

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 07/14/2026
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 Intakes 470700 and 470805. Intake 470700 - State deficiencies related to the allegations are cited at R52. Intake 470805 - No deficiencies related to the allegations are cited. Survey date: July 14, 2026 Facility number: 013766 Residential Census: 86 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 16, 2026.	R 0000			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	What corrective action will be accomplished for those residents found to have been	08/07/2026	

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

(v) Residents have the right to be free from:

- (1) sexual abuse;
- (2) physical abuse;
- (3) mental abuse;
- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse for 1 of 3 residents reviewed for abuse. (Resident B)

Finding includes:

On 7/14/26 at 8:18 a.m., Resident B was observed to be sitting in the memory care dining room eating breakfast. A faded purple bruise, approximately four inches by six inches on Resident B's right forearm was observed.

During an interview on 7/14/26 at 8:35 a.m., CNA 1 indicated, on 7/5/26, after dinner she witnessed Resident B and CNA 2 "going back and forth with each other". CNA 1 couldn't remember what was said back and forth, but CNA 2 sounded mean and was talking down to Resident B. CNA 1 had not

affected by the deficient practice.

-The resident was assisted and when bruising found on her right arm, resident was assessed by nurse. Resident had no complaints of injury or pain. Management, Physician and POA notified.

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 had the potential to be affected, but none were found to be affected.

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

-The staff member was placed on suspension pending investigation, the investigation completed, including interviewing suspended employee. The suspended employee admitted to slapping the resident in reaction to being slapped. The employee was terminated. The incident was reported to IDOH. All care staff will complete abuse prevention training.

How the corrective actions will be monitored to ensure the

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

reported this to a manager because she was providing care to another resident at that time.

The clinical record for Resident B was reviewed on 7/14/26 at 9:17 a.m. The diagnoses included, but were not limited to, major depressive disorder and cognitive impairment with memory loss.

A progress note, dated 7/6/26 at 2:16 p.m., indicated, on 7/5/26 at 10:13 p.m., Resident B presented with bruising to the front and back of her forearm.

During an interview on 7/14/26 at 9:39 a.m., the Administrator indicated they had called CNA 2 to place her on suspension and CNA 2 admitted to slapping Resident B on the arm.

During an interview on 7/14/26 at 9:59 a.m., CNA 4 indicated she came into work, on 7/5/26 at approximately 11:00 p.m., to work third shift. During shift change report, CNA 2 reported that staff should monitor for bruising on Resident B's right arm. CNA 2 went on to explain that Resident B had smacked her so CNA 2 smacked Resident B in the right arm. CNA 2 also indicated that nobody was going to hit her and if Resident B smacked her again then CNA 2 would smack Resident B again. CNA 4 didn't believe what CNA 2 reported so

deficient practice will not recur, i.e., what quality assurance program will be put into place.

Staff will complete training to ensure proper reporting of incidents. Managers will be responsible for conducting random care observation and education to ensure the prevention of abuse. Care observations will be conducted for twice weekly for two weeks than once weekly for two weeks to ensure compliance.

By what date the systemic changes will be completed.
8/7/2026

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

CNA 4 did not report the abuse allegation to a manager at that time. The next morning, on 7/6/26, during morning care a large bruise was observed on Resident B's right forearm. The bruise covered almost her entire forearm.

On 7/14/26 at 10:00 a.m., the Administrator provided a copy of a facility policy, titled Resident Neglect, Abuse, and Misappropriation of Property Policy, dated 12/30/15, and indicated this was the current policy used by the facility. A review of the policy indicated residents would be free from physical abuse including hitting and slapping.

This citation relates to Intake 470700.

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) DATE07/24/2026
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