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	07/18/2024

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 Complaints IN00437910, IN00437350, IN00438368, and IN00438009 . Complaint IN00437910 - No deficiencies related to the allegations are cited. Complaint IN00437350 - No deficiencies related to the allegations are cited. Complaint IN00438368 - No deficiencies related to the allegations are cited. Complaint IN00438009 - State deficiencies related to the allegations are cited at R241. Survey date: July 17 and 18, 2024 Facility number: 013766 Residential Census: 101 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 22, 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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Holstein	Executive Director	08/03/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on interview and record review, the facility failed to ensure a medication was administered per the physician's order for 1 of 3 residents reviewed for medication administration. (Resident B) Finding includes: On 7/17/24 at 11:40 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, vascular dementia and hypertension. A physician's order with a start date of 6/29/24 indicated the resident was prescribed a Rivastigmine (a medication used to treat Alzheimer's disease) patch with a strength of 9.5 milligrams per hour to be applied daily. The Medication Administration Record indicated the patch was administered on 6/29/24. At the family's request, the resident was transferred to the emergency department on 7/3/24 due to concerns regarding the resident's condition. The emergency room final report, dated 7/3/24 indicated the resident's Rivastigmine patch had not been changed for several days, and the date written on the patch positioned on the resident was 6/29/24. The resident was provided electrolytes and was discharged to return to the facility. There was no indication the resident's condition was due to a medication error. On 7/18/24 at 9:45 a.m., the Administrator provided a Medication Error Incident Report, dated 7/3/24, which indicated, " ...upon assessment at ED [Emergency Department], resident noted with Rivastigmine patch dated 6/29/24 and current date is 7/3/24 ..." During an interview on 7/18/24 at 10:55 a.m., the	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. The resident was evaluated by a physician in the E.R. and noted no adverse effects from this deficient practice. As soon as staff was aware, the patch dated 6/29/2024 was removed and proper administration of another patch was placed on 7/3/2024. Increased monitoring was put in place to ensure no adverse effects. DON, family and physician were notified. 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. The review included auditing all physician orders for patches and accuracy of each order and administration of patch. No other residents were found to have been affected. Nurse managers audited the medication records and the proper	08/09/2024

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	Administrator indicated Resident B's Rivastigmine patch had been administered on 6/29/24. The resident went to the emergency department on 7/3/24 where it was discovered the resident's Rivastigmine patch had not been administered since 6/29/24. This citation relates to Complaint IN00438009.		administration of all residents receiving patches to ensure all staff were accurate in this medication administration, and to offer education where necessary. 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 medication administration staff will complete medication administration in service training. Nurse Managers will perform routine mediation administration audits weekly for four weeks, then monthly for two months and random checks thereafter to ensure appropriate medication administration. Corrective action will be conducted as necessary as well as continued education. 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 A weekly medication cart review will include making any needed corrections immediately, ensuring proper medication administration records and auditing any medication changes from the physician. This will include monitoring the process of the updated medication being	

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			delivered and available for administration. 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 August 9, 2024.	