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	09/26/2023

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 the Investigation of Complaint IN00415966. Complaint IN00415966 - State deficiencies related to the allegations are cited at R349. Survey date: September 25 and 26, 2023 Facility number: 014018 Residential Census: 56 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed September 28, 2023.	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 September 26th, 2023.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on interview and record review, the facility failed to ensure a complete and accurate resident record was readily available for 1 of 3 residents reviewed for complete and accurate records. (Resident B) Finding includes: During an interview on 9/25/23 at 9:06 a.m., the DON (Director of Nursing) indicated, on 7/22/23, a packet containing 28 tablets of hydrocodone - acetaminophen 5mg (milligrams)/325mg (opiod pain medication) was delivered for Resident B. On 8/5/23, two packets each containing 30 tablets of hydrocodone - acetaminophen 5mg/325mg were delivered for Resident B. Both prescriptions were	R 0349	The following Plan of Correction is as follows: 1 On 8/29/23, 9/1/23, and via phone on 8/29/23 and 8/31/23 the Director of Resident Care (DRC) in-serviced licensed nurses and QMAs on new policy for the counting, documentation, and storage of narcotics. 2 Licensed nurses and QMAs signed in-service attendance sheet acknowledging compliance with new policy. 3 All residents who take narcotic medications have the potential to be affected by the	09/26/2023

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

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	for the medication to be administered as Resident B needed it and each was to last for 15 days. On 8/22/23, the DON was notified that 2 of the packets that contained Resident B's hydrocodone - acetaminophen 5mg/325mg were unaccounted for. The DON was not able to account for the remaining tablets because the narcotic sign out sheet (hand written administration record for each packet of medication that indicated the date, time, quantity, and initials of the nurse that administered each pill) were also unaccounted for. The 25 tablets that were accounted for because the staff initialed the MAR (Medication Administration Record). The clinical record for Resident B was reviewed on 9/25/23 at 12:02 p.m. The diagnoses included, but were not limited to, Crohn's disease, hypertension, and anemia. The physician's orders included, but were not limited to: - Norco (an opiod pain medication) 5mg/325mg, take one tablet every 6 hours by mouth as needed for 15 days, dated 7/20/23. - Hydrocodone - acetaminophen 5mg/325mg orally every 6 hours as needed for 15 days, dated 8/4/23. The July 2023 MAR included, but was not limited to: - Hydrocodone - acetaminophen 5mg/325mg was administered to Resident B 8 times, on 7/21/23 at 9:00 p.m., 7/22/23 at 8:00 p.m., 7/24/23 at 9:00 p.m., 7/25/23 at 9:00 p.m., 7/26/23 at 9:00 p.m., 7/29/23 at 9:00 p.m., 7/31/23 at 8:30 a.m., and 7/31/23 at 9:00 p.m. The August 2023 MAR included, but was not limited to: - Hydrocodone - acetaminophen 5mg/325mg was		deficient practice. 4 A new Narcotic Inventory Count Verification form has been implemented for licensed nurses and QMAs to complete when: a A new narcotic medication is delivered by the pharmacy or family or; b When the narcotic medication bottle or card is emptied and removed from the medication cart. 5 On 9/1/23 the DRC or designee began auditing the Narcotic Shift Change Sheet for compliance. The audits will continue with the following frequency: 5x/week for 4 weeks, 3x/week for 8 weeks, 2x/week for 12 weeks, 1x/week for 6 months.	

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	administered to Resident B 11 times, on 8/1/23 at 9:00 p.m., 8/2/23 at 9:00 p.m., 8/3/23 at 9:00 p.m., 8/4/23 at 9:00 p.m., 8/5/23 at 9:00 p.m., 8/6/23 at 8:45 p.m., 8/7/23 at 9:00 a.m., 8/8/23 at 9:00 a.m., 8/14/23 at 4:30 p.m., 8/18/23 at 9:00 p.m., and 8/19/23 at 4:00 p.m. During an interview on 9/25/23 at 12:21 p.m., LPN 1 (Licensed Practical Nurse) indicated when LPN 1 left work, on 8/18/23, there were 2 packets of hydrocodone - acetaminophen 5mg/325mg in the locked narcotic box on the medication cart for Resident B. When LPN 1 came into work, on 8/22/23, both packets were unaccounted for, so LPN 1 notified the DON. LPN 1 did not know how many tablets remained in each packet. During an interview on 9/25/23 at 12:45 p.m., LPN 2 indicated when LPN 2 left work, on 8/18/23, there were 2 packets of hydrocodone - acetaminophen 5mg/325mg in the narcotic lock box. When she came to work, on 8/22/23, both packets were unaccounted for. This was reported on 8/22/23. LPN 2 did not know how many tablets remained in each packet. It had already been reported by LPN 1. LPN 2 indicated if she dropped a narcotic pill, she would notify the DON right away. She indicated she could not destroy medications, but even if she could she wouldn't destroy it because she would want to show it to the RN and DON. During an interview on 9/26/23 at 8:55 a.m., the DON indicated the narcotic sign out sheets for Resident B's hydrocodone - acetaminophen 5mg/325mg that was delivered, on 7/22/23 and on 8/5/23, could not be located. The narcotic sign out sheets should have remained in the narcotic book until Resident B's hydrocodone - acetaminophen 5mg/325mg was completed or discontinued and destroyed.			

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	On 9/26/23 at 10:00 a.m., the facility was unable to provide a policy regarding documentation before survey exit. This State tag relates to Complaint IN00415966.			