 4/6/26 for Resident 15's STAT lab orders. He did not know why the labs were not drawn until 4/8/26. An interview was conducted with the Regional Director of Clinical Services (RDCS)on 4/15/26 at 10:14 a.m. She indicated the facility was integrating their new lab system on 4/6/26. Somehow, the stat lab orders were not going through. They discovered the issue on 4/8/26, the day they reordered Resident 15's labs. They had a phone call with their lab provider on 4/13/26 and working out the issue. An interview was conducted with Physician 6 on 4/15/26 at 2:10 p.m. He indicated stat labs had a six to eight hour turn around time. When NP 5 saw Resident 15 on 4/6/26, the labs could have been ordered to be done the next day, on 4/7/26. Resident 15 had a history of nausea and vomiting, was unstable, didn't absorb very well, had stomach distention on and off, and tendencies to go into renal failure quickly. When the CBC and BMP labs were not done by 4/7/26, he seemed okay, so the delay may have worked in his favor, in that the critical lab results were picked up on 4/8/26. Resident 15 had chronic kidney disease for a long time. The Laboratory Procedures were provided by the RDCS on 4/15/26 at 12:20 p.m. It indicated, STAT draws are to be dispatched out and received by phlembotomist within 15-30 minutes.STAT turnaround time is defined as 5 hours. 410 IAC (Indiana Administrative Code) 16.2-3.1-49(a)