

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>03/06/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR RESIDENCES OF BANTA POINTE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6510 U.S. 31 SOUTH INDIANAPOLIS, IN 46227</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00453428 completed on February 14, 2025.</p> <p>Complaint IN00453428 - Corrected.</p> <p>Survey date: March 6, 2025</p> <p>Facility number: 014018</p> <p>Residential Census: 54</p> <p>Five Star Residences of Banta Pointe was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00453428.</p> <p>Quality review completed March 10, 2025.</p>	{R 000}		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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