STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/22/2026

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 a Post Survey Revisit (PSR) to the Investigation of Intake 468208 completed on March 18, 2026. This visit was in conjunction with the Investigation of Intake 469221. Intake 468208 - Not corrected. Intake 469221 - State deficiencies related to the allegation are cited at R52. Survey date: April 22, 2026 Facility number: 013766 Residential Census: 89 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April 29, 2026.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.	

R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.	R 0029	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The resident involved was assessed for any effects of the reported incident. Resident was found to not have any psychosocial distress related to the reported incident. An investigation was initiated related to the report provided to the community. The employee involved was interviewed and placed on suspension pending 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 residents had the potential to be affected, although no others were noted 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. Care staff will receive in-service re-training on resident rights, choices and care approaches for residents with dementia by 5/18/26. How the corrective action will be monitored to ensure the	05/18/2026

			deficient practice will not recur, i.e., what quality assurance program will be put into place. **The administrator or designee will spot check resident care and medication administration to ensure compliance with resident rights. Spot checks will be conducted for ten residents per week for four weeks, five residents per week for four weeks, and as needed thereafter to ensure compliance.** By what date the systemic changes will be completed. Effective date is 5/18/2026.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (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 interview and record review, the facility failed to	R 0052	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The investigation of this incident resulted in the QMA being suspended pending investigation and then terminated. 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.	05/18/2026

	protect the resident's right to be free from neglect for 1 of 3 residents reviewed for elopement. This deficient practice resulted in multiple staff assisting a cognitively impaired resident to exit the facility without supervision. (Resident B) Findings include: On 4/22/26 at 10:48 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, vascular dementia and anxiety disorder. The Pre-Admission Assessment, dated 4/9/26, indicated Resident B was independent in mobility, had severe cognitive impairment, and was at risk for elopement. The Individual Service Plan, dated 4/9/26, indicated Resident B required to be on a Memory Care unit. Resident B's Observations Notes indicated the following:		**All residents had the potential to be affected. Resident interviews will be conducted regarding the cited concern to identify others potentially affected.** **Corrective action of re-training care staff on resident rights, abuse prevention, and care approaches for residents with dementia will be taken by 5/18/2026.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Care staff will receive re-training on resident rights, abuse prevention and care approaches for residents with dementia by 5/18/2026. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The administrator or designee will spot check resident care and medication administration to ensure compliance with resident rights and abuse prevention. Spot checks will be conducted for ten residents per week for four weeks, five residents per week for four**	

	- On 4/14/26 at 3:43 p.m., Resident B was extremely upset about being placed in the facility by her family. A Wanderguard (wearable device designed to protect memory care residents from elopement) was placed on Resident B. She was exit seeking. - On 4/15/26 at 10:52 a.m., Resident B was exit seeking and was struggling to be redirected successfully. She indicated she needed to leave and was not supposed to be at the facility. The Management - Verification of Incident Investigation Summary, dated 4/15/26 at 12:31 p.m., indicated Resident B was seen walking in the parking lot. The Activity Director (AD) identified Resident B and walked with her back into the facility. During an interview on 4/22/26 at 11:20 a.m., Qualified Medication Aide (QMA) 1 indicated Resident B had a history of exit seeking. On 4/15/26, Resident B was exit seeking and her interventions were not effective. Early in the afternoon, she was in the medication room talking with the Director of Nursing (DON). QMA 1 heard someone ask to be let out of the memory care unit doors. She was unsure who the		**weeks, and as needed thereafter to ensure compliance.** By what date the systemic changes will be completed. Effective date 5/18/2026	

	DON opened the memory care unit door for. Resident B's Wanderguard did not alarm when she exited the memory care unit door. On 4/22/26 at 12:18 p.m., the AD indicated on 4/15/26 around 12:30 p.m., she was in the Community Room and saw Resident B walking outside the facility. She immediately went outside to assist Resident B back to the facility. On 4/22/26 at 12:45 p.m., the ADM provided a written statement from QMA 2. The statement, dated 4/15/26, indicated he let Resident B out of the facility at the back exit. He saw her knock on the back door, he opened the door by keypad access, and she walked out. On 4/22/26 at 12:45 p.m., the ADM provided a written statement from the DON. The statement included, " I was in MC [Memory Care] speaking to members of MC staff when a lady approached med [medication] room. Well dressed + [and] cognitively intact at that time. Stated [sic] she had been visiting + forgot the code. MC staff did not seem alarmed, nor did MC doors lock by a wanderguard. Code was placed into door + resident exited MC." During an interview on 4/22/26 at 1:05 p.m., the DON indicated			

	she "activated" Resident B's Wanderguard on 4/14/26. When she tested the Wanderguard, it was functioning. When Resident B was admitted she was agitated and she could not place the Wanderguard on her. She placed the Wanderguard on the Memory Care Director's (MCD) desk. On 4/22/26 at 1:15 p.m., the MCD indicated on 4/14/26 around 1:30 p.m., he placed the Wanderguard on Resident B's right ankle. Resident B's Wanderguard did not function when she was assisted back through the front door. On 4/22/26 at 2:34 p.m., the ADM provided the facility policy, " ...Elopement/Missing Resident," revised date of 3/24, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " ...It is the policy of this facility that personnel who have residents under their care are responsible for knowing the location of those residents ..." This deficiency was cited on 3/18/26. The facility failed to implement a systemic plan of correction to prevent recurrence. This citation relates to the Intake 469221.			

R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse.	R 0053	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The resident was assessed when facility was notified of this incident with no psychosocial distress noted. Care staff received resident rights and abuse prevention in service re-training to be completed by 5/18/26. The investigation of this incident resulted in the QMA being suspended pending investigation and then subsequently terminated. 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 residents had the potential to be affected. Resident interviews will be conducted regarding the cited concern to identify others potentially affected.**	05/18/2026

			Corrective action of re-training care staff on resident rights, abuse prevention, and care approaches for residents with dementia will be taken by 5/18/26. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Care staff will receive re-training on resident rights, abuse prevention and care approaches for residents with dementia by 5/18/26. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The administrator or designee will spot check resident care and medication administration to ensure compliance with resident rights and abuse prevention. Spot checks will be conducted for ten residents per week for four weeks, five residents per week for four weeks, and as needed thereafter to ensure compliance.** By what date the systemic changes will be completed.	

			Effective date 5/18/2026	
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the	R 0090	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Administrator, Wellness Director and Memory Care Director will receive re-training regarding state incident reporting guidelines and timely reporting. This training will be completed by the Area Vice President of Operations and/or the Regional Director of Clinical Services by 5/18/26. 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. No other residents were found to be potentially affected by this practice after a review of state incident reporting process by the Administrator/designee. 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 Administrator, Wellness Director and Memory Care Director will receive in-service re-training regarding state	05/18/2026

	resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request		reporting guidelines and timely reporting. This re-training will be completed by the Area Vice President of Operations and/or the Regional Director of Clinical Services by 5/18/26. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Administrator or designee will review and audit alleged abuse reports daily to ensure timely investigation and state reporting. Regional Staff Member will conduct weekly review of these audit results for eight weeks and ongoing as needed to ensure compliance. By what date the systemic changes will be completed. Effective date is 5/18/2026.	
R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel.	R 0245	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The QMA related to this report was placed on suspension	05/18/2026

			pending investigation completion and subsequently terminated due to not providing appropriate documentation regarding insulin certification. All other QMA's certifications were reviewed and verified to hold appropriate documentation of an active insulin certification. 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. Insulin dependent residents had the potential to be affected by this practice with no adverse findings noted. 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 QMA's will be educated by the Wellness Director on the QMA scope of practice and duties pertaining to maintaining Insulin Certifications by 5/18/26. Insulin Certifications were reviewed for current QMA's to determine appropriate scope. Insulin Certification documentation will be reviewed upon new hire and newly hired QMA's will be educated on QMA scope of practice before commencement of medication administration duties involving	

			insulin administration. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. QMA certifications were reviewed for current staff. The Administrator or designee will review monthly the completion of new hire verification of active Insulin Certification documentation of new QMA staff and review monthly current QMA staff active Insulin Certification documentation to maintain compliance. By what date the systemic changes will be completed. Effective date 5/18/2026	

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) DATE05/09/2026