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	05/12/2023

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 11 and 12, 2023 Facility number: 013766 Residential Census: 75 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 16, 2023.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Holstein	Executive Director	05/25/2023

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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	every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a staff member with current first aid certification worked onsite at all times for 4 of 7 days reviewed. Findings include: On 5/11/23 at 2:30 p.m., the Executive Director provided the facility's schedule, dated 5/6/23 through 5/12/23, and all employees' first aid certification cards. A review of the schedule indicated the following: - On 5/8/23, the second shift did not have a first aid certified staff member onsite. - On 5/9/23, the second and third shift did not have a first aid certified staff member onsite. -On 5/10/23, the second and third shift did not have a first aid certified staff member onsite. - On 5/12/23, the second shift did not have a first aid certified staff member scheduled to be onsite. On 5/12/23 at 11:00 a.m., the Executive Director indicated they could not find first aid cards for certified staff members to cover the missing shifts in the schedule.	R 0117	R117 **What corrective action will be accomplished for those residents found to** have been affected by the deficient practice. The facility will ensure that that a staff member with a current first aid certification will be onsite at all times. No residents were found to be affected by this practice. 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. The facility completed an audit of all staff needing current first aid training. An online training class option was secured effective 5/23/23 for staff to take their first aid training. The Nursing Director and the Business Office Director will monitor that designated staff complete the course and submit their completed first aid training by 5/30/23 to ensure that a staff member with a current first aid certification will be onsite at all times. No other residents were affected by this practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not	06/08/2023

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			recur. The Business Office Director will continue to monitor the audit and staff's current first aid certification to ensure compliance. The audit will be reviewed monthly with the Executive Director. 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 Monthly at the Quality Assurance meeting, the first aid certification audit will be reviewed to ensure we remain current. The Nursing Director and Business Office Director will be responsible to obtain and ensure completion and compliance. The Executive Director will monitor. Effective date June 2, 2023.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to			

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	self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure a semi-annual evaluation was completed for 1 of 7 of residents reviewed for semi-annual evaluations. (Resident 2) Findings include: On 5/11/23 at 12:07 p.m., Resident 2's clinical record was reviewed. The diagnoses included, but were not limited to hypertension, osteoarthritis, and dementia. The clinical record indicated Resident 2's Comprehensive Resident Evaluation was completed on 9/20/22. The clinical record lacked documentation of a semi-annual evaluation since 9/20/22. During an interview on 5/12/23 at 1:00 p.m., the Executive Director indicated Resident 2's most recent semi-annual evaluation was 9/20/22. On 5/12/23 at 1:15 p.m., the Executive Director provided the facility's policy, "Resident Service Plan," dated on 6/2014, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate how often a semi-annual evaluation should be completed.	R 0216	R216 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility will ensure that a semi-annual evaluation will be completed for every resident. The resident was not affected by this practice. The semi annual evaluation for this resident was completed on 5/24/23. 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. The facility reviewed all residents and found no resident affected by this practice. A review of each resident semi annual evaluation was completed and each resident requiring a semi annual evaluation will be completed by 6/1/23. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. A schedule of semi annual evaluations will be kept to ensure that they are completed timely. The Nursing Director will ensure	06/01/2023

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			that the schedule will be kept current and evaluations completed. 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 Monthly at the Quality Assurance meeting the Nursing Director, Executive Director and any assigned designees will review the timeliness of semi annual evaluations and put into practice any directive to ensure timely completion with an effective start date of 6/1/23.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was stored in a sanitary manner for 2 of 2 days during the survey. Food was stored beneath a water line and the theater popcorn machine was not clean and had an undated container of popcorn oil. Findings include: 1. During tours of the facility's walk-in freezer, on 5/11/23 at 10:20 a.m.,two open boxes of bagged	R 0273	R273 What corrective action will be accomplished for those residents found to have been affected by this practice. The facility will ensure that food will be stored in a sanitary manner. No resident was found to be affected by this practice. The food items in the freezer were evaluated for sanitary standard	05/25/2023

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	hotdog buns and bread was observed to be stored beneath the freezer condenser water line, upon which ice had formed. Ice was on the bags of buns and bread. On 5/12/23 at 12:15 p.m., the same was observed. 2. On 5/11/23 at 10:30 a.m., the popcorn machine in the facility theater room was observed to have old popcorn inside. The machine cooking kettle had old, thickened grease on the inside and outside surfaces. A white squeeze bottle, inside of which appeared to be oil was not labeled to identify its contents or date of expiration. On 5/12/23 at 11:00 a.m., the same was observed. During an interview on 5/12/23 at 12:30 p.m., Cook 1 indicated the food was stored beneath the leaking freezer condenser and should have been stored where it would not have been exposed to ice. The theater popcorn machine was in need of cleaning on a regular basis, and the oil should have been labeled and dated. During an interview on 5/12/23 at 12:40 p.m., the facility Administrator indicated the facility used the Indiana State Department of Health Retail Food Establishment Sanitation Requirements, effective date, November 13, 2004, as the facility policy and procedure regarding food storage. A review of the policy indicated, "...410 IAC 7-24-177 Food storage Sec. 177... food shall be protected from contamination by storing the food as follows:...(5) In packages, covered containers, or wrappings...", and "...410 IAC 7-24-178 Food storage; prohibited areas Sec. 178. (a) Food may not be stored as follows:...(2) Under the following:...under lines on which water has condensed...", and, "...410 IAC 7-24-295 Equipment food-contact surfaces, nonfood-contact surfaces, and utensils		and any item in question was thrown out. The popcorn machine was cleaned out and the popcorn oil was discarded. 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. No residents were found to be affected by this practice. Beginning 5/23/23 all food items will be stored in a sanitary manner to include food storage in the freezer, and cleanliness of the popcorn machine and correctly dating the open popcorn oil container. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Culinary Director will ensure that food is stored in a sanitary manner following safe food handling standards. The freezer will be checked twice weekly to ensure proper food storage. The popcorn machine will be placed on a twice weekly cleaning schedule to ensure cleanliness and that food items are correctly stored and open food items correctly dated. How the corrective action will be	

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	Sec. 295. (a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations...and shall be cleaned at a frequency necessary to preclude accumulation of soil residue..."		monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and The Culinary Director and the Activities Director will ensure that the popcorn machine and items to make popcorn remain in compliance with twice weekly checks. The Culinary Director will ensure proper food storage for food items in the freezer and kitchen. Review of compliance will be conducted at the monthly Quality Assurance meeting. The Executive Director will monitor for compliance with an effective date of 5/25/23.	