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 the Investigation of Intake 469221. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Intake 468208 completed on March 18, 2026. Intake 469221 - State deficiencies related to the allegations are cited at R52. Intake 468208 - Not corrected. 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 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 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	R 0052	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. -The resident was assisted by staff back into the building. Nurse assessment was completed. Resident wanderguard device was checked reset and confirmed to be working by the Memory Care Director. Resident received increased supervision and assistance to divert her from any other attempts to leave the secure area. 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 with the potential to wander and exit seek have the potential to be affected but none were affected. Staff will complete resident safety training to include elopement prevention and procedure. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. -Staff will complete the elopement prevention training. Notifications in written and by	05/18/2026

	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: - 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		staff messaging system will be provided to staff regarding new resident move ins and/or the potential for any resident to need increased supervision to prevent elopement. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. -Management will review daily and with staff on a weekly basis to review new resident move ins, planned new residents moving in and residents displaying exit seeking behaviors to ensure resident safety. Staff will not let anyone out of the secured unit before verifying safety and supervision. By what date the systemic changes will be completed. The effective date of this correction is 5/18/2026	

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 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 citation relates to the Intake 469221.			

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