STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR RESIDENCES OF BANTA POINTE	6510 U.S. 31 SOUTH, INDIANAPOLIS, , 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00457589. Complaint IN00457589 - State deficiencies related to the allegations is cited at R0053. Survey date: April 29, 2025 Facility number: 014018 Residential Census: 48 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed May 2, 2025.	R 0000	PLAN OF CORRECTION CONSTITUTES FIVER STAR RESIDENCES OF BANTA POINTE'S WRITTEN ALLEGATION OF COMPLIANCE FOR THE ALLEGED DEFICIENCY CITED. SUBMISSION OF THIS PLAN OF CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAW. FIVE STAR RESIDENCES OF BANTA POINTE RESPECTFULLY REQUESTS A DESK REVIEW FOR THIS PLAN OF CORRECTION. ALLEGED DATE OF COMPLIANCE IS 5/28/25 . THE FOLLOWING PLAN OF CORRECTION IS AS FOLLOWS;	
R 0053	Residents' Rights - Deficiency	R 0053	R053 – RESIDENTS RIGHTS –	05/28/2025

	410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse for 1 of 3 residents reviewed. (Resident B) Findings include: During an interview on 4/29/25 at 10:40 a.m., the Administrator indicated QMA 1's employment with the facility had been terminated due to QMA 1 using foul language while speaking to Resident B. During an interview on 4/29/25 at 1:20 p.m., QMA 2 indicated, on 4/14/25 around 2:00 p.m., Resident B was complaining of having pain and requested pain medication from QMA 1. QMA 1 stated to Resident B, "You are a complaining [expletive] [expletive] now shut the [expletive] up!" CNA 1 took Resident B to her room to get her away from the situation. QMA 1 seemed to be having a bad day, but staff were not supposed to talk to residents in a rude way. During an interview on 4/29/25 at 2:05 p.m., CNA 1 indicated, on 4/14/25 around 2:00 p.m., Resident B was asking for pain		DEFICIENCY WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? RESIDENT B NO LONGER RESIDES IN THE COMMUNITY; THEREFORE, NO FURTHER CORRECTIVE ACTION COULD BE TAKEN FOR THIS RESIDENT. 2 HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED, AND WHAT CORRECTIVE ACTION (S) WILL BE TAKEN? ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. THE DHW COMPLETED AN AUDIT TO DETERMINE WHAT IF ANY RESIDENTS ARE AT RISK. SERVICE PLANS WERE UPDATED AS NEEDED.	

	medication. CNA 1 took her to the nurse's station and asked QMA 1 if the resident could have some pain medication. QMA 1 stated medication would not help her and told the resident to "Shut the [expletive] up and quit [expletive] complaining all the time!" CNA 1 removed the resident from the area and took her back to her room. QMA 1 was uncharacteristically in a foul mood, but that was no excuse for speaking to a resident in a rude way. On 4/29/25 at 11:10 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and anxiety disorder. On 4/29/25 at 2:30 p.m., the Administrator provided the Resident Rights, undated, and indicated these were the resident rights currently used by the facility. A review of the policy indicated, "Residents have the right to be free from verbal abuse". This citation relates to Complaint IN00457589. Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse for 1 of 3 residents reviewed. (Resident B)		3WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? STAFF WILL BE INSERVICED OF RESIDENT RIGHTS, AND ALL NEW EMPLOYEES WILL RECEIVE RESIDENT RIGHTS IN SERVICE TRAINING DURING INITIAL NEW EMPLOYEE ONBOARDING. THE ED, AND OR THEIR DESIGNEEE WILL MONITOR ALL NEW EMPLOYEES TO ENSURE COMPLETION OF RESIDENT RIGHTS TRAINING DURING THE NEW EMPLOYEE ONBOARDING PROCESS FOR A PERIOD THIRTY (30) DAYS. 4HOW WILL THE CORRECTIVE ACTION (S) BE MONITORED? THE ED, AND OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR MONITORING THAT ALL NEW EMPLOYEES RECEIVE	

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	uncharacteristically in a foul mood, but that was no excuse for speaking to a resident in a rude way. On 4/29/25 at 11:10 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and anxiety disorder. On 4/29/25 at 2:30 p.m., the Administrator provided the Resident Rights, undated, and indicated these were the resident rights currently used by the facility. A review of the policy indicated, "Residents have the right to be free from verbal abuse". This citation relates to Complaint IN00457589.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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