PRINTED: 03/04/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICAT		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
		B. WING		02/14/2025				
NAME OF P	ROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP COD				
			6510 U.S. 31 SOUTH					
FIVE STA	AR RESIDENCES	OF BANTA POINTE	INDIAN	IAPOLIS, IN 46227				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
R 0000								
Bldg. 00								
Blug. 00			R 0000	THIS PLAN OF CORRECTIO	N			
	This visit was for t	he Investigation of Complaint	K 0000	CONSTITUTES FIVER STAR				
	IN00453428.	me in testigation of complaint		RESIDENCES OF BANTA	`			
				POINTE'S WRITTEN				
	Complaint IN0045	3428 - State deficiencies related		ALLEGATION OF COMPLIAN	NCE			
	to the allegations are cited at R90 and R241.			FOR THE ALLEGED				
				DEFICIENCY CITED.				
	Survey date: February 14, 2025 Facility number: 014018			SUBMISSION OF THIS PLAN	l OF			
				CORRECTION IS NOT AN				
				ADMISSION THAT A				
				DEFICIENCY EXISTS OR TH				
	Residential Census	s: 45		ONE WAS CITED CORRECT				
	These State Deside	ential Findings are cited in		THIS PLAN OF CORRECTIO SUBMITTED TO MEET	N IS			
	accordance with 4	_		REQUIREMENTS ESTABLIS	HED			
	accordance with 4	10 11 10 10.2-3.		BY STATE AND FEDERAL LA				
	Ouality review cor	mpleted February 18, 2025.		FIVE STAR RESIDENCES OF				
		J		BANTA POINTE RESPECTF				
				REQUESTS A DESK REVIEW				
				FOR THIS PLAN OF				
				CORRECTION. ALLEGED DA	ATE			
				OF COMPLIANCE IS 3/4/25				
				THE FOLLOWING PLAN OF				
				CORRECTION IS AS FOLLO	WS;			
R 0090	410 100 46 2 5 4	2(a)(1.6)						
11.0030	410 IAC 16.2-5-1	.ડ(g)(ા-૦) nd Management - Deficiency						
Bldg. 00	, willing auton al	ia management - Deliciency						
			R 0090	R090 – Administration and	03/04/2025			
	Based on interview	v and record review, the facility	10070	Management – Deficiency	03/04/2023			
		required facility reportable						
		te Department of Health		1 What corrective action(s)	will			
	regarding a significant medication error that			be accomplished for those				
	resulted in a reside	ent having been transferred to		residents found to have been				
		partment for evaluation and		affected by the deficient pract	ice?			
		3 residents reviewed for		Resident #B no longer resides	s in			
	medication admini	stration. (Resident B)		the community; therefore, no				
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	I IGNATURE	TITLE	(X6) DATE			

Tim Cooper

(X6) DATE 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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Executive Director

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/14/2025			
NAME OF PROVIDER OR SUPPLIER FIVE STAR RESIDENCES OF BANTA POINTE			STREET ADDRESS, CITY, STATE, ZIP COD 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		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Findings include:				further corrective action could taken for this resident.	be		
	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.				2 How other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential be affected. An audit was conducted to identify any other residents who could potentially affected. 3 What measures will be purinto place and what systemic changes will be made to ensure that the deficient practice does recur? All staff approved to submit reportable events were re-educated relative to Administration and Management Deficiency, including, but not limited to the facilities Reportate Events Policy. 4 How the corrective action will be monitored? Executive Director, or designed will be responsible for monitor any potential reportable events will submit to the appropriate State agency. The Executive Director, or, designee, will be responsible for reviewing all potential reportable events 5 can week for 1 month, thereafter	the the al to r y tt re s not ent – able (s) ee, ing , and		
	On 2/14/25 at 10:30 a.m., the DON indicated				days a week for 2 months.	, -		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			E SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		B. WING			02/14/2025		
				CTDEET A	ADDRESS STEW STATE ZID SOD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
FIVE STAR RESIDENCES OF BANTA POINTE					.S. 31 SOUTH		
FIVE SIF	AR RESIDENCES C	DE BANTA POINTE		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PL		PROVIDER'S PLAN OF CORRECTION	AN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ſΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	Resident B's INR (international normalized ratio)				5 Completion date: 3/4/25		
	result at the hospital was "7 ish" (normal INR						
	levels 2.0-3.0). The	e nurse at the time of the					
	transcription error,	wrote the order for twice the					
	dose as the physicia	n had ordered. The resident					
	received twice the p	rescribed 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"						
	THE 1 TO 1 T						
	This citation relates to Complaint IN00453428.						
D 0244	410 IAC 16 2 5 4(a)(1)						
R 0241 410 IAC 16.2-5-4(e)(1) Health Services - Offense							
Bldg. 00	Health Services -	Ollense					
Blug. 00	Događ an intervious	and record review, the facility	D 0/	241	D244 Health Carriage Offe		02/04/2025
	Based on interview and record review, the facility failed to administer medications per the		R 0241		R241 – Health Services – Offe	rise	03/04/2025
					1 What corrective action(a)	aill	
	physician's orders for 1 of 2 residents reviewed receiving warfarin (blood thinner). This deficient				1.What corrective action(s) v	/III	
	-				be accomplished for those residents found to have been		
	practice resulted in the resident sustaining an uncontrolled nosebleed and a prolonged blood					202	
					affected by the deficient practi		
	clotting time, resulting in hospitalization.				Resident #B no longer resides the community; therefore, no	III	
	(Resident B) Finding includes:				further corrective action could	ho	
					taken for this resident.	pe	
					Lakeli loi lilis lesidelli.		
	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				1.How other residents having	n the	
					potential to be affected by the	,	
					same deficient practice will be		
	disease.	,			identified and what corrective		
	albeade.		1				

State Form Event ID: TTZ811 Facility ID: 014018 If continuation sheet Page 3 of 5

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
			B. WING		02/14/2025		
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					.S. 31 SOUTH		
FIVE STAR RESIDENCES OF BANTA POINTE					APOLIS, IN 46227		
FIVE SIF	AK KESIDENCES (DE BANTA POINTE		INDIAN	APOLIS, IN 40221		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		1110			DATE
					action(s) be taken?		
	_	ated 1/28/25 at 8:13 p.m.,			All newly admitted, or readmit	ted,	
		was called to the resident's			residents have the potential to	be	
	-	or the resident's nose bleeding.			affected. Physician orders of a	all	
		d but unsuccessful. DON			residents admitted, or readmit	ted,	
		g) notified, and DON indicated			within the past 60 days have b	een	
		to the hospital. Resident was			reviewed to ensure transcription	on	
	transported to hospi	tal.			accuracy. Any identified conce		
					were promptly addressed with		
		lated 1/14/25, indicated			resident physicians with		
		ng, one tablet once every			clarifications obtained, as		
	evening at 4:00 p.m.				necessary.		
	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).						
					1.What measures will be put	t	
					into place and what systemic		
					changes will be made to ensu	I .	
					that the deficient practice does	s not	
		a.m., the DON provided a copy			recur?		
		ident, dated 1/29/25. The			All licensed nurses have been		
		ne family of Resident B			re-educated relative to Health		
	-	ity that Resident B's Coumadin			Services – Offense, including		
		ere wrong in the clinical record.			not limited to, proper transcrip	tion	
		e hospital on 1/28/25 due to			of physician orders upon		
		eed lasting 40 minutes. The			admission, or readmission.		
	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] , , , , , , , , , , , , , , , , , , ,	,	
					1.How the corrective action(s)	
					will be monitored?		
					Director of Health and Wellnes		
					or designee, will be responsible	le for	
					auditing the charts of all new	41	
					admissions, or readmissions,	ıne	
					day following the		
					admission/readmission for 1	.	
					month to ensure all necessary	I .	
					physician orders are transcribe		
					correctly. Thereafter, the DHW	I .	
					designee, will be responsible t	or	
					auditing the charts of all new	.	
					admissions/readmissions with	ın	

State Form Event ID: TTZ811 Facility ID: 014018 If continuation sheet Page 4 of 5

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	· ′	JILDING	onstruction 00	(X3) DATE COMPL 02/14 /	ETED
NAME OF PROVIDER OR SUPPLIER FIVE STAR RESIDENCES OF BANTA POINTE			STREET ADDRESS, CITY, STATE, ZIP COD 6510 U.S. 31 SOUTH INDIANAPOLIS, IN 46227				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	dated 6/9/23, and in policy being used b policy indicated " and Order Changes appropriately disperprescription for the	tled Medication Management, dicated it was the current y the facility. A review of the J. Prescription Requirements 1. All medications are used and labeled as per the appropriate resident."			48 hours of admission/readmission for 2 months to ensure all necessar physician orders are transcribe correctly. Any identified concervill be promptly addressed with the responsible individual(s). 1.Completion date: 3/4/25	ed rns	

State Form Event ID: TTZ811 Facility ID: 014018 If continuation sheet Page 5 of 5