STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTRY PARK	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 Intake 466474. Intake 466474 - State deficiencies related to the allegation are cited at R0035. Survey date: December 19, 2025 Facility number: 013766 Residential Census: 93 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed December 23, 2025.	R 0000		
R 0035	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(j)(1-7) (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in	R 0035	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The resident was assessed and care and monitoring was	01/09/2026

any updates of that service plan.

(2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals.

(3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement.

(4) Refuse any treatment or service, including medication.

(5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility.

(6) Be afforded confidentiality of treatment.

(7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities.

increased to ensure appropriate care was given and to determine if additional care was needed. The employee who provided the care on 11/26/25 was interviewed and placed on suspension pending an investigation.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All Memory Care residents were assessed with no other findings.

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 Staff will complete inservice training to include, Resident Rights, Abuse Prevention and Care Approaches for Residents with Dementia

Each new hire will receive the same training.

Care giving staff will to trained to include allowing resident choices when providing care, to allow a resident time to be included in care, to request another employee assistance when needed.

How the corrective action will be monitored to ensure the deficient practice will not recur,

	Based on interview and record review, the facility failed to ensure a resident retained the right to refuse treatment or services for 1 of 3 residents reviewed for resident rights. (Resident B). Findings include: During an interview on 12/19/25 at 11:15 a.m., the Executive Director (ED) indicated on 11/28/25 at 5:32 p.m., she received an email from Resident B's Power of Attorney (POA) regarding an incident which occurred on 11/26/25 around 9:30 a.m. The POA indicated there was a video of CNA 1 attempting to transfer Resident B out of bed, despite the resident's desire to remain in bed. The resident resisted attempts to transfer from the bed and appeared to wish to stay in bed. On the third attempt to transfer the resident from the bed, CNA 1 attempted to pull the resident from the bed by pulling on her right arm and forearm. The resident continued to resist and did not wish to leave the bed. On 12/2/25 at 4:00 p.m., the ED met with the POA and observed a video recording recorded from a video camera which had previously been placed in the resident's room. The video indicated CNA attempted three times to transfer the resident		i.e., what quality assurance program will be put into place. The Administrator, the Director of Nursing and the Memory Care Director will supervise caregivers to ensure proper procedures are followed when providing care. This will include direct observation, resident and resident POA interaction to ensure proper care is provided. Caregivers will be encouraged to report any unusual circumstances or observations immediately for management review. A weekly check will be made for allResidents for four weeks and a weekly check will be made for Memory Care residents for six weeks to ensure proper resident care is provided. By what date the systemic changes will be completed. Effective date is 1/9/2026.	

from the bed, despite the resident's objections. During the third attempt, CNA 1 attempted to pull the resident from the bed by pulling on the resident's right arm and forearm. The resident pulled away from CNA 1 in order to stay in the bed. The ED interviewed CNA 1 who indicated it was understood the POA wanted the resident to be out of bed by the third attempt. CNA 1 attempted to transfer the resident from the bed three times, though the resident did not want to leave the bed. On the third attempt, CNA 1 pulled on the resident's right arm to attempt to transfer her from the bed. The resident pulled away and did not get out of the bed. The ED indicated it was the resident's right to stay in bed, and CNA 1 should not have attempted to pull the resident from the bed after the resident indicated the desire to stay in bed.

On 12/19/25 at 2:55 p.m., the ED provided the Indiana Resident Rights Policy, undated, and indicated these were the Resident Rights currently used by the facility. A review of the policy indicated, "...residents have the right to...refuse any treatment or service..."

This citation relates to Intake 466474.

Based on interview and record review, the facility failed to ensure a resident retained the right to refuse treatment or services for 1 of 3 residents reviewed for resident rights. (Resident B).

Findings include:

During an interview on 12/19/25 at 11:15 a.m., the Executive Director (ED) indicated on 11/28/25 at 5:32 p.m., she received an email from Resident B's Power of Attorney (POA) regarding an incident which occurred on 11/26/25 around 9:30 a.m. The POA indicated there was a video of CNA 1 attempting to transfer Resident B out of bed, despite the resident's desire to remain in bed. The resident resisted attempts to transfer from the bed and appeared to wish to stay in bed. On the third attempt to transfer the resident from the bed, CNA 1 attempted to pull the resident from the bed by pulling on her right arm and forearm. The resident continued to resist and did not wish to leave the bed.

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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.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURELisa Holstein, HFA	TITLEExecutive Director	(X6) DATE01/09/2026