

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/18/2024	
NAME OF PROVIDER OR SUPPLIER GENTRY PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 901 S HASTINGS DR, BLOOMINGTON, , 47401					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00437910, IN00437350, IN00438368, and IN00438009 . Complaint IN00437910 - No deficiencies related to the allegations are cited. Complaint IN00437350 - No deficiencies related to the allegations are cited. Complaint IN00438368 - No deficiencies related to the allegations are cited. Complaint IN00438009 - State deficiencies related to the allegations are cited at R241. Survey date: July 17 and 18, 2024 Facility number: 013766 Residential Census: 101	R 0000					

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	This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 22, 2024.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure a medication was administered per the physician's order for 1 of 3 residents reviewed for medication administration. (Resident B) Finding includes: On 7/17/24 at 11:40 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, vascular dementia and hypertension. A physician's order with a start date of 6/29/24 indicated the	R 0241	R241 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility will ensure that staff follow physician's order for medication administration. The resident was evaluated by a physician in the E.R. and noted no adverse effects from this deficient practice. As soon as staff was aware, the patch dated 6/29/2024 was removed and proper administration of another patch was placed on 7/3/2024. Increased monitoring was put in place to ensure no adverse effects. DON, family and physician were notified. How the facility will identify other residents	08/09/2024

resident was prescribed a Rivastigmine (a medication used to treat Alzheimer's disease) patch with a strength of 9.5 milligrams per hour to be applied daily. The Medication Administration Record indicated the patch was administered on 6/29/24.

At the family's request, the resident was transferred to the emergency department on 7/3/24 due to concerns regarding the resident's condition. The emergency room final report, dated 7/3/24 indicated the resident's Rivastigmine patch had not been changed for several days, and the date written on the patch positioned on the resident was 6/29/24. The resident was provided electrolytes and was discharged to return to the facility. There was no indication the resident's condition was due to a medication error.

On 7/18/24 at 9:45 a.m., the Administrator provided a Medication Error Incident Report, dated 7/3/24, which indicated, "...upon assessment at ED [Emergency Department], resident noted with Rivastigmine patch dated 6/29/24 and current date is 7/3/24 ..."

During an interview on 7/18/24 at 10:55 a.m., the Administrator indicated Resident B's Rivastigmine patch had been

having the potential to be affected by the same deficient practice and what corrective action will be taken.

A medication review was conducted to include checking medication orders with medications.

The review included auditing all physician orders for patches and accuracy of each order and administration of patch. No other residents were found to have been affected. Nurse managers audited the medication records and the proper administration of all residents receiving patches to ensure all staff were accurate in this medication administration, and to offer education where necessary.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

All medication administration staff will complete medication administration in

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OMB NO. 0938-0391

administered on 6/29/24. The resident went to the emergency department on 7/3/24 where it was discovered the resident's Rivastigmine patch had not been administered since 6/29/24.

This citation relates to Complaint IN00438009.

Based on interview and record review, the facility failed to ensure a medication was administered per the physician's order for 1 of 3 residents reviewed for medication administration. (Resident B)

Finding includes:

On 7/17/24 at 11:40 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, vascular dementia and hypertension.

A physician's order with a start date of 6/29/24 indicated the resident was prescribed a Rivastigmine (a medication used to treat Alzheimer's disease) patch with a strength of 9.5 milligrams per hour to be applied daily. The Medication Administration Record indicated the patch was administered on 6/29/24.

At the family's request, the resident was transferred to the emergency department on 7/3/24 due to concerns

service training. Nurse Managers will perform routine medication administration audits weekly for four weeks, then monthly for two months and random checks thereafter to ensure appropriate medication administration. Corrective action will be conducted as necessary as well as continued education.

How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and

A weekly medication cart review will include making any needed corrections immediately, ensuring proper medication administration records and auditing any medication changes from the physician. This will include monitoring the process of the updated medication being delivered and available for administration. The results of the weekly reviews will be presented at the monthly QA meetings. The nurse manager or designee will be responsible for the oversight of medication

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regarding the resident's condition. The emergency room final report, dated 7/3/24 indicated the resident's Rivastigmine patch had not been changed for several days, and the date written on the patch positioned on the resident was 6/29/24. The resident was provided electrolytes and was discharged to return to the facility. There was no indication the resident's condition was due to a medication error.

On 7/18/24 at 9:45 a.m., the Administrator provided a Medication Error Incident Report, dated 7/3/24, which indicated, " ...upon assessment at ED [Emergency Department], resident noted with Rivastigmine patch dated 6/29/24 and current date is 7/3/24 ..."

During an interview on 7/18/24 at 10:55 a.m., the Administrator indicated Resident B's Rivastigmine patch had been administered on 6/29/24. The resident went to the emergency department on 7/3/24 where it was discovered the resident's Rivastigmine patch had not been administered since 6/29/24.

This citation relates to Complaint IN00438009.

administration compliance.

The effective date is August 9, 2024.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

PRINTED: 01/01/2026

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