STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155655	A. Building B. Wing	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Retirement Community	400 W Seventh St North Manchester, IN 46962

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 30920 Based on interview and record review, the facility failed to prevent physical abuse of a resident when a contracted staff member (LPN 1) grabbed her wrist in an attempt to remove her from an area for 1 of 6 residents reviewed for abuse (Resident B). Findings include: An Indiana Department of Health (IDOH) reportable was provided by the Administrator on 7/18/22 at 11:05 a. m. The report indicated on 7/10/22 at 7:25 p.m., CNA 2 observed LPN 1 pushing Resident B and observed LPN 1 having her arms wrapped around the resident and forcibly pushing her through the common area and telling her she needed to go to her room. Review of the facility investigation indicated the following: a. A computer progress note, dated 7/10/22 at 8:32 p.m., LPN 1 indicated she attempted to get Resident B to take her medications. The resident was extremely anxious about another resident standing to close, so the other resident was redirected. At that point, Resident B threw her pills into the trash and began acting out. She was asked to leave the nurses station, sit down or go to her room. She continued to work and opened the top drawer of the medication cart and the resident grabbed all the diabetic finger-sticks and threw them onto the floor. She was finished with current medication administration and attempted to crowd her back to her room. The resident became combative and aggressive, then an aide came to help and she stepped away from the situation. The aide redirected her back to her room. b. A written statement by CNA 2 indicated on 7/10/22, she was standing outside the soiled utility room when she heard voices coming from the common area. She went to see what was going on and saw LPN 1 forcefully pushing and grabbing Resident B. LPN 1 was telling the resident she needed to go to her room. The resident was yelling why are you doing this to me, you're hurting me, ow [sic] you cut me, she cut me. CNA 2 asked what was going on and LPN 1 indicated the resident knocked items off the medication cart and she needed to go to her room. CNA 2 offered to take her to her room and the resident agreed to go with her. While walking back to her room, the resident was upset and told her she was scared and afraid someone was going to lock her up and kill her. The resident indicated she was cut, but only a scratch was noted. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	c. A statement provided by QMA 3 indicated she heard LPN 1 talking in a stern voice to get away from her and indicated she was bothering her. Resident B was asking LPN 1 why she was mad at her and LPN 1 indicated to the resident she was being disrespectful. Later in the evening, she was taking Resident B to her room and she was very upset. She kept showing her arm where the nurse had a hold of her. The resident indicated it hurt and a small bruise her right arm. She kept saying to not let that woman hurt her again and to not let her kill her. d. The 5-day follow up indicated LPN 1 was suspended and placed on a do not return list. The nursing agency was contacted and informed of the incident. The agency indicated they would also take disciplinary action following the investigation. The Director of Nursing (DON) assessed the resident for injuries and was noted to have some discoloration on her right hand that measured 1.5 cm x 1.5 cm. The family and Nurse Practitioner (NP) were notified of the incident. On 7/18/22 at 2:25 p.m. with the Administrator, the video surveillance was viewed for 7/10/22. At 7:11 p.m., Resident B and LPN 1 were observed at the medication cart. The nurse and resident continued to stand near each other, then LPN 1 opened the medication cart and turned to throw something away and the resident reached into the drawer, grabbed the finger sticks and dropped them onto the floor. The nurse quickly grabbed her right wrist, turned her around and the resident was leaning back attempting to not be moved. The resident grabbed the handrails and the nurse appeared to be attempting to remove her hands from the handrail. She was behind the resident, bumping her in an attempt to move her along, the resident was still holding and then let go of the handrails. The nurse was still holding the resident as the resident was moving around. LPN 1 was seen to be holding her wrist then had her hands on the resident's back. CNA 2 comes into view and LPN 1 leaves the area. The clinical record for Resident B was reviewed on 7/18/22 at 9:15 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, social phobia, major depressive disorder, chronic kidney disease and anxiety. The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/28/22, indicated the resident had moderate cognitive impairment. During the assessment period, she had 12-14 days of having little interest in doing things, 12-14 days of feeling depressed and 7-11 days of difficulty falling asleep. She required set-up help for mobility and was able to ambulate per self. A care plan, dated 2/22/22, indicated the resident had the potential to be physically aggressive and had poor impulse control. Behaviors included throwing water, ripping paper and foam cups. Interventions included, but were not limited to, redirect to room and provide one on one visits. Another care plan, dated 4/13/22, indicated the resident had delusions and hallucinations related to dementia. Interventions included, but were not limited to, reassure resident of safety, validate feelings and offer rosary for prayers. A social service progress note, dated 7/11/22 at 12:18 p.m., indicated the resident was assessed following the incident. The resident was unable to recall any event with any staff member, but repeatedly asked for her family to visit. A NP note, dated 7/11/22 at 5:55 p.m., indicated the resident was evaluated following the 7/10/22 incident. The resident indicated she was having a great day so far and was very pleasant. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A skin assessment, dated 7/12/22 at 12:38 p.m., indicated a new bruise to the back of her left hand that measured 1.5 cm x 1.5 cm. An Interdisciplinary Team (IDT) note, dated 7/15/22 at 3:08 p.m., behaviors were reviewed that included refusing medications, excessive worrying, throwing items, exit seeking and crying. The NP was to follow up for the increased behaviors. During an interview with the Administrator on 7/18/22 at 12:29 p.m., she indicated the cameras were reviewed and that was why she was not allowed to return. She was bothered by what she saw on the cameras. CNA 2 called immediately and the contracted agency was contacted. During a telephone interview on 7/18/22 at 12:37 p.m., LPN 1 indicated she was in the middle of medication administration. The resident always stood with whoever was at the med cart. The resident was bothered by another resident so when she removed that resident, Resident B freaked out. She had asked her several times to leave and then she grabbed the finger sticks and threw them on the floor. She dealt with the situation in the wrong manner. She was a little more aggressive than she should have been, but the goal was to just remove her from the situation. She remained in the building for about 1 hour until the nurse manager came to relieve her. She knew she messed up when she let go of her wrist and at that time, the CNA took over. Staff has been asking the NP for awhile to adjust her medications. During an interview on 7/18/22 at 2:42 p.m., the Administrator indicated the Unit Manager clocked in at 8:15 p.m. and LPN 1 left at 8:37 p.m. She received the initial call at 7:52 p.m. She indicated the Unit Manager sat with her at the nurses station while she completed her documentation. During a telephone interview 7/19/22 at 2:03 p.m., CNA 2 indicated she was at the soiled utility room washing her hand when she heard raised voices. She went out and saw LPN 1 had the resident in front of the nurses station and was kind of pushing her towards her room. The nurse kept telling the resident to go to her room. She asked the nurse what happened and she said the resident knocked stuff off the med cart. The resident was acting scared and asked why she was being mean and hurting her. LPN 1 had a hold of the resident in a couple different areas since she was trying to get loose. She took her to her room and she calmed down. She then told the other aide she was leaving the unit to call and report the incident. She did not speak to the nurse after she reported it and the nurse remained in the office with the Unit Manger who came in to relieve her. Review of timecard for LPN 1, she arrived to work on 7/10/22 at 5:55 a.m. and left at 8:37 p.m. Review of the timecard for Nurse Manager 4, she arrived to work on 7/10/22 at 8:15 p.m. and left at 10:15 p. m. Review of LPN 1's education courses, she completed the following: a. Dementia training: 6-hours on 1/27/22. b. Abuse: Child, Elder, Intimate Partner on 1/27/22. c. Patient Rights on 1/27/22. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A current policy, titled Abuse Prevention Program, was provided by the Director of Nursing on 7/18/22 at 8:52 a.m. The policy indicated the following: It is the policy of this community to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion .d. Physical abuse is defined as hitting, slapping, pinching, kicking, etc. .III. Preventing Resident Abuse - Establishing a Resident Sensitive Environment .V. Protection of Residents: The community will take steps to prevent mistreatment while the investigation is underway. .Employees .who have been accused of abuse, neglect, or mistreatment will be immediately suspended until the results of the investigation have been reviewed by the administrator or designee. This Federal tag relates to Complaint IN00385095. 3.1-27(a)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30920 Based on interview and record review, the facility failed to immediately remove a staff person (LPN 1) from the facility after an allegation of physical abuse towards a resident (Resident B) was made for 1 of 6 residents reviewed for abuse (Resident B). Findings include: An Indiana Department of Health (IDOH) reportable was provided by the Administrator on 7/18/22 at 11:05 a.m. The report indicated on 7/10/22 at 7:25 p.m., CNA 2 observed LPN 1 pushing Resident B and observed LPN 1 having her arms wrapped around the resident and forcibly pushing her through the common area and telling her she needed to go to her room. Review of the facility investigation indicated the following: a. A computer progress note, dated 7/10/22 at 8:32 p.m., LPN 1 indicated she attempted to get Resident B to take her medications. The resident was extremely anxious about another resident standing to close, so the other resident was redirected. At that point, Resident B threw her pills into the trash and began acting out. She was asked to leave the nurses station, sit down or go to her room. She continued to work and opened the top drawer of the medication cart and the resident grabbed all the diabetic finger-sticks and threw them onto the floor. She was finished with current medication administration and attempted to crowd her back to her room. The resident became combative and aggressive, then an aide came to help and she stepped away from the situation. The aide redirected her back to her room. b. A written statement by CNA 2 indicated on 7/10/22, she was standing outside the soiled utility room when she heard voices coming from the common area. She went to see what was going on and saw LPN 1 forcefully pushing and grabbing Resident B. LPN 1 was telling the resident she needed to go to her room. The resident was yelling why are you doing this to me, you're hurting me, ow [sic] you cut me, she cut me. CNA 2 asked what was going on and LPN 1 indicated the resident knocked items off the medication cart and she needed to go to her room. CNA 2 offered to take her to her room and the resident agreed to go with her. While walking back to her room, the resident was upset and told her she was scared and afraid someone was going to lock her up and kill her. The resident indicated she was cut, but only a scratch was noted. d. The 5-day follow up indicated LPN 1 was suspended and placed on a do not return list. The nursing agency was contacted and informed of the incident. The agency indicated they would also take disciplinary action following the investigation. The Director of Nursing (DON) assessed the resident for injuries and was noted to have some discoloration on her right hand that measured 1.5 cm x 1.5 cm. The family and Nurse Practitioner (NP) were notified of the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/22 at 2:25 p.m. with the Administrator, the video surveillance was viewed for 7/10/22. At 7:11 p.m., Resident B and LPN 1 were observed at the medication cart. The nurse and resident continued to stand near each other, then LPN 1 opened the medication cart and turned to throw something away and the resident reached into the drawer, grabbed the finger sticks and dropped onto the floor. The nurse quickly grabbed her right wrist, turned her around and the resident was leaning back attempting to not be moved. The resident grabbed the handrails and the nurse appeared to be attempting to remove her hands from the handrail. She was behind the resident, bumping her in an attempt to move her along, the resident was still holding and then let go of the handrails. The nurse was still holding the resident as the resident was moving around. LPN 1 was seen to be holding her wrist then had her hands on the resident's back. CNA 2 comes into view and LPN 1 leaves the area. The clinical record for Resident B was reviewed on 7/18/22 at 9:15 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, social phobia, major depressive disorder, chronic kidney disease and anxiety. The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/28/22, indicated the resident had moderate cognitive impairment. During the assessment period, she had 12-14 days of having little interest in doing things, 12-14 days of feeling depressed and 7-11 days of difficulty falling asleep. She required set-up help for mobility and was able to ambulate per self. A care plan, dated 2/22/22, indicated the resident had the potential to be physically aggressive and had poor impulse control. Behaviors included throwing water, ripping paper and foam cups. Interventions included, but were not limited to, redirect to room and provide one on one visits. Another care plan, dated 4/13/22, indicated the resident had delusions and hallucinations related to dementia. Interventions included, but were not limited to, reassure resident of safety, validate feelings and offer rosary for prayers. A skin assessment, dated 7/12/22 at 12:38 p.m., indicated a new bruise to the back of her left hand that measured 1.5 cm x 1.5 cm. During an interview with the Administrator on 7/18/22 at 12:29 p.m., she indicated the cameras were reviewed and that was why she was not allowed to return. She was bothered by what she saw on the cameras. CNA 2 called immediately and the contracted agency was contacted. During a telephone interview on 7/18/22 at 12:37 p.m., LPN 1 indicated she was in the middle of medication administration. The resident always stood with whoever was at the med cart. The resident was bothered by another resident so when she removed that resident, Resident B freaked out. She had asked her several times to leave and then she grabbed the finger sticks and threw them on the floor. She dealt with the situation in the wrong manner. She was a little more aggressive than she should have been, but the goal was to just remove her from the situation. She remained in the building for about 1 hour until the nurse manager came to relieve her. She knew she messed up when she let go of her wrist and at that time, the CNA took over. Staff has been asking the NP for awhile to adjust her medications. During an interview on 7/18/22 at 2:42 p.m., the Administrator indicated the Unit Manager clocked in at 8:15 p.m. and LPN 1 left at 8:37 p.m. She received the initial call at 7:52 p.m. She indicated the Unit Manager sat with her at the nurses station while she completed her documentation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/22 at 1:16 p.m., Unit Manager indicated she arrived to the facility at 8:15 p.m. LPN 1 was already in the nurses station charting and she asked her to explain the incident. She asked LPN 1 to write out her statement but she decided to put her statement into the computer. She remained at the nurses station with LPN 1 the whole time and then walked her out. She was not left alone and the CNA and QMA were taking care of other residents. During a telephone interview 7/19/22 at 2:03 p.m., CNA 2 indicated she was at the soiled utility room washing her hand when she heard raised voices. She went out and saw LPN 1 had the resident in front of the nurses station and was kind of pushing her towards her room. The nurse kept telling the resident to go to her room. She asked the nurse what happened and she said the resident knocked stuff off the med cart. The resident was acting scared and asked why she was being mean and hurting her. LPN 1 had a hold of the resident in a couple different areas since she was trying to get loose. She took her to her room and she calmed down. She then told the other aide she was leaving the unit to call and report the indicant. She did not speak to the nurse after she reported it and the nurse remained in the office with the Unit Manger who came in to relieve her. Review of timecard for LPN 1, she arrived to work on 7/10/22 at 5:55 a.m. and left at 8:37 p.m. Review of the timecard for Nurse Manager 4, she arrived to work on 7/10/22 at 8:15 p.m. and left at 10:15 p. m. A current policy, titled Abuse Prevention Program, was provided by the Director of Nursing on 7/18/22 at 8:52 a.m. The policy indicated the following: It is the policy of this community to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion .The community will take steps to prevent mistreatment while the investigation is underway. .Employees .who have been accused of abuse, neglect, or mistreatment will be immediately suspended until the results of the investigation have been reviewed by the administrator or designee. This Federal tag relates to Complaint IN00385095. 3.1-28(c)