

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/23/2024	
NAME OF PROVIDER OR SUPPLIER FIVE STAR RESIDENCES OF BANTA POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a State Residential Licensure Survey. Survey Dates: April 22 and 23, 2024 Facility Number: 014018 Residential Census: 56 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 25, 2024.	R 0000	This Plan of Correction constitutes Five Star Residences of Banta Pointe's written allegation of compliance for the alleged deficiency cited. Submission of the 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 May 2, 2024 The following Plan of Correction is as follows:				
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2)	R 0092	The following corrective actions were accomplished for those residents affected by the deficient practice:			05/07/2024	

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(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:

(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.

(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.

Based on interview and record review, the facility failed to ensure that twelve fire drills were completed in a calendar year and fire drills were completed quarterly on each shift for 4 of 4 quarters reviewed.

Findings include:

On 4/22/24 at 9:30 a.m., the

Maintenance Director has conducted the following fire drills:

A 3rd shift fire drill was conducted on 4/27/2024 to make up for the lack of documentation for the second quarter of 2023 and the 3rd quarter of 2023 and the 1st quarter of 2024.

A 1st shift fire drill was conducted on 4/27 to make up for the lack of documentation for the 4th quarter of 2023.

A 2nd shift fire drill was conducted on 4/29 to make up for the lack of documentation for the 1st quarter of 2024.

All residents have the potential to be affected by the deficient practice.

Upcoming fire drills are scheduled quarterly on each shift and are documented by having staff sign a sheet to show who participated in the fire drill.

The maintenance director or designee will be responsible to ensure the deficient practice does not recur.

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Administrator provided copies of the fire drills that were conducted from April 2023 through March 2024. A review of the documentation indicated the following:

- The monthly documents included but were not limited to: the date, time and shift the fire drill was conducted.

-The second quarter of 2023 (April, May, and June) documentation lacked a fire drill having been conducted on 3rd shift. The record indicated three fire drills were conducted during the quarter.

- The third quarter of 2023 (July, August, and September) documentation lacked a fire drill having been conducted on 3rd shift. The record indicated two fire drills were conducted during the quarter.

-The fourth quarter of 2023 (October, November, and December) documentation lacked a fire drill having been conducted on 1st shift. The record indicated three fire drills were conducted during the quarter.

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-The first quarter of 2024 (January, February, and March) documentation lacked a fire drill having been conducted on 2nd and 3rd shifts. The record indicated one fire drill was conducted during the quarter.

The facility records lacked supporting documentation that on a quarterly basis each shift had a fire drill conducted and 12 fire drills were conducted in the calendar year. Nine fire drills were completed from April 2023 through March 2024.

During an interview on 4/22/24 at 11:45 a.m., the Maintenance Director indicated no fire drills were conducted in February and March of 2024. Fire drills were to be conducted quarterly on each shift.

During an interview on 4/22/24 at 2:15 p.m., the Administrator indicated, on a quarterly basis, a fire drills were to have been conducted on every shift. Staff shift hours were as follows: first shift - 7:00 a.m. to 3:00 p.m.; second shift - 3:00 p.m. to 11:00 p.m.; and third shift - 11:00 p.m. to 7:00 a.m. No fire drills were conducted in September of 2023; February of 2024; or March of 2024.

During an interview on 4/23/24 at 8:25 a.m., the Administrator indicated the facility did not have a specific fire drill policy.

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The facility was to follow the State regulations for conducting quarterly fire drills for each shift and for a total of twelve fire drills per twelve calendar months.

Based on interview and record review, the facility failed to ensure that twelve fire drills were completed in a calendar year and fire drills were completed quarterly on each shift for 4 of 4 quarters reviewed.

Findings include:

On 4/22/24 at 9:30 a.m., the Administrator provided copies of the fire drills that were conducted from April 2023 through March 2024. A review of the documentation indicated the following:

- The monthly documents included but were not limited to: the date, time and shift the fire drill was conducted.

- The second quarter of 2023 (April, May, and June) documentation lacked a fire drill having been conducted on 3rd shift. The record indicated three fire drills were conducted during the quarter.

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R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure a Resident Assistant had a valid Certified Nursing Assistant (CNA) certification prior to working as a Resident Assistant for 1 of 10 Resident Assistants reviewed for	R 0118	The following corrective actions were accomplished for those residents affected by the deficient practice: Resident Assistant 8 has her assignment modified to provide no more than limited assistance with residents, as the rule states. Her assignment duties are attached to this plan of correction for your reference. Resident Assistant 8 is taking coursework and the exam to become certified with the IDOH Home Health Aide Registry. Once she receives that certification, she will resume her normal duties as a Resident Assistant.	05/07/2024

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certification status. (Resident Assistant 8)

Findings include:

On 4/22/24 at 10:00 a.m., the Administrator provided a copy of the "as-worked" staffing schedule from 3/24/24 through 4/22/24. A review of the document indicated that Resident Assistant 8 worked 16 eight-hour shifts and one six and a half-hour shift during that time period providing more than limited assistance to residents.

On 4/22/24 at 10:00 a.m., the Administrator provided the facility employee list that included staff member's name, job title, and employment start date. A review of the document indicated Resident Assistant 8 was hired on 6/26/19 and the job title was Resident Assistant.

On 4/23/24 at 9:00 a.m., Resident Assistant 8's file was reviewed. Resident Assistant 8 was hired on 6/26/19 as a Resident Assistant. Resident Assistant 8's professional licensure document indicated she was licensed as an Occupational Therapy Assistant (OTA). The license was valid through 12/31/2024.

On 4/23/24 at 11:40 a.m., the Director of Resident Care provided a copy of Resident Assistant 8's job description. A review of the Resident Assistant

All residents have the potential to be affected by this deficient practice.

The following changes have been made to ensure the deficient practice does not recur: all future employees providing more than limited assistance to residents must have either their HHA or CNA certification.

Executive Director or designee will monitor all potential hires providing more than limited assistance with residents by reviewing an applicant's HHA or CNA certification to ensure they are active and in good standing before they are hired.

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job description indicated "...education and/or experience:...must have valid, unrestricted certification in the state (CNA) [Certified Nursing Assistant]..." The document was signed by Resident Assistant 8 on 6/26/19.

Resident Assistant 8's file lacked a valid CNA certification.

During an interview on 4/23/24 at 9:10 a.m., the Director of Resident Care indicated CNA staff were called Resident Assistant staff and the job duties and qualifications were the same.

During an interview on 4/23/24 at 10:00 a.m., the Director of Resident Care indicated Resident Attendant 8 was licensed as an OTA; however, she did not possess a CNA certification. The Director of Resident Care indicated her understanding was that since she was licensed as an OTA, Resident Assistant 8 would not need a CNA certification. The Director of Resident Care indicated the facility followed the State regulations regarding the required licenses and certifications for staff.

Based on interview and record review, the facility failed to ensure a Resident Assistant had a valid Certified Nursing Assistant (CNA) certification

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prior to working as a Resident Assistant for 1 of 10 Resident Assistants reviewed for certification status. (Resident Assistant 8)

Findings include:

On 4/22/24 at 10:00 a.m., the Administrator provided a copy of the "as-worked" staffing schedule from 3/24/24 through 4/22/24. A review of the document indicated that Resident Assistant 8 worked 16 eight-hour shifts and one six and a half-hour shift during that time period providing more than limited assistance to residents.

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On 4/23/24 at 11:40 a.m., the Director of Resident Care

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provided a copy of Resident Assistant 8's job description. A review of the Resident Assistant job description indicated "...education and/or experience:...must have valid, unrestricted certification in the state (CNA) [Certified Nursing Assistant]..." The document was signed by Resident Assistant 8 on 6/26/19.

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R 0148	Sanitation and Safety Standards -	R 0148	The following corrective actions	05/07/2024
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Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secure behind locked doors to prevent resident's access to the hazardous materials for 3 of 56 self-mobile cognitively impaired residents residing in the facility. Findings include:		were accomplished for those residents affected by the deficient practice: An audit is being conducted to ensure the Beauty Shop and the two Mechanical Rooms are locked. The audit schedule is as follows: 5 days a week for 2 weeks, 3 days a week for 2 weeks, 2 days a week for 1 week, 1 day a week for 1 week. A copy of the audit is attached for your reference. All residents have the potential to be affected by the deficient practice. Ongoing weekly audits will be conducted to ensure the electrical rooms and beauty shop are locked. Documentation to ensure the corrective actions will be recorded to ensure the deficient practice will not recur.	
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On 4/22/24 from 9:00 a.m. to 9:30 a.m., during the initial tour of the facility with the AD (Activities Director), the following was observed:

1. At 9:05 a.m., between Room 31 and the AD's office, observed the salon/beauty shop room door to be unlocked. No staff were visible in the area. During an interview with the AD at that time, the AD indicated the salon was to be kept locked. Inside the salon were multiple canisters and containers of chemicals and assorted hair care products, including, but not limited to:

- A plastic container approximately 3/4 full of blue liquid containing multiple hair combs.

- An approximately 1/4 full bottle of blue liquid in a nearby unlocked cabinet labeled Barbicide. The manufacturer's warning indicated, "keep out of reach..". The cabinet also contained some razors.

- Three unopened boxes of DP Hue daily scalp serum. The manufacturer's warning indicated, "keep out of reach.."

- An almost full metal canister of Andis cool care plus for clipper blades. The manufacturer's warning indicated, "keep out of reach.."

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- A partially full plastic container of Quick Shine multi-surface floor polish finish. The manufacturer's warning indicated, "keep out of reach.."

2. At 9:15 a.m., between Room 33 and Room 35, an unlocked electrical closet was observed. No staff were visible in the area. Inside were two electrical breaker panels, labeled "Panel C - General" and "Panel D - Heat". Both panels were closed but each had the key visibly inserted into the locking mechanism. The closet also had multiple wires and cables along the left wall.

3. At 9:20 a.m., between Room 9 and Room 11, an unlocked electrical closet was observed. No staff were visible in the area. Inside were two electrical breaker panels, labeled "Panel G - General" and "Panel H - Heat". Both panels were closed but Panel G had the key visibly inserted into the locking mechanism. The closet also had multiple wires and cables along the right wall.

During an interview, on 4/22/24 at 9:50 a.m., the Administrator indicated the beauty shop door should be kept locked when not in use and the electrical closets should be locked as well.

During an interview on 4/22/24 at 11:45 a.m., the Maintenance

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Director indicated that the electrical closet doors should be kept locked.

On 4/22/24 at 12:00 p.m., the DON (Director of Nursing) provided a list of residents who were both self-mobile and cognitively impaired. A review of the document indicated 3 residents residing in the facility were both self-mobile and cognitively impaired of the 56 residents residing in the facility.

On 4/22/24 at 1:35 p.m., the DON provided a copy of the Five Star Senior Living Resident Safety Equipment policy, effective date of 4/1/21, and indicated it was the current policy in use by the facility. A review of the policy indicated, "All areas where hazardous [materials] area stored must remain locked at all times when not working in that area."

Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secure behind locked doors to prevent resident's access to the hazardous materials for 3 of 56 self-mobile cognitively impaired residents residing in the facility.

Findings include:

On 4/22/24 from 9:00 a.m. to 9:30 a.m., during the initial tour of the facility with the AD

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1. At 9:05 a.m., between Room 31 and the AD's office, observed the salon/beauty shop room door to be unlocked. No staff were visible in the area. During an interview with the AD at that time, the AD indicated the salon was to be kept locked. Inside the salon were multiple canisters and containers of chemicals and assorted hair care products, including, but not limited to:

- A plastic container approximately 3/4 full of blue liquid containing multiple hair combs.

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3. At 9:20 a.m., between Room 9 and Room 11, an unlocked electrical closet was observed. No staff were visible in the area. Inside were two electrical breaker panels, labeled "Panel G - General" and "Panel H - Heat". Both panels were closed but Panel G had the key visibly inserted into the locking mechanism. The closet also had multiple wires and cables along the right wall.

During an interview, on 4/22/24 at 9:50 a.m., the Administrator indicated the beauty shop door should be kept locked when not in use and the electrical closets should be locked as well.

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R 0187	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(k) (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained	R 0187	The following corrective actions were accomplished for those residents affected by the deficient practice: The Maintenance Director has contacted a plumbing contractor to replace the hot water mixer valve. A quote for the cost of the work conducted is attached for your reference. The work was completed on 5/6/24. Resident #80's water temperature is being monitored to ensure the hot water temperature is within state standards to	05/07/2024

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between one hundred (100) degrees Fahrenheit and one hundred and twenty (120) degrees Fahrenheit for 1 of 7 resident apartments reviewed. (Resident 80)

Finding include:

During a facility tour with the Maintenance Director on 4/22/24 at 11:15 a.m., Resident 80's apartment water temperatures were observed. The kitchen sink's hot water temperatures ranged between 120 degrees Fahrenheit (F) and 124 degrees F. Resident 80 indicated at that time, a nurse stated, "the water gets really hot." At that time, the Maintenance Director indicated, the hot water temperatures were to be monitored and maintained between 100 degrees F and 120 degrees F.

On 4/23/24 at 8:24 a.m., the Maintenance Director provided a copy of the "Logbook Report: water temperature checks: test and log the hot water temperatures" for the previous 12 months. A review of the document indicated daily hot water temperatures were recorded throughout the facility. The report lacked any documentation that Resident 80's room had any previous water temperature checks performed.

maintain compliance.

All residents have the potential to be affected by the deficient practice

Weekly random water temperature checks throughout the building will be conducted by the Maintenance Director or a designee to ensure the water temperature is within the state's safety standards.

Documentation of the weekly water temperature checks will be recorded by the Maintenance Director or designee to ensure the deficient practice will not recur.

During an interview at that time, the Maintenance Director indicated that hot water temperatures were monitored from random rooms on each unit on a daily basis. The Maintenance Director indicated "sometimes" the water would have to run for "a while to get the hot water down to an acceptable hot water temperature range for the facility." The hot water temperatures were to be monitored and maintained between 100 degrees F and 120 degrees F.

During an interview on 4/22/24 at 12:10 p.m., the Administrator indicated the water temperatures are to be monitored and maintained between 100 degrees F and 120 F.

Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between one hundred (100) degrees Fahrenheit and one hundred and twenty (120) degrees Fahrenheit for 1 of 7 resident apartments reviewed. (Resident 80)

Finding include:

During a facility tour with the Maintenance Director on 4/22/24 at 11:15 a.m., Resident 80's apartment water

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OMB NO. 0938-0391

temperatures were to be monitored and maintained between 100 degrees F and 120 degrees F.

During an interview on 4/22/24 at 12:10 p.m., the Administrator indicated the water temperatures are to be monitored and maintained between 100 degrees F and 120 F.

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