STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GENTRY PARK	901 S HASTINGS DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00430382. Complaint IN00430382 - State deficiencies related to the allegations are cited at R241. Survey date: April 3, 2024 Facility number: 013766 Residential Census: 89 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April 5, 2024.	R 0000		
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure staff followed physician's order when a medication was administered after it had been discontinued for 1 of 3 residents reviewed. (Resident B) Finding included: During an interview on 4/3/24 at 9:35 a.m., the Memory Care Director indicated, on 3/1/24, a	R 0241	R241 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility will ensure that staff follow physician's order for medication administration including when a medication is	05/03/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Holstein	Executive Director	04/19/2024

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	physician's order was received to discontinue rivastigmine (a prescription medication used to treat dementia) 4.6 mg/24 hours (milligrams per 24 hours) patch. The rivastigmine 4.6 mg/24 hour patch was administered during the morning on 3/9/24. The patch was removed the same day. During an interview on 4/3/24 at 11:34 a.m., the DON (Director of Nursing) indicated an investigation was completed regarding a medication error when the facility received an email from Resident B's daughter on 3/12/24, that Resident B was wearing a rivastigmine 4.6 mg/24 hour patch when she visited on 3/9/24. Resident B's daughter removed the patch. The QMA that worked the morning shift, on 3/9/24, admitted to placing the patch between 7:00 a.m. and 8:00 a.m. On 4/3/24 at 11:45 a.m., the DON provided a copy of a Medication Incident Report, dated 3/12/24, and indicated this was the investigation regarding the medication error. A review of the document indicated a family member of Resident B noted a rivastigmine 4.6 mg/24 hour patch applied to Resident B during a morning visit on 3/9/24. The clinical record for Resident B was reviewed on 4/3/24 at 9:48 a.m. The diagnoses included, but were not limited to, Lewy body dementia, vitamin D deficiency, and anxiety. Resident B resided on the secure memory care unit. A progress note, dated 3/1/24 at 12:45 p.m., indicated the writer received a new physician's orders to discontinue rivastigmine 4.6 mg/24 hour patch. A progress note, dated 3/12/24 at 5:01 p.m., indicated a medication error occurred on 3/12/24 at 8:57 a.m. The Memory Care Director was notified		discontinued. As soon as the facility was aware of the medication error, nursing staff ensured that the medication patch was removed, the resident was checked for an adverse reaction and none was noted, the discharged medication patches were removed from the medication cart, the staff member was questioned and counseled about the medication error, family was aware, physician was notified, a medication error investigation and documentation was completed and notification was made to the DON, Director of Memory Care, ADM and regional nurse. 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. A medication review was conducted to include checking medication orders with medications, and ensuring that all discharged medications were removed from the medication carts. No other residents were found to have been 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.	

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	by Resident B's family that Resident B had a rivastigmine 4.6 mg/24 hour patch applied to her back. The patch was removed on 3/12/24 at 8:57 a.m. On 4/3/24 at 10:57 a.m., the Administrator provided a copy of a facility policy, titled Medication Administration, dated April 2023, and indicated this was the current policy used by the facility. A review of the policy indicated no medication shall be given to any resident unless ordered by a physician or individual authorized under state law to prescribe medication. This citation relates to Complaint IN00430382.		Medication carts will be reviewed each week by a nurse manager or designee to ensure proper medication administration to include removing discharged medications. All medication administration staff will complete medication administration in service training. Corrective action will be conducted as necessary. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and The weekly medication cart review will include making any needed corrections immediately. The results of the weekly reviews will be presented at the monthly QA meetings. The nurse manager or designee will be responsible for the oversight of medication administration compliance. The effective date is May 3, 2024.	