STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/27/2022

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 Complaints IN00389357 and IN00389898. Complaint IN00389357 - Unsubstantiated due to lack of evidence. Complaint IN00389898 - Substantiated. State deficiencies related to the allegations are cited at R53. Survey date: September 27, 2022 Facility number: 013766 Residential Census: 90 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed September 29, 2022.	R 0000		
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w)	R 0053	PRINTED: 10/04/2022	10/14/2022

	(w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes: During an interview on 9/27/22 at 9:13 a.m., the Business Office Manager indicated she was the weekend supervisor on 9/10/22 when she received a phone call from the Memory Care Director. The Memory Care Director notified her that CNA (Certified Nursing Aide) 1 was rude to Resident B. When she was notified, she came to the facility and interviewed CNA 1 regarding the allegation. CNA 1 admitted that the allegation was true and she had said rude things to Resident B. After the interview, CNA 1 was asked to leave the facility. CNA 1 did not understand why she would be asked to leave since she had apologized for her behavior. CNA 1 worked for an agency. The Business Office Manager indicated this was verbal abuse. During an interview on 9/27/22 at 9:20 a.m., the Memory Care Director indicated Resident B did have a fall when CNA 1 asked what she was doing on		FORM APPROVED Indiana State Department of Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED C **09/27/2022**	

	the floor and to get herself up. The clinical record for Resident B was reviewed on 9/27/22 at 9:20 a.m. The diagnoses included, but were not limited to, major depressive disorder and anxiety disorder. Resident B was not cognitively intact. An email sent by the Director of Plant Operations, dated 9/10/22 at 1:35 p.m., indicated at approximately 9:00 a.m. he was cleaning memory care apartment 1020. As he exited the apartment, he overheard CNA 1 saying the following to Resident B "get your hands out of there. I don't need your stress today." At that time Resident B had her hands in the dish bucket where dirty flatware was placed. At approximately 10:10 a.m., he was preparing to clean apartment 1011. CNA 1 said that she would get Resident B out of the room so he could clean it. CNA 1 said to Resident B "you need to get out of your chair and get cleaned up. You are completely saturated, and stink and these people need to clean your room." He intentionally did not inform CNA 1 of who he was in an attempt to see how she would continue to act. At that point, he moved down the hall to give the resident time to get herself together. As he was entering apartment 1026 to get it cleaned up he heard CNA 1 re-enter		M B E R : **0** **1** **3** **7** **6** **6**	

apartment 1011 and say "why are you on the floor? You need to get yourself up." At that point, he entered the room and informed CNA 1 that we do not speak to our residents that way and that we do not allow residents to get up without help and without being evaluated by a nurse. CNA 1 said she would never allow someone to get up or tell them they needed to. Then CNA 1 left the room to get the nurse on duty. The nurse and our care partner came to assist in getting Resident B evaluated and then getting her in the shower to get her cleaned up. He then enacted calling personnel to inform them of the situation and to get CNA 1 dealt with accordingly.

An email sent by the Administrator to the Regional Director of the agency CNA 1 worked for, dated 9/10/22 at 5:15 p.m., indicated she wanted to notify the Regional Director we let CNA 1 go home today due to verbal abuse. CNA 1 will not be allowed back in our building.

On 9/27/22 at 8:37 a.m., the Assistant Director of Nursing provided a copy of a facility policy, titled "Abuse and Neglect, Observed or Suspected," dated 6/11/20, and indicated this was the current policy used by the facility. A review of the policy indicated "it

is the policy that residents will not be abused or neglected by anyone at any time while residing..."

This State tag relates to Complaint IN00389898.

Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents reviewed for abuse. (Resident B)

Finding includes:

During an interview on 9/27/22 at 9:13 a.m., the Business Office Manager indicated she was the weekend supervisor on 9/10/22 when she received a phone call from the Memory Care Director. The Memory Care Director notified her that CNA (Certified Nursing Aide) 1 was rude to Resident B. When she was notified, she came to the facility and interviewed CNA 1 regarding the allegation. CNA 1 admitted that the allegation was true and she had said rude things to Resident B. After the interview, CNA 1 was asked to leave the facility. CNA 1 did not understand why she would be asked to leave since she had apologized for her behavior. CNA 1 worked for an agency. The Business Office Manager indicated this was verbal abuse.

During an interview on 9/27/22 at 9:20 a.m., the Memory Care

Director indicated Resident B did have a fall when CNA 1 asked what she was doing on the floor and to get herself up.

The clinical record for Resident B was reviewed on 9/27/22 at 9:20 a.m. The diagnoses included, but were not limited to, major depressive disorder and anxiety disorder. Resident B was not cognitively intact.

An email sent by the Director of Plant Operations, dated 9/10/22 at 1:35 p.m., indicated at approximately 9:00 a.m. he was cleaning memory care apartment 1020. As he exited the apartment, he overheard CNA 1 saying the following to Resident B "get your hands out of there. I don't need your stress today." At that time Resident B had her hands in the dish bucket where dirty flatware was placed. At approximately 10:10 a.m., he was preparing to clean apartment 1011. CNA 1 said that she would get Resident B out of the room so he could clean it. CNA 1 said to Resident B "you need to get out of your chair and get cleaned up. You are completely saturated, and stink and these people need to clean your room." He intentionally did not inform CNA 1 of who he was in an attempt to see how she would continue to act. At that point, he moved down the hall to give the resident time to get herself

SUMMARY STATEM

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

	together. As he was entering apartment 1026 to get it cleaned up he heard CNA 1 re-enter apartment 1011 and say "why are you on the floor? You need to get yourself up." At that point, he entered the room and informed CNA 1 that we do not speak to our residents that way and that we do not allow residents to get up without help and without being evaluated by a nurse. CNA 1 said she would never allow someone to get up or tell them they needed to. Then CNA 1 left the room to get the nurse on duty. The nurse and our care partner came to assist in getting Resident B evaluated and then getting her in the shower to get her cleaned up. He then enacted calling personnel to inform them of the situation and to get CNA 1 dealt with accordingly. An email sent by the Administrator to the Regional Director of the agency CNA 1 worked for, dated 9/10/22 at 5:15 p.m., indicated she wanted to notify the Regional Director we let CNA 1 go home today due to verbal abuse. CNA 1 will not be allowed back in our building. On 9/27/22 at 8:37 a.m., the Assistant Director of Nursing provided a copy of a facility policy, titled "Abuse and Neglect, Observed or Suspected," dated 6/11/20, and		ENTOFDEFICIENCIES (EACHDEFICIENCYMUSTBEPRECED	

	indicated this was the current policy used by the facility. A review of the policy indicated "it is the policy that residents will not be abused or neglected by anyone at any time while residing..." This State tag relates to Complaint IN00389898.		E D B Y F U L L	

			N) INITIAL COMMENTS This visit was for the Investigation of Compl	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	

			ai nt s IN 00 38 93 57 an d IN 00 03 89 89 8.	or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies. Correction of Cited Deficiency: Agency Employee is unable to work in the community after the incident on 09/10/22. Resident is doing well and has no recall of the incident. No injury noted. Family and Physicians were notified. Community staff was educated on company policy of abuse, neglect, and misappropriation on 09/12/22 by the community Executive Director. Community staff also receive this training annually. Procedure to ensure on-going compliance: Business Office Director will monitor department head and staff training on company policy on abuse, neglect, and misappropriation monthly for new hires and annually for	

			- Unsubstantiated due to lack of evidence.	current staff by examining attendance logs.

			8-Substantiated. Stated deficiencies related to the allegations are cited at R		

			53. Survey date: September 27, 2022 Facility number: 013766	

			Residential Census: 90 This State Residential Finding is cited in	

			c c ord a n c e w it h 4 1 0 I A C 1 6. 2- 5.		

			ber 29, 2022. 410 IAC 16.2-5-1.2(w) Residents' Rights -	

			Deficiency	

			s e. T hi s R U L E is n ot m et a s e vi d e n c e d b y: B a s e d o n in te rv ie w a n d	

			record review, the facility failed to ensure a resident was free from verb		

			al a bu se fo r 1 of 3 re si d e nt s re vi e w e d fo r a b u s e. (R e si d e nt B)		

			ng includes:	

			Office Manager indicated she was the week end supervisor on 9/10/		

			22 when she NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **901 S HASTINGS DR** **GENTRY PARK** **BLOOMINGTON, IN 47401**		
			SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	

				RIATE DEFICIENCY)	
			Continued From page 1 received a phone call from the Memory Care Director. The Memory Care Director notified her that CNA (Certified Nursing Aide) 1 was rude to Resident B. When she was notified, she came to the facility and interviewed CNA 1 regarding the allegation. CNA 1 admitted that the allegation was true and she had said rude things to Resident B. After the interview, CNA 1 was asked to leave the facility. CNA 1 did not understand why she would be asked to leave since she had apologized for her behavior. CNA 1 worked	Community leadership will continue to provide new hire and annual education to staff on company policy related to abuse and identifying if a resident shows signs of being or concerns. This in-service will be presented upon hire, annually and as needed within the year.	

			for an agency. The Business Office Manager indicated this was verbal abuse. During an interview on 9/27/22 at 9:20 a.m., the Memory Care Director indicated Resident B did have a fall when CNA 1 asked what she was doing on the floor and to get herself up. The clinical record for Resident B was reviewed on 9/27/22 at 9:20 a.m. The diagnoses included, but were not limited to, major depressive disorder and anxiety disorder. Resident B was not cognitively intact. An email sent by the Director of Plant	Grievance and Abuse log maintained by Director of Wellness per company policy and monitored by Executive Director monthly.	

			Operations, dated 9/10/22 at 1:35 p.m., indicated at	misappropriation upon hire and annually.	

			saturated, and stink and these people need to clean your room."	wellness nurse. DOW and MCD will monitor monthly to ensure complian ce. Audit will be conducte d monthly X 3 months Agency Represe ntative for CNA 1 notified on date of incident and CNA 1 placed on do not return list.	

Indiana State Department of Health

STATE FORM 6899 WGX611 If continuation sheet 2 of 3

PRINTED: 10/04/2022

FORM APPROVED

Indiana State Department of Health

			(X1) PROVIDER/SUPPLIER/ CLIA IDENTIFICATION NUMBER: **013766**	

			SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	

Continued From page 2

He intentionally did not

			inform CNA 1 of who he was in an attempt to see how she would continue to act. At that point, he moved down the hall to give the resident time to get herself together. As he was entering apartment 1026 to get it cleaned up he heard CNA 1 re-enter apartment 1011 and say "why are you on the floor? You need to get yourself up." At that point, he entered the room and informed CNA 1 that we do not speak to our residents that way and that we do not allow residents to get up without help and without being evaluated by a nurse. CNA 1 said she would never allow someone to get up or tell them they needed to. Then CNA 1 left the room to get the nurse on duty. The nurse and our care partner came to assist in getting Resident B evaluated and then getting her in the shower to get her cleaned up. He then enacted calling personnel to inform them of the situation and to get CNA 1 dealt with accordingly.	

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This State tag relates to Complaint IN00389898.

Indiana State Department of Health

instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE