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	04/26/2023

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 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 Based on observation, interview and record review, the facility failed to provide appropriate interventions related to dementia behavioral care for 1 of 3 residents reviewed for behaviors (Resident B). This deficient practice resulted in an altercation with staff, the police were called, and the resident was placed in handcuffs. Using the reasonable person concept, it is likely that this would lead to humiliation, chronic or recurrent fear, and anxiety. Findings include: On 4/25/23 at 10:00 a.m., Resident B was sitting quietly in a facility chair in the common area with other residents during an activity. He had dark purple discoloration to his bilateral upper extremities, from his hands and the length of his forearms. Resident B's clinical record was reviewed on 4/25/23 at 9:45 a.m. Diagnoses included mild cognitive impairment of uncertain or unknown etiology, chronic migraine without aura, not intractable, without status migrainosus, Alzheimer's disease, adult failure to thrive, and restlessness and agitation. His current orders included ibuprofen (pain reliever) 400 mg twice daily (10/5/22), divalproex sodium (anticonvulsant) 250 mg daily (2/13/23), lorazepam (treat anxiety) 1 mg (milligram) every eight hours as needed (only for agitation episodes) (4/23/23), psychiatric provider to evaluate and treat (4/25/23), and apply skin repair lotion to discoloration bilateral arms and hands every shift until resolved, and monitor discolorations to left forearm, right forearm, and right and left posterior hands - report to physician any complications (4/26/23). A quarterly MDS (Minimum Data Set) assessment, dated 3/23/23, indicated he was severely cognitively impaired. He had other behavioral symptoms not directed towards others one to three days during the assessment period. He wandered one to three days during the assessment period. He needed supervision for bed mobility, transfers, walking in his room and corridor and locomotion on and off the unit. A Trauma Informed Care Screening PTSD (Post-Traumatic Stress Disorder) test, dated 9/15/22, indicated he did not have any known previous trauma. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0744 Level of Harm - Actual harm Residents Affected - Few	He had a current behavior care plan for removing the headboard from his bed, and he became agitated with staff when they attempted to re-attach it. He threw his clothes around the room, and was agitated about needing to help his brother. He banged the door into the wall and put a hole in the wall. He hoarded items in his room including silverware, bottles of hand sanitizer, and he may become resistive or become agitated when staff cleaned his room. He banged his head against the wall, he had no bruising or marks, and he was able to be redirected (11/8/22). His interventions were anticipate and meet his needs (11/8/22), caregivers to provide opportunity for positive interaction, attention, stop and talk with him as you were passing by (11/8/22), explain all procedures to him before starting, and allow him time to adjust to changes (11/8/22). If reasonable, discuss his behavior, explain/reinforce why his behavior was inappropriate and/or unacceptable (11/8/22). His POA was agreeable to staff removing hoarded items from his room as needed (2/13/23). He preferred not to have a headboard on his bed (11/8/22). Validate his feelings of anger/frustration (12/12/22), and one on one conversation to redirect him (12/12/22). A behavior note, dated 4/23/23 at 5:36 a.m., indicated he was in and out of a female resident's room after supper. He was difficult to re-direct with several attempts made by staff. He was re-directed to his room multiple times, and each time he would state the room was not his. He sat in the common area for a few hours and finally returned to his room without incident. No further issues were noted. A behavior note, dated 4/23/23 at 3:31 p.m., indicated he was pleasant with staff upon rising. He was friendly and joking per his normal. He went to the dining room for lunch. It was reported to the nurse he refused to leave the dining room. She approached him in an attempt to assist him from the dining room. He continuously repeated to himself while he held his head in his hands and scratched his head repeatedly. She offered to take him to his room and administer headache medication if needed. He stated he didn't need any headache medicine. The nurse again was notified he would not leave the dining room. He was the only resident who remained in the dining room at that time. The dementia unit dining room doors were to always remain locked once meals were completed. He continued to refuse to leave the dining room. He doubled his fist and threatened to hit the nurse. The other staff went to the opposite side of him as he began to lift the dining room chair to hurt the nurse. The nurse and the CNA placed their arms under his arms to assist him to stand and he fought the entire time. He attempted to bite the nurse and the other staff member. As they walked with him, he fought and pulled away. At this point, he threw the nurse onto the table as he continually pushed against her. She was able to get to a standing point and again he threw his body weight against her onto the dining room table. He shoved her into the wall multiple times, pinched her, and attempted to bite her. She told the aide to bring her the phone and call 911. The aide handed the phone to the nurse and indicated she didn't know how to call the police. The nurse made the call and attempted to speak with dispatch as she tried to avoid being bitten and pinched. The resident realized the nurse was speaking with 911 so he acted like he was fainting. Staff ensured his safety and kept him upright. He again became combative and very aggressive with the nurse and the CNA. A nurse from another unit arrived to provide assistance, if needed. The police arrived and staff assisted with holding him so police could handcuff him. Another officer arrived on scene and Resident B kicked the officer in the groin. The nurse left to print paperwork for the officers. When the nurse returned, Resident B was in a wheelchair. The nurse remained with the officers at the rotunda until EMS arrived. He was placed on gurney and taken to a local hospital. The incident was reported to the unit manager, administrator, and social service. (continued on next page)

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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 from the resident's door and asked him if he was tired. He stated that he supposed he was. He was assisted back 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. A 4/24/23, weekly vital signs/skin observation tool indicated his vitals were taken and no skin issues were noted. A psychosocial note, dated 4/24/23 at 4:25 p.m., indicated he wandered the unit and was conversational with staff and visitors. He appeared to have no lasting effect and did not remember incident from the previous day. A social service note, dated 4/25/23 at 11:17 a.m., indicated the daughter shared that she believed her father had some PTSD. A trauma informed screening would be conducted. A risk management note, dated 4/25/23 at 12:19 p.m., indicated the interdisciplinary team met to review his behaviors during the reference period of 4/18/23 to 4/24/2. He became extremely physical and verbally aggressive with staff and agitated. Interventions included calling police and going to the emergency room . He returned with a new order of lorazepam. His care plan was appropriate. He would continue to be followed and assisted as needed. A 4/26/23, revised care plan, initiated on 4/25/23, indicated he had latent discolorations to his right forearm, left forearm, and post right and left hands related to altercation with staff and police/handcuffs. His interventions included administer skin repair as directed (4/25/23), assess for pain (4/25/23), follow skin at risk care plan (4/25/23) and notify physician of worsening condition (4/25/23). His behavior care plan was revised, on 4/25/23, and indicated he may not want to leave an area when requested, give him plenty of time. His intervention was to allow him to exit areas in his own time and provide a safe environment (4/25/23). (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A nurses note, dated 4/26/23 at 12:18 a.m., indicated he was pleasant with staff and other residents. After supper, he visited in the common area with other residents, and he smiled and laughed. He joked with the nurse when medications were administered. He denied pain or discomfort. He had latent discolorations noted to his bilateral forearms related to his recent altercation with staff and police/handcuffs. He had dark purple discoloration to his right forearm that measured 20 cm (centimeters) x 9 cm with no swelling and his skin was intact, it joined up to his right posterior hand with discoloration that measured 10 cm x 8 cm. He had purple discoloration to his left forearm that measured 13 cm x 8 cm with no swelling and his skin was intact. His left post hand had purple discoloration and measured 12 cm x 7 cm with no swelling observed and his skin was intact. He was able to move his bilateral arms without difficulty. The security video footage for the [NAME] Way dining room, from 4/23/23, was reviewed on 4/24/23 at 3:15 p.m. The video was without sound and time. The approximate time was observed from a clock visible in the kitchen area in the video footage. The video footage indicated the following: At 12:12 p.m., Resident B ambulated into the dining room and sat in a chair at a table, his back was towards the camera. At 12:48 p.m., there was a female resident sitting at another table in the dining room. CNA 6 talked with Resident B and touched him on the arm. He rubbed his face with open hands and rubbed the back of his head. CNA 6 sat down across from him at the table and talked to him and the dietary aide that was cleaning up the dining room. At 12:50 p.m., he continued to rub his head. CNA 6 got up and went to his left side then stood away from him to his left. The female resident was still at the other table. At 12:54 p.m., CNA 6 walked to the [NAME] doors. LPN 26 entered the dining room and talked with the female resident at the other table. She then walked to Resident B's left side and placed her hand on his back and appeared to be talking with him. She stopped talking to him and stood at his left side with her hand on the back of his chair and slightly leaned over his left shoulder as she talked to him, then pushed his chair back from the table. He continued to rub his head. The female resident continued to sit at the other table. At 12:57 p.m., LPN 26 continued to stand to his left side slightly behind him as she talked with CNA 6 who was standing in front of him. The female resident continued to sit at the other table. At 12:58 p.m., LPN 26 placed her hands in front of him as if to indicate for him to take her hands, then she placed her hands on his knees as she spoke to him. LPN 26 spoke to CNA 6 and CNA 6 moved the dietary cleaning cart out of the walkway. She walked towards Resident B to his right side, between him and the table where he sat, and LPN 26 was on his left. At 1:00 p.m., Resident B slightly pushed his chair back and stood up. He walked forward, away from the exit door from the [NAME] Way unit, and was faced towards the camera. LPN 26 moved in front of him and when he moved, she moved and placed her arms out to her side to block him from walking the opposite direction from the exit doorway. CNA 6 walked up to the right side of him. At 1:01 p.m., the female resident left the dining room. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	At 1:02 p.m., LPN 26 took the resident's right arm, and he turned around with his back towards the camera. CNA 6 was on the left side of him, and LPN 26 was in front of him. They were struggling with him and their arms were interlocked with his arms as they struggled to hang onto him. CNA 17 entered the dining room and appeared to talk to him while CNA 6 and LPN 26 struggled with him. He moved his body from side to side with his legs spread apart. CNA 17 left the dining room. As he moved side to side, he pushed LPN 26 to where her buttocks landed on top of the table he had been sitting at. CNA 17 brought LPN 26 the phone. CNA 17 bent down and appeared to speak to him as they struggled with him and continued to have their arms in his. He broke free from CNA 6's arm and LPN 26 remained sitting on the table. He started to walk forward, and CNA 6 held onto him with both her hands and stood to the left behind him. LPN 26 was blocked by the [NAME] door from the camera view. CNA 6 held his left arm while CNA 17 was at eye level with him and appeared to be going through his pockets. As CNA 17 left the dining room, the resident turned to where CNA 6 was on his left, and LPN 26 was on his right up against the wall, holding onto him. He appeared to be kicking at them. A dietary aide in the area had her hands out in front of her and moved them in a downward motion, as if to indicate to calm down. At 1:10 p.m., police officers entered the dining room, held the resident's legs, and handcuffed his hands in front of his body. They sat him in a dining room chair with his back towards the camera. The policeman to his right placed his left hand on Resident B's right shoulder and the other policeman stood in front of him. They stood him up and walked him out of the dining room, then brought him back into the dining room. CNA 6 brought a wheelchair in the dining room and they placed him in the wheelchair and pushed him out of the dining room at 1:15 p.m. During an interview with the DON, on 4/25/23 at 10:22 a.m., she indicated there was a physical altercation with Resident B, a CNA and a nurse. The police tried to restrain him. He continued to kick at them, and they took him to the hospital. He was returned to the facility. The dietary staff was cleaning the dining room, and the resident was putting his hands on his head as if he may of had an actual headache. He had no real behaviors before or after the incident. He had been easily redirected the morning of the incident. They tried to handle the situation gingerly, but he was physically hitting the staff and had the nurse pinned up to the table. He had silverware in his pocket. He had her arm in his and she couldn't break free. EMTs were called, but the police arrived first. No one grabbed him until the police came. The CNA was able to get the silverware from him. The police put him in an arm move to sit him down into the chair and held that position as they handcuffed him. The Unit Manger had indicated she was on call that day, and was told the basically the same thing. He was fine in the morning and was easily redirectable. They were cleaning in the dining room and asked if he was ready to go and he lost it on them and became physically aggressive. They called 911 and EMTs took him to the hospital, where an evaluation was done. They sent him back because he was not aggressive while he was at the hospital. During an interview with Social Service 12, on 4/25/23 at 10:45 a.m., she indicated Resident B was a veteran with behaviors. He had banged his head on the wall; it was care planned. He had taken a sliding bathroom door, bent it, and removed it from the tract. He was not normally aggressive towards anyone, nor threatened anyone. He did not receive psychiatric services. The VA (Veterans Affairs) would not pay for services in the facility and the facility's provider was not in their network. The VA offered psychiatric services, but they didn't want to take him there because he was an elopement risk, and his family felt they would not be able to get him back into the facility. She thought he may have gone to a VA appointment last week. On 4/24/23, he walked around and talked to people like a normal dementia resident. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 4/25/23 at 11:13 a.m., LPN 26 indicated Resident B's morning was great on 4/23/23. He was talkative with staff and left the dining room per his usual. Lunch was served later than usual, between 12:45 p.m. and 1:00 p.m. The facility policy was the dining room doors were to be locked, as the unit next door was under construction. The doors must be locked on their side to keep the residents safe. She approached him and he was rubbing his head. He suffered from migraines, and she offered him migraine medication, per his migraine protocol. He became more and more agitated and verbally threatening. He said if you don't leave me alone, I'm going to hurt you. When he stood up, he was going to pick up the chair and she put her foot on the chair. He was going to leave the dining room and he was going to walk past her to go to the other side. She walked side to side to keep him from going the other direction. She was on his left side and the aide on his right. Then she was pushed up against the table, and he pressed up against her. Her arm was locked in his arm as they walked and turned, and she was up against the wall and he kept pushing and pushing. Her back hurt as a result. He had escalated so much with no redirection or calming. He stomped at her feet as she was up against the wall. He tried to bite her while she was on the phone with the 911 dispatch. The police arrived and approached him, and he started to fight. The officer had his hand on Resident B's shoulder and reached around to hand cuff him. Normally Resident B needed prompts to come to the dining room for meals and he would bring himself out to the dining room. This was a new behavior, she had never seen him act like this before. She felt for everyone's safety, it was necessary to remove him from the dining room. She didn't know if reapproaching him would have made a difference. She felt he was familiar with her, and would approach her to call his family. 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 CNA 6 had his other. She was not sure what got them to this point. He collected silverware, and if you tried to get the silverware from him, he got upset. She would normally let him take the silverware back to his room and then go back to his room and collect it later. She wished she was in the dining room before all this happened. Normally, you could coax him to leave or leave him and reapproach him later, and she would watch him through the window. He didn't usually get mad. He would sit in the dining room for a minute, and then she would wave him on. When he showed any sign of irritation, she would leave him and come back later. He kept screaming he had a migraine during the incident, and she felt they made things worse by holding his arms. He was not normally aggressive. It was totally different with a military man, you don't know about his past and what he had been through. He was trying to get away from 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)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview with CNA 6, on 4/25/23 at 2:46 p.m., she indicated the resident had been in a good mood until after lunch, when he lingered to come out of the dining room. LPN 26 came in and thought she could talk to him and walk him to his room. He was absolutely not having it, and he screamed and doubled up his fist. He tried to pick up the chair with his left hand and she put her leg on it. He just went off, and pushed her into the table. He was hitting, pinching, and kicking. LPN 26 called the police. They took silverware from his pockets and went to sit him in the chair. Police used a pressure point on his shoulder because he kicked the policeman in the groin. He was normally kind of aggressive, but not to the point of hitting. She didn't push him, if she tried to get him out of a room, he would yell at her. A staff member had said Resident B was going to use the silverware on someone, but didn't report it. They couldn't have left him in the dining room, the dietary people couldn't of handled him. When he was first approached, he indicated he was not ready, and she sat down across the table from him for a while and talked to him. Then the nurse came in. He was already mad and got up from the chair and doubled his fist. He was fine until she asked him to leave the dining room. He had complained of a headache before it started. LPN 26 asked him if he needed medicine, and he said he didn't need anything. He complained of headaches all of the time. When he was asked to leave the dining room, he was probably going to collect more silverware. He tried to pocket silverware on his way out of the dining room. When the police handcuffed him, she took the silverware from his pockets. Other residents collected silverware, too. One resident collected silverware on her way out of the dining room and put the silverware in her room. The other resident put the silverware in her purse. CNA 6 was very upset about the incident. She knew he would probably blow one day. She heard he may have planned to use the silverware as a weapon. During an observation of the dining room between the [NAME] Way unit and the Evergreen Park Unit, on 4/26/23 at 8:58 a.m., the following was observed: a dining area on the side of the [NAME] Way unit, a dining area on the Evergreen Park side, and another dining area in the middle of them. The dining rooms were open, but separated by half walls with windows. There was a walkway between the kitchen area and the dining rooms allowing free access from one dining room to the next dining room. The double doors to enter Evergreen Park were locked,with a handle with a turn style lock on the right-side door. During an interview with Agency QMA, on 4/26/23 at 9:08 a.m., she indicated she had not seen Resident B have behaviors. Sometimes, he didn't want to come out of his room, because he was tired or he had a headache. She had not seen him be aggressive. When he had a headache, he would put his head down. Both noise and talking bothered him. He had chronic migraines. He was usually one of the last residents to come out of the dining room, and he liked to steal the silverware. He just took them back to his room, and if you tried to take them from him, he would get upset. They just went in and took it from his room later. A lot of residents would take silverware from the dining room. If he didn't want to leave the dining room and was eating, they stood there or would come back if he was just sitting in there. If he tried to go to the other side, they stayed in there with him. If you pushed his chair back or touched him, it would just make him mad. She walked beside him but didn't touch him, he was not a touchy person. There was a note in the dining room to indicate the doors were not to be opened until they were ready to serve meals so the residents didn't go in there. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview with QMA 29, on 4/26/23 at 9:52 a.m., she indicated Resident B was normally in a happy mood, and not aggressive with her. He refused to shower for her. He liked to sleep most of the day. He was good if he stayed in his routine. Once he got upset then he would get really upset. He became upset if disrupted from what he wanted to do. He needed more encouragement to redirect him. She did not touch him or pull on his arm, as it would upset him. He normally was the last one to leave the dining room, and most of the time he would go out on his own. If he was just sitting there, she encouraged him with an activity to come out of the dining room. During an interview with Dietary Aide 15, 4/26/23 at 10:11 a.m., she indicated she was not working the day of the incident and she was shocked that it happened. Resident B was nice. He was usually one of the last residents to leave the dining room, and they would let him sit. He would eventually leave. She had not seen him be aggressive. During an interview with Housekeeper 4, on 4/26/23 at 10:15 a.m., she indicated Resident B was nice talk to. She talked to him about how he used to fly airplanes and the weather. They made small talk. He was a nice gentleman. She had not seen him be aggressive. Review of a document tilted Communication and Alzheimer's, Communication in the middle stage, (2023) was retrieved on 4/26/23 from the Alzheimer's Association website (www.alz.org/help-support/caregiving/daily-care/communications). The document indicated the following: .The tips for successful communication included engage the person in one-on-one conversation in a quiet space that has minimal distractions, speak slowly and clearly, maintain eye contact. It shows you care about what he or she is saying, give the person plenty of time to respond so he or she can think about what to say . be patient and offer reassurance. It may encourage the person to explain his or her thoughts . avoid arguing. If the person says something you don't agree with, let it be A current, undated, facility policy tilted Dementia - Clinical Protocol, provided by the DON, on 4/26/23 at 2:55 p.m., indicated the following: .Assessment and Recognition .4. The IDT will review the past and current physical, functional, and psychosocial status of each individual with dementia to formulate an accurate overall picture of the individual's condition, related complications and functional impairments. a. Using several sources, including the resident (if appropriate), family and information form prior records, the following information will be collected and documented in the resident's record: 1. Life experiences .5. Mood and behavior patterns, including how the resident typically expresses physical, emotional and psychosocial needs including distress The deficient practice was corrected by April 24, 2023, prior to the start of the survey, and was therefore past noncompliance. The facility had completed assessments, audits, and education related to the facility's dementia care protocol. This Federal tag relates to complaint IN00407085. 3.1-37(a)