Printed: 12/22/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER Peabody Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		on)
F 0744 Level of Harm - Actual harm Residents Affected - Few	SUMMARY STATEMENT OF DEFICIENCIES		ovide appropriate interventions viors (Resident B). This deficient e resident was placed in handcuffs. miliation, chronic or recurrent fear, in the common area with other all upper extremities, from his ses included mild cognitive ra, not intractable, without status and agitation. 0/5/22), divalproex sodium milligram) every eight hours as luate and treat (4/25/23), and apply resolved, and monitor nds - report to physician any ed he was severely cognitively one to three days during the nt period. He needed supervision n on and off the unit.

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 155655

If continuation sheet Page 1 of 8

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER Peabody Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W Seventh St North Manchester, IN 46962	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0744 Level of Harm - Actual harm Residents Affected - Few	staff when they attempted to re-atta needing to help his brother. He bar his room including silverware, bottl when staff cleaned his room. He bar able to be redirected (11/8/22). His provide opportunity for positive inte (11/8/22), explain all procedures to reasonable, discuss his behavior, of (11/8/22). His POA was agreeable preferred not to have a headboard and one on one conversation to red. A behavior note, dated 4/23/23 at 5 supper. He was difficult to re-direct multiple times, and each time he whours and finally returned to his room and joking per his normal. He went leave the dining room. She approacontinuously repeated to himself woffered to take him to his room and headache medicine. The nurse agaresident who remained in the dining remain locked once meals were cofist and threatened to hit the nurse, dining room chair to hurt the nurse, stand and he fought the entire time walked with him, he fought and pul pushed against her. She was able onto the dining room table. He sho her. She told the aide to bring her to indicated she didn't know how to calispatch as she tried to avoid being 911 so he acted like he was fainting combative and very aggressive with assistance, if needed. The police and Another officer arrived on scene ar paperwork for the officers. When the with the officers at the rotunda until with the officers at the rotunda until	In for removing the headboard from his ach it. He threw his clothes around the aged the door into the wall and put a hores of hand sanitizer, and he may becord anged his head against the wall, he had interventions were anticipate and meeteraction, attention, stop and talk with his him before starting, and allow him time explain/reinforce why his behavior was to staff removing hoarded items from hon his bed (11/8/22). Validate his feeling direct him (12/12/22). 5:36 a.m., indicated he was in and out of with several attempts made by staff. Hould state the room was not his. He says my without incident. No further issues were to the dining room for lunch. It was reported him in an attempt to assist him frow hile he held his head in his hands and administer headache medication if never head was notified he would not leave the groom at that time. The dementia unit is mpleted. He continued to refuse to learn the other staff went to the opposite sing the nurse and the CNA placed their as and the daway. At this point, he threw the nurse and the CNA placed their as and the daway. At this point, he threw the nurse and the continued to refuse to learn the other into the wall multiple times, ping the phone and call 911. The aide hand all the police. The nurse made the call as go bitten and pinched. The resident realing. Staff ensured his safety and kept him he he nurse and the CNA. A nurse from the toth officer in the good and staff assisted with holding he and Resident B kicked the officer in the good and staff assisted with holding here nurse returned, Resident B was in a service and staff assisted with holding here nurse returned, Resident B was in a service and staff assisted with holding here nurse returned, Resident B was in a service and staff assisted with holding here nurse returned, Resident B was in a service and staff assisted with holding here nurse returned.	room, and was agitated about one in the wall. He hoarded items in the resistive or become agitated of no bruising or marks, and he was this needs (11/8/22), caregivers to mas you were passing by the to adjust to changes (11/8/22). If inappropriate and/or unacceptable his room as needed (2/13/23). He hags of anger/frustration (12/12/22), for a female resident's room after the was re-directed to his room the common area for a few overe noted. If the staff upon rising. He was friendly borted to the nurse he refused to me the dining room. He scratched his head repeatedly. She had the stated he didn't need any dining room doors were to always ove the dining room. He doubled his de of him as he began to lift the farms under his arms to assist him to be other staff member. As they have onto the table as he continually threw his body weight against her ched her, and attempted to bite hed the phone to the nurse and and attempted to speak with a upright. He again became an another unit arrived to provide him so police could handcuff him. If the provide and atken to a local hospital. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER Peabody Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W Seventh St North Manchester, IN 46962	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0744 Level of Harm - Actual harm Residents Affected - Few	A nurses note, dated 4/23/23 at 9:00 p.m., indicated the resident returned to the facility. He was in a good mood and joked around with a male EMT while he was assisted to his room. A new order was received for lorazepam one tablet every eight hours for anxiety (agitation episodes only). After the EMTs left the unit, he came to the common area and attempted to go into a female resident's room. He was re-directed away fron the resident's door and asked him if he was tired. He stated that he supposed he was. He was assisted bac to his room and he asked about his children. He was told his children had not been at the facility, but he would be notified if they were seen. He yelled they were at the facility and he was being lied to. He was reassured the nurse had been at the facility since 6:00 p.m. and may had missed them. He apologized and stated he appreciated the service that was given to him, and he didn't want to be nasty, but he would if he needed to be. A female resident walked up the nurse and he rudely asked her what she was looking at and to get away from him because the situation was none of her concern. The female resident walked away with no further altercation.		
	noted. A psychosocial note, dated 4/24/23 staff and visitors. He appeared to h day. A social service note, dated 4/25/2 had some PTSD. A trauma informed A risk management note, dated 4/2 behaviors during the reference per aggressive with staff and agitated. He returned with a new order of lor and assisted as needed. A 4/26/23, revised care plan, initiat left forearm, and post right and left interventions included administer s risk care plan (4/25/23) and notify pure the properties of the pr	bservation tool indicated his vitals were at 4:25 p.m., indicated he wandered the ave no lasting effect and did not remer as at 11:17 a.m., indicated the daughter as screening would be conducted. 15/23 at 12:19 p.m., indicated the intercod of 4/18/23 to 4/24/2. He became extended the included calling police an azepam. His care plan was appropriate and a serious and the serious and the serious and the serious as a serious as a serious and the serious at the serious and the	ne unit and was conversational with mber incident from the previous shared that she believed her father disciplinary team met to review his tremely physical and verbally d going to the emergency room. He would continue to be followed discolorations to his right forearm, and police/handcuffs. His for pain (4/25/23), follow skin at 23).

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER Peabody Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W Seventh St North Manchester, IN 46962	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0744 Level of Harm - Actual harm Residents Affected - Few	supper, he visited in the common a nurse when medications were adm noted to his bilateral forearms relat purple discoloration to his right fore skin was intact, it joined up to his ri purple discoloration to his left foreath His left post hand had purple discoskin was intact. He was able to mo The security video footage for the [p.m. The video was without sound kitchen area in the video footage. The table of the camera. At 12:12 p.m., Resident B ambulate the camera. At 12:48 p.m., there was a female of Resident B and touched him on the head. CNA 6 sat down across from up the dining room. At 12:50 p.m., he continued to rub to his left. The female resident was at 12:54 p.m., CNA 6 walked to the female resident at the other table. Sound appeared to be talking with him the back of his chair and slightly leads from the table. He continued to was standing in front of him. The female resident and his knees as soleaning cart out of the walkway. So where he sat, and LPN 26 was on the table of the placed her hands on his knees as soleaning cart out of the walkway. So where he sat, and LPN 26 was on the lateral of the walkway. So where he sat, and LPN 26 way unit, and the lateral of the walkway. So where he sat, and LPN 26 way unit, and the lateral was the lateral was on the lateral way unit, and the lateral was the lateral was supplied to the lateral was the	e [NAME] doors. LPN 26 entered the di She then walked to Resident B's left sidn. She stopped talking to him and stood aned over his left shoulder as she talke to rub his head. The female resident constant to his left side slightly behind his emale resident continued to sit at the other at the spoke to him. LPN 26 spoke to CN he walked towards Resident B to his rights left. In the constant of him as if to indicate for she spoke to him. LPN 26 spoke to CN he walked towards Resident B to his rights left. It is the constant of him as if to indicate for she spoke to him. LPN 26 spoke to CN he walked towards Resident B to his rights left. It is the constant of him as if to indicate for she spoke to him. LPN 26 spoke to CN he walked towards Resident B to his rights left.	and laughed. He joked with the the had latent discolorations and police/handcuffs. He had dark s) x 9 cm with no swelling and his at measured 10 cm x 8 cm. He had o swelling and his skin was intact. iith no swelling observed and his was reviewed on 4/24/23 at 3:15 beserved from a clock visible in the g: air at a table, his back was towards wining room. CNA 6 talked with nds and rubbed the back of his the dietary aide that was cleaning as left side then stood away from him and placed her hand on his back of at his left side with her hand on his back of this left side with her hand on his back of this left side with her hand on his back of this left side with her hand on his back of this left side with her hand on his back of this left side with her hand on his back of the him to take her hands, then she had 6 and CNA 6 moved the dietary ght side, between him and the table walked forward, away from the exit 26 moved in front of him and when

Printed: 12/22/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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.		agency.	
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.		with his back towards the camera. Were struggling with him and their CNA 17 entered the dining room He moved his body from side to diside to side, he pushed LPN 26 to 17 brought LPN 26 the phone. In and continued to have their on the table. He started to walk off behind him. LPN 26 was blocked CNA 17 was at eye level with him room, the resident turned to where boding onto him. He appeared to be or and moved them in a downward regs, and handcuffed his hands in some the camera. The policeman to his ceman stood in front of him. They cake into the dining room. CNA 6 chair and pushed him out of the If there was a physical altercation continued to kick at them, and they was cleaning the dining room, and ual headache. He had no real morning of the incident. They tried had the nurse pinned up to the ldn't break free. EMTs were called, CNA was able to get the to the chair and held that position hat day, and was told the basically hey were cleaning in the dining physically aggressive. They called hey sent him back because he was indicated Resident B was a veteran He had taken a sliding bathroom we towards anyone, nor threatened) would not pay for services in the psychiatric services, but they didn't felt they would not be able to get	

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 155655

If continuation sheet Page 5 of 8

	I		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION		A. Building	04/26/2023
	155655	B. Wing	07/20/2020
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact 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)		on)
F 0744		11:13 a.m., LPN 26 indicated Resident	
Level of Harm - Actual harm		the dining room per his usual. Lunch w The facility policy was the dining room	
Residents Affected - Few		on. The doors must be locked on their ubbing his head. He suffered from migr	•
	migraine medication, per his migrai	ine protocol. He became more and mor	re agitated and verbally
		ave me alone, I'm going to hurt you. Whoot on the chair. He was going to leave	
	to walk past her to go to the other s	side. She walked side to side to keep h de on his right. Then she was pushed u	im from going the other direction.
	pressed up against her. Her arm w	as locked in his arm as they walked an	d turned, and she was up against
		ushing. Her back hurt as a result. He h l at her feet as she was up against the	
	was on the phone with the 911 disp	patch. The police arrived and approach	ed him, and he started to fight. The
		s shoulder and reached around to han- ing room for meals and he would bring	•
		never seen him act like this before. She dining room. She didn't know if reappro	•
	1	with her, and would approach her to ca	•
	During an interview with CNA 17, on 4/25/23 at 2:32 p.m., she indicated the resident was fine at lunch. After lunch, he was always the last one out. He sometimes got irritated when asked to leave the dining room. She was walking another resident from the dining room when she heard someone screaming for her. She walked		
	into the dining room, and she asked Resident B what was wrong and if she could fix it. She had never seen him that mad, but she would be mad too if someone was holding both of her arms. They were trained not to hold anyone down, as it would put him into a fight or flight mode. They were taught that in dementia training.		
	LPN 26 had one of his arms and C	NA 6 had his other. She was not sure was not	what got them to this point. He
	1	n and then go back to his room and co	
		pened. Normally, you could coax him to ld watch him through the window. He d	
	in the dining room for a minute, and	d then she would wave him on. When h	ne showed any sign of irritation, she
	they made things worse by holding	ter. He kept screaming he had a migrai his arms. He was not normally aggres	sive. It was totally different with a
		his past and what he had been through	, , ,
	staff. The police took him and handcuffed him. The officer grabbed his shoulder and the resident started to cry. The police officer told him don't cry now. It was really hard to watch.		
	(continued on next page)		

		1	1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED
	155655	B. Wing	04/26/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact 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)		on)
F 0744 Level of Harm - Actual harm Residents Affected - Few	mood until after lunch, when he ling could talk to him and walk him to hi up his fist. He tried to pick up the clipushed her into the table. He was his silverware from his pockets and we because he kicked the policeman in hitting. She didn't push him, if she is said Resident B was going to use to in the dining room, the dietary peophe was not ready, and she sat down came in. He was already mad and to leave the dining room. He had comedicine, and he said he didn't need asked to leave the dining room, he silverware on his way out of the dirn his pockets. Other residents collect the dining room and put the silverwas very upset about the incident. planned to use the silverware as a During an observation of the dining 4/26/23 at 8:58 a.m., the following area on the Evergreen Park side, a open, but separated by half walls we dining rooms allowing free access the Evergreen Park were locked, with a During an interview with Agency Que have behaviors. Sometimes, he did headache. She had not seen him be Both noise and talking bothered hir come out of the dining room, and hyou tried to take them from him, he residents would take silverware froeating, they stood there or would on they stayed in there with him. If you walked beside him but didn't touch	a 4/25/23 at 2:46 p.m., she indicated the gered to come out of the dining room. Let is room. He was absolutely not having hair with his left hand and she put her I nitting, pinching, and kicking. LPN 26 cent to sit him in the chair. Police used a in the groin. He was normally kind of agained to get him out of a room, he would he silverware on someone, but didn't repole couldn't of handled him. When he was nacross the table from him for a while got up from the chair and doubled his formplained of a headache before it standed anything. He complained of headach was probably going to collect more silventing room. When the police handcuffed ted silverware, too. One resident collect vare in her room. The other resident put She knew he would probably blow one weapon. If room between the [NAME] Way unit a was observed: a dining area on the sid and another dining area in the middle of with windows. There was a walkway bet from one dining room to the next dining a handle with a turn style lock on the right. And A/26/23 at 9:08 a.m., she indicated in the middle of the had chronic migraines. He was use liked to steal the silverware. He just the would get upset. They just went in anom the dining room. If he didn't want to loome back if he was just sitting in there. It would get upset. They just went in anom the dining room. If he didn't want to loome back if he was just sitting in there. It pushed his chair back or touched him him, he was not a touchy person. There pened until they were ready to serve mental the silverware in the pened until they were ready to serve mental the silverware.	LPN 26 came in and thought she it, and he screamed and doubled eg on it. He just went off, and alled the police. They took pressure point on his shoulder gressive, but not to the point of lyell at her. A staff member had eport it. They couldn't have left him ras first approached, he indicated and talked to him. Then the nurse fist. He was fine until she asked him ted. LPN 26 asked him if he needed nes all of the time. When he was verware. He tried to pocket him, she took the silverware from ted silverware on her way out of the silverware in her purse. CNA 6 day. She heard he may have and the Evergreen Park Unit, on the of the [NAME] Way unit, a dining if them. The dining rooms were tween the kitchen area and the groom. The double doors to enter the head and he, he would put his head down. It is also took them back to his room, and if dook it from his room later. A lot of leave the dining room and was the tried to go to the other side, if the would just make him mad. She we was a note in the dining room to

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER Peabody Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W Seventh St North Manchester, IN 46962	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0744 Level of Harm - Actual harm Residents Affected - Few			
	needs including distress The deficient practice was correcte	by the resident typically expresses phy and by April 24, 2023, prior to the start of mpleted assessments, audits, and edu	the survey, and was therefore past
	This Federal tag relates to complai 3.1-37(a)	nt IN00407085.	