STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/06/2021

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 Complaint IN00366933. Complaint IN00366933-Substantiated. State Residential deficiencies related to the allegations are cited at R0036, R0297, and R0356. Survey date: December 06, 2021 Facility number: 013766 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on December 09, 2021.	R 0000	This plan of correction is submitted as required under State and/or Federal law.The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom.Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied.Any changes to the community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis.The community submits this plan of correction with the intention	

			that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney **R000** It is the practice of Gentry Park Bloomington to ensure resident's rights are protected and abide by the rules listed under the Indiana State Board of Health Facility Administrators Laws and Regulations.	
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record	R 0036	**R036** **Describe what the facility did to correct the deficient practice for each client cited the deficiency.** Internal audit of all residents to ensure that residents legal representative contact information is entered correctly into Point Click Care. Inservice with all department	12/10/2021

	review, the facility failed to ensure that a resident's legal representative was notified after a resident eloped from the facility, exhibited continued exit seeking behavior, and was moved to a different room on a secure unit for 1 of 3 residents reviewed for notification of legal representative. (Resident B) Findings include: On 12/6/2021 at 10:30 a.m., Resident B's closed clinical record was reviewed. Diagnoses included, but were not limited to unspecified dementia without behavioral disturbance and hypertension. A review of Resident B's progress notes indicated the following: - 9/14/21 at 8:05 a.m., "... Resident is alert to self only, at approximately 2:30 a.m. resident got out of door to outside, alarms alerted, but resident was able to go as far as the front door. Three staff followed as soon as alarms were initiated. Writer spoke at length to resident explaining safety issues, but she did not seem to understand. Staff began one on one care as resident attempted to leave a second time. Resident does appear cognizant of where exits are. Family to be alerted, resident placed in Memory Care		heads, operations coordinator, and nursing staff to ensure that legal representative contact information is entered in Point Click Care. Moving forward ensure that legal representative information is entered in Point Click Care prior to move in. Inservice with DOW, ED, and Nursing Staff to review policy on notification of change or condition/behavior protocol to ensure everyone understands steps to take **Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected** Internal audit of all residents clinical chart in Point Click Care. Actions taken were to educate and in-service the steps that need taken prior to move in. Actions taken were to educate and in-service on policy for	

	for safety purposes. Resident again began exit seeking behavior. Resident placed in room with new bedding, but continued to wander about watching doors to the outside. Resident has remained confused and at times very argumentative with staff ..." A review of the clinical record did not indicate the resident representative was notified of the elopement nor the room change to a secure memory care unit for Resident B. During an interview, on 12/6/21 at 11:05 a.m., the Wellness Director indicated Resident B's family was not notified of the incident or the move to the memory care unit as Resident B's contact information was missing from the electronic health record and staff were unable to call an emergency contact. On 12/6/21 at 2:55 p.m., a policy related to notifying the family representative of when resident's have a significant change was requested of the facility Executive Director and Wellness Director. A policy was not received by the time of survey exit. This Resident tag relates to Complaint IN00366933. Based on interview and record review, the facility failed to		notification of change or condition/behavior protocol. **Describe the steps or systemic changes the facility has made or will take to ensure that the deficient practice does not recur, including any in services, but this also should include any system changes you made.** Internal audit of all residents to ensure that residents legal representative contact information is entered correctly into Point Click Care. Inservice was done with all department heads, operations coordinator, and nursing staff to ensure that legal representative contact information is entered in Point Click Care prior to move in. Department heads in-service on Move In Coordination checklist so ensure all necessary legal representative contact info is gathered and entered into Point Click Care. Inservice completed with DOW, ED, and Nursing Staff to review policy on notification of	

	ensure that a resident's legal representative was notified after a resident eloped from the facility, exhibited continued exit seeking behavior, and was moved to a different room on a secure unit for 1 of 3 residents reviewed for notification of legal representative. (Resident B) Findings include: On 12/6/2021 at 10:30 a.m., Resident B's closed clinical record was reviewed. Diagnoses included, but were not limited to unspecified dementia without behavioral disturbance and hypertension. A review of Resident B's progress notes indicated the following: - 9/14/21 at 8:05 a.m., "... Resident is alert to self only, at approximately 2:30 a.m. resident got out of door to outside, alarms alerted, but resident was able to go as far as the front door. Three staff followed as soon as alarms were initiated. Writer spoke at length to resident explaining safety issues, but she did not seem to understand. Staff began one on one care as resident attempted to leave a second time. Resident does appear cognizant of where exits are. Family to be alerted, resident placed in Memory Care for safety purposes. Resident		change or condition/behavior protocol to ensure everyone understands steps to take. DOW and ED will be notified by nursing staff immediately if there is a significant change in condition with a resident. At that time the DOW or Nursing staff will notify residents legal representative and physician immediately. **Describe how the corrective action will be monitored to ensure the deficient practice will not recur i.e, what quality assurance program will be put in to place.** **Who:** Ops Coordinator and DOW or designee **How it will be monitored:** Ops Coordinator and DOW or designee will check written paperwork and Point Click Care prior to move in to ensure that residents legal representative contact information is entered in Point Click Care.	

	again began exit seeking behavior. Resident placed in room with new bedding, but continued to wander about watching doors to the outside. Resident has remained confused and at times very argumentative with staff ..." A review of the clinical record did not indicate the resident representative was notified of the elopement nor the room change to a secure memory care unit for Resident B. During an interview, on 12/6/21 at 11:05 a.m., the Wellness Director indicated Resident B's family was not notified of the incident or the move to the memory care unit as Resident B's contact information was missing from the electronic health record and staff were unable to call an emergency contact. On 12/6/21 at 2:55 p.m., a policy related to notifying the family representative of when resident's have a significant change was requested of the facility Executive Director and Wellness Director. A policy was not received by the time of survey exit. This Resident tag relates to Complaint IN00366933.		DOW and ED will be notified by nursing staff immediately if there is a significant change in condition with a resident. At that time the DOW or Nursing staff will notify residents legal representative and physician immediately. **Frequency of Monitor**: All new admissions will be monitored to ensure complete accurate legal representative contact info is submitted and entered in Point Click Care upon admission. DOW will monitor incidents reports daily and dashboard to make sure that all steps have been taken by nursing to notify legal representative and physician when a significant change of condition is noted	

R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure a newly admitted resident received ordered medications for 1 of 3 residents observed for medication administration. (Resident B) Findings include: On 12/6/2021 at 10:30 a.m., Resident B's closed clinical record was reviewed. Diagnoses included, but were not limited to unspecified dementia without behavioral disturbance and hypertension. Physician orders, dated 9/8/2021, lacked documentation of Resident B being ordered any medications.	R 0297	**R297** **Describe what the facility did to correct the deficient practice for each client cited the deficiency.** Conducted an in-service with department heads and nursing staff on move in coordination and responsibilities that include medication procedures, pharmacy ordering and administration of medication. **Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected** Audit was performed on all upcoming move ins to ensure we have documentation needed to order medication prior to move in.	12/31/2021

	The clinical record contained a document titled "Medication List" for Resident B with a print date of 9/8/2021. The medications included: -alprazolam (an antianxiety) 0.25 mg (milligrams) 1 tablet every 24 hours prn (as needed). -amlodipine (for blood pressure) 5 mg 1 tablet by mouth everyday as needed for B/P (blood pressure) greater than 150/100 and symptoms. -donepezil (for dementia) 10 mg 1 tablet every morning. -lisinopril (for blood pressure) 40 mg 1 tablet every day. -olanzapine (an antispsychotic) 2.5 mg 1 tablet every day. -sertraline (an antidepressant) 50 mg 2 tablets every morning. Start 1/2 tablet by mouth every morning x 2 weeks then take 1 tablet by mouth every morning x 2 weeks then take 1.5 mg tablet every morning x 2 weeks then take 2 tablets every morning. -trazodone (an antidepressant) 50 mg 2 tablets at bedtime. The Medication Administration Record (MAR), dated September, 2021, lacked documentation of any medication having been given during Resident B's stay in the facility. The document was		Inservice with department heads and nursing staff on move in coordination and responsibilities that include medication procedures, pharmacy ordering and administration of medication. Inservice nursing staff on Wellness Coordination – Preparing the Wellness File, Confirming current medications and treatments, documentation and administration of medication. **Describe the steps or systemic changes the facility has made or will take to ensure that the deficient practice does not recur, including any in services, but this also should include any system changes you made.** Audit was performed on all upcoming move ins to ensure we have documentation needed to	

	blank. During an interview, on 12/6/2021 at 12:20 p.m., the Wellness Director indicated the pharmacy is responsible for entering the medications for a new admission into the clinical record. The medications had not been entered and a MAR had not been generated for Resident B. She was unsure if any medications had been administered to Resident B during her stay at the facility. The Medication List in the clinical record would be considered the physician orders. On 12/7/2021 at 3:57 p.m., the Wellness Director provided the facility policy, "Medication - New Move-In Possession," undated, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate ensuring residents receive ordered medications. This Residential tag relates to Complaint IN00366933. Based on interview and record review, the facility failed to ensure a newly admitted resident received ordered medications for 1 of 3 residents observed for medication administration. (Resident B) Findings include: On 12/6/2021 at 10:30 a.m., Resident B's closed clinical		order medication prior to move in. Inservice with department heads and nursing staff on move in coordination and responsibilities that include medication procedures, pharmacy ordering and administration of medication. Inservice nursing staff on Wellness Coordination – Preparing the Wellness File, Confirming current medications and treatments, documentation and administration of medication. **Describe how the corrective action will be monitored to ensure the deficient practice will not recur i.e, what quality assurance program will be put in to place.** **Who:** Nursing Staff and DOW	

	record was reviewed. Diagnoses included, but were not limited to unspecified dementia without behavioral disturbance and hypertension. Physician orders, dated 9/8/2021, lacked documentation of Resident B being ordered any medications. The clinical record contained a document titled "Medication List" for Resident B with a print date of 9/8/2021. The medications included: -alprazolam (an antianxiety) 0.25 mg (milligrams) 1 tablet every 24 hours prn (as needed). -amlodipine (for blood pressure) 5 mg 1 tablet by mouth everyday as needed for B/P (blood pressure) greater than 150/100 and symptoms. -donepezil (for dementia) 10 mg 1 tablet every morning. -lisinopril (for blood pressure) 40 mg 1 tablet every day. -olanzapine (an antispsychotic) 2.5 mg 1 tablet every day.		**How it will be monitored:** Nursing Staff and DOW will verify that all documents needed to order, receive, and administer medication is included in all new move in paperwork. **Frequency of Monitor:** 3 days prior to move in and then on going with nursing and DOW’s review of the MAR and new physician orders that are monitored daily.	

	-sertraline (an antidepressant) 50 mg 2 tablets every morning. Start 1/2 tablet by mouth every morning x 2 weeks then take 1 tablet by mouth every morning x 2 weeks then take 1.5 mg tablet every morning x 2 weeks then take 2 tablets every morning. -trazodone (an antidepressant) 50 mg 2 tablets at bedtime. The Medication Administration Record (MAR), dated September, 2021, lacked documentation of any medication having been given during Resident B's stay in the facility. The document was blank. During an interview, on 12/6/2021 at 12:20 p.m., the Wellness Director indicated the pharmacy is responsible for entering the medications for a new admission into the clinical record. The medications had not been entered and a MAR had not been generated for Resident B. She was unsure if any medications had been administered to Resident B during her stay at the facility. The Medication List in the clinical record would be considered the physician orders. On 12/7/2021 at 3:57 p.m., the Wellness Director provided the facility policy, "Medication - New Move-In Possession," undated, and indicated it was the policy			

	currently being used by the facility. A review of the policy did not indicate ensuring residents receive ordered medications. This Residential tag relates to Complaint IN00366933.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if	R 0356	**R356** **Describe what the facility did to correct the deficient practice for each client cited the deficiency.** Internal audit of all residents to ensure that residents emergency contact information is entered correctly in to Point Click Care. Inservice with all department heads, operations coordinator, and nursing staff to ensure that emergency contact information is entered in Point Click Care. Moving forward ensure that emergency information is entered in Point Click Care prior to move in.	12/10/2021

available.

Based on interview and record review, the facility failed to ensure that emergency contact information was available for 1 of 3 residents reviewed for emergency information. (Resident B)

Findings include:

On 12/6/2021 at 10:30 a.m., Resident B's closed clinical record was reviewed. Diagnoses included, but were not limited to unspecified dementia without behavioral disturbance and hypertension.

A review of Resident B's progress notes indicated the following:

-Nursing note, 9/14/21 at 8:05 a.m., "... Resident is alert to self only, at approximately 2:30 a.m. resident got out of door to outside, alarms alerted, but resident was able to go as far as the front door. Three staff followed as soon as alarms were initiated. Writer spoke at length to resident explaining safety issues, but she did not seem to understand. Staff began one on one care as resident attempted to leave a second time. Resident does appear cognizant of where exits are. Family to be alerted, resident placed in Memory Care for safety purposes. Resident

Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected

Internal audit of all residents clinical chart in Point Click Care.

Actions taken were to educate and in-service the steps that need taken prior to move in.

Inservice on where to look in Point Click Care for emergency contact information.

Describe the steps or systemic changes the facility has made or will take to ensure that the deficient practice does not recur, including any in services, but this also should include any system changes you made.

Internal audit of all residents to ensure that residents emergency contact information is entered correctly into Point

again began exit seeking behavior. Resident placed in room with new bedding, but continued to wander about watching doors to the outside. Resident has remained confused and at times very argumentative with staff ..."

A review of the clinical record did not indicate the resident representative was notified of the elopement nor the room change to a secure memory care unit for Resident B.

A review of the clinical record did not indicate any emergency contact listed for Resident B.

During an interview, on 12/6/21 at 11:05 a.m., the Wellness Director indicated Resident B's family was not notified of the incident or the move to the memory care unit as Resident B's contact information was missing from the electronic health record and staff were unable to call an emergency contact.

On 12/6/21 at 2:55 p.m., a policy related to resident emergency contact information was requested of the facility Executive Director and Wellness Director. A policy was not received by the time of survey exit.

This Resident tag relates to Complaint IN00366933.

Click Care.

Inservice was done with all department heads, operations coordinator, and nursing staff to ensure that emergency contact information is
entered in Point Click Care prior to move in.
Department heads in-service on Move In Coordination checklist so ensure
all necessary emergency contact info is gathered and entered into Point Click
Care.

Describe how the corrective action will be monitored to ensure the deficient practice will not recur i.e, what quality assurance program will be put in to place.

Who: Ops Coordinator and Director of Wellness
(DOW) or designee

	Based on interview and record review, the facility failed to ensure that emergency contact information was available for 1 of 3 residents reviewed for emergency information. (Resident B) Findings include: On 12/6/2021 at 10:30 a.m., Resident B's closed clinical record was reviewed. Diagnoses included, but were not limited to unspecified dementia without behavioral disturbance and hypertension. A review of Resident B's progress notes indicated the following: -Nursing note, 9/14/21 at 8:05 a.m., "... Resident is alert to self only, at approximately 2:30 a.m. resident got out of door to outside, alarms alerted, but resident was able to go as far as the front door. Three staff followed as soon as alarms were initiated. Writer spoke at length to resident explaining safety issues, but she did not seem to understand. Staff began one on one care as resident attempted to leave a second time. Resident does appear cognizant of where exits are. Family to be alerted, resident placed in Memory Care for safety purposes. Resident again began exit seeking behavior. Resident placed in		**How it will be monitored:** Ops Coordinator and Director of Wellness or designee will check written paperwork and Point Click Care prior to move in to ensure that residents legal representative contact information. **Frequency of Monitor**: 3 days prior to move in and then on going with monthly report review to make sure that contact information has not been removed from Point Click Care. **How it will be monitored:** Ops Coordinator and DOW or designee will check written paperwork and Point Click Care prior to move in to ensure that residents emergency contact information is entered into system and then monthly via printing report from Point Click Care and auditing emergency contacts.	

	room with new bedding, but continued to wander about watching doors to the outside. Resident has remained confused and at times very argumentative with staff ..." A review of the clinical record did not indicate the resident representative was notified of the elopement nor the room change to a secure memory care unit for Resident B. A review of the clinical record did not indicate any emergency contact listed for Resident B. During an interview, on 12/6/21 at 11:05 a.m., the Wellness Director indicated Resident B's family was not notified of the incident or the move to the memory care unit as Resident B's contact information was missing from the electronic health record and staff were unable to call an emergency contact. On 12/6/21 at 2:55 p.m., a policy related to resident emergency contact information was requested of the facility Executive Director and Wellness Director. A policy was not received by the time of survey exit. This Resident tag relates to Complaint IN00366933.		DOW and ED will be notified by nursing staff immediately if there is a change in condition with a resident. At that time the DOW or Nursing staff will notify residents legal representative and physician immediately. **Frequency of Monitor**: All new admissions will be monitored to ensure complete accurate emergency contact info is submitted and entered in Point Click Care upon admission.	

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 SIGNATURE	TITLE	(X6) DATE