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	10/06/2022

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 IN00391488. Complaint IN00391488 - Substantiated. State deficiencies related to the allegations are cited at R52. Unrelated deficiencies are cited. Survey date: October 6, 2022 Facility number: 013766 Residential Census: 87 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 7, 2022.	R 0000		
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 for 1 of 3 residents reviewed for elopement. (Resident B) Finding includes: During an interview on 10/6/22 at 8:53 a.m., the	R 0052	PLAN OF CORRECTION Provider/Supplier Name: Gentry Park Senior Living Street Address, City, Zip: 901 S Hastings Drive Bloomington, IN 47401 Date of Survey:	10/23/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Bennett	RDO	11/17/2022

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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	ADON (Assistant Director of Nursing) indicated Resident B had exited the facility more than once. There was an incident on 9/29/22, when a new resident's family was moving in furniture and when they left for the night, Resident B followed them out the memory care doors and then followed them out the service doors near the memory care entrance. Resident B walked out the service door and around to the front of the facility where another resident's care giver saw her and brought her back into the facility. The next day Resident B held the fire exit door, at the back of the memory care unit, long enough to open and she walked outside. During initial tour of the facility from 8:22 a.m. to 8:24 a.m., observed the service hall. The service hall was located approximately 10 feet from the memory care entrance. The service hall was approximately 20 feet long. At the end of the service hall was the employee entrance also called the service entrance. The service entrance was a set of double doors, located approximately 30 feet from the memory care entrance. During an interview on 10/6/22 at 8:24 a.m., QMA 1 (Qualified Medication Aide) indicated staff do not need a key nor a code to open the service door to exit the facility. She believed the service doors locked from 7 p.m. to 7 a.m. At that time, QMA 1 easily pushed open the service door without typing in a code or using a key. During an interview on 10/6/22 at 8:30 a.m., QMA 2 indicated she was made aware that Resident B had exited the memory care unit last week. Resident B resided in apartment 1008. On 10/6/22 at 8:35 a.m., observed apartment 1008. Apartment 1008 was located at the back of the		10/06/22 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE 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 and 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	

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	memory care unit. The door to apartment 1008 was located approximately 20 feet from a locked fire exit door at the end of the hall. On 10/6/22 at 8:45 a.m., Resident B was observed to be sitting in the dining room on the Memory Care Unit. Resident B had a wanderguard located on her right ankle. The clinical record of Resident B was reviewed on 10/6/22 at 10:50 a.m. The diagnoses included, but were not limited to, major depressive disorder and dementia. A Comprehensive Resident Evaluation, dated 9/15/22 at 10:37 a.m., indicated Resident B was orientated to herself and required assistance with time and place orientation. A Primary Care Physician's Progress Note, dated 8/23/22, indicated Resident B was currently residing at a long-term care facility on the memory care unit. A progress note, dated 9/13/22 at 5:35 p.m., indicated at 3:02 p.m., the family reported that Resident B was missing. Her daughter reported that Resident B and her husband had a disagreement and Resident B left the apartment. An elopement drill was initiated both inside and outside the building. A police officer called the facility at 3:09 p.m., and said he had Resident B with him. He brought Resident B back to the facility without incident. Resident to be moved to the Memory Care Unit on 9/14/22. A progress note, dated 9/29/22 at 7:29 p.m., indicated Resident B followed a new resident's family member out of the memory care door at 5:08 p.m. Resident B was dressed appropriately for the		inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies. R052 Correction of Cited Deficiency: Community was notified of a resident who exited the community on 9/29/22. Resident was returned safely and assessed. Family and physician notified. Upon investigation it was determined that the resident followed the family of another resident out the door when the family exited memory care. Interim ED and DOW educated family of the new resident on memory care exit procedures. Verified proper signage in place for guests visiting to not allow others to follow them out of the memory care. Staff alerted and responded to the exit door alarm. Upon investigation it was determined that the resident held the door prompting it to open after 15 seconds. Resident wander guard alerted staff to the sound of the door. Upon staff responding to the door, the resident returned to the community safely. Interventions moving forward include: ¿ Verified proper signage	

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	weather. Resident B was found at the front of the building at 5:35 p.m. and was escorted back in by another resident's private care giver. Resident B's wanderguard was in place at that time. A progress note, dated 9/30/22 at 7:24 p.m., indicated the fire door alarm went off at 6:30 p.m. and Resident B was back in memory care unit by 6:38 p.m. The clinical lacked any documentation related to when Resident B's wanderguard was initiated or if the wanderguard was checked for placement and function. On 10/6/22 at 9:20 a.m., the Administrator provided a copy of a facility policy, titled Elopement Protocol, dated 6/11/20, and indicated this was the current policy used by the facility. A review of the policy indicated "Our first step in preventing elopements is to identify those residents with the identifiable potential to wander or elope...all new residents with any type of cognitive impairment or depression are considered at increased risk during this time frame..." This State tag relates to Complaint IN00391488.		in place for guests visiting to not allow others to follow them out of the memory care ¿ Audited all exit doors to ensure working properly ¿ Door vendor, who services the doors, came out and assessed that the doors are working properly. ¿ Verified wander guard system was working correctly on all doors within expected engagement range. Staff educated on checking wander guard tags each shift based on Plan of Care. ¿ Verified all alarms work and sound as required. Verified door signal radios when opened or tampered with. ¿ Inserviced staff on elopement policies and procedures to include the following: a head count must be done anytime a staff member has to use the code to disarm in all instances where the staff member did not actively see the resident attempt to exit the door. ¿ 1:1 initiated and ongoing with resident. This will be reassessed on a regular basis based on the needs of the resident and recommendation of the resident's physician. ¿ Education provided to the resident's spouse and family on how to leave memory care following a visit to reduce agitation of resident.	

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			¿ Door Frosting and audible external alarm added to emergency exit doors in Memory Care. This is as an additional safeguard to allow for a secondary notification to staff of a resident exiting the door to the exterior. ¿ Daily schedule reviewed and modified for resident to include programming, purposeful activities, and engagement. R052 Assessment to Identify other Residents that may be affected: Elopement Risk Book for Memory Care and Assisted Living Residents who score a Medium or High risk on their Elopement Evaluation Assessment. Book will include a picture and face sheet. All Memory Care residents wear a wander guard. Wander guard checks will be conducted every shift. 10/23/22 R052 Procedure to ensure on-going compliance: Elopement Risk Book is being created for all residents score a Medium or High on the Elopement	

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			Evaluation Assessment. Book will be audited weekly X 4 weeks and then monthly by the Assistant Executive or designee for compliance. Director of Wellness or designee audit weekly documentation for verification that the wander guard is in place and functioning properly every shift. (Twice daily). Audit will be conducted weekly X 4 weeks and monthly for 2 months to ensure compliance The Business Office Director will audit new employee files to ensure that all staff have received Elopement training upon hire and again on the last day of orientation to show competency of the policy. Additional refresh in-service on Elopement Procedures at November Employee Town Hall. 10/23/22 R052 Monitoring for on-going compliance: All audit tools will be reviewed at the weekly Department Director Meeting X 4 weeks. Audits will be presented to the QAPI Committee monthly X 3 months. 10/23/22	

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R 0088 Bldg. 00	410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management - Noncompliance c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on interview, and record review, the facility failed to ensure a licensed administrator was appointed to work in the facility. Finding includes: On 10/6/22 at 9:20 a.m., the Administrator provided a copy of a document that listed facility employees with titles. A review of the document indicated an Administrator was not listed. During an interview on 10/6/22 at 10:44 a.m., the	R 0088	PLAN OF CORRECTION Provider/Supplier Name: Gentry Park Senior Living Street Address, City, Zip: 901 S Hastings Drive Bloomington, IN 47401 Date of Survey: 10/06/22 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	10/23/2022

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	Administrator indicated she did not have an Administrators license. She spoke to a Regional Administrator daily, but the last time the Regional Administrator was in the facility was the week of 9/12/22. The Regional Administrator was located in Ohio and was a licensed Administrator in Ohio, but not in Indiana. On 10/6/22 at 1:10 p.m., the facility was unable to provide a policy on Administration prior to exit.		ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE 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 and 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, or	

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			shareholder of the community or affiliated companies. R088 Correction of Cited Deficiency: Notification of change & coverage of assisted living administrator sent to ISDH LTC Provider Services and B. Buroker on 09.14.22 via email. Received confirmation of receipt on 09.14.22 from ISDH LTC Provider Services. Notified via telephone by Miriam Buffington, Enforcement & Provider Services Manager at ISDH of 6-week grace period for search & onboarding of licensed administrator starting on 09.18.22. The new Executive Director has been identified and scheduled to start at Gentry Park on 11/28/2022. The Interim Executive Director remains in place with home office support. 10/23/22 R088 Assessment to Identify other Residents that may be affected: Review of assisted living and memory care residents during the time of coverage by interim ED.	

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			10/23/22 R088 Procedure to ensure on-going compliance: Onboarding Executive Director with active Indiana Health Facility Administrator License #14003902 and notification of change on 11/28/22. The Assistant Executive Director is pursuing licensure and plans to remain at community for additional license onsite, in case of future vacancy. 10/23/22 R088 Monitoring for on-going compliance: Audit of Executive Director licensure at time of hire, annually, and prior to required state renewal; current renewal period is August 31 of even-numbered years. 10/23/22	