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	08/29/2022

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 IN00388861. Complaint IN00388861 - Substantiated. State deficiencies related to the allegations are cited at R52. Survey date: August 29, 2022 Facility number: 013766 Residential Census: 91 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed August 31, 2022.	R 0000	Response in R0052 for our correction	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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 neglected to prevent a cognitively impaired resident from exiting the facility. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 8/29/22 at 8:20 a.m. The diagnosis included, but was not limited to, essential hypertension.	R 0052	**What Corrective action will be accomplished for those residents found to have been affected by the deficient practice:** **Resident transferred from our Assisted Living to our secured Memory Care unit.** **How the facility will identify**	08/30/2022

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

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	A Comprehensive Resident Evaluation, dated 8/16/22, indicated Resident B used a 4 wheel walker, was independent with transfers and bed mobility, did not require staff escort, and had no known history of wandering with or without exit seeking. Resident B's elopement risk could be management without a wander guard or secure unit. A Comprehensive Resident Assessment, dated 8/25/22, indicated Resident B required assistance with escorting such as verbal reminders and cueing, had a history of wandering and exit seeking, and had received assistance to minimize his risk of wandering. Resident B's elopement risk could been managed with a wander guard but not a secure unit. The Progress Notes included, but were not limited to: On 8/24/22 at 10:00 a.m., the note indicated on 8/22/22 at 6:30 p.m., another resident reported to staff that Resident B had knocked on her outside door. She let him into her apartment and into the hallway. She called the staff and let them know he was looking for his apartment and staff escorted him back to his apartment. On 8/25/22 at 5:10 p.m., indicated when staff were leaving last evening (8/24/22) at 7:10 p.m., they saw Resident B on another resident's patio. Staff came back in the building and reported the incident. Staff escorted Resident B back into the building and to his room. During an interview on 8/29/22 at 8:36 a.m., the Administrator indicated Resident B had exited the facility on 8/22/22 and was found on another resident's patio. Then he exited the facility again		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** **Director of Wellness and ADON will be completing Elopement Assessments on all our Assisted Living Residents. If any residents are found to be an elopement risk, a wanderguard will be place on them immediately and the DOW and ADON will notify POA. If any resident is found to have a high elopement risk then plans will be made immediately to move resident to our secure memory care unit.** **What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** **DOW and ADON will perform elopement assessments upon any new move in, every 6 months or if there is any change in condition with the resident. If a wanderguard or interventions is needed the DOW and/or ADON will initiate immediately and notify physician and family. Elopement inservice with staff was completed on 9/12/22.**	

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	on 8/24/22 and was found on that same resident's patio. She indicated the facility believed the resident exited the building out of the back door by the dining room. The door that Resident B exited the building from was alarmed. She indicated that on the days Resident B exited the facility, no alarms were sounding. The Administrator indicated that Resident B was moved to the secure unit on 8/25/22. During an interview on 8/29/22 at 9:20 a.m., Resident J indicated Resident B was outside her back door that leads to her outdoor patio, trying to get into her apartment. When she opened her door, she didn't hear any alarms. She brought Resident B back into the facility through her apartment. She walked him to the hallway where his apartment was located. Once on his hallway, Resident B was unable to locate his apartment even though he was able to give an accurate apartment number. During an interview on 8/29/22 at 10:25 a.m., CNA 1 indicated she was working on 8/24/22 and she was the person that saw Resident B on Resident J's outdoor patio. After she saw Resident B outside, she came back into the facility and went to Resident J's apartment to bring Resident B back into the facility. CNA 1 indicated that on the morning of 8/24/22, the DON instructed her to place a wanderguard on Resident B. CNA 1 further indicated that when she assisted Resident B back into the facility, no alarms were sounding. On 8/29/22 at 8:36 a.m., The Administrator provided a copy of a facility document, untitled, dated 6/11/20, and indicated this was the current policy used by the facility. A review of the policy indicated ...first step in preventing an elopements is to identify those residents with identifiable		**How the corrective action will be monitored to ensure the deficient practice will not recur:** **DOW and ADON will audit Point Click Care monthly by running a report to ensure that all necessary elopement assessments have be done to remain in compliance.** **By what date the systemic changes will be completed:** **DOW and ADON will monitor this ongoing to remain in compliance. Date on the systemic change was immediate.**	

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	potential to wander or elope..." This State tag relates to Complaint IN00388861.			