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	02/14/2025

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 the Investigation of Complaint IN00453428. Complaint IN00453428 - State deficiencies related to the allegations are cited at R90 and R241. Survey date: February 14, 2025 Facility number: 014018 Residential Census: 45 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. 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 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency 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)	R 0090	R090 – Administration and Management – Deficiency 1 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	03/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Cooper	Executive Director	03/03/2025

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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	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 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 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. On 2/14/25 at 10:30 a.m., the DON indicated		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. An audit was conducted to identify any other residents who could potentially affected. 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 approved to submit reportable events were re-educated relative to Administration and Management – Deficiency, including, but not limited to the facilities Reportable Events Policy. 4 How the corrective action(s) will be monitored? Executive Director, or designee, will be responsible for monitoring any potential reportable event, and will submit to the appropriate State agency. The Executive Director, or, designee, will be responsible for reviewing all potential reportable events 5 days a week for 1 month, thereafter, 3 days a week for 2 months.	

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	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. 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. 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..." This citation relates to Complaint IN00453428.		5 Completion date: 3/4/25	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense 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.	R 0241	R241 – Health Services – Offense 1.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. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	03/04/2025

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	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 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. 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. On 2/14/25 at 11:46 a.m., the Executive Director		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 Health Services – Offense, including but not limited to, proper transcription of physician orders upon admission, or readmission. 1.How the corrective action(s) will be monitored? 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. Thereafter, the DHW, or designee, will be responsible for auditing the charts of all new admissions/readmissions within	

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	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.		48 hours of admission/readmission for 2 months to ensure all necessary physician orders are transcribed correctly. Any identified concerns will be promptly addressed with the responsible individual(s). 1.Completion date: 3/4/25	