STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/14/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00453902. Complaint IN00453902 - State deficiencies related to the allegations are cited at R306. Survey dates: March 13 and 14, 2025 Facility number: 014018 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 17, 2025.	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 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. THIS PROVIDER RESPECTFULLY REQUESTS THAT THE 2567 PLAN OF CORRECTION BE CONSIDERED FOR DESK REVIEW IN LIEU OF POST SURVEY REVIEW.	
R 0054 Bldg. 00	410 IAC 16.2-5-1.2(x) Residents' Rights - Deficiency Based on observation, interview, and record review, the facility failed to protect the residents' right to confidentiality of their clinical and personal records, with the potential to affect 48 of 48 residents. Findings include: On 3/13/25 from 9:50 a.m. to 10:15 a.m., during a walkthrough of the facility, the following was	R 0054	R054 – RESIDENTS RIGHTS – DEFICIENCY 1 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? NO RESIDENT WAS DIRECTLY	04/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Cooper	Executive Director	04/07/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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		A. BUILDING 00 B. WING	03/14/2025

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FIVE STAR RESIDENCES OF BANTA POINTE	6510 U.S. 31 SOUTH INDIANAPOLIS, IN 46227

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	observed: 1. At 10:00 a.m., in the south side of the facility's hallway, between Rooms 66 and 68, was an unlocked and unattended room labeled "Storage". Inside the following were observed: - On top of the filing cabinets were a few stacks of printed resident eMAR's (electronic medication administration records). - Three four-drawer metal file cabinets on the back right wall of the room. From left to right, the top drawer of each filing cabinet were labeled "2023", "2022", and "Current Resident Overflow". The second file on the far right cabinet just below "Current Resident Overflow" was labeled "2024 Discharged Records". Each filing cabinet drawer was unlocked and each contained resident files. The unlabeled files contained large manilla envelopes with resident names on them and appeared to also be filled with resident files. There were no staff in the hallway after leaving the storage room area. 2. At 10:10 a.m., in the south side of the facility's hallway, across from Room 65 and next to Room 74, was a room labeled as the Nurse Station. The door was open and no staff were present in the room or in the hallway. The room contained dozens of green hard plastic folder resident charts with resident documentation noted inside. During an interview on 3/13/25 at 10:21 a.m., the DON (Director of Nursing) indicated that the storage room and the nursing station with resident documents should have both been locked. On 3/14/25 at 11:00 a.m., the BOM (Business		AFFECTED BY THE DEFICIENT PRACTICE, THE FACILITY IMMEDIATELY INSTALLED PUSH-BUTTON, SELF-LOCKING DOOR HANDLES TO EACH IDENTIFIED ROOM, I.E. ROOM 67, LABELED “STORAGE”, AND THE ROOM IDENTIFIED AS “NURSE STATION” 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. ALL FACILITY STAFF WILL BE IN-SERVICED ON RESIDENT RIGHTS, AND THE AREAS IDENTIFIED HAVE HAD NEW SELF-LOCKING DOOR HANDLES INSTALLED. 3 WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ALL STAFF WILL RE-EDUCATED ON PROTECTING THE RESIDENTS RIGHT TO CONFIDENTIALITY OF THEIR CLINICAL AND PERSONAL RECORDS. ADDITIONALLY, PUSH-BUTTON SELF-LOCKING DOOR HANDLES WERE INSTALLED IMMEDIATELY UPON IDENTIFICATION OF THE	

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FIVE STAR RESIDENCES OF BANTA POINTE	6510 U.S. 31 SOUTH INDIANAPOLIS, IN 46227

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	Office Manager) provided a copy of the Five Star Senior Living "Assisted Living Resident Handbook", dated January 2013, that new residents receive during the admission process. A review of the resident handbook included an "Attachment B - Resident Rights", which under section (x) stated "Resident have the right to confidentiality of all personal and clinical records ..."		CONCERN. 4 HOW WILL THE CORRECTIVE ACTION(S) BE MONITORED? THE EXECUTIVE DIRECTOR, OR THEIR DESIGNEE, WILL BE RESPONSIBLE FOR MONITORING THROUGH WEEKLY ROUNDS THAT THE SELF-LOCKING DOOR HANDLES ARE FUNCTIONING PROPERLY. MONITORING WILL TAKE PLACE WEEKLY FOR THREE MONTHS, AND WILL BE BROUGHT TO THE FACILITIES QAPI PROGRAM. ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESPONSIBLE INDIVIDUAL(S) 5 COMPLETION DATE: 4/30/25	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to ensure that potentially hazardous materials were kept secure behind locked doors to prevent residents' access to hazardous materials for 8 of 48 self-mobile and cognitively impaired residents residing in the facility. Findings include: On 3/13/25 from 9:50 a.m. to 10:15 a.m., during a walkthrough of the facility, the following was observed:	R 0148	R148 – SANITATION AND SAFETY STANDARDS – DEFICIENCY 1 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? NO RESIDENTS WERE DIRECTLY AFFECTED BY THE DEFICIENT PRACTICE. THE	04/30/2025

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	1. At 9:51 a.m., in a section of the north side of the facility's hallway, and spanning along the opposite side of the hallway from Rooms 22, 23, and 24, was an open common area space for resident activities. The space was set up with chairs and a table with religious icons for a church service. The table included two unlit candles and one red Bic multi-purpose wand lighter on the side of the table. The lighter device was observed to be functional. No staff were present in the hallways or activity area. 2. At 9:55 a.m., in the north side of the facility's laundry room, next to Room 15 and across from Room 21, an unmarked door to the right of the washing machines was unlocked. The small, unmarked supply closet had cleaning equipment and a one open gallon container, approximately one third full, of EcoLab 3-in-1 cleaner. The labeling on the container indicated "keep out of reach". There were no staff present in the laundry room or hallway outside. 3. At 10:00 a.m., in the south side of the facility's hallway between Rooms 66 and 68, was an unlocked and unattended room labeled "Storage". Inside the storage room were multiple containers of liquids and cleaning wipes, including, but not limited to: - One open gallon container, approximately one third full, of hand sanitizer fluid. - Eight unopened gallon containers of hand sanitizer fluid. - A box of thirty-eight smaller three fluid ounce sized containers of hand sanitizer fluid.		FACILITY IMMEDIATELY REMOVED THE CANDLES, (WILL UTILIZE BATTERY OPERATED CANDLES) AND THE BIC MULTI PURPOSE LIGHTER, AND IMMEDIATELY INSTALLED SELF-LOCKING DOOR HANDLES ON THE SUPPLY CLOSET, AND THE ROOM LABELED “STORAGE” 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. ALL FACILITY STAFF WILL BE IN-SERVICED ON SAFETY AND SANITIATION AND THE FACILITY IMMEDIATELY INSTALLED SELF-LOCKING DOOR HANDLES TO THE SUPPLY CLOSET AND STORAGE AREA. 3 WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. ALL STAFF HAVE BEEN IN SERVICED ON FACILITY SAFETY AND SANITATION STANDARDS, THE NON USE OF LIGHTERS OF ANY TYPE, AND MONITORING THAT THE SUPPLY CLOSET, AND THE	

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	- Ten Sani-Cloth disposable germicidal wipe containers. The labeling for all containers indicated to "keep out of reach". When leaving the storage room, no staff were present in the hallway outside. During an interview on 3/13/25 at 10:21 a.m., the DON (Director of Nursing) indicated that both the supply closet and the storage room doors should have been locked. The DON further indicated that the lighter should not have been left out in the open. On 3/13/25 at 1:45 p.m., the DON provided a copy of the Five Star Senior Living "Resident Safety and Equipment Policy", with an 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] are stored must remain locked at all times when not working in that area" and "products in use will not be left unattended in non-employee areas". On 3/14/25 at 10:20 a.m., the BOM (Business Office Manager) verbalized that there were eight residents who were both independently mobile and cognitively impaired resided at the facility.		STORAGE AREA REMAIN LOCKED AT ALL TIMES. TO THAT END, THE FACILITY IMMEDIATELY INSTALLED SELF LOCKING DOOR HANDLES ON BOTH ROOMS. 4 HOW WILL THE CORRECTIVE ACTION(S) BE MONITORED? THE EXECUTIVE DIRECTOR, OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR MONITORING THROUGH WEEKLY FACILITY ROUNDS, TO ENSURE THE SELF-LOCKING DOOR HANDLES ARE FUNCTIONING PROPERLY, AND THAT NO LIGHTERS OF ANY TYPE ARE OBSERVED. MONITORING WILL TAKE PLACE WEEKLY FOR THREE MONTHS, AND WILL BE BROUGHT TO THE FACILITIES QAPI PROGRAM FOR REVIEW. ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESPONSIBLE INDIVIDUAL(S) 5 COMPLETION DATE: 4/30/25	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure resident service plans had a signature from the resident or the responsible party for 2 of 7 residents reviewed for service	R 0217	R217 EVALUATION – DEFICIENCY 1 WHAT CORRECTIVE	04/30/2025

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	plans. (Resident 10, Resident 42) Findings included: 1. On 3/13/25 at 10:43 a.m., the clinical record for Resident 10 was reviewed. The most recent service plan, dated 12/26/24, lacked a resident or responsible party signature. 2. On 3/13/25 at 10:45 a.m., the clinical record for Resident 42 was reviewed. The most recent service plan, dated 10/3/24, lacked a resident or responsible party signature. During an interview on 3/13/25 at 11:30 a.m., the Director of Nursing indicated she was unable to find current signed service plans for Resident 10 and Resident 42. On 3/14/25 at 9:26 a.m., the Business Office Manager proved a policy titled Resident Service Plans, dated 4/1/19, and indicated it was the current policy being used by the facility. A review of the policy indicated "...Provisions and Procedures...B. The resident (and family/caregiver if desired by the resident) is involved in all aspects of the assessment and service planning process. A meeting is held with the resident (family/caregiver) to review and sign the service plan.		ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? RESIDENT #42s SERVICE PLAN WAS REVIEWED AND UPDATED, WITH THE RESIDENTS/RESPONSIBLE PARTIES SIGNATURE. RESIDENT #10 HAD THEIR SERVICE PLAN REVIEWED, AND SIGNED BY THE RESIDENT/RESPONSIBLE PARTY. 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. ALL RESIDENT SERVICE PLANS WERE REVIWED/AUDITED BY THE DIRECTOR OF HEALTH AND WELLNESS TO ENSURE THE SERVICE PLANS HAD THE SIGNATURE OF THE RESIDENT/RESPONSIBLE PARTY FOR DATES 1/6/25 THROUGH 4/9/25. SERVICE PLANS PRIOR TO 1/6/25 WILL BE REVIEWED AT THE NEXT EVALUATION DATE AND THE RESIDENT/RESPONSIBLE PARTIES WILL BE INFORMED. ANY SERVICE PLANS MISSING	

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			THE PROPER SIGNATURE FOR DATES 1/6/25 – 4/9/25 WERE REVIEWED AND CORRECTED. 3 WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? THE DIRECTOR OF HEALTH AND WELLNESS WILL DO A 100% AUDIT OF ALL RESIDENT SERVICE PLANS TO ENSURE THE PROPER SIGNATURES ARE IN PLACE. DHW WILL AUDIT ALL SERVICE PLANS MONTHLY TO ENSURE COMPLIANCE. 4 HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED? THE DHW, OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR AUDITING ALL RESIDENT SERVICE PLANS MONTHLY FOR THREE MONTHS TO ENSURE PROPER SIGNATURES OF THE RESIDENT/RESPONSIBLE PARTY ARE PRESENT. ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESIDENT/RESPONSIBLE PARTY. ANY CONCERNS NOTED WILL BE BROUGHT TO THE FACILITIES QAPI MEETING.	

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			5 COMPLETION DATE: 4/30/25	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure foods were maintained and served in a sanitary and safe manner for 2 of 3 observations. Facility prepared foods were not kept covered or dated when stored. Finding includes: 1. On 3/13/25 at 9:15 a.m., during the initial kitchen observation the dry storage room was observed. Inside the room was a tall open sided wheeled cart with multiple shelves observed. The shelves held multiple trays of facility prepared foods. The following facility prepared food items lacked a cover and a date that indicated when they were prepared: - one medium sized pan of brownies - two trays of cookies - one tray that held 15 cupcake like items, including one food item that had a dried substance partially covering the item - one tray that held 24 cupcake like items 2. On 3/13/25 at 9:30 a.m., during the kitchen tour with the Dietary Manager (DM), the same uncovered and undated prepared foods stored on the tall open sided wheeled cart, located in the dry	R 0273	R273 – FOOD AND NUTRITIONAL SERVICES – DEFICIENCY 1 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? SAFE FOOD HANDLING, COVERING OF FOODS, PROPER LABELING, AND DATING OF FOODS WILL BE MONITORED FOR 30 DAYS. THE CULINARY DIRECTOR AND DIETARY STAFF WILL RECEIVE ADDITIONAL TRAINING ON THE PROPER METHOD OF STORING FOOD AND THE PROPER METHOD OF COVERING, LABELING, AND DATING USED PORTIONS AND OPEN PACKAGES. 2 HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THEM SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN? ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. PROPER COVERING,	04/30/2025

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	storage room, were observed. On 3/13/25 at 9:40 a.m., the DM indicated she was unsure when the food items were prepared or when they were placed on the cart in the dry storage room. The DM indicated all foods were to be kept covered and dated. On 3/13/25 at 12:40 p.m., the DM provided an undated copy of the Storage of Food and Supplies policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...All food...shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption...cover, label and date used portions and open packages..."		LABELING, AND DATING OF USED PORTIONS AND OPEN PACKAGES WILL BE OBSERVED FOR THIRTY (30) DAYS TO ENSURE COMPLIANCE. TEAM MEMBERS NOT FOLLOWING THE POLICY ON COVERING, LABELING, AND DATING OF USED PORTIONS AND OPEN PACKAGES WILL RECEIVE ADDITIONAL TRAINING. 3 WHAT MEASURES WILL BE PUT INTO PLACE, AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? ALL STAFF WILL BE IN-SERVICED ON THE PROPER METHOD OF COVERING, LABELING, AND DATING OF USED PORTIONS AND OPEN PACKAGES. THE CULINARY DIRECTOR AND/OR DESIGNEE WILL BE RESPONSIBLE FOR OVERSEEING AND MONITORING THE DIETARY DEPARTMENT TO ENSURE THE PROPER PROCEDURES FOR COVERING, LABELING, AND DATING OF USED PORTIONS, AND OPEN PACKAGES ARE BEING FOLLOWED. TEAM MEMBERS NOT FOLLOWING POLICY WILL RECEIVE ADDITIONAL TRAINING. 4 HOW THE CORRECTIVE	

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			ACTION(S) WILL BE MONITORED? THE CULINARY DIRECTOR OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR MONITORING THROUGH DAILY OBSERVATION FOR THIRTY (30) DAYS TO ENSURE COMPLIANCE. ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESPONSIBLE INDIVIDUAL(S). CULINARY DIRECTOR WILL BRING ANY POTENTIAL CONCERNS TO THE FACILITIES QAPI MEETING. 5 COMPLETION DATE: 4/30/25	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to document a completed drug disposition for a resident that was discharged for 1 of 2 residents reviewed for drug disposition. (Resident B) Finding included: On 3/14/25 at 11:16 a.m., the clinical record for Resident B was reviewed. The diagnosis included, but was not limited to, chronic kidney disease. A progress note, dated 2/4/25 8:16 a.m., indicated Resident B was hospitalized. The most recent list of physicians orders, dated January 2025, included but was not limited to:	R 0306	R306 – PHARMACEUTICAL SERVICES – NON-COMPLIANCE 1 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? RESIDENT #8 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	04/30/2025

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FIVE STAR RESIDENCES OF BANTA POINTE	6510 U.S. 31 SOUTH INDIANAPOLIS, IN 46227

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	- Aspirin (non-steroidal anti-inflammatory medication) 81 mg (milligrams) - Cephalexin (antibiotic) 250 mg - Cyanocobalamin (Vitamin B12) 1000 mcg - Donepezil HCL (medication used to treat dementia) 5 mg - Ferrous sulfate (iron supplement) 325 mg - Furosemide (diuretic medication) 20 mg - Hydrocodone- Acetaminophen (an opiod pain medication) 5-325 mg - Lisinopril (a medication used to treat high blood pressure) 40 mg - Myrbetriq Extended Release (a medication used to treat over active bladder) 50 mg - Trazodone (anti-depressant) 50 mg - Warfarin (blood thinner) 2.5 mg A progress note, dated 2/11/25 (late entry) indicated Resident B's daughter requested all medications, entire supply given to daughter with two QMA's as witness. The clinical record lacked a specific detailed list of all medications and the quantity sent with Resident B's daughter. On 3/14/25 at 10:20 a.m., the Business Office Manager indicated the facility sent all of the medications home with Resident B's daughter and did not document the quantity or specifics of the medications sent. This citation relates to Complaint IN00453902.		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 WILL INSERVICE CLINICAL STAFF ON THE POLICY FOR DRUG DISPOSITION. THE DHW, OR DESIGNEE WILL MONITOR ALL DISCHARGED RESIDENTS FOR PROPER DRUG DISPOSITION FOR THIRTY (30) DAYS TO ENSURE THE DEFICIENT PRACTICE HAS BEEN CORRECTED. 3 WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? THE DHW HAS IN-SERVICED CLINICAL STAFF RELATIVE TO PHARMACEUTICAL SERVICES NON-COMPLIANCE. THE DHW AND/OR DESIGNEE WILL MONITOR ALL DISCHARGED RESIDENTS FOR THIRTY (30) TO ENSURE THAT A PROPER DRUG DISPOSITION MEETING HAS TAKEN PLACE WITH THE RESIDENT/RESPONSIBLE PARTY. 4 HOW WILL THE CORRECTIVE ACTION(S) BE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			MONITORED? DHW AND/OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR MONITORING ALL RESIDENT DISCHARGES FOR THIRTY (30) DAYS TO ENSURE A PROPER DRUG DISPOSITON REVIEW/MEETING HAS TAKEN PLACE AND HAS BEEN PROPERLY DOCUMENTED. ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESPONSIBLE INDIVIDUAL(S). 5 COMPLETION DATE: 4/30/25	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure that annual health statements were documented for 1 of 7 residents reviewed. (Resident 63) Findings include: On 3/14/25 at 9:30 a.m., the clinical record for Resident 63 was reviewed. The diagnoses included, but were not limited to, congestive heart failure and diabetes. Resident 63's clinical record lacked documentation of an annual health statement. On 3/13/25 at 11:30 a.m., the Director of Nursing indicated the facility was unable to provide the annual health statement for Resident 63.	R 0409	R409 – INFECTION CONTROL – NON-COMPLIANCE 1 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? RESIDENT #63 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	04/30/2025

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	On 3/14/25 at 11:58 a.m., the Business Office Manager indicated the facility was unable to provide a specific policy regarding the annual health statement.		IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN? ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. THE DHW COMPLETED AN AUDIT TO ENSURE ALL RESIDENTS HAVE AN ANNUAL HEALTH STATEMENT. 3 WHAT MEASURES WILL BE PUT IN PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? ALL LICENSED STAFF WILL BE IN-SERVICED ON THE NEED FOR RESIDENTS TO HAVE AN UPDATED ANNUAL HEALTH STATEMENT. THE DHW AND/OR THEIR DESIGNEE WILL CONDUCT AN AUDIT TO DETERMINE THAT ALL RESIDENTS HAVE A COMPLETED ANNUAL HEALTH STATEMENT. 4 HOW WILL THE CORRECTIVE ACTION(S) BE MONITORED? THE DHW AND/OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR AUDITING RESIDENT CHARTS TO ENSURE ALL RESIDENTS HAVE AN UPDATED ANNUAL HEALTH STATEMENT. ANY IDENTIFIED CONCERNS WILL BE PROMPTTLY ADDRESSED WITH	

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			THE RESPONSIBLE INDIVIDUAL(S). ANY ONGOING CONCERNS WILL BE ADDRESSED AT THE FACILITIES QAPI MEETING. 5 COMPLETION DATE; 4/30/25	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure a resident was provided the second step of a two-step Mantoux skin test (tool used for screening for tuberculosis) upon admission for 1 of 7 residents reviewed for tuberculosis skin tests. (Resident 63) Finding includes: On 3/13/25 at 12:25 p.m., Resident 63's clinical record was reviewed. Resident 63's diagnoses included, but were not limited to, congestive heart failure (a condition where the heart cannot pump blood effectively) and diabetes mellitus. Resident 63's clinical record lacked documentation of a second step Mantoux skin test. During an interview on 3/13/25 at 1:50 p.m., the DON (Director of Nursing) indicated that she could only find documentation for Resident 63's first step admission Mantoux skin test and that the facility followed State guidelines, and he should have had a second one. On 3/14/25 at 11:00 a.m., the BOM (Business Office Manager) provided a Five Star Senior Living policy titled "Tuberculosis Control Plan",	R 0410	R410 – INFECTION CONTROL – NON-COMPLIANCE 1 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? RESIDENT #63 NO LONGER RESIDES IN THE COMMUNITY; THERFORE, NO FURTHER 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. ALL RESIDENT CHARTS HAVE BEEN REVIEWED TO ENSURE THAT THEY HAVE RECEIVED A TWO-STEP MANTOUX SKIN	04/30/2025

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	with an effective date of 10/1/17, and indicated it was the current policy in use by the facility. A review of the policy indicated that the facility follows the recommendations of the Center for Disease Control and Prevention (CDC) which recommends a two-step tuberculosis skin test for all new admissions in long-term care facilities.		TEST. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? THE DHW, AND OR THEIR DESIGNEE WILL MONITOR ALL NEWLY ADMITTED RESIDENTS TO ENSURE THAT THEY HAVE BEEN PROVIDED A TWO-STEP MANTOUX SKIN TEST. ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED. 3 HOW WILL THE CORRECTIVE ACTION(S) BE MONITORED? THE DHW, AND OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR AUDITING THE CHARTS OF ALL NEW ADMISSIONS FOR 1 MONTH TO ENSURE THEY HAVE BEEN ADMINISTERED A TWO-STEP MANTOUX SKIN TEST. THEREAFTER, THE DHW AND/OR THEIR DESIGNEE WILL BE RESPONSIBLE TO REVIEW ALL NEW ADMISSION CHARTS FOR 2 MONTHS TO ENSURE THEY HAVE BEEN ADMINISTERED A TWO-STEP MMANTOUX SKIN TEST. ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESPONSIBLE INDIVIDUAL(S) AND ANY	

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