| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 02/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaint IN00453428.<br><br>Complaint IN00453428 - State deficiencies related to the allegations are cited at R90 and R241.<br><br>Survey date: February 14, 2025<br><br>Facility number: 014018<br><br>Residential Census: 45<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed February 18, 2025. | R 0000 | THIS 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 3/4/25 . THE FOLLOWING PLAN OF CORRECTION IS AS FOLLOWS; | |
| R 0090 | Administration and Management - Deficiency | R 0090 | R090 –<br>Administration and Management | 03/04/2025 |

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| | 410 IAC 16.2-5-1.3(g)(1-6)<br><br>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:<br><br>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:<br><br>(A) epidemic outbreaks;<br><br>(B)poisonings;<br><br>(C) fires; or<br><br>(D) major accidents.<br><br>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.<br><br>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.<br><br>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. | | – Deficiency<br><br>1 What corrective action(s) will be<br>accomplished for those residents found to have been affected by the deficient practice?<br><br>Resident #B no longer resides in the community; therefore, no further corrective action could be taken for this resident.<br><br>2 How other residents having the<br>potential to be affected by the same deficient practice will be identified and<br>what corrective action(s) will be taken?<br><br>All residents have the potential to be affected. An audit was conducted to identify any other residents who could potentially affected. | |

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| | (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:<br><br>(A) employee's full name; and<br><br>(B) dates and hours worked during the past twelve (12) months.<br><br>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.<br><br>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request<br><br>Based on interview and record review, the facility failed to submit a required facility reportable incident to the State Department of Health regarding a significant medication error that resulted in a resident having been transferred to the Emergency Department for evaluation and treatment for 1 of 3 residents reviewed for medication administration. (Resident B)<br><br>Findings include:<br><br>On 2/14/25 at 9:35 a.m., the | | 3 What measures will be put into place<br>and what systemic changes will be made to ensure that the deficient practice<br>does not recur?<br><br>All staff approved to submit reportable events were re-educated<br>relative to Administration and Management – Deficiency, including, but not<br>limited to the facilities Reportable Events Policy.<br><br>4 How the corrective action(s) will be<br>monitored?<br><br>Executive Director, or designee, will be responsible for monitoring any potential reportable event, and will submit to the appropriate<br>State agency. The Executive Director, or, designee, will be responsible for<br>reviewing all potential reportable events 5 days a week for 1 month,<br>thereafter, 3 days a week for 2 months.<br><br>5 Completion date: 3/4/25 | |

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| | clinical record of Resident B was reviewed. The diagnosis included, but was not limited to, atherosclerotic heart disease.<br><br>A Progress Note, dated 1/28/25 at 8:13 p.m., indicated the writer was called to the resident's room by the CNA for the resident's nose bleeding. First aid was applied but unsuccessful. DON (Director of Nursing) notified, and DON indicated to send the resident to the hospital. Resident was transported to hospital.<br><br>Admission orders, dated 1/14/25, indicated warfarin (blood thinner) tablet 2.5 mg, one tablet once every evening at 4:00 p.m.<br><br>The Medication Administration Record (MAR), dated January 2025, indicated Resident B received warfarin 2.5 mg, two tablets at 4:00 p.m., from January 14 through January 28, 2025 (15 days).<br><br>On 2/14/25 at 10:00 a.m., the DON provided a copy of a Medication Incident, dated 1/29/25. The incident indicated the family of Resident B reported to the facility that Resident B's Coumadin (warfarin) orders were wrong in the clinical record. Resident went to the hospital on 1/28/25 due to uncontrolled nosebleed lasting 40 minutes. The severity | | | |

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| | of the medication incident indicated a transcription error. LPN 2 transcribed the Coumadin order on 1/14/25 for two tablets of 2.5 mg (milligrams) Coumadin. The order should have been written for one tablet of 2.5 mg Coumadin.<br><br>On 2/14/25 at 10:30 a.m., the DON indicated Resident B's INR (international normalized ratio) result at the hospital was "7 ish" (normal INR levels 2.0-3.0). The nurse at the time of the transcription error, wrote the order for twice the dose as the physician had ordered. The resident received twice the prescribed dose for 15 days.<br><br>During an interview on 2/14/25 at 10:20 a.m., the Administrator indicated the facility reportable for the significant medication error and subsequent hospitalization should have been reported to the State Department of Health.<br><br>On 2/14/25 at 11:32 a.m., the DON provided a copy of the Reportable Events policy, dated 8/1/22, and indicated it was the current policy in use by the facility. A review of the document indicated, "...any major occurrence/incident of unusual nature as required by state regulations..."<br><br>This citation relates to | | | |

Complaint IN00453428.

Based on interview and record review, the facility failed to submit a required facility reportable incident to the State Department of Health regarding a significant medication error that resulted in a resident having been transferred to the Emergency Department for evaluation and treatment for 1 of 3 residents reviewed for medication administration. (Resident B)

Findings include:

On 2/14/25 at 9:35 a.m., the clinical record of Resident B was reviewed. The diagnosis included, but was not limited to, atherosclerotic heart disease.

A Progress Note, dated 1/28/25 at 8:13 p.m., indicated the writer was called to the resident's room by the CNA for the resident's nose bleeding. First aid was applied but unsuccessful. DON (Director of Nursing) notified, and DON indicated to send the resident to the hospital. Resident was transported to hospital.

Admission orders, dated 1/14/25, indicated warfarin (blood thinner) tablet 2.5 mg, one tablet once every evening at 4:00 p.m.

The Medication Administration Record (MAR), dated January

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| | 2025, indicated Resident B received warfarin 2.5 mg, two tablets at 4:00 p.m., from January 14 through January 28, 2025 (15 days).<br><br>On 2/14/25 at 10:00 a.m., the DON provided a copy of a Medication Incident, dated 1/29/25. The incident indicated the family of Resident B reported to the facility that Resident B's Coumadin (warfarin) orders were wrong in the clinical record. Resident went to the hospital on 1/28/25 due to uncontrolled nosebleed lasting 40 minutes. The severity of the medication incident indicated a transcription error. LPN 2 transcribed the Coumadin order on 1/14/25 for two tablets of 2.5 mg (milligrams) Coumadin. The order should have been written for one tablet of 2.5 mg Coumadin.<br><br>On 2/14/25 at 10:30 a.m., the DON indicated Resident B's INR (international normalized ratio) result at the hospital was "7 ish" (normal INR levels 2.0-3.0). The nurse at the time of the transcription error, wrote the order for twice the dose as the physician had ordered. The resident received twice the prescribed dose for 15 days.<br><br>During an interview on 2/14/25 at 10:20 a.m., the Administrator indicated the facility reportable | | | |

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| R 0241 | Health Services - Offense<br><br>410 IAC 16.2-5-4(e)(1)<br><br>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:<br><br>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.<br><br>Based on interview and record review, the facility failed to administer medications per the physician's orders for 1 of 2 residents reviewed receiving warfarin (blood thinner). This | R 0241 | R241<br>– Health Services – Offense<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br><br>Resident #B no longer resides in the community; therefore, no further corrective action could be taken for this resident. | 03/04/2025 |

deficient practice resulted in the resident sustaining an uncontrolled nosebleed and a prolonged blood clotting time, resulting in hospitalization. (Resident B)

Finding includes:

On 2/14/25 at 9:35 a.m., the clinical record of Resident B was reviewed. The diagnosis included, but was not limited to, atherosclerotic heart disease.

A Progress Note, dated 1/28/25 at 8:13 p.m., indicated the writer was called to the resident's room by the CNA for the resident's nose bleeding. First aid was applied but unsuccessful. DON (Director of Nursing) notified, and DON indicated to send the resident to the hospital. Resident was transported to hospital.

Admission orders, dated 1/14/25, indicated warfarin tablet 2.5 mg, one tablet once every evening at 4:00 p.m.

The Medication Administration Record (MAR), dated January 2025, indicated Resident B received warfarin 2.5 mg, two tablets at 4:00 p.m., from January 14 through January 28, 2025 (15 days).

On 2/14/25 at 10:00 a.m., the DON provided a copy of a Medication Incident, dated 1/29/25. The incident indicated

1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken?

All newly admitted, or readmitted, residents have the potential to be affected. Physician orders of all residents admitted, or readmitted, within the past 60 days have been reviewed to ensure transcription accuracy. Any identified concerns were promptly addressed with resident physicians with clarifications obtained, as necessary.

1. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?

All licensed nurses have been re-educated relative to

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| | the family of Resident B reported to the facility that Resident B's Coumadin (warfarin) orders were wrong in the clinical record. Resident went to the hospital on 1/28/25 due to uncontrolled nosebleed lasting 40 minutes. The severity of the medication incident indicated a transcription error. LPN 2 transcribed the Coumadin order on 1/14/25 for two tablets of 2.5 mg (milligrams) Coumadin. The order should have been written for one tablet of 2.5 mg Coumadin.<br><br>On 2/14/25 at 10:30 a.m., the DON indicated Resident B's INR (international normalized ratio) result at the hospital was "7 ish" (normal INR levels 2.0-3.0). The nurse at the time of the transcription error, wrote the order for twice the dose as the physician had ordered. The resident received twice the prescribed dose for 15 days. | | Health Services – Offense, including but not limited to, proper transcription of physician orders upon admission, or readmission.<br><br>1. How the corrective action(s) will be monitored?<br><br>Director of Health and Wellness, or designee, will be responsible for auditing the charts of all new admissions, or readmissions, the day following the admission/readmission for 1 month to ensure all necessary physician orders are transcribed correctly.<br>Thereafter, the DHW, or designee, will be responsible for auditing the charts of all new admissions/readmissions within 48 hours of admission/readmission for 2 months to ensure all necessary physician orders are transcribed correctly.<br>Any identified concerns will be promptly addressed with the responsible individual(s). | |

On 2/14/25 at 11:46 a.m., the Executive Director provided a policy titled Medication Management, dated 6/9/23, and indicated it was the current policy being used by the facility. A review of the policy indicated "...J. Prescription Requirements and Order Changes 1. All medications are appropriately dispensed and labeled as per the prescription for the appropriate resident."

This citation relates to complaint IN00453428.

Based on interview and record review, the facility failed to administer medications per the physician's orders for 1 of 2 residents reviewed receiving warfarin (blood thinner). This deficient practice resulted in the resident sustaining an uncontrolled nosebleed and a prolonged blood clotting time, resulting in hospitalization. (Resident B)

Finding includes:

On 2/14/25 at 9:35 a.m., the clinical record of Resident B was reviewed. The diagnosis included, but was not limited to, atherosclerotic heart disease.

A Progress Note, dated 1/28/25 at 8:13 p.m., indicated the writer was called to the resident's room by the CNA for the resident's nose bleeding. First aid was applied but

1. Completion date: 3/4/25

unsuccessful. DON (Director of Nursing) notified, and DON indicated to send the resident to the hospital. Resident was transported to hospital.

Admission orders, dated 1/14/25, indicated warfarin tablet 2.5 mg, one tablet once every evening at 4:00 p.m.

The Medication Administration Record (MAR), dated January 2025, indicated Resident B received warfarin 2.5 mg, two tablets at 4:00 p.m., from January 14 through January 28, 2025 (15 days).

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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.)

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETim Cooper | TITLEExecutive Director | (X6) DATE03/03/2025 |