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	03/17/2022

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40461 Based on observation, record review and interview, the facility failed to ensure residents were served their meals in a dignified manner for 2 of 3 residents reviewed for dignity (Residents 113 and 40). Findings include: During an observation of meal service, on 3/10/22 at 11:39 a.m., CNA 13 delivered a meal tray to Resident 113, he did not speak to her or take the domed lid off of the plate. Her tablemate, Resident 40, had her meal tray in front of her, the domed lid covered the meal. After a couple of minutes of sitting and looking at their trays, Resident 113 removed her domed lid and Resident 40 then removed her lid. Both resident tried unsuccessfully to cut their meat. They were eating the side dishes. On 3/10/22 at 11:53 a.m., both residents continued to try to cut meat but were unable. On 3/10/22 at 11:56 a.m., a staff member got up form assisting another resident with her meal and cut the meat on both resident's plates. 1. Resident 113's clinical record was reviewed on 3/16/22 at 2:38 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, protein-calorie malnutrition and body mass index 19.9 or less. A 2/15/22 quarterly MDS (Minimum Data Set) assessment indicated she had severe cognitive impairment and required set-up assistance with meals. A current care plan, with a revised date of 2/1/22, indicated she had an ADL (Activity of Daily Living) performance deficit. Interventions included, but were not limited to, staff assisted with eating as needed, the date initiated was 10/25/21. 2. Resident 40's clinical record was reviewed on 3/16/22 at 2:55 p.m. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance and need for assistance with personal care. A 12/29/21 quarterly MDS assessment indicated she had severe cognitive impairment and required set-up assistance with meals. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current care plan, with a revised date of 2/5/21, indicated she had impaired nutrition altered nutritional status. Interventions included, but were not limited to, staff assisted with meals (feed/set-up) as needed, the date initiated was 2/5/21. Review of a current facility policy, titled Abuse Prevention Program,' with a revised date of 8/2016 and received from entrance conference on 3/7/22, indicated .II. Orientation and Training of Employees. During orientation of new employees, the community will cover at least the following topics: *Sensitivity to resident rights and resident needs 3.1-3(t)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35283 Based on observation, interview and record review, the facility failed ensure Advanced Directives were signed by the resident/resident representative and updated in the clinical record for 3 of 4 residents reviewed for Advance Directives (Resident 26, 79 and 279). Findings include: 1. Review of Resident 26's clinical record was completed on [DATE] at 11:02 a.m. He had a current physician order for Do Not Resuscitate. Review of a [DATE] Indiana Physician Orders for Scope of Treatment (POST) document indicated it was signed by the Physician Assistant, but not by the resident/resident representative. 2. Review of Resident 79's clinical record was completed on [DATE] at 9:50 a.m. She had a current physician order for Do Not Resuscitate. Review of a POST form, dated [DATE], indicated it was signed by the Physician Assistant, but not by the resident/resident representative. Review of [DATE] hospital transfer documents indicated a copy of the [DATE] POST form had been sent to the hospital as proof of the resident's wishes. During an interview, on [DATE] at 12:08 p.m., the DON indicated the facility had identified a problem with a number of resident's advance directives documents the prior Friday, [DATE] and were reviewing them for accuracy. 40461 3. During a random observation, on [DATE] at 8:48 a.m., first responders had been been observed exiting from room [ROOM NUMBER]. Resident 279's clinical record was reviewed on [DATE] at 2:46 p.m. Diagnoses included, but were not limited to, acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, stage 3 chronic kidney disease, type 2 diabetes mellitus and pleural effusion. Physician orders included, but were not limited to, DNR (Do Not Resuscitate), the revised date was [DATE]. A discontinued care plan, dated [DATE] and discontinued on [DATE], indicated resident and power of attorney had elected a full code status. An interact change of condition evaluation, dated [DATE] at 9:13 a.m., indicated she had increased shortness of breath, altered mental status and hypotensive. An order to send the resident to the emergency room had been received. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated [DATE] at 6:45 p.m., indicated she had readmitted to the facility from the hospital A nursing progress note, dated [DATE] at 4:53 a.m., indicated her oxygen saturation had been between , d+[DATE]%, lungs sounds were diminished throughout. A provider note, dated [DATE] at 10:57 a.m., indicated she had originally admitted to the facility for rehabilitation but her condition had quickly deteriorate, she had recently readmitted to the facility from the hospital with comfort care and hospice referral orders. Her prognosis was very poor, she had been discharge from the hospital to be placed on hospice care. A progress note, dated [DATE] at 12:32 p.m., indicated the Social Service Director had spoke with the POA regarding notes from the hospital requesting hospice/comfort measures be considered. The POA was agreeable with a hospice referral and wanted to change the resident's code status to DNR, he planned to be at the facility after lunch and would sign forms for the DNR code status. A referral had been made to a hospice provider. A nursing progress note, dated [DATE] at 3:10 p.m., indicated the POA had signed papers for DNR code status. Review of an Indiana POST (Physician Orders for Scope of Treatment) form, signed by the resident's POA (Power of Attorney) on [DATE] and the NP (Nurse Practitioner) on [DATE], indicated comfort measures (allow natural death). A nursing progress note, dated [DATE] at 8:53 a.m., indicated the resident had been found unresponsive, CPR (Cardio-Pulmonary Resuscitation) had been initiated because the facility had not yet received a physician or NP signature on the DNR order . 911 was called. DON arrived to the room and called the NP. The NP indicated the POA was firm that he did not want CPR performed. Staff stopped performing CPR. POA was notified that his mother had passed away. First responders arrived at the facility and indicated that without a signed order for DNR, had minimal requirements to sustain life. First responders had been notified of the verbal DNR order, their protocol included a signed order. POA was notified, he indicated he was upset and hung the phone up. POA called back into the facility and spoke with the DON and first responders. Staff performed post mortem care. During an interview, on [DATE] at 1:28 p.m., the DON indicated the son had signed the DNR code status, the nurse had thought the order was not valid until it had been signed by the physician or NP. An order was considered valid once it was entered into the clinical record. The NP had signed the POST form after the resident had passed away. Review of a current facility policy, titled Advance Directive, with a revised date of [DATE] and provided by the DON on [DATE] at 11:18 a.m., indicated Advance directives will be respected in accordance with state law and facility policy .7. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive 3XXX,d+[DATE](d)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 45122 Based on interview and record review, the facility failed to provide notification of Medicare noncoverage for 1 of 4 residents reviewed for beneficiary protection notifications (Resident 112). Findings include: Review of a record, provided by SSD 47 on 3/10/22 at 3:08 p.m., indicated Resident 112's last covered day of Part A (Medicare) service was 1/31/22. Information about the notice of Medicare noncoverage and the skilled nursing facility advance beneficiary notice of non-coverage was lacking. During an interview, on 3/10/22 at 4:08 p.m., [NAME] Specialist 48 indicated the social services worker who would have performed the task of ensuring notification paperwork was completed was no longer employed at the facility. She indicated the facility was unable to locate paperwork for Resident 112's notification of Medicare noncoverage. Review of a current facility policy, titled Medicare Advance Beneficiary Notice and dated 4/2021, provided by the DON on 3/11/22 at 3:27 p.m., indicated . 1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). a. The facility issues the Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers but may not pay for because the care is considered 'not medically reasonable and necessary,' or 'custodial' .2. If the resident's Medicare Part A benefits are terminating for coverage reasons, the director of admissions or benefits coordinator issues the Notice of Medicare Non-Coverage (CMS form 10123) to the resident at least two calendar days before Medicare covered services end (for coverage reasons) . 3.1-4(f)(3)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45122 Based on observation, interview, and record review the facility failed to provide adequate supervision and intervention to prevent resident to resident abuse for 4 of 7 residents reviewed for resident to resident abuse. (Resident 117, Resident 93, Resident 107, and Resident 108) This deficiency resulted in Resident 117 grabbing Resident 65 resulting in Resident 117 falling and fracturing her left hand. The immediate jeopardy began on 2/9/22, when Resident 117 grabbed Resident 65 and had a fall that resulted in a left hand fracture. The Administrator and DON were notified of the immediate jeopardy on 3/15/22 at 11:04 a.m. Findings include: 1.On 3/08/22 at 2:03 p.m., Resident 117 was observed ambulating independently in the common area, she stopped and stroked another resident's hair. On 3/10/22 at 8:52 a.m., Resident 117 was observed ambulating independently into Resident 93's room. On 3/15/22 at 9:00 a.m., Resident 117 was observed ambulating into another resident's room. There were no facility staff visible. Resident 117's clinical record was reviewed, on 3/10/22 at 3:01 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, repeated falls, difficulty in walking, and displaced fracture of base of second metacarpal bone of left hand (2/14/22). A quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was severely cognitively impaired. She was never or rarely understood. Inattention or disorganized thinking behaviors were continuously present. Staff assessment of the resident's mood indicated, she was short-tempered or easily annoyed two to six days. Her verbal behavioral symptoms directed toward others occurred one to three days. She required extensive assist of one staff member for walking in room, walking in corridor, and locomotion on unit. No mobility devices were listed. Medication orders included, but were not limited to, Lexapro 5 mg daily and Tylenol 650 mg three times a day. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She had a focused care plan, initiated 2/23/22, for resident to resident altercations which indicated, but was not limited to, when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings (2/23/22), allow resident to express their emotions/feelings about (2/23/22) , consult with: pastoral care, social services, psych services (2/23/22), encourage participation from resident who depends on others to make own decisions (2/23/22), high risk walking rounds (2/23/22), increase communication between resident/family/caregivers about care and living environment: explain all procedures and treatments, medications, results of labs/tests, condition, all changes(2/23/22), initiate referrals as needed or increase social relationships(2/23/22), monitor/document resident's usual response to problems: Internal how individual makes own changes, external - expects others to control problems or leaves to fate, or luck (2/23/22). A progress note, on 2/9/22 at 7:40 p.m., indicated the resident was ambulating in the hallway. She grabbed the arm of Resident 65. Resident 65 jerked her arm away causing the resident to lose balance and sit on floor. On the way down, she encountered Resident 65's zipper on sweater causing a laceration. An Interdisciplinary Team (IDT) progress note, on 2/10/22 at 9:10 a.m., indicated the resident grazed her left eyebrow on Resident 65's sweater. A progress note, dated 2/11/22 at 2:07 a.m., indicated the resident's left hand was swollen over the knuckle. A progress note, dated 2/12/22 at 2:44 p.m., indicated the left hand was swollen and bruised. The nurse practitioner (NP) ordered X-rays of the left hand. The Xray on 2/13/22 of the left hand with two views indicated an acute oblique fracture at base of the 2nd proximal phalanx. During a confidential interview a staff member indicated she did not have enough help to do what she needed to do. She indicated there were times when she worked when there was only one CNA there for the unit. She indicated she was supposed to keep an eye on Resident 117. During an interview, with RN 43 on 3/10/22 at 12:32 p.m., she indicated high risk walking rounds signified residents were checked every 15 minutes. She indicated the high risk walking rounds were signed off in the treatment administration record one time a shift, not every 15 minutes. During an interview, with LPN 46 on 3/11/22 at 11:00 a.m., she indicated she would give Resident 117 a cookie to distract her. To prevent altercations, she would intervene immediately and remove the residents from the situation. QMA 44 indicated, during an interview on 3/11/22 at 11:18 a.m., she had not worked this unit much, but she asked the other staff at shift change what interventions were needed for the residents. She indicated it was tough to know what the interventions were but would get to know them as she worked the unit more often. During an interview, on 3/14/22 11:11 a.m., CNA 42 indicated the care plans in the kiosk gave the interventions for the residents. She indicated Resident 117 needed directed away from crowded areas. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 3/15/22 at 9:19 a.m., CNA 41 indicated they have activities for the residents. She indicated they try to distract the residents as much as they can when the residents were upset. She indicated Resident 117 liked to go into other residents' rooms and the staff try to direct her out. 2. On 3/7/22 at 11:21 a.m., Resident 93 was observed ambulating independently about the unit. On 3/8/22 at 8:25 a.m., Resident 93 was observed sitting at table in the activity/dining area with her head resting on a table and was wearing a helmet. On 3/14/22 at 10:16 a.m., Resident 93 was observed ambulating independently in her room and wearing a helmet. Resident 93's clinical record was reviewed on 3/10/22 at 11:16 a.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, Alzheimer's early onset, major depressive disorder, restlessness and agitation, anxiety disorder, psychosis and cognitive communication deficit. A quarterly MDS, dated [DATE], indicated the resident was severely cognitively impaired. The resident was never or rarely understood. The resident never or rarely understands. Inattention or disorganized thinking behaviors were continuously present. The resident required supervision with one staff member assist for walking in her room, the corridor and locomotion on the unit. Her physician orders included, but were not limited to, lorazepam 0.5 mg three times a day for agitated catatonia. A focused care plan for resident to resident altercations included, but was not limited to the following interventions: allow resident to express their emotions/feelings about incident (10/23/21), consult with: pastoral care, social services, psych services (10/23/21), high risk walking rounds (10/23/21), and if resident moving furniture in common area, staff to move furniture back to original (10/25/21). A progress note, dated 3/3/22 at 2:30 p.m., indicated Resident 93 was wandering around in the common area when she came up behind and pinched Resident 108. An IDT note, dated 3/4/22 at 9:20 a.m., indicated during the resident to resident altercation, Resident 93 walked up behind another resident and pinched other resident 108 on back of right upper arm. Residents were immediately separated. RN 43 indicated, during an interview, on 3/14/22 at 10:22 a.m., Resident 93 liked to touch others, the staff try to intervene when necessary. During an interview, on 3/14/22 at 11:11 a.m., CNA 42 indicated the stop signs seem to come up missing. She indicated she thought Resident 108 was supposed to have a stop sign hanging across her doorway but was not certain. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 3/15/22 at 9:15 a.m., CNA 42 indicated she tries to keep the residents separated to prevent altercations. She indicated Resident 108 became upset if anyone touched her. Resident 93 upset other residents. 3. On 3/7/22 at 3:56 p.m. Resident 45 was observed sitting in a chair and participating in an activity. On 03/15/22 at 09:35 a.m., Resident 45 was observed lying in her bed turned away from the door covered by a blanket. Resident 45's record was reviewed on 3/14/22 at 3:45 p.m. Her diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance and age related cognitive decline. A quarterly MDS, dated [DATE], indicated the resident was severely cognitively impaired. Staff assessment of mood indicated the resident was short-tempered, easily annoyed two to six days. A focused care plan on resident to resident altercations included, but was not limited to, the following interventions: consult with pastoral care, social services, psych services, Psych nurse to assess for anxiety (11/8/21) , high risk wandering rounds (2/21/21), social service to look in on resident offer support to resident and family (2/21/21), visits from spiritual leaders and other individuals as identified by resident and family(2/21/21), and when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings(2/21/21). A progress note, dated 10/23/21 at 1:16 a.m., indicated a review of a video showed Resident 45 pushed the chair out from under Resident 93 when Resident 93 went to sit back down in the char that was in front of Resident 45's room door. An IDT note, dated 10/25/21 at 9:13 a.m., indicated Resident 45 also pushed chair into Resident 93. Interventions were separation of residents and placement on high risk walking rounds. A progress note, dated 11/7/21 at 2:30 p.m., indicated Resident 45 was in the main dining area where activities staff were serving ice cream. Resident 93 placed her hand on Resident 45's shoulder. Resident 45 then began yelling at Resident 93 and tried to knock her away by elbowing Resident 93 in the stomach. A progress note for risk management, dated 1/9/21 09:20 a.m., indicated during the resident to resident altercation on 11/7/21, Resident 45 elbowed Resident 93 in the stomach due to Resident 93 touching her. No interventions listed. RN 43 indicated, during an interview, on 3/14/22 at 10:22 a.m., Resident 93 liked to touch others, the staff try to intervene when necessary. During an interview, on 3/15/22 at 9:15 a.m., CNA 42 indicated she tries to keep the residents separated to prevent altercations. Resident 93 upset other people. During an interview, on 3/15/22 at 9:19 a.m., CNA 41 indicated they have activities for the people. She indicated they try to distract the residents as much as they can when the residents were upset. They make sure to distract Resident 93 and redirect her the best they can. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On 3/7/22 at 9:41 a.m., Resident 120 was observed sitting on the bed in another resident's room. On 3/10/22 at 9:02 a.m., Resident 120 was observed in another resident's room lying on the bed. On 3/11/22 at 9:30 a.m., Resident 120 was observed ambulating with a rolling walker independently wandering in and out of other resident's rooms. On 3/11/22 at 1:52 p.m., Resident 120 was observed ambulating independently with a rolling walker going in and out of other residents' rooms. Resident 120's record was reviewed on 3/11/22 at 9:48 a.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, generalized anxiety disorder, restlessness and agitation, major depressive disorder, recurrent, delusional disorder, and cognitive communication deficit. A quarterly MDS assessment on 8/23/21 indicated the resident was severely cognitively impaired. She demonstrated behavioral symptoms not directed toward others one to three days. An annual MDS assessment, dated 11/23/21, indicated the resident was severely cognitively impaired. Staff assessment of mood indicated resident was short-tempered, easily annoyed seven to eleven days. The resident was identified as having delusions. Physical and verbal behavioral symptoms directed toward others occurred one to three days. According to the MDS, there was not change in behavior or other symptoms since the last assessment (8/23/21). Physician's orders on 10/30/21 included, but were not limited to, risperidone, an antipsychotic medication, 0. 25 mg every evening and acetaminophen, a pain medication, 500 mg three times a day. Physician's orders on 1/12/22 included, but were not limited to, risperidone 0.50 mg two times a day and acetaminophen 500 mg three times a day. A focused care plan on resident to resident altercations included, but were not limited to, the following interventions: allow resident to express their emotions/feelings about incident (10/30/21), consult with: pastoral care, social services, psych services (10/30/21), high risk walking rounds (initiated 1/12/22), when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings (10/30/21). A progress note, dated 10/16/21 at 6:20 a.m., indicated the resident had been up walking through facility since 3 am. The resident ambulated without her walker many times pushing a stationary chair instead. She snarled and swore at staff when chair was replaced with walker. She was seen talking and swearing at an invisible companion. She was not easily redirected. One on one intervention seemed to increase her agitation. A progress note, dated 10/29/21 at 7:09 p.m., indicated resident was in an argumentative and agitated mood. The resident said there were men out there that were going to kill them. The nurse indicated she told resident that security had been notified and the men were no longer there. The resident did not accept the explanation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 10/30/21 2:14 a.m., indicated resident walked the hall all night. Resident was aggressive toward staff and other residents. She ran her walker into staff and would have acted out on other residents if staff had not intervened with one on one conversation and an ice cream snack. A progress note, dated 10/30/21 at 9:20 a.m., indicated loud voices were heard in the dining room. Per the dining room staff resident pushed her walker into the back of Resident 93's legs. Staff indicated Resident 120 said Resident 93 was crawling on the floor and biting her. An IDT note, dated 11/1/21 at 09:14 a.m., indicated the IDT met to review the resident to resident altercation on 10/30/21. They determined the resident was having delusions as Resident 93 was not on the floor trying to bite Resident 120 when Resident 120 pushed her walker into Resident 93. The interventions for the altercation were the immediate separation of the Resident 120 from others. Resident 120 was placed on one on one supervision until calm and then placed on high risk walking rounds. Risperidone 0.25 mg daily was increased to twice a day after the nurse practitioner (NP) assessed the resident. A progress note, dated 1/4/22 at 9:35 a.m., indicated the resident was ambulating with her walker throughout the unit. She went into other residents' rooms and banged her walker into objects. Staff was able to redirect the resident though redirection was met with resistance. A progress note, dated 1/4/202 2:26 p.m., indicated the resident was lying on another resident's couch. The CNA redirected the resident by saying the people and the police (from the resident's delusion) could come with them. The resident ambulated out of the room and into the common area. The resident yelled at the staff to leave her alone because the police were coming. Staff were unable to redirect her. A progress note, dated 1/5/22 at 10:08 p.m., indicated the resident was wandering in and out of other residents' rooms. The resident was heard yelling at a sleeping resident to get out of the room. Resident 120 was about to strike the sleeping resident and had her hand up above the other resident's head when the staff intervened. Staff was unable to calm the resident with one on one support or a snack. Resident 120 ran her walker into items on the unit, flipped a table in the common area and took items off a shelf to throw at the staff members. The staff monitored the resident from a distance to ensure the resident's safety and to prevent the resident from going into other residents' rooms. Resident120 began to go into another resident's room. The other resident was asleep in a recliner. Resident 120 began to yell Get out of my room. Resident 120 was redirected out of the other resident's room. Psych NP was notified of the resident's behaviors and ordered a one time dose of Buspar 15 mg to be administered right away. A progress note, dated 11/9/22 at 11:21 a.m., indicated the resident ambulated into another room with her walker and slammed the walker into the inside of the closet. The resident was redirected but cursed at the staff member saying the police will be coming. The resident lied down in her own bed, then 20 minutes later she ambulated into a different room. She attempted to hit the staff member with her walker when the staff member redirected her back to her own room. A progress note, dated 1/9/22 at 12:37 p.m., indicated the resident was agitated and ambulated in and out of other residents' rooms throughout shift. She was verbally and physically aggressive with staff when redirected. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 1/10/22 at 11:33 a.m., indicated the resident was incontinent of urine. A staff member persuaded resident to go back to room to get her pants changed. The resident was toileted and soiled clothing was removed. The resident became upset when staff attempted to assist with putting on of a new brief. The resident pulled out a handful of the staff's hair. The resident was reapproached and pulled staff's hair and struck the staff member three times with fist during the encounter. Staff member left the room, reapproached again and was able to put pants on the resident. The resident was verbally abusive and struck the staff member again. A progress note, dated 1/11/22 at 11:00 p.m., indicated the resident came out of her room yelling that everyone needs to stay away from her because she called the police. She threw items at the staff, attempted to tip over tables, and attempted to enter other residents' rooms. The staff stood in the doorways of other residents' rooms to prevent the resident from entering. Resident 120 hit the staff blocking the doorways and said the residents in the rooms had it coming because that was her room. Staff was unable to redirect or distract resident. Psych NP was notified and ordered Haldol 2.5 mg intramuscularly immediately. Haldol was given. The resident was not affected. She continued to require one on one for safety. A progress note, dated 1/12/22 at 12:28 a.m., indicated the resident continued to wander on the unit and attempted to go in other residents' rooms. She stopped yelling and was assisted to bed. She whispered to herself while her eyes were closed. A progress note, dated 1/12/22 at 11:54 a.m., indicated the resident ambulated through the shift going in and out of other residents' rooms. She lied in the other residents' beds and couches. A progress note, dated 1/12/22 at 2:07 pm., indicated Resident 120 went into Resident 107's room and rammed walker into Resident 107's shins causing a bruise to the left lower extremity. A spouse of a different resident witnessed the event and told Resident 120 to leave the room. Resident 120 left Resident 107's room. She walked into the common area and attempted to enter another resident's room. The QMA used the medication cart to block the entrance. RN 43 indicated, during an interview, on 3/14/22 at 10:22 a.m., high risk walking rounds signified they put eyes on every resident. She indicated they try to do this every 15 minutes and do the best they can. She indicated Resident 120 was much easier to redirect than she used to be prior to medication change. During an interview, on 3/14/22 at 11:07 a.m., RN 43 indicated Resident 107 should have a stop sign hanging across doorway. She indicated the stop signs often disappear and are probably in someone's room. She indicated she will find and hang a stop sign across the doorway right away. During an interview, on 3/14/22 at 11:11 a.m., CNA 42 indicated the stop signs seem to come up missing. She indicated she thought Resident 107 was supposed to have stop signs hanging across her doorway but was not certain. During an interview, on 3/15/22 at 9:15 a.m., CNA 42 indicated she tries to keep the residents separated to prevent altercations. Resident 120 became upset if people were in her way. Resident 107 did not like people in her room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 3/15/22 at 9:44 a.m., RN 43 indicated the staff try to keep the residents as occupied as they can. She indicated Resident 120 liked to lie in other residents' beds. During an interview, on 3/15/22 at 9:52 a.m., the Administrator indicated their IDT updated the care plans after resident to resident altercations. She indicated either she or the DON provided immediate interventions for the resident altercations depending on which of them completed the reportable. They have the staff do high risk walking rounds which means walk around unit every 10 to 15 minutes. They have activity programming during the day and some activity programming during the evening and weekends. A current policy, titled Abuse Prevention Program, provided upon entrance to the facility, indicated 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 . Physical abuse is defined as hitting, slapping, pinching, kicking, etc.Resident Assessment: As part of the resident social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, mistreatment, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, or mistreatment for these residents .Protection of Residents. The community will take steps to prevent mistreatment while the investigation is underway. Resident who allegedly mistreat another resident will be removed from contact with other resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents . The immediate jeopardy that began on 2/9/2022 was removed on 3/17/22 when the facility reviewed and updated resident care plans, began educating staff on the interventions in place to prevent abuse, and developed intervention sheets, that included interventions related to resident-to-resident altercations and behaviors and updated as needed. The facility developed and implemented staffing strategies to ensure supervision and care of residents at risk of expressing behavioral symptoms. The noncompliance remained at a level of no actual harm with the potential for more than minimal harm as the monitoring and education remained ongoing. 3.1-27(a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45122 Based on record review and interview, the facility failed to provide written notice of transfer to residents or their representative for 1 of 8 residents reviewed for hospitalization . (Resident 120). Findings include: Resident 120's clinical record was reviewed on 3/11/22 at 9:48 a.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, generalized anxiety disorder, restlessness and agitation, major depressive disorder, recurrent, and delusional disorder. A nurses note, on 1/13/22 at 5:51 p.m., indicated the resident was transferred to a behavioral hospital. The clinical record did not indicate a Notice of Transfer/Discharge was provided to the resident or her representative. During an interview, on 3/11/22 at 3:50 p.m., the Administrator indicated she was unable to locate the Notice of Transfer/Discharge paperwork for Resident 120's transfer on 1/13/22. Review of a current policy, revised 8/2014, titled, Transfer or Discharge Documentation, provided by the DON on 3/16/22 at 11:18 a.m., indicated .Documentation from the Care Planning Team concerning all transfers or discharges must include, as a minimum, and as they apply .That an appropriate notice was provided to the resident and/or representative . 3.1-12(a)(6)(A)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 45122 Based on record review and interview, the facility failed to provide notice of the facility's bed hold policy to residents or their representative for 1 of 8 residents reviewed for hospitalization . (Resident 120). Findings include: Resident 120's clinical record was reviewed on 3/11/22 at 9:48 a.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, generalized anxiety disorder, restlessness and agitation, major depressive disorder, recurrent, and delusional disorder. A nurses note, on 1/13/22 at 5:51 p.m., indicated the resident was transferred to a behavioral hospital. The clinical record did not indicate a bed hold notification was provided to the resident or her representative. During an interview, on 3/11/22 at 3:50 p.m., the Administrator indicated she was unable to locate documentation of the notification of bed hold that was provided to the resident or her representative for Resident 120's transfer on 1/13/22. Review of a current policy, revised 3/2017, titled Bed-Holds and Returns, provided by the administrator, on 3/11/22 at 3:50 p.m., indicated .Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents), c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents) . 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 Based on record review and interview, the facility failed to ensure timely completion of a required Level I assessment for 2 of 4 residents reviewed for PASARR (Preadmission Screening and Resident Review) (Resident 90 and 107). Findings include: 1. Resident 90's clinical record was reviewed on 3/9/22 at 2:39 p.m. He admitted to the facility on [DATE]. His clinical record lacked a pre-admission Level I PASARR. A Level I PASARR was provided by Social Service Coordinator 12, on 3/14/22 at 4:20 p.m., and indicated Level I outcome: refer for Level II onsite. Rationale: PASARR Level 1 indicated A PASARR Level II evaluation must be conducted. That evaluation would occur as an onsite/face to face evaluations. PASARR Level II was conducted on 3/5/20 and indicated long term approval without specialized services. During an interview with Social Service Director 26, on 3/15/22 at 10:14 a.m., she indicated Resident 90 came from another facility and was unable to obtain the PASARR from the other facility and found out the other facility did not complete one. His PASARR was obtained late because they were unable to retrieve it from the other facility and they would normally complete it prior to admittance to the facility. 45122 2. Resident 107's clinical record was reviewed on 3/10/22 at 1:41 p.m. She was admitted on [DATE]. Diagnoses included, but were not limited to, major depressive disorder, dementia with behavioral disturbance, delusional disorders, unspecified psychosis due to substance or known physiological condition and altered mental status. The clinical record lacked a Preadmission Screening and Resident Review (PASARR). During an interview, on 3/11/22 at 3:15 p.m., the DON indicated paperwork for the PASARR was submitted earlier that day. During an interview, on 3/14/22 at 10:08 a.m., Social Services Director (SSD) 47 indicated the PASARRs were being completed by the admissions personnel. They missed Resident 107's PASARR. This was discovered on 3/11/22. Information was submitted to obtain the PASARR following the discovery. Review of a document from the Maximus website for PASARR submissions, provided by the DON on 3/11/22 at 3:15 p.m., indicated the PASARR information had been submitted on 3/11/22 at 10:47:24 a.m. Review of a current policy, revised 4/29/20, titled INDIANA PASRR Level 1 & Level of Care Screening Procedures for Long Term Care Services Provider Manual, provided by SSD 47, on 3/15/22 at 10:19 a.m., indicated Federal Requirements of PASRR .The PASRR must be completed before a person admits and when a person's status significantly changes . (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-16(d)(1)(A)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40461 Based on observation, record review and interview, the facility filed to ensure a resident with limited functional range of motion was assisted to wear a physician ordered splint and failed to develop a care plan for the splint use, for 1 of 2 residents reviewed for limited range of motion (Resident 50). Findings include: During an observation, on 3/8/22 at 10:11 a.m., Resident 50 was in a wheel-chair and had wheeled himself, with his right hand, from the common area to the small dining room on the unit. His left hand noted to have visible contracture, no splint, brace or any other positioning device was in his left hand. During an observation, on 3/9/22 at 10:12 a.m., Resident 50 was in the common area watching television, sitting in a wheel-chair, no splint was visible to his left hand. During an observation, on 3/9/22 at 1:07 p.m., he was sitting in a wheel-chair in the common area watching television, no splint noted to his left hand. During an observation, on 3/11/22 at 1:55 p.m., he was sitting in a wheel-chair in the common area watching television, no splint noted to his left hand. His clinical record was reviewed on 3/9/22 at 1:08 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Current physician orders included, but were not limited to, resident to have splint donned to left hand at all times except for hand hygiene or showers, the order date was 6/11/21. A 1/8/22 annual MDS (Minimum Data Set) assessment indicated he required extensive assistance with bed mobility, dressing, toilet use and personal hygiene, he was totally dependent with transfers, required supervision with eating and locomotion on the unit, walking in room and corridor had not occurred and locomotion off the unit had not occurred. He had functional limitation in range of motion to upper and lower extremity, the impairment was on one side. The restorative nursing programs section indicated he had not received any assistance with a splint or a brace during the assessment period. His current care plans did not include indication of splint use to his left hand. The March 2022 MAR (Medication Administration Record) and TAR (Treatment Administration Record) did not include the order for the splint to his left hand. During an interview, on 3/11/22 at 2:12 p.m., LPN 11 indicated sometimes he wore the splint and sometimes he didn't, couldn't find the order in the MAR or TAR, she checked the physician orders and noticed the order had been entered incorrectly, it had not been entered to show up on the MAR or TAR for the nurse to sign off that it had been worn or declined. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/16/22 at 1:27 p.m., the DON indicated they hadn't been able to find his splint, she didn't know when he had worn it last and the resident wasn't reliable with his responses. Review of a current facility policy, titled Restorative Nursing Services, with a revised date of July 2017 and provided by the DON on 3/16/22 at 2:56 p.m., indicated Policy Statement. Residents will receive restorative nursing care as needed to help promote optimal safety and independence .3. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care 3.1-37(a)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 Based on observation, interview and record review, the facility failed to prevent development of pressure ulcers for 4 of 6 residents reviewed for pressure ulcers (Resident 12, 125, 57 and 63). This deficient practice resulted in Resident 12 sustained a stage 4 pressure ulcer to her right elbow and a stage 2 to her coccyx. Resident 125 sustained an SDTI (Suspected Deep Tissue Injury) pressure ulcer to her right heel and a stage 2 pressure ulcer to her coccyx. Resident 57 sustained an unstageable pressure ulcer to his left heel. Resident 63 sustained an unstageable pressure ulcer to her coccyx. Findings include: 1. On 3/9/22 at 12:55 p.m., Resident 12's dressing change was observed to her right elbow, with RN 70, she indicated the wound edges were rolled, 25% of the wound had yellow slough in it and the wound was an approximate size of a dime. The wound bed was clean and pink. The resident did not complain of pain. RN 70 indicated there was maceration/shearing to both buttocks and on coccyx and it did not have a treatment for it. On 3/10/22 at 3:00 p.m., she was lying in bed with the gingerbread pillow under the blanket elevating her right arm. On 3/11/22 at 2:01 p.m., an observation of the resident's wheelchair with CNA 55, her wheelchair had a standard pillow with a pillowcase cover and dycem on the seat of the chair. CNA 55 indicated the dycem was there so the pillow did not slip. Resident 12's clinical record was reviewed on 3/8/22 at 12:31 p.m. Diagnoses included, but were not limited to, unspecified protein-calorie malnutrition, malignant neoplasm of unspecified site of left female breast, abnormal weight loss, adult failure to thrive, cognitive communication deficit, stiffness of right knee, and need for assistance with personal care. Her orders included, but were not limited to, fluoxetine solution (treat depression) 60 mg (milligram) by daily, gabapentin (treat neuropathy pain) 300 mg daily, letrozole (treat breast cancer) 2.5 mg daily, mirtazapine (appetite stimulant) 7.5 mg daily, vitamin D3 (supplement) 25 mcg (microgram) daily, buspirone (treat anxiety) twice 10 mg daily, weekly vital signs and skin assessment to be completed first shower day of the week. (Complete weekly vital signs/skin assessment in assessments) every day shift on Mondays, fortified foods three times daily for weight loss and supplement, medpass (supplement) 90 ml (milliliters) three times daily for malnutrition risk, apply skintergrity impregnated gauze after cleansing wound daily for pressure ulcer to right elbow and apply calazime to bilateral buttocks every shift for MASD (Moisture-Associated Skin Damage) until resolved. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A quarterly MDS (Minimum Data Set), dated 12/6/2, indicated she was severely cognitively impaired. She required extensive assistance of two staff members for bed mobility. She required total assistance of one staff member for transfers and toilet use. She required extensive assistance of one staff member for dressing and personal hygiene. She had an impairment to her bilateral lower extremities. She used a wheelchair. She was always incontinent of bowel and bladder. She was at risk for pressure ulcer development. She did not have a pressure reducing device in place and was not on a turning/repositioning program. Her care plans included, but were not limited to, the following: a. She had a potential for impaired skin integrity related to impaired mobility, medication use, pain and incontinence, She wore a brace. Her goal was that she would be free from skin impairment through the review date. Her interventions included, but were not limited to, encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, keep skin clean and dry and use lotion on dry skin. b. She had a stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.) pressure ulcer to her right elbow 2/2/22, now presenting as a stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.). Her goal was her pressure ulcer would show signs of healing and remain free from infection by/through the review date. Her interventions included, but were not limited to, educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size (length X width X depth), stage and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. c. She had cellulitis of the right elbow related to infection to stage 4 decubitus ulcer of elbow, revised on 2/8/22. Her goal was that she would have no complications resulting from the cellulitis through the review date. Interventions included, give antibiotics for infection and mild analgesics to relieve discomfort as prescribed by physician, monitor/document side effects and effectiveness, monitor /document healing of the cellulitis and any new or worsening symptoms should be reported to MD (Medical Doctor). d. She had a stage 2 pressure ulcer to her coccyx. Her goal was her pressure ulcer would show signs of healing and remain free from infection by/through review date. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor dressing every shift to ensure it is intact and adhering, report lose dressing to treatment nurse, monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate Wound-weekly observation tool for her right elbow indicated the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a. On 1/27/22 at 12:54 p.m., the unstageable (Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.) pressure ulcer was facility acquired, on 1/17/22, 75% of the tissue was slough (yellow, tan, white, stringy). It measured 1.5 cm x 1.5 cm x 0.3 cm. Infection was suspected and slight redness was noted to the wound edges. She continued on an antibiotic and no changes to the treatment. Her January orders indicated she started cephalexin (antibiotic) 500 mg three times daily for right elbow wound infection for one week and Dakins (treat skin and tissue infections) (full strength) Solution 0.5 % cleanse wound and cover with Optifoam dressing on right elbow twice daily on 1/17/22. b. On 2/2/22 at 8:11 p.m., the unstageable was documented as a stage 4 pressure ulcer. The wound was moist and tendon was visible. Measurements remained the same. The pressure area was red and swollen, the wound edges were rolled. New treatment orders were received to cleanse and apply skintegrity impregnated gauze and cover with foam dressing daily. She continued on an antibiotic. c. On 2/16/22 at 1:19 p.m., the stage 4 pressure area was improving. Wound was moist with tendon visible and measured 0.8 cm x 0.5 cm x 0.2 cm. No changes in treatment and she continued on an antibiotic. d. On 2/23/22 at 3:44 p.m., the pressure ulcer was worsening, epithelial tissue was present (pink), moist. tendon visible, 1.0 cm x 1.0 cm x 0.2 cm. There were no changes in treatment. e. On 3/2/22 at 12:31 p.m., the pressure ulcer was unchanged and the treatment remained the same. f. On 3/9/22 at 6:46 p.m., the pressure ulcer was unchanged and the treatment remained the same. Wound-weekly observation tool for her coccyx indicated the following: a. On 2/16/22 at 1:19 p.m., the stage 2 pressure ulcer to her coccyx was facility acquired, on 2/10/22, it measured 0.2 cm (centimeters) x 0.2 cm x 0.2 cm. The current treatment was to apply calazime every shift. Continue current plan of care and dietary was updated. b. On 2/23/22 at 3:44 p.m., there were not changes to the pressure ulcer or treatment. c. On 3/2/22 at 12:31 p.m., there were no changes to the pressure ulcer or treatment. d. On 3/9/22 at 6:46 p.m., there were no changes to the pressure ulcer or treatment. e. On 3/16/22 at 5:10 a.m. there were no changes to the pressure ulcer or treatment. During an interview on 3/10/22 at 11:52 a.m., the DON indicated Resident 12 had COVID then developed the pressure ulcer to her elbow, she had been noted to tuck her elbow in her wheelchair and in bed, they used the gingerbread pillow to try to keep her elbow elevated. She did not have the low loss air mattress when the area developed on her elbow. She currently had a pressure reducing mattress. She had been in bed more, she was incontinent and prone to skin breakdown, she had seen a trend with covid and staying in bed more. Resident 12 was positive for COVID on 11/30/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with QMA 71, on 3/10/22 at 3:02 p.m., she indicated Resident 12 had a tendency to tuck her arms in, in her wheelchair and her bed. They monitored the placement of her arm and used the gingerbread shaped pillow in her wheelchair and in bed. She had COVID and was in the COVID unit a while ago and a lot of residents came back with skin issues. 2. On 3/10/22 at 8:53 a.m., Resident 125's dressing change was observed to her right heel with RN 70. It was an unstageable pressure ulcer and observed as a half dollar sized area, she was sleeping and lying on an air mattress with a top sheet, bed pad and a chux under her. RN 70 indicated the estimated width was 9 cm by length of 8 cm with no depth. RN 70 indicated she was going to a wound clinic appointment today. On 3/11/22 at 8:32 a.m., she was observed in bed. On 3/15/22 at 9:55 a.m., she sat in her wheelchair at the table in the common area with a pressure relieving boot on her right foot. On 3/15/22 at 10:41 a.m., an observation of the pressure ulcer to her coccyx with Unit Manager 74, small amount of exudate to the old dressing, stage 2 with granular tissue, no eschar, area was pink and blanchable. Resident 125's clinical record was reviewed on 3/8/22 at 3:05 p.m. Diagnoses included, but was not limited to, weakness, altered mental status, cognitive communication deficit, edema, anorexia, abnormal weight loss, vitamin B12 deficiency anemia, muscle wasting and atrophy, unspecified lower leg, need for assistance with personal care, displaced intertrochanteric fracture of the right femur, subsequent encounter for closed fracture with routine healing and muscle weakness (generalized). Her current orders included, but were not limited to, citalopram hydrobromide (treat depression) 20 mg daily, cyanocobalamin (supplement) 1000 mcg daily, furosemide (diuretic) 20 mg every other day, mirtazapine (depression) 7.5 mg daily, multivitamin daily for wound healing, vitamin D3 125 mcg daily, medpass (nutritional supplement) 120 ml three times daily, buspirone (treat anxiety) 10 mg three times daily, skin prep to right heel twice daily and apply border foam dressing to sacral ulcer change every three days and PRN (as needed). An annual MDS, dated [DATE], indicated she was moderately cognitively impaired. She required extensive assistance with two staff members for bed mobility, transfers, dressing, toilet use and personal hygiene. She had an impairment to one side of her lower extremity. She used a wheelchair. She was always incontinent of bowel and bladder. She had a stage 1 or greater pressure ulcer and was at risk for developing pressure ulcers. She had a stage 2 unhealed pressure ulcer and a surgical wound. She had a pressure reducing device to her chair and bed. She received pressure ulcer care, application of non surgical dressing other than to her feet and applications of ointments/medications other than to her feet. Her care plans included, but were not limited to, the following: a. She had an actual impaired skin integrity related to surgical wound to right hip. Her goal was the wound would be healed by next review. Her intervention included treatments as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b. She had a stage 2 pressure ulcer to her coccyx, initiated on 2/16/22. Her goal was her pressure ulcer would show signs of healing and remain free from infection by/through review date. Her interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing weekly and as needed measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (Medical Doctor), educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. c. She had a DTI (Deep Tissue injury) (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) to her right heel, initiated on 2/23/22. Her goal was her DTI would heal without complications through next review. Her interventions included, but were not limited to, follow facility protocols for treatment of injury, heel boot to right foot, monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD and weekly skin assessments and PRN (as needed). A Braden scale for predicting pressure sore risk, dated 2/15/22, indicated she was at high risk. A nurses note, dated 2/15/22 at 5:10 p.m., indicated resident's coccyx was assessed and an open area was noted and measured 3 cm x 3 cm x 0.2 cm. There was not drainage present. Surrounding tissue was pink and intact. She denied any pain or discomfort. An order was obtained to apply xeroform to area and cover with dry dressing daily and as needed. On 2/16/22 at 9:20 a.m. IDT met to review the new open area to coccyx. She was noted to have open area to coccyx during care. She had a decline in condition and recent fracture to her hip. She had poor intakes. The intervention was treatment as ordered and low air mattress to bed. Wound-weekly observation tool for her 2/15/22 facility acquired pressure ulcer to her coccyx indicated the following: a. On 2/16/22, she had a new stage 2 pressure ulcer to her coccyx. Preventative measures was a cushion to her wheelchair. There was epithelial tissue present (pink) and the wound measured 3.0 cm x 3.0 cm x 0.2 cm, low air loss mattress to be applied to bed and pressure reducing cushion to wheelchair. Treatment was to apply xeroform and dry dressing daily. She requested to stay in bed throughout the day. b. On 2/23/22, her stage 2 pressure ulcer was improving and measured 1.5 cm x 0.8 cm x 0.2 cm. There were no changes in treatment. Plan of care was in place and interventions remained appropriate. Resident continued to request to stay in bed throughout the day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	c. On 3/2/22, her stage 2 pressure ulcer was improving. She had a cushion to her wheelchair and a low air loss mattress on her bed. Her wound measured 2.0 cm x 0.5 cm x 0.2 cm. There were no changes in treatment. Plan of care was in place and interventions remained appropriate. She continued to request to stay in bed throughout the day. d. On 3/9/22, there were no changes to her pressure ulcer or treatment. She continued to request to stay in bed throughout the day. e. On 3/16/22, her stage 2 pressure ulcer was unchanged and measured 0.75 cm x 0.3 cm x 0.2 cm. Plan of care was in place and interventions remained appropriate. Resident continued to request to stay in bed throughout the day. A nurses note, dated 2/23/22 at 4:48 p.m., indicated while doing routine treatment to open areas of coccyx and top of right foot writer noted a DTI to her right heel. Her skin was evaluated. A treatment was put into place and preventative measures put into place. Do we know what they were? This is when the CP and interventions were initiated 2/23/22 and I did not see a treatment on her Feb MAR. Skin prep was started on 3/10/22. On 2/24/22 at 9:42 a.m., IDT met to review new DTI to her right heel that was noted on 2/23/22. The area was noted during care. She continued to have a decline in condition, poor intakes and not getting out of bed. She had been kicking heel boot off. Intervention was to continue to encourage heel boot and turn and reposition every two hours. Wound-weekly observation tool for her 2/23/22 facility acquired DTI pressure ulcer to her right heel indicated the following: a. On 3/2/22, she had a cushion to her wheelchair and low air loss mattress on her bed. The SDTI was new and described with 100 % necrotic tissue present (brown, black, leather, scab-like) and measured 3.0 cm x 4. 3 cm. The peri-wound was pink, moist with well defined attached edges. The current treatment plan was apply foam dressing as ordered. The plan of care was in place and the interventions remained appropriate. She continued to request to stay in bed throughout the day. Dietary was updated. b On 3/9/22, her SDTI was unchanged. Plan of care was in place and the interventions remained appropriate. She continued to request to stay in bed throughout the day. Dietary was updated and her appetite was poor. c. On 3/16/22, her SDTI was unchanged. Plan of care was in place and the interventions remained appropriate. She continued to request to stay in bed throughout the day. Dietary was updated and her appetite was poor. During an interview, on 3/10/22 at 11:18 a.m., the DON indicated she had a huge blister on her foot that had popped due to the edema she had from her hip fracture, while doing the treatment to the top of her foot, she noticed the area on her heel. She had a heel float boot on at the time of noticing it and an air mattress was in place. She refused to get out of bed. She told the staff she wanted to be left alone. She was not eating well. The interventions were in place because she was in bed more due to the hip fracture. She tested positive for COVID on 12/5/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3. On 3/8/22 at 2:02 p.m., Resident 57 was lying on a low loss air mattress, his head of bed was elevated. On 3/9/22 at 1:08 p.m., during a wound observation, with RN 70, of Resident 57's left heel, he indicated his pain was not too bad. The left heel was dry and flaky. There was not an area on the right heel. Resident 57's clinical record was reviewed, on 3/9/22 at 2:44 p.m. Diagnoses included, but were not limited to, edema, acute diastolic (congestive) heart failure, anemia, malignant neoplasm of prostate, muscle wasting and atrophy unspecified lower leg, stiffness of unspecified joint and acute respiratory failure with hypoxia. His current orders included, but were not limited to, cleanse left heel with soap and water, pat dry then cover with optifoam dressing daily. Monitor for s/s of infection until healed and notify MD of any changes every day shift., Medpass 90 ml (milliliters) twice daily for wound healing two times daily for wound healing between meals, fortified foods at bedtime for wound healing give fortified cookie and skin prep wipes apply to bilateral heels topically every shift for prevent skin breakdown. A significant change MDS, dated [DATE], indicated he was cognitively intact. He required extensive assistance of two staff members for bed mobility. He required total assistance of two staff members for transfers and toilet use. He required extensive assistance of one staff member for dressing and personal hygiene. He used a wheelchair. He had a life expectancy less than 6 months. He had MASD and a pressure reducing device to bed and chair. He had a care plan for DTI pressure ulcer to his left and right heel related to immobility initiated on 1/26/22. His goal was his pressure ulcer would show signs of healing and remain free from infection by/through review date. His interventions, initiated on 1/26/22, included, but were not limited to, administer treatments as ordered and monitor for effectiveness, follow facility policies/protocols for the prevention/treatment of skin breakdown, if the resident refused treatment, confer with the resident, IDT and family to determine why and try alternative methods to gain compliance, document alternative methods, monitor nutritional status, serve diet as ordered, monitor intake and record, monitor/document/report PRN any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), stage, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. A Braden scale for predicting pressure sore risk, dated 1/17/22, indicated he was at moderate risk for developing pressure ulcers. A nurses note, dated 1/22/22 at 7:00 p.m., indicated skin prep was applied to both of his heels and both heels felt hardened. Both heels were black, the left heel measured 4.5 cm x 3 cm, the right heel measured 1 cm x 1.5 cm. He showed no signs of pain, both feet were elevated on pillows, not touching pillows or the bed. He had been wearing boots to both feet. On 1/24/22 at 9:46 a.m., IDT met to review pressure areas to bilateral heels from 1/22/22. Nurse applied skin prep and noted heels to be dark in color. He did have heel boots and low air loss mattress. The intervention was heels to be elevated on pillows when in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Wound-weekly observation tool for his 1/22/22 facility acquired DTI pressure ulcer to his left heel indicated the following: a. On 1/26/22, he had a low air loss mattress. DTI was new, it was a dry area hard tan with burgundy center and measured 4.5 cm x 3 cm. The peri-wound was pale white with edema noted to feet, wound edges were intact and irregular. Staff was to use pillows to float heels and not heel boots. The treatment was skin prep every shift. The plan of care updated and interventions in place. b. On 2/2/22, his DTI was unchanged. The plan of care was updated and interventions in place. c. On 2/16/22, the DTI worsened and was an unstageable pressure ulcer. The ulcer was 90 % slough tissue present (yellow, tan, white, stringy) it was moist and measured 4.5 cm x 3.0 cm x 0.1cm. The peri wound was pale white with edema was noted to feet. The edges were intact and irregular. No changes in treatment. The wound declined since last assessment. The plan of care was updated and interventions in place. d. On 2/23/22, the unstageable pressure ulcer improved since last assessment. Epithelial tissue was present (pink), slough tissue was present (yellow, tan, white, stringy), the ulcer was moist and measured 3.0 cm x 3.0 cm. The peri wound was pale white with edema noted to feet, the edges were intact and irregular. The treatment was changed to cleanse left heel with soap and water, pat dry then cover with optifoam dressing daily. The plan of care was updated and interventions in place. e. On 3/2/22, the unstageable pressure ulcer improved. 100% tan slough tissue present and the pressure ulcer was moist and measured 1.5 cm x 1.5 cm. The peri-wound appearance did not change. The treatment remained the same. The plan of care was updated and interventions were in place. f. On 3/9/22, the unstageable pressure ulcer improved and measured 1.5 cm x 1.0 cm. The peri-wound was pink, dry and flaky. There were no changes in treatment. The plan of care was updated and interventions were in place. g. On 3/16/22, the unstageable pressure ulcer was unchanged. The plan of care was updated and interventions were in place During an interview, on 3/10/22 at 11:40 a.m., the DON indicated the resident had tested positive for COVID-19 at the end of November, he tested negative at the facility, he was sent to the hospital and tested positive there. He had pressure areas on both heals and was put on hospice due to cancer. He returned from the hospital on 1/3/22. Once he found out he had cancer he has remained in bed a lot. She was not sure how the areas started. He started on hospice on 1/13/22 and the air mattress was delivered on 1/8/22. He had pressure relieving boots on his feet according to a nurses note dated 1/22/22. 4. On 3/10/22 at 12:45 p.m., Resident 63's coccyx pressure ulcer was observed with RN 70. RN 70 indicated she was so contracted as she took the blankets from between her legs. RN 70 indicated her coccyx was unstageable with necrotic, yellow tissue, little epithelial tissue, little tunneling at 10 o'clock, the edges were rolled and looked like a Kennedy ulcer. The resident was grimacing in pain as she completed the treatment. RN 70 indicated she had been given pain medication about an hour prior to the dressing change. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 63's clinical record was reviewed on 3/10/22 at 12:00 p.m. Diagnoses included, but was not limited to, other specified disorders of bone density and structure, acute kidney failure, need for assistance for personal care, abnormal weight loss, kidney transplant status, dementia with Lewy bodies, unspecified jaundice, type II diabetes without complications, unspecified protein-calorie malnutrition, personal history of covid 19 and contracture right and left knee. Her current orders included, but were not limited to, cleanse area to coccyx with soap and water, pat dry, apply calcium alginate to wound bed, apply skin prep to surrounding tissue, cover with adhesive dressing daily, admit to hospice, on 3/4/22, with diagnosis of cerebral atherosclerosis/dementia with Lewy Bodies with a prognosis of 6 months or less if the disease runs its normal course, 72 hour fentanyl (treat pain) patch 50 mcg/hr (microgram/hour) at bedtime every 72 hours, oxycodone (narcotic pain reliever) 5 mg every four hours for pain and every hour as needed for pain, optifoam sacrum dressing to coccyx as needed for wound prevention, change when soiled or as needed, dated 10/1/21, resident to be turned every two hours every shift for nursing preventative. A quarterly MDS, dated [DATE], indicated she was severely cognitively impaired. She required extensive assistance of one staff member for bed mobility and dressing. She required total assistance of one staff member for transfer, toilet use and personal hygiene. She had an impairment to her bilateral upper and lower extremities. She was frequently incontinent of bowel and bladder. She was at risk for developing pressure ulcers. She had a pressure reducing device to her chair and bed. Her care plan included, but were not limited to, the following: She had a potential for impaired skin integrity related to decreased oral intakes, PVD (Peripheral Vascular Disease, history of pressure area stage 2, revised on 10/5/21. Her goal was she would be free from skin breakdown through next assessment. Her interventions included, but were not limited to, assist with checking and changing her incontinent brief every two hours and as needed, revised on 4/27/21, evaluate skin integrity, initiated on 8/18/20, low air loss mattress for bed initiated 4/27/21, perform objective pressure ulcer risk tool such as Braden / Norton Scale, initiated on 8/18/20, pressure reducing cushion to wheelchair and chair, initiated on 9/3/20, provide skin care per facility guidelines and PRN as needed, initiated on 8/18/20, turn and reposition every two to three hours initiated: 5/19/21. She had a stage 2 pressure ulcer to her sacrum, revised on 2/21/22. Her goal was her pressure ulcer would show signs of healing and remain free from infection. Her interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness, initiated on 2/10/22, assess/record/monitor wound healing weekly and as needed, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the MD, revised on 2/15/22, follow facility policies/protocols for the prevention/treatment of skin breakdown, initiated on 2/10/22, monitor/document/report PRN any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), stage, initiated on 2/10/2022, treat pain as per orders prior to treatment/turning etc . to ensure her comfort, initiated on 2/10/22, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, initiated on 2/10/22. A Braden scale for predicting pressure sore risk, dated 10/1/21, indicated she was at high risk for developing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nurses note, dated 2/10/22 at 10:37 a.m., indicated the CNA asked the writer to assess the coccyx and heel area for notable areas. Writer assessed her coccyx area and found an opened area. Wound bed was red with edges well rounded and approximated, no drainage, painful to touch. New treatment order was noted. Area to left side of great toe was intact, bright red, and blanchable and painful to touch. On 2/11/22 at 9:47 a.m., IDT met to review an open area on her coccyx from 2/10/22. Area noted during care. She was incontinent of bowel and bladder. She continued to be turned and repositioned every two hours. She was currently working with therapy. The intervention was treatment as ordered. A Wound-weekly observation tool for her 2/10/22 facility acquired stage 2 pressure ulcer to her coccyx indicated the following: a. On 2/16/22, a low air loss mattress pressure reducing cushion was in place. The stage 2 pressure ulcer was new. Epithelial tissue present (pink) and measured 0.3 cm x 0.1 cm x 0.1 cm. The peri wound was pink and moist with well-defined edges. Therapy was to assess for a different wheelchair. The current treatment was to cleanse area to coccyx with soap and water, pat dry, apply skin prep to surrounding tissue, cover with adhesive dressing daily. The plan of care was updated. On 2/23/22, the stage 2 pressure ulcer measured 0.3 cm x 0.3 cm x 0.1 cm. There was no change to wound since last assessment and to continue current plan of care. The interventions remained appropriate. On 3/2/22, the stage 2 pressure ulcer was worsening. Epithelial tissue present (pink) and moist, the wound bed top of wound was white and below it appeared to have a blood blister that ruptured. Measurements were 3.0 cm x 3.0 cm x 0.2 cm. The peri-wound was pink and moist. The wound edges were well defined. Continue current plan of care, The interventions remained appropriate. On 3/9/22, the stage 2 had worsened and was considered an unstageable pressure. Epithelial tissue was present (pink), 25 % of white necrotic tissue was present (brown, black, leather, scab-like), there was a foul smell and it measured 10 cm x 3 cm x 0.2 cm. The peri-wound was pink and moist, the edges were irregular. The treatment was changed to cleanse area to coccyx with soap et water, pat dry, apply calcium alginate to wound bed, apply skin prep to surrounding tissue, cover wit [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35283 Based on observation, interview, and record review, the facility failed to provide supervision and immediate individualized interventions to prevent falls. This deficient practice resulted in 4 of 8 residents reviewed for falls sustaining fractures (Residents 79, 179, 125, and 18). The immediate jeopardy began on 1/24/22, when Resident 79 fell and sustained a right femur fracture and immediate interventions to prevent falls were not put into place, resulting in additional falls. The Administrator and DON were notified of the immediate jeopardy on 3/15/22 at 11:04 a.m. Findings include: 1. On 3/8/22 at 2:16 p.m., Resident 79 was seated in her wheelchair at a table in the unit common area. Activity Aide 31 was seated next to her. On 3/8/22 at 2:30 p.m., she was saying she wanted to get up; Activity Aide 31 was encouraging her to sit still. On 3/9/22 at 9:14 a.m., she was sitting up on the side of her bed, with her feet on the floor. CNA 34 entered the room and asked if she was ready to get up for the day. On 3/9/22 at 9:33 a.m., she was up walking alone in her darkened room, partially dressed, standing near her armoire. She then walked to her recliner chair, sat down, and began putting on socks. During an interview, on 3/9/22 at 9:35 a.m., LPN 51 indicated staff tried to keep her from being up by herself. At 9:42 a.m., she was assisted to the common area via wheelchair. On 3/9/22 at 10:43 a.m., she was up walking away from the activity group in the common area. LPN 51 went to assist her and asked her to sit in a chair near the fireplace sitting area. On 3/9/22 at 1:10 p.m., she was seated at a table in the common area with a baby doll during a small group activity. On 3/10/22 at 8:51 a.m., she was seated in her wheelchair in the common area with her head in her hands. On 3/10/22 at 9:20 a.m., she remained in her wheelchair near an activity group, holding her head up with her fingers in her eyes. On 3/10/22 at 11:18 a.m., the resident's wheelchair sat in the common area, with the cushion tilted forward. There was no anti-slip mat observed in the seat. CNA 52 assisted the resident from a chair into her wheelchair for lunch in the dining room. (continued on next page)

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Peabody Retirement Community	400 W Seventh St North Manchester, IN 46962

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/10/22 at 3:06 p.m., the resident left her wheelchair in the common area and began walking. CNA 53 assisted her to a chair in the lounge area near the fireplace. The CNA walked away and then the resident got up and walked to a chair across the lounge area and sat down with two other residents. On 3/11/22 at 8:35 a.m., she was up walking around the unit with CNA 39, looking for her family member. On 3/11/22 at 9:32 a.m., she was up walking toward the medication carts. LPN 37 assisted her back to her wheelchair near a small group of residents and walked away. On 3/14/22 at 9:59 a.m., she was in bed, laying facing the wall. Her bed was elevated to approximately knee height. During an interview, at the time of the observation, CNA 52 indicated the bed was at knee height, but there were no current interventions for the resident's bed to be kept low. On 3/15/22 at 9:36 a.m., she was seated in a recliner in the common area, asleep, with a pillow on her lap. Resident 79's clinical record was reviewed on 3/8/22 at 9:50 a.m. Diagnoses included, but were not limited to, (1/27/22) fracture of unspecified part of neck of right femur, major depressive disorder, transient ischemic attack (TIA), restlessness and agitation, psychotic disorder with delusions, dysphagia, unsteadiness on feet, age-related physical debility, and Alzheimer's disease. She had current physician orders for, but not limited to, sertraline (anti-depressant) 50 mg daily, nortriptyline (anti-depressant) 25 mg at HS for insomnia and neuropathic pain secondary to hip fracture, tramadol (opiate pain medication) 50 mg every six hours as needed for pain, acetaminophen (analgesic) 325 mg two tablets three times daily, quetiapine (anti-psychotic) 25 mg 0.5 tablet (12.5 mg) at bedtime, and alprazolam (anti-anxiety) 1 mg twice daily. A 12/17/21, annual, Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired and required supervision for ADLs and mobility. A 1/31/22, 5 day, MDS assessment indicated she was severely cognitively impaired and required extensive assistance for ADLs and supervision for mobility. She had a current, 2/10/22, care plan problem of confusion/distress as evidenced by calling her family members and them asking about her husband, wanting to go home, stating husband has given her money, and being unable to find her husband. She had a current, 3/4/22, care plan problem of risk for falls related to confusion, wandering, and behaviors. She had impaired safety awareness and attempted to transfer and ambulate without assistance. She had a walker, but at times would not use it, stating she did not need it. Interventions included, but were not limited to, the following: a. anti- rollbacks to wheelchair (1/28/22) b. encourage to sit in common area if awake during high risk walking rounds (1/28/22) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. hipsters to be worn at all times (1/31/22) d. be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. (2/2/22) e. anti-slip mat to wheelchair (2/7/22) f. keep footrest to recliner down while resident is sitting in recliner (2/7/22) g. remove exercise equipment from across the nook area (2/7/22) h. encourage to sit in common area while awake, offer activity and/or conversation (2/14/22) i. staff to get resident up and ready for breakfast between 6-7 am and assist to common area. (2/17/22) j. keep bed at appropriate height (2/18/22) k. staff to encourage resident to wear glasses appropriately (2/22/22) l. non-skid strips in and out of bathroom doorway (2/23/22) m. high risk walking rounds-if awake during rounds, encourage to sit in common area. If awake during sleep hours, offer/assist to toilet (2/24/22) n. offer/encourage to rest in recliner in common area (2/24/22) o. obtain urinalysis sample (3/4/22) p. assist to common area when finished eating meals (3/8/22) q. assist to toilet before and after meals (3/8/22) Review of progress notes and assessments indicated the following: On 1/11/21, she was started on buspirone 5 mg at bedtime and a one time dose of 15 mg. On 1/13/22, a Nurse Practitioner note indicated she had a shuffling gait; the resident didn't realize she was walking any differently. On 1/18/22, the facility's secured unit and it's residents were moved to another area of the facility. On 1/20/22, a Nurse Practitioner note indicated an acute visit, per staff request, for an aggressive episode towards another resident, throwing belongings out the window, and continued delusions. She was started on quetiapine 12.5 mg daily. Review of a 1/24/22 at 6:30 p.m. fall risk assessment indicated score of 6, low fall risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/24/22 at 11:01 p.m., the resident was standing next to another resident in the common area, when she turned around and then fell on the ground, landing on her right hip. She was unable to move her right leg and complained of severe pain when attempting to sit up. She was sent to the emergency department for evaluation. A 1/25/22 Interdisciplinary Team (IDT) note indicated therapy was to evaluate her when returned from the hospital. On 1/27/22 at 3:40 p.m., she returned from the hospital following a surgical repair of a right hip fracture. On 1/27/22 at 8:23 p.m., she was found sitting on her bottom in front of the fireplace, with her legs bent at the knee and feet flat on floor. Staff were to continue high risk walking rounds. Staff was in the back cluster of the unit, and the resident had been seen in the common area talking with another resident 5 minutes before the fall. No immediate intervention was implemented to prevent further falls. On 1/27/22 at 10:08 p.m., she was found lying on her right side in front of her room, facing the hallway. She stated she was just going for a walk and fell . She had a 2-centimeter (cm) bruise to her right shoulder and swelling to her right outer hip area and appeared inwardly rotated. She was transferred to the Emergency Department for evaluation. She returned to the facility on [DATE] at 2:40 a.m. and was to be placed on 1:1 supervision. A 1/28/22 IDT note indicated she was currently using a wheelchair and an intervention would be added for an anti-rollback device to her wheelchair. A 1/28/22 IDT note indicated she had dementia and poor safety awareness and continued to attempt to walk. An intervention was added to encourage her to be in the commons area if awake during walking rounds. Review of a 1/28/22 Nurse Practitioner note indicated she had fallen twice since return to the facility and was now unable to ambulate and had an obvious deformity to her right hip. Staff report she fell out of bed and onto her right side. She had a large abrasion and hematoma to her right shoulder and redness and swelling to her right hip. A progress note dated 1/28/22 at 2:41 p.m. indicated she had an unwitnessed fall requiring a further evaluation. No new fractures were identified, and the resident was expected to return to the facility. On 1/28/22, new orders were received to discontinue the buspirone, wean the sertraline, and start nortriptyline for mood, sleep, and neuropathic pain secondary to falls and hip fracture. On 1/29/22 at 7:20 a.m., she had an unwitnessed fall in the common area. She had last been seen 15 minutes prior, sitting in a chair in the common area. Resident stated she got tripped up on her own feet and was lying on her left side, with her right leg at an awkward angle, bent inward; she complained of pain when moved. She was transferred to the emergency department for evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	No interventions were implemented upon her return to the facility on [DATE]. A 1/31/21 IDT note indicated she had experienced increased anxiety and was unable to understand she couldn't get up on her own. An intervention was added to wear hipsters at all times. A 2/1/22 IDT note indicated a review of staff monitoring of the fall interventions from 1/24/22, 1/27/22, 1/27/22, and 1/29/22. The IDT found the interventions remained effective and continued to follow care plan. On 2/2/22 at 11:25 p.m., she was found sitting on her bed with an abrasion to her right lower arm posteriorly, measuring 1.1 cm long x 4.9 cm wide. She was unable to state what had occurred. On 2/3/22 at 2:55 p.m., she was in the common area, near the fireplace, visiting with another resident, when staff heard the other resident asking her to wait for help as she slid out of her wheelchair and onto the floor. No injuries were noted. No immediate intervention was implemented to prevent further falls. On 2/4/22 at 12:10 p.m., she was propelling herself in the common area, stood up to ambulate and fell backwards, hitting her head on exercise equipment. She was conscious but moaning and wanting to hold the back of her head; her pupils were dilated. A laceration of at least 4 cm in length and unknown depth was noted to the back of her head. She was transferred to the emergency department for evaluation. On 2/4/22 at 5:10 p.m., report was received from the hospital of the resident having six sutures to her head and a possible compression fracture. She was to be transferred back to the facility. Review of a 2/4/22 Emergency Department visit summary indicated diagnoses of compression fracture, closed head injury, and stitches. No immediate intervention was implemented to prevent further falls. On 2/5/22 at 7:55 p.m., she was observed sitting in front of her recliner. She stated she was going walking and was unable to remember to not get up on her own. She was assisted into her wheelchair and to bed. There was no immediate intervention implemented to prevent further falls. A 2/7/22 IDT note indicated an anti-slip mat would be placed on her wheelchair seat due to the her having slid from her wheelchair on 2/3/22. A 2/7/22 IDT note indicated the unit's exercise equipment would be removed due to her striking her head on it on 2/4/22. A 2/7/22 IDT note indicated an intervention was added to ensure the footrest was down on her recliner when she was sitting in it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A 2/11/22 IDT note indicated a review of staff monitoring of the fall interventions from 2/2/22, 2/3/22, 2/4/22, and 2/5/22. The IDT found the interventions remained effective and continue to follow care plan. On 2/12/22 at 4:24 p.m., a yell then a thud was heard in the hallway off the side of the nurses station. The resident was found on the floor, laying on her back, crying. She complained of pain, but no injury was noted. No immediate intervention was implemented to prevent further falls. On 2/13/22 at 4:09 p.m., the nurse was informed the resident was on the floor again, and went to the unit to assess her. An x-ray of her hip was ordered. No immediate intervention was implemented to prevent further falls. A 2/14/22 IDT note indicated she was not injured in the 2/13/22 fall. An intervention was added to encourage her to stay in the common area when awake and offer her a snack. On 2/14/22 at 8:04 p.m. staff heard an oomph and turned and found the resident sitting in the middle of the hallway in front of her wheelchair. No injuries were noted. She was kept in staff's line of sight. A 2/15/22 IDT note indicated an intervention was added to keep her walker within reach at all times. On 2/16/22 at 7:00 a.m., she came out of her room earlier in the morning, tearful, and stated I woke up to use the bathroom and just broke my self all up. She had been in bed sleeping approximately 15 minutes prior. She had a 2 cm linear skin tear under her chin and complained of a headache. High risk walking rounds continued due to high fall risk. No immediate intervention was implemented to prevent further falls. A 2/16/22 IDT note indicated a review of staff's monitoring of the fall on 2/12/22 intervention. The IDT found the intervention remained effective and continued to follow the care plan. A 2/17/22 IDT note indicated she had been going to the bathroom on 2/16/22 broke herself all up. She had a laceration to her chin. A new intervention was added to assist her with getting up in the morning between 6:00 and 7:00 a.m., then to the common area. On 2/18/22 at 1:37 a.m., she was heard by staff, calling out for help, and was found sitting on the floor at the end of her bed. She stated she was trying to get up to use the bathroom. The bed was in the lowest position. No injuries were noted. She was assisted to the bathroom. No immediate intervention was implemented to prevent further falls. A 2/18/22 IDT note indicated an intervention was added to keep bed at an appropriate height. The appropriate bed height was not defined by the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/19/22 at 7:24 p.m., she was seen in front of the chair on one knee, halfway into getting up. She claimed she did not fall she just sat down; other residents in the area said she sat too far forward on the chair and slipped out and down to ground. She was assisted to her room and then was resting. No immediate intervention was implemented to prevent further falls. A 2/21/22 IDT note indicated she had missed the chair on 2/19/22 and fell to her left side, due to not wearing her glasses appropriately. A new intervention was added to encourage her to wear her eye glasses appropriately. On 2/23/22 at 12:42 a.m., she was found lying on her back on the floor in her room at the bathroom entrance. She had a light red 2 cm long x 2 cm wide abrasion to her left buttock. She complained of back pain and had no visible injuries noted. She was assisted to the bathroom, then back to bed. No immediate intervention was implemented to prevent further falls. A 2/23/22 IDT note indicated she had lost her balance while ambulating, causing her last fall. An intervention was added for non-skid strips to the floor in front of her bathroom and inside of her bathroom. On 2/23/22 at 11:06 a.m., she was found laying on the floor, on her left side, in front of the recliner in her room. She was assisted to her wheelchair and transported to the bathroom for ADL care. She denied any pain or discomfort and no new injury was noted. No immediate intervention was implemented to prevent further falls. On 2/24/22 at 1:35 a.m., she was found sitting in front of her wheelchair beside her bed. She said she was on the way to the bathroom and she slipped. She grimaced slightly when she stood and then took off walking on her own. She was assisted to the bathroom. No pain indicators were noted. No immediate intervention was implemented to prevent further falls. A 2/24/22 IDT note indicated on 2/23/22, she had attempted to transfer by herself and lost balance. An intervention was added to offer her to rest in recliner in common area during day. A 2/24/22 IDT note indicated an intervention was added to offer to assist to toilet if awake during high-risk walking rounds. A 2/25/22 IDT note indicated a review of staff's monitoring of the fall interventions from 2/14/22, 2/16/22, 2/18/22, 2/19/22. The IDT found the interventions remained effective and continued to follow the care plan. A 3/1/22 IDT note indicated a review of staff's monitoring of the fall interventions from 2/22/22, 2/23/22, and 2/24/22. The IDT found the interventions remained effective and continued to follow the care plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/3/22 at 3:05 p.m., she was sitting in the common area during an activity. When the activity staff went to attend to another resident, Resident 79 got up and fell beside her wheelchair. No injury was noted. No immediate intervention was implemented to prevent further falls. On 3/3/22 at 7:51 p.m., she was found on the floor in the common area with her wheelchair behind her. No injuries were noted. The nurse observed her wheelchair and the cushion seemed to be slanted, with the anti-rollback system was pushing it up into the chair, causing the cushion to slant forward. A maintenance request was made for the cushion to be evaluated. A 3/4/22 IDT note indicated an intervention of risk versus benefit, and she continued to be a fall risk related to her dementia and poor safety awareness. A 3/4/22 IDT note indicated the resident had been experiencing increased urinary frequency and a urinalysis order would be requested of the Nurse Practitioner. On 3/6/22 at 5:16 p.m., she was found on her knees in front of her wheelchair in the common area. Staff had reported leaving her to sit in a chair while they assisted another resident. When they returned 10 minutes later, she was on the floor. No injuries were noted. No immediate intervention was implemented to prevent further falls. On 3/7/22 at 6:45 p.m., staff was assisting another resident out of the dining room, and observed Resident 79 walking, while holding on to the tray line rails. She went down and sat on her buttocks and then laid back on the floor. Her wheelchair was still sitting at the table where she had been seated. No injuries were noted and she was assisted back into her wheelchair. The nightshift QMA was to keep the resident close while passing medications to prevent repeated fall. A 3/8/22 IDT note indicated a new intervention of toileting before and after meals. A 3/8/22 IDT note indicated a new intervention of assist out of dining room after finished eating. Review of a 3/10/22 Nurse Practitioner note indicated she was seen at 9:05 a.m. due to a fall earlier in the morning and hitting her head on a filing cabinet. She complained of a headache right after the fall but denied one at the time of the exam. A 3/10/22 at 5:04 p.m. progress note indicated the nurse had been at the medication cart and the resident was inside the nurses station, organizing her purse, when she lost balance and fell backward, hitting her head against the filing cabinet. Pain medication was administered for head pain. No immediate intervention was implemented to prevent further falls. A 3/11/22 IDT note indicated a new intervention to wear tennis shoes when awake. On 3/12/22 at 5:03 p.m., she had a witnessed fall in the commons area, landing on her right side. She had been wandering the unit all day, had been difficult to redirect, and continued to walk without assistance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/15/22 at 7:13 p.m., the facility had been unable to transport her to the orthopedic facility due to a staff shortage. Transportation was set up for the next day at 8:00 a.m. During an interview, on 3/11/22 at 10:22 a.m., CNA 30 indicated she did not know where fall interventions were located but could go ask. She was not sure what Resident 79's specific interventions were, but knew she fell a lot. During an interview, on 3/11/22 at 10:40 a.m., the DON indicated all fall information and investigations were noted in the clinical record. During an interview, on 3/11/22 at 1:22 p.m., RN 33 indicated following a resident fall, she would be expected to develop and add an appropriate intervention to the resident's plan of care. During an interview, on 3/14/22 at 9:59 a.m., CNA 52 indicated the nurses would post any new fall interventions at the nurses station. They attempted to keep Resident 79 in a chair and to keep her busy and in activities. She was frustrated she couldn't walk. During an interview, on 3/14/22 at 12:12 p.m., the DON indicated the resident got up frequently, even if someone was standing right next to her. The DON would expect the nurses to implement immediate interventions to prevent further falls, but it does not always get done. The IDT looked at fall specifics afterward and placed interventions as well. The interventions were added to the care plan and at times, added to the kiosk to have the CNAs look at them. They try to keep her within sight. They have discussed her falls with the Nurse Practitioner and asked to have her medications adjusted; her family thought it may be related to anxiety. 2. On 3/9/22 at 9:07 a.m., Resident 179 was in bed, being assisted with breakfast. Resident 179's clinical record was reviewed on 3/9/22 at 1:55 p.m. Diagnoses included, but were not limited to, fracture of left upper end of humerus, hypertensive heart disease, and COVID-19. She had a current, 2/25/22 care plan for risk for falls. Interventions included, but were not limited to, non-skid strips on floor (3/8/22). A 2/25/22 admission assessment indicated she was independent with ADLs and mobility. A 2/28/22 Nurse Practitioner note indicated she had viral pneumonia and a slight increase in cough and malaise. A 3/5/22 at 11:45 a.m. progress note indicated she was found at 7:15 a.m., sitting on the floor, scared and crying. She indicated she had fallen and couldn't get back up. She did have a disfigured left shoulder area, and was transferred to the emergency department. She remained on the floor until EMS arrived and helped get her off the floor. There was no immediate intervention implemented to prevent further falls. Review of a 3/6/22 Nurse Practitioner note indicated she a left humerus fracture and had been sent to the emergency department due to a head injury and use of Eliquis (a blood thinner). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a 3/7/22 Nurse Practitioner note indicated her pain was poorly controlled. A new order was placed for Fentanyl patch (opioid pain medication). A 3/8/22 IDT note indicated non-skid strips would be placed on the floor beside her bed due to having loss of balance when she fell . During an interview, on 3/7/22 at 10:21 a.m., LPN 30 indicated Resident 179 had not been doing well due to a recent decline and recent fall. She had required total assistance since her decline. 40241 3. On 3/8/22 at 2:05 p.m., Resident 125's door was closed. On 3/9/22 at 9:13 a.m. her door was slightly ajar, unable to see resident from the doorway. On 3/11/22 at 2:08 p.m., Resident 125 was lying on her back in bed, her bed was at thigh height, fall mat in place. Her overbed table was on top of the floor mat and over the resident's lap, her head was elevated. On 3/15/22 at 9:55 a.m. she was in her wheelchair at a table in the common area. Resident 125's clinical record was reviewed on 3/8/22 at 3:05 p.m. Diagnoses included, but were not limited to, hypertensive heart disease with heart failure, age-related osteoporosis without current pathological fracture, generalized anxiety disorder, weakness, altered mental status, repeated falls, dizziness and giddiness, cognitive communication deficit, muscle wasting and atrophy, not elsewhere classified, unspecified lower leg, unsteadiness on feet, need for assistance with personal care, muscle weakness (generalized), difficulty in walking, not elsewhere classified, encounter for other orthopedic aftercare, displaced intertrochanteric fracture of right femur, and subsequent encounter for closed fracture with routine healing, Her orders included, but were not limited to, hydrocodone-acetaminophen (narcotic pain reliever) 5-325 mg (milligram) twice daily, mirtazapine (treat depression) 7.5 mg daily, furosemide (diuretic) 20 mg every other day, citalopram hydrobromide (treat depression) 20 mg daily, buspirone (treat anxiety) 10 mg three times daily and high-risk walking rounds. A quarterly MDS (Minimum Data Set), dated 11/21/21, indicated she was severely cognitively impaired. She required limited assistance of one staff member for bed mobility, transfers, walk in room/corridor, locomotion on/off unit. She required extensive assistance of one staff member for dressing, toilet use and personal hygiene. She used a walker and a wheelchair. She was occasionally incontinent of bladder and continent of bowel. She had one fall with injury. A Fall Risk Assessment, dated 11/19/21, indicated she was a low risk for falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She had a care plan that indicated she was at high risk for fall related to history of falls and she attempted to put herself on the floor to pray initiated on 2/15/21 and revised on 11/26/21. Her goal was she would be free of fall with injury through the review date. Her interventions included, but were not limited to, anti-roll back bars to her wheelchair initiated on 7/27/21, anticipate and meet the resident's needs initiated on 2/15/21, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance initiated on 2/15/21, dycem to recliner and wheelchair initiated on 2/17/21, encourage to keep door open to room initiated on 5/17/21, ensure recliner foot rest are not up initiated on 2/17/21, ensure that she was wearing appropriate footwear (non-skid socks/shoes) when ambulating or mobilizing in wheelchair, initiated on 2/15/21, fall mat beside her bed initiated on 2/15/21, follow facility fall protocol initiated on 2/15/21, gait belt to be used for all transfers initiated on 10/7/21, high risk walking rounds initiated on 2/15/21, keep transfer wheelchair folded up and out of sight initiated 7/27/21, offer prayer visitation services per Catholic Priest initiated on 5/17/21, evaluate and treat per falls initiated on 2/15/21, review information on past falls and attempt to determine cause of falls. Record possible root causes, alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes initiated 2/15/21, the resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, personal items within reach) initiated on 2/15/21. Her nurses notes and care plan interventions indicated the following: On 12/3/21 at 4:29 a.m., resident called for help at 2:00 a.m., she was lying on her back between her bed and the entrance to her room. She was swaddled in her bed linen and some blood was noted to the linen. She reported that she had rolled from the bed, the low air loss bed was noted to be half deflate, the connection from the foot blow up and mattress had failed. To attempt the use of standard pressure reduction mattress to promote sleep. She had a frequent history of wandering from her bed during the night hours, possibly, her bed caused sleep disturbances. to She stated mild discomfort to left hip during the assessment. She had no signs or symptoms of pain or injury with AROM (Active Range of Motion) or weight bearing. Discomfort was resolved with position change. Her gait was at her baseline when she walked to the restroom post fall. She was noted to be incontinent. Staff reported, she was toileted an hour prior and she was seen resting in bed 15-20 minutes before fall. A 6 cm x 3 cm skin tear was noted to her right [TRUNCATED]

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35283 Based on observation, interview, and record review, the facility failed to act upon a significant weight loss and develop personalized interventions for a resident at risk for weight loss (Resident 79). This deficient practice resulted in the resident experiencing a 10% loss of weight in one month with no interventions being put into place. Findings include: On 3/8/22 at 2:30 p.m., Resident 79 was seated at a table with an activity group, and was saying she wanted to get up; Activity Aide 31 was encouraging her to sit still. On 3/9/22 at 10:43 a.m., she was up walking away from the activity group in the common area. LPN 51 went to assist her and asked her to sit in a chair near the fireplace sitting area. On 3/10/22 at 8:51 a.m., she was seated in her wheelchair in the common area with her head in her hands. On 3/10/22 at 9:20 a.m., she remained in her wheelchair near an activity group, holding her head up with her fingers in her eyes. On 3/10/22 at 11:39 a.m., she was seated at a dining table for lunch. She had a cold cut sandwich and French fries. She was taking the sandwich apart and holding the bread in her hand and placing it on the table, the holding it in her hand again. While placing the bread on the table, she spilled her drink onto her plate and onto her lap. At 11:44 a.m., her tablemate alerted the Unit Manager of the spill. The Unit Manager placed the cup upright and left to order a replacement meal. The plate was left at the table and she continued to nibble a French fry. At 11:56 a.m., a new meal was offered to her. On 3/10/22 at 12:40 p.m., she was seated in her wheelchair in the common area. Her plate remained at the dining table, with the sandwich taken apart and a small amount of cold meat gone. Resident 79's clinical record was reviewed on 3/8/22 at 9:50 a.m. Diagnoses included, but were not limited to, (1/27/22) fracture of unspecified part of neck of right femur, major depressive disorder, transient ischemic attack (TIA), restlessness and agitation, psychotic disorder with delusions, dysphagia, unsteadiness on feet, age-related physical debility, and Alzheimer's disease. She had current physician orders for, but not limited to, sertraline (anti-depressant) 50 mg daily, nortriptylline (anti-depressant) 25 mg at HS for insomnia and neuropathic pain secondary to hip fracture, tramadol (opiate pain medication) 50 mg every six hours as needed for pain, acetaminophen (analgesic) 325 mg two tablets three times daily, quetiapine (anti-psychotic) 25 mg 0.5 tablet (12.5 mg) at bedtime, and alprazolam (anti-anxiety) 1 mg twice daily. She received a mechanical soft diet with thin liquids. A 12/17/21, annual, Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired. She required supervision with eating and had a weight gain of 5% since her last assessment. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A 1/31/22, 5 day, MDS indicated she was severely cognitively impaired. She required supervision with eating and had no weight change. She had a current, 2/10/22, care plan problem of exhibited behavior of confusion/distress as evidenced by calling her family members and them asking about her husband, wanting to go home, stating her husband has given her money, being unable to find her husband, and wanting to go home. She had a current, 2/10/22, care plan problem of risk for potential alteration of nutrition and/or weight status related to diagnoses and mechanically altered diet. She had a history of weight changes or significant weight changes. Interventions included, but were not limited to, encourage fluids, serve diet as ordered, offer alternatives if intake was poor, and obtain and evaluate weights. Review of a 1/27/22 progress note indicated she had returned from the hospital following a surgical repair of a hip fracture. Review of weights indicated she had weighed 124 pounds on 2/1/22. On 3/1/22, she weighed 112 pounds, which was a loss of 10%. There was no physician notification of the weight loss, nor were interventions put into place to prevent further weight loss. Review of a 2/2/22 dietary short assessment indicated she received a regular diet with regular texture. A 2/5/22 dietary assessment indicated she received a regular diet, weighed 124 pounds and accepted 51-100% at most meals. Review of a 2/8/22 Occupational Therapy (OT) note indicated she was having increased difficulty with self-feeding. She required verbal cues for task initiation and continuation in a busy environment. On 2/8/22, her diet was downgraded from regular to mechanical soft. Review of meal intakes from 2/9/22 through 3/9/22 indicated the following: She accepted 76-100% of 18 meals. She accepted 51-75% of 15 meals. She accepted 26-50% of 19 meals. She accepted 1-25% of 18 meals. She refused four meals. There was no documentation of replacements being offered or accepted. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of a 3/4/22 OT discharge summary indicated she demonstrated poor ability to comprehend new information and safety awareness. Review of a 3/14/22 nutrition note indicated she continued to receive a mechanical soft diet with extra gravy on ground meat. She fed herself and her average meal consumption over the past 7 days was 43% and she drank eight ounces of fluid at most meals. She weighed 112 pounds on 3/1/22. Her current weight reflected a significant loss of 8.7% x 1 month, 11.3% x 3 months and 13.4% x 6 months. Her BMI was 18.0 and was below goal range. A variety of supplements had been offered in the past and she had not been accepting of them. A re-weight was requested. During an interview, on 3/11/22 at 10:22 a.m., CNA 53 indicated residents were weighed by the CNAs and the nurses documented the weights in the clinical record. During an interview, on 3/11/22 at 10:40 a.m., the DON indicated the dietary department monitored resident weights. During an interview, on 3/11/22 at 11:22 a.m., Agency RN 37 indicated nurses documented resident weights. The previous weights were visible sometimes. She would request a re-weight if there was a 5% difference or an obvious discrepancy. She would then contact the medical provider and tell the unit manager, so the dietician could be notified. During an interview, on 3/16/22 at 1:19 p.m., Agency LPN 31 indicated the resident could feed herself with cuing. She had needed a little extra help that morning, but usually just needed cuing. During an interview, on 3/16/22 at 1:23 p.m., CNA 53 indicated the resident could feeds herself, but was not a big eater. During an interview, on 3/16/22 at 2:09 p.m., the Certified Dietary Manager indicated monthly weights were completed by the 10th of the month, then the dietician reviewed them on the 10th or 11th and pulled any pertinent reports and reviews. Review of a current facility policy, titled Weight Assessment and Intervention, dated September 2008 and provided by the DON on 3/14/22 at 2:15 p.m., indicated the following: .Any weight change of 5% of more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietician in writing. Verbal notification must be confirmed in writing .The Physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss, or increasing the risk of weight loss 3.1-46(a)(1)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40461 Based on observation, interview and record review, the facility failed to ensure staffing levels were adequate related to falls, abuse prevention, meal timing and call lights for 12 of 46 residents reviewed for staffing, (Residents 179, 125, 18, 93, 117, 65, 108, 14, 86, 91 and Resident B). The immediate jeopardy began on 12/3/21, when the facility failed to ensure staffing levels were adequate to allow supervision of residents to prevent frequent falls resulting in major injury of cognitively impaired residents and resident to resident abuse and altercations. The Administrator and DON were notified of the immediate jeopardy on 3/15/22 at 11:04 a.m. Findings include: During a confidential interview, on 3/9/22, Employee 8 indicated the facility had been working short of staff, especially lately, it had been hard to get everything done and be able to spend time talking to any of the residents. During an interview, on 3/9/22 at 3:05 p.m., Resident 38 indicated sometimes it took the staff an hour to answer his call light, he knew it had been an hour because he had two clocks in his room. He had fallen five times and had a whistle to alert staff. During a confidential interview, on 3/11/22, Employee 2 indicated she didn't always have time to look for interventions due to not having enough staff. During an interview, on 3/14/22 at 12:20 p.m., the Scheduler for the Nursing Department indicated ideally she would schedule one CNA per eight bed cluster of residents, had recently tried having two CNAs per unit with an additional float between the two units, this would have been about 9.5 residents per CNA. Tried to do this will all Healthcare units. Tried to schedule one nurse and one QMA per unit, there had been a nurse that called off today so there was only one nurse and one QMA to work that unit. The facility had six different agencies they used to supplement staffing. She did not consider acuity of residents with scheduling. During a confidential interview, on 3/15/22, Employee 10 indicated they had tried to give residents showers but the nurse would have had to watch the floor for them while they were in a resident's room. Cross reference F689. During a confidential interview, on 3/11/22, Employee 4 indicated they didn't have enough staff a lot of the time and the residents aren't able to the time and care they deserved. During a confidential interview, on 3/11/22, Employee 6 indicated they didn't have enough help to what needed to be done. They didn't have enough time to do anything, sometimes they only had one CNA for a whole unit. They had gotten so stressed they cried and had been yelled at for not being able to get everything done. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 3/11/22 at 11:18 a.m., QMA 44 indicated they sometimes had enough help to do what needed to be done. During an interview, on 3/14/22 at 12:12 p.m., the DON indicated they had not been able to do 1:1 with residents due to not having the staffing available. Cross reference F600. Cross reference F744 . During an observation of meal service on Cedar Ridge, on 3/9/22 from 9:10 a.m. to 10:04 a.m., residents were sitting in the small dining room across from the nurses' station, a dietary staff member was picking up trays from resident rooms that were finished eating, a covered breakfast tray was sitting on the ledge outside of the Nurses' Station. The meal tray also included a glass of apple juice and a covered breakfast tray sitting on a table in the small dining room across from the Nurses' Station. This tray included a glass of milk and a glass of orange juice. During an interview, on 3/9/22 at 9:19 a.m., CNA 21 had picked up the tray from the ledge and started to place in the open serving rack. She indicated it was Resident 14's breakfast, she was trying figure out what to do next, she needed to get a resident up for breakfast, Resident 14 needed to be assisted with her meal. Immediately after the interview she went into another resident's room to check on her. 3/9/22 at 9:22 a.m., CNA 21 entered Resident 86's room with a mechanical lift, then exited the room. On 3/9/22 at 9:24 a.m., CNA 21 entered room [ROOM NUMBER], a resident exited from the bathroom, CNA 21 assisted her to sit on the side of her bed and prepared her meal tray that was sitting on the over-bed table. She brought out the other resident's meal tray. On 3/9/22 at 9:27 a.m., CNA 21 pulled Resident 14's meal tray out from the open serving rack and sat it on the ledge outside of the Nurses' Station. On 3/9/22 at 9:28 a.m., CNA 21 entered Resident 86's room and closed the door. On 3/9/22 at 9:34 a.m., CNA 21 exited Resident 86's room and let the dietary staff member know to not pick up Resident 14 and Resident 86's meal trays yet, then re-enter the room. On 3/9/22 at 9:42 a.m., CNA 21 exited Resident 86's room with the mechanical lift and re-entered the room. On 3/9/22 at 9:46 a.m., CNA 21 assisted Resident 86 to the dining room, removed the cover, took the plate to the kitchenette and placed it in the microwave, the milk and orange juice remained on the resident's tray. On 3/9/22 at 9:49 a.m., CNA 21 brought Resident 86 a cup of coffee then retrieved the plate from the microwave and took to the resident, cut up the pancakes and poured syrup over them. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/9/22 at 9:51 a.m., CNA 21 picked Resident 14's meal tray off the ledge, warmed the food in the microwave, the apple juice remained on the tray, then took the tray to the resident's room. Resident 14's clinical record was reviewed on 3/11/22 at 11:56 a.m. Diagnoses included, but were not limited to, dementia, major depressive disorder and anxiety disorder. Current physician orders included, but were not limited to the following: a. Med Pass (nutritional supplement), 90 ml (milliliters) three times a day for weight loss, the order date was 7/19/21. b. Mirtazapine (antidepressant), 7.5 mg (milligram), one tablet at bedtime for weight loss, the order date was 7/21/21. c. Regular diet, pureed texture, liquids at pudding consistency. A 3/9/22 quarterly MDS (Minimum Data Set) assessment indicated she had severe cognitive impairment and required extensive assistance with eating. A current care plan, with a revised date of 1/19/22, indicated she was at risk for potential alteration of her nutrition and/or weight status related to diagnoses dementia, major depressive disorder, anxiety, atrila-fibrillation and abnormal weight loss. She received mirtazapine to stimulate her appetitive, her meal intakes were inadequate to meet her nutritional needs and she required supplementation. A review of her weights indicated, on 10/7/21 she weighed 84.7 lbs (pounds) and on 3/1/22 she weighed 78. 2 lbs, a 7.67% weight loss. Resident 86's clinical record was reviewed on 3/16/22 at 3:13 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety disorder and major depressive disorder. Current physician orders included, but were not limited to, regular diet with regular texture. A 2/5/22 quarterly MDS assessment indicated she had severe cognitive impairment and required extensive assistance with eating. A current care plan, with a revised date of 2/18/22, indicated she had the potential for alteration of her nutritional and weight status related to dementia, dysphagia, anxiety and depression. Interventions included, but were not limited to, she needed assistance with eating and drinking, date initiated was 11/6/21. A review of her weights indicated, on 11/2/21 she weighed 159.8 lbs and on 3/1/22 she weighed 153.3 lbs, a 4.07% weight loss. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Assessment, dated 2/21/22 and scheduled to be reviewed with QAA/QAPI on 3/9/22, indicated their staffing plan indicated their general approach was to maintain a PPD (Per Patient Day) of 4.2 based on a budgeted census of 173, staff adjusted accordingly as acuity and census fluctuated, up with increased census/acuity or down with decline in census/acuity. The staff training/education and competencies section indicated to see staff development list. The section for policies and procedures for provision of care indicated the Medical Director reviews with the DON, Pharmacy, QAPI, QAA, and Administration all policies and procedures reviewed and instituted on a quarterly basis. The section identified to describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments did not include a response. A staffing formula included in the Facility Assessment indicated the number of CNA's X 8 hours X 7 days would equal 2,072 hours. A review of the facility's working schedules indicated the following: On 3/6/22, there had been 228 CNA hours worked. On 3/7/22, there had been 252.5 CNA hours worked. On 3/8/22, there had been 212.5 CNA hours worked. On 3/9/22, there had been 277 CNA hours worked. On 3/10/22, there had been 293 CNA hours worked. On 3/11/22, there had been 208.5 CNA hours worked. On 3/12/22, there had been 212.5 CNA hours worked. The total of the above hours was 1,684 hours. The difference between the number indicated on the Facility Assessment and the number from the working schedule indicated 48.5 less hours had been worked. The immediate jeopardy that began on 10/23/21 was removed on 3/17/22 when the facility began education and interventions for staffing, but the noncompliance remained at the lower scope and severity level of actual harm that is not immediate jeopardy because the facility had not completed education with all staff and had not completed monitoring to ensure staff was following the plan. This Federal Tag relates to Complaint IN00371468. 3.1-17(a)

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Peabody Retirement Community	400 W Seventh St North Manchester, IN 46962

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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 0744 Level of Harm - Immediate jeopardy to resident health or safety 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 adequate supervision, failed to implement behavior interventions, and failed to provide adequate dementia care to prevent resident to resident altercations for 4 of 7 cognitively impaired residents reviewed for abuse (Resident 45, Resident 93, Resident 117, and Resident 120) and failed to identify and implement individualized, non-pharmacological interventions for 2 of 10 residents reviewed for dementia care (Resident 1 and Resident 79). The immediate jeopardy began on 10/23/21, when Resident 45 pushed a chair out from under Resident 93. The Administrator and DON were notified of the immediate jeopardy on 3/15/22 at 11:04 a.m. The immediate jeopardy was removed on 3/17/22, but noncompliance remained at the lower scope and severity level of actual harm that is not immediate jeopardy. Findings include: 1. Resident 1's clinical record was reviewed on 3/16/22 at 9:22 a.m. Diagnoses included, but were not limited to, anxiety disorder, unspecified dementia without behavioral disturbance, major depressive disorder, recurrent, moderate, cognitive communication deficit, other symptoms and signs involving cognitive functions and awareness, and insomnia. Her current orders included, but were not limited to, buspirone (treat anxiety) 10 mg (milligram) three times daily, trazadone (treat insomnia) 50 mg daily, duloxetine (treat depression) delayed release sprinkle 60 mg daily and gabapentin (treat pain) 300 mg three times daily. She had a previous order from 1/28/22 to 3/12/22 for buspirone 10 mg at bedtime and 5 mg two times daily. A quarterly MDS (Minimum Data Set), dated 2/26/22, indicated she was severely cognitively impaired. She had physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) daily. She had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) that occurred 4 to 6 days. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred daily. She rejected evaluation or care daily and she wandered daily. Her care plans included, but were not limited to the following: She had the potential to be verbally aggressive related to dementia, and poor impulse control. She may yell at staff or other residents, initiated on 5/24/21. Her goal was that she would demonstrate effective coping skills through the review date. Her interventions, initiated on 5/24/21, included administer medications as ordered, monitor/document for side effects and effectiveness, give the resident as many choices as possible about care and activities. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She had the potential to be physically aggressive (hitting, slapping, grabbing staff) related to dementia, initiated on 1/21/22. Her goal was that she would not harm self or others through the review date. Her interventions, initiated on 1/21/22 included, but were not limited to, administer medications as ordered, monitor/document for side effects and effectiveness, analyze times of day, places, circumstances, triggers, and what de-escalated behavior and document, assess and address for contributing sensory deficits, assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc . Communication: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, give the resident as many choices as possible about care and activities, monitor/document/report PRN (as needed) any sign and symptom of resident posing danger to self and others, psychiatric/psychogeriatric consult as indicated. She used anti-anxiety medication Buspar related to anxiety disorder, initiated on 6/25/21. Her goal was that she would be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Her interventions, initiated on 6/25/21, included, but were not limited to, administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift, educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Buspar, monitor the resident every shift for safety. She took anti-anxiety medication which were associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. unexpected side effects: mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Monitor/record occurrence of targeted behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc .) and document per facility protocol. She was at risk for decline in psychosocial wellbeing related to resident to resident altercations. On 6/5/21, she was hit/scratched by a female peer during a verbal argument. This was an unwitnessed altercation reported by another resident. On 2/23/22, she wandered into other resident's room, staff heard yelling, entered room and found both residents hitting each other. On 3/10/22, she hit another resident with lint roller. Her goal was that she would not have indications of psychosocial well-being problem by/through review date. Her interventions included, but were not limited to, allow resident to express their emotions/feelings about incident, initiated on 6/5/21, encourage her to visit in common area, initiated on 6/7/21, high risk walking rounds, initiated on 6/5/21, psychiatric NP (Nurse Practitioner) to assess for behaviors of wandering, agitation and aggression, when conflict arises initiated on 3/11/22, remove residents to a calm safe environment and allow to vent/share feelings, initiated on 6/5/21. On 2/18/22 at 3:07 p.m., IDT met to review behaviors from 1/24/22 through 2/13/22 of agitation, combative with care, intrusive wandering, took others things, took toilet apart and flooded the bathroom. Immediate interventions were to redirect her to her own room or common area, switch caregivers and re-approach at later time. The psychiatric NP referral with new order to change times of medication administration. The care plan was reviewed and was current. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/23/22 at 3:43 p.m., staff heard yelling coming from a resident's room, staff entered room and found she had wandered into another residents room and both residents were hitting each other. Residents were immediately separated and placed on high risk walking rounds. Stop sign placed across other resident's door to deter her from wandering in. The care plan was updated. On 2/24/22 at 9:05 a.m., IDT met to review resident to resident altercation from 2/23/22 in which resident had entered another resident's room, staff heard yelling and upon entry, found residents hitting each other. Residents were immediately separated and Resident 1 was removed from the room. The other resident had abrasions to left forearm . A stop sign was placed across other resident's doorway to deter her from wandering into other's rooms. On 3/1/22 at 3:10 p.m., IDT met to review behaviors from 2/14/22 - 2/20/22 of aggressive with care, intrusive wandering and she took others things. Physical aggression during when redirection attempted. The immediate interventions were to attempt to redirect to common area or own room, approach at later time to retrieve other's belongings, offer snack/drink which are occasionally successful. On 3/7/22 on 4:37 p.m., IDT met to review behaviors from 2/21/22 - 2/27/22 of hitting, punching, spitting, kicking staff, cursing at staff, disrobing in the common area, attempted to urinate on the floor in another resident's room, resident to resident altercation in which resident was in another's room and hit the other resident. The immediate interventions were to separate her from other resident, redirected her to a quiet area and reproached for care. The psychiatric NP notified and assessed with no new orders. The care plan was reviewed and current. On 3/10/22 at 10:10 p.m., there was yelling that came from a resident's room. Resident 1 was observed hitting another resident in the leg with a lint roller. She was asked to stop hitting the other resident and she replied I hate that b----. She also tried to take the other resident's rolling walker and became very aggressive when the writer tried to stop her from taking it. The writer let her take the walker in order to allow space between the two resident's. The walker was found in the common area. Resident 1 was redirected to her room without incident. On 3/12/22 at 2:49 p.m., a psychiatric provider note, indicated an acute visit per staff request for an incident that took place on 3/10/22. She had hit another resident with a lint roller. The staff reported she had increased restlessness and agitation. The plan was to increase buspirone to 10 mg three times daily which would help treat anxiety by easing symptoms of restlessness, irritability, and difficult concentrating. Discontinue buspirone 5 mg twice daily and 10 mg at bedtime and start buspirone 10 mg three times daily. Staff was to monitor for changes in moods, behaviors, sleep, and appetite. During an interview, on 3/16/22 at 1:43 p.m., the SSD (Social Service Director) indicated she was not sure why the decision was made to increase her buspirone, it was the psychiatric NP. They have GDR (Gradual Dose Reduction) meetings monthly and review psychotropic and increased or new behaviors and had not reviewed her yet. The NP came in on a Saturday and saw the resident. The NP would rather increase medication than start a new one, to prevent poly pharmacy. It is ultimately up to the prescriber. 35283 (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 3/8/22 at 2:16 p.m., Resident 79 was seated in her wheelchair at a table in the unit common area. Activity Aide 31 was seated next to her. On 3/8/22 at 2:30 p.m., she was saying she wanted to get up; Activity Aide 31 was encouraging her to sit still. On 3/9/22 at 10:43 a.m., she was up walking away from the activity group in the common area. LPN 51 went to assist her and asked her to sit in a chair near the fireplace sitting area. On 3/9/22 at 1:10 p.m., she was seated at a table in the common area with a baby doll during a small group activity. On 3/10/22 at 8:51 a.m., she was seated in her wheelchair in the common area with her head in her hands. On 3/10/22 at 9:20 a.m., she remained in her wheelchair near an activity group, holding her head up with her fingers in her eyes. On 3/10/22 at 3:06 p.m., the resident left her wheelchair in the common area and began walking. CNA 53 assisted her to a chair in the lounge area near the fireplace. The CNA walked away and then the resident got up and walked to a chair across the lounge area and sat down with two other residents. On 3/11/22 at 8:35 a.m., she was up walking around the unit with CAN 39, looking for her spouse. On 3/11/22 at 9:32 a.m., she was up walking toward the medication carts. LPN 37 assisted her back to her wheelchair near a small group of residents and walked away. On 3/15/22 at 9:36 a.m., she was seated in a recliner in the common area, asleep, with a pillow on her lap. Resident 79's clinical record was reviewed on 3/8/22 at 9:50 a.m. Diagnoses included, but were not limited to, (1/27/22) fracture of unspecified part of neck of right femur, major depressive disorder, transient ischemic attack (TIA), restlessness and agitation, psychotic disorder with delusions, dysphagia, unsteadiness on feet, age-related physical debility, and Alzheimer's disease. She had current physician orders for, but not limited to, sertraline (anti-depressant) 50 mg daily, nortriptylline (anti-depressant) 25 mg at HS for insomnia and neuropathic pain secondary to hip fracture, tramadol (opiate pain medication) 50 mg every six hours as needed for pain, acetaminophen (analgesic) 325 mg two tablets three times daily, quetiapine (anti-psychotic) 25 mg 0.5 tablet (12.5 mg) at bedtime, and alprazolam (anti-anxiety) 1 mg twice daily. A 12/17/21, annual, Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired. She experienced hallucinations and delusions, and had behaviors not directed at herself or other for 1-3 days of the assessment period. They did not interfere with her daily functioning, nor those of other people. A 1/31/22, 5 day, MDS indicated she was severely cognitively impaired. She had no hallucinations or delusions and wandered daily. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She had a current, 2/10/22, care plan problem of exhibited behavior of confusion/distress as evidenced by calling her family members and them asking about her husband, wanting to go home, stating her husband has given her money, being unable to find her husband, and wanting to go home. Interventions included call representative, reminisce, remind her that her husband's ashes were in her room. The care plan did not include any additional individualized, targeted interventions to support the resident's confusion or distress. She had a current, 1/26/21 care plan problem of verbal and/or physical aggression towards staff. Interventions included, but were not limited to, medications, assess needs, intervene as needed, guide away from situation, and engage in conversation. She had a current, 1/19/22, care plan problem of elopement risk. Interventions included, but were not limited to, distract with activities the resident prefers such as [left blank], high-risk walking rounds, offer a snack, call her spouse, and redirection. The care plan did not include any additional individualized, targeted interventions to support the resident's wandering and elopement risks. She had a current, 1/21/22, care plan problem of anti-psychotic medication use. Interventions included, but were not limited to, medications, monitor for adverse reactions, and record delusions. The care plan did not define her delusional thoughts, nor did it include any additional individualized, targeted interventions to support her delusional thoughts or hallucinations. She had a current, 6/29/21, care plan for leisure/activity interests. She enjoyed being around animals such as pets, it was not very important to her to do things with groups of people, her favorite activities included TV and to go outside for fresh air, she may enjoy spending time in her room and would be offered 1:1 visits from staff. Review of progress notes indicated the following: On 1/1/22, she was looking for her babies and her husband, and had been up at least 15 times. A snack calmed her for a few minutes. She was opening windows in her room, then saying she didn't open them. She attempted to get her leg over a half-door on the unit, attempting to open a window. Attempts were made to redirect her with conversation but were unsuccessful. She continued on increased alprazolam. She came out of her room repeatedly with no pants on at 11:05 p.m. On 1/2/22, she was looking for her husband and the little boy that was there earlier. She continued to search for a way out of the facility. She calmed after 1:1 and support of staff. On 1/3/22, the Interdisciplinary Team (IDT) met to review behaviors during the period of 12/13-12/26/21 of exit seeking (attempting to open windows, banging on doors demanding to be let out, asking to go home), delusions (looking for children she thinks were in her room, husband waiting for her at home), slamming doors, increased confusion and verbal aggression. Immediate interventions were to redirect to own room, redirect to an activity, offer snacks/drinks, 1:1 conversation/support which is usually successful for short periods. The Psychiatric Nurse Practitioner (NP) assessed her, with a new order for increased alprazolam. Her care plan was reviewed and found to be current. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/5/22, a Psychiatric NP note indicated the resident had been experiencing anxiety, wandering, and exit-seeking since January 2021. A 1/5/22 Social Services note indicated her family took the urn containing her spouse's ashes home. On 1/5/22, she had been restless and delusional, and had taken items out of her room and then said she had no idea how they got out here and someone had stolen them. On 1/7/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. On 1/10/22, the IDT met to review her behaviors for the week of 12/27 - 1/2/22. She continued with exit-seeking, delusions there were children around, her husband was waiting for her, and tearfulness. Immediate interventions were 1:1 support, snack, and redirection to her room. A 1/11/22 Psychiatric NP note indicated she was seen for paranoid thoughts and starting to speak in word salad. A new order for buspirone 5 mg at bedtime for anxiety. On 1/11/22, she was looking for her keys, stating her kids were out in the freezing cold and no one cared. 1:1 support was not successful and she began throwing items off of the medication cart. An order was received for a one-time dose of buspirone 15 mg and the resident accepted the medication on the second attempt of offering it. On 1/13/22, she attempted to climb the half-door and open the windows. She was looking for her husband and her babies. She continued to look for her keys and packing up her personal items. On 1/13/22, the resident was transferred to a different room and nursing unit, when the secured unit was moved within the facility. On 1/16/22, she continued to look for her husband, wandering and exit-seeking. On 1/19/22, she was looking for her grandmother. On 1/20/22, she was seen by the Psychiatric NP per staff request for the altercation with the other resident, throwing belongings out the window, and continued delusions. A new order was received for quetiapine 12.5 mg daily and she was to continue on sertraline 100 mg daily, alprazolam 1 mg twice daily, and buspirone 5 mg at bedtime. On 1/21/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. On 1/22/22, she continued with packing her belongings and exit-seeking. Redirection continued at times. On 1/24/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/24/22, she tripped on another resident's wheelchair and sustained a hip fracture. On 1/27/22, she returned to the facility at 3:40 p.m., following surgical repair of her hip fracture. She fell twice after her return, with the second fall requiring a transfer to the emergency department. On 1/28/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. On 1/28/22, she fell , requiring a transfer to the emergency department. On 1/28/22, a Nurse Practitioner note indicated she continued to exit-seek. On 1/31/22, she was yelling at staff to find her car and her husband. Review of January CNA behavior monitoring indicated her interventions were remove from situation, calm environment, meaningful activity, reapproach, 1:1, food or drink, toilet, and provide comfort such as massage or repositioning. There were no individualized interventions included. A 1/31/22 NP note indicated she had several falls over the weekend. On 2/18/22, the IDT met to review behaviors from 1/24 - 2/13/22 of yelling out, agitation, exit seeking, and refusing care. Immediate interventions were to offer reassurance, redirect to her room and allow time and space for her to calm, which was successful. Her care plan was reviewed and found to be current. On 2/19/22, she had been agitated and yelling out, going in and out of other resident rooms, taking other resident's belongings, yelling, and cursing at staff, stating that she was going to her mom's and continued to exit-seek. Staff was unable to redirect, she refused to sit in her wheelchair and insisted on wandering about the unit. On 3/7/22, she became combative with staff when they attempted to direct her to her room, as she was in the hallway undressed. She calmed when they entered her room. On 3/8/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. On 3/11/22, she was found to have a urinary tract infection. During an interview, on 3/11/22 at 9:07 a.m., RN 37 indicated agency staff obtained information about the residents from report and reviewing the clinical record at the start of the shift. During an interview, on 3/11/22 at 10:22 a.m., CNA 39 indicated behaviors were documented in the clinical record with some interventions listed for each resident, but she wasn't sure what Resident 79's specific interventions were. She was very difficult to redirect and calm. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 3/11/22 at 1:50 p.m., the Social Services Director (SSD) indicated the resident's spouse had recently passed away and she didn't recall that. Interventions for her were reassurance, 1:1, and try to get her involved in activities and keep her with the group of friends in the common area. She had been started on quetiapine for agitation and aggression and also for delusional thoughts her husband was still here or at the bar drinking, and she had seen some kids running around. Care plans were reviewed with the MDS schedule. During an interview, on 3/14/22 at 9:59 a.m., CNA 52 indicated Resident 79 would become frustrated from wanting to walk. Staff encouraged her to remain seated and to stay busy with activities. During an interview, on 3/15/22 at 10:19 a.m., the SSD indicated medication initiation and adjustments would be up to the Psychiatric NP. The facility sent her an acute list weekly for new or worsening behaviors and had her assess the residents. The resident had been on anxiety medication and an anti-depressant, but they were ineffective, and her behavior was out of control. She was seeing kids running around and thought her husband was at the bar to the point she would grab her purse, wanting to go find him. 45122 3. On 3/7/22 at 11:21 a.m., Resident 117 was observed aimlessly ambulating throughout the unit wearing nonskid socks. 03/8/22 at 8:20 a.m., the resident was observed wandering in and out of other residents' rooms wearing nonskid socks. On 3/8/22 at 2:03 p.m., the resident was observed ambulating independently in the common area, she stopped and stroked another resident's hair. No stuffed animal or doll was in her hands or around the resident. On 3/10/22 at 8:52 a.m., the resident was observed ambulating independently into Resident 93's room. No stuffed animal or doll was in her hands or around the resident. On 3/10/22 at 12:25 p.m., the resident was observed ambulating independently in the hall. No stuffed animal or doll was in her hands or around the resident. On 3/11/22 at 1:38 p.m., the resident was observed ambulating independently in the hall with a soft helmet and nonskid socks on. No stuffed animal or doll was in her hands or around the resident. On 3/14/22 at 10:15 a.m., the resident was observed ambulating independently in hall with a soft helmet and nonskid socks on. No stuffed animal or doll was in her hands or around the resident. On 3/15/22 at 9:00 a.m., the resident was observed ambulating into another resident's room. No facility staff were visible. No stuffed animal or doll was in her hands or around the resident. Resident 117's clinical record was reviewed, on 3/10/22 at 3:01 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, repeated falls, difficulty in walking, and displaced fracture of base of second metacarpal bone of left hand (2/14/22). (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was severely cognitively impaired. She never or rarely understood. Staff assessment of the resident's mood indicated, she was short-tempered or easily annoyed two to six days during the assessment period. Her verbal behavioral symptoms directed toward others occurred one to three days during the assessment period. She required extensive assistance of one staff member for walking in her room, walking in the corridor, and locomotion on the unit. No mobility devices were listed. Her medications included, but were not limited to, Lexapro (antidepressant) 5 mg daily and Tylenol (for pain) 650 mg three times a day. She had a focused care plan initiated 2/23/22 for resident to resident altercations which indicated, but was not limited to, when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings (2/23/22), allow resident to express their emotions/feelings about incident (2/23/22), consult with: pastoral care, social services, psych services (2/23/22), encourage participation from resident who depends on others to make own decisions (2/23/22), high risk walking rounds (2/23/22), increase communication between resident/family/caregivers about care and living environment(2/23/22): explain all procedures and treatments, medications, results of labs/tests, condition, all changes (2/23/22), initiate referrals as needed or increase social relationships (2/23/22), monitor/document resident's usual response to problems: Internal - how individual makes own changes, external - expects others to control problems or leaves to fate, or luck (2/23/22). She had a care plan for risk for falls related to Alzheimer's initiated on 2/8/21. Interventions included, but were not limited to, anticipate and meet the resident's needs (2/8/22), high risk walking rounds (2/8/22), the resident needs activities that minimize the potential for falls while providing diversion and distraction (2/8/22), and offer doll or stuffed animal to hold while walking (2/10/22). She had a care plan for impaired cognitive function related to dementia initiated on 2/8/21. Interventions included, but were not limited to, cue, supervise, and reorient as needed (2/8/21) and reminisce with the resident using photos of family and friends (2/8/21). A progress note, dated 2/9/22 at 7:40 p.m., indicated the resident ambulated in the hallway. She grabbed the arm of Resident 65. Resident 65 jerked her arm away and caused the resident to lose balance and sit on the floor. On the way down, she encountered Resident 65's sweater zipper which caused a laceration. An Interdisciplinary Team (IDT) progress note, on 2/10/22 at 9:10 a.m., indicated the resident grazed her left eyebrow on Resident 65's sweater. A progress note, dated 2/11/22 at 2:07 a.m., indicated the resident's left hand was swollen over the knuckle. A progress note, dated 2/12/22 at 2:44 p.m., indicated the left hand was swollen and bruised. The nurse practitioner (NP) ordered X-rays of the left hand. The X-ray on 2/13/22 of the left hand with two views indicated an acute oblique fracture at base of the 2nd proximal phalanx (the index finger base where it connects to the left hand). (continued on next page)

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	155655	A. Building B. Wing	03/17/2022

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

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, on 2/16/21 at 1:42 p.m., indicated the resident wandered in and out of other residents' rooms most of the evening. She sat or stood and randomly screamed. A progress note, on 2/19/22 at 10:57 p.m., indicated the resident wandered in and out of other residents' rooms and placed her hands on other residents causing the other residents to become upset. Staff attempted to intervene and separate the residents. A progress note, on 2/21/22 at 3:32 a.m., indicated the resident wandered in and out of nearly every room. She grabbed other people and angered them. A progress note, on 3/7/22 at 5:58 a.m., indicated the resident wandered in and out of most rooms while she picked up items along the way. She also tried to reach into the staff member's pocket several times. During a confidential interview, (CNA 45 on 3/11/22 at 9:12 a.m.) a staff member indicated she did not have enough help to do what she needed to do. She indicated there were times when she worked when there was only one CNA there for the unit. She indicated she was supposed to keep an eye on the resident. During an interview, with CNA 41 on 3/14/22 at 10:43 a.m., she indicated she regularly worked on the unit. She indicated for interventions it was really knowing everyone and how they reacted to stuff. She indicated someone usually passed on any new interventions for the residents. During an interview, on 3/15/22 at 9:19 a.m., CNA 41 indicated they had activities for the people. She indicated they tried to distract them as much as they can if the residents were getting upset. She indicated the resident liked to go into other residents' rooms, and the staff tried to direct her out. 4. On 3/7/22 at 11:21 a.m., Resident 93 was observed ambulating independently about the unit. On 3/8/22 at 8:25 a.m., the resident was observed sitting at a table in the activity/dining area with her head resting on the table. She was wearing a soft helmet. On 3/10/22 at 8:50 a.m., the resident was observed standing, bent over a table in the activity/dining area wearing a soft helmet and lace up shoes. On 3/14/22 at 10:16 a.m., the resident was observed ambulating independently in her room and wearing a soft helmet. Resident 93's clinical record was reviewed, on 3/10/22 at 11:16 a.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, Alzheimer's early onset, major depressive disorder, catatonic disorder, restlessness and agitation, anxiety disorder, psychosis and cognitive communication deficit. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A quarterly MDS, dated [DATE], indicated the resident was severely cognitively impaired. She was never or rarely understood. The resident never or rarely understood others. Continuous presence of disorganized thinking and inattention that did not fluctuate was indicated. The resident required supervision with assistance of one staff member for walking in her room, the corridor and locomotion on the unit. Her physician orders included, but were not limited to, lorazepam (antianxiety) 0.5 mg three times a day for agitated catatonia. A focused care plan for resident to resident altercations included, but was not limited to the following interventions: allow resident to express their emotions/feelings about incident (10/23/21), consult with: pastoral care, social services, psych services (10/23/21), high risk walking rounds (10/23/21) and if resident moving furniture in common area, staff to move furniture back to original place (10/25/21). A care plan for elopement risk was initiated on 2/21/21 and revised on 12/2/21. Interventions included, but were not limited to, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Resident prefers listening to music in common area or her room (2/21/21). Allow resident to walk in secured courtyard with supervision when weather permits (2/21/21). A current care plan for impaired cognitive function/dementia or impaired thought processes related to dementia indicated resident may wander around unit or into others' rooms. Interventions included, but were not limited to cue, reorient, and supervise as needed (2/10/21), high risk walking rounds (2/25/21), and redirect from others' rooms with music, coloring, snack/beverage (2/25/21). A progress note, on 12/18/21 at 4:30 a.m., indicated the reside [TRUNCATED]

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40461 Based on observation, record review and interview, the facility failed to monitor a resident for adverse side effects related psychotropic medications, for 1 of 6 residents reviewed for psychotropic medication use (Resident 38). Findings include: During an interview, on 3/7/22 at 11:34 a.m., Resident 38 had visible facial muscle movements, lip smacking, tongue darting in and out of his mouth, irregular movements of his upper arms and hip twisting movements. He indicated he took Ativan (anti-anxiety) to help with abnormal movements. Resident 38's clinical record was reviewed on 3/8/22 at 3:16 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, post-traumatic stress disorder, bipolar disorder, manic severe with psychotic features, depressive episodes and drug induced subacute dyskinesia. Current physician orders included, but were not limited to the following: a. Sertraline (antidepressant) 100 mg, one tablet once a day related to post-traumatic stress disorder, the order date was 12/20/21. b. Remeron (antidepressant) 15 mg, one-half tablet (7.5 mg) every morning for depression and appetite stimulant, the order date was 12/20/21. c. Depakote (mood stabilizer) extended release 250 mg tablet, three tablets (750 mg) every morning and bedtime for bipolar disorder, manic severe with psychotic features, the order date was 12/20/21. d. Zyprexa (antipsychotic) 2.5 mg, one tablet every morning and bedtime for bipolar disorder, manic severe with psychotic features, the order date was 12/20/21. e. Ativan 1 mg, one tablet every morning and bedtime for anxiety, the order date was 12/27/21. Physician orders did not include monitoring for side effects for Ativan, sertraline, remeron, depakote or Zyprexa. A 12/20/21 entry tracking MDS (Minimum Data Set) assessment indicated he had readmitted to the facility after an acute hospital stay. A 12/24/21 quarterly MDS assessment indicated he was cognitively intact. He had received an antipsychotic five days during the assessment period and an antidepressant four days during the assessment period. The antipsychotic was received on a routine basis and GDR (Gradual Dose Reduction) had not been attempted. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an AIMS (Abnormal Involuntary Movement Scale) assessment, dated 2/22/21 and provided by SSD (Social Service Director) 8 on 3/11/22 at 9:44 a.m., indicated he had been admitted to the facility on [DATE]. His score was 6 out of a possible 0-28 score. The score key indicated the higher the score (0-28), the greater the impact of observed movements on resident. Review of an AIMS assessment, with a locked date of 1/10/22 and provided by SSD 8 on 3/11/22 at 9:44 a.m., indicated a score of 20 out of a possible 0-28 score. The score key indicated the higher the score (0-28), the greater the impact of observed movements on resident. During an interview, on 3/11/22 at 9:42 a.m., SSD 8 indicated AIMS assessments and monitoring of side effects related to psychotropic medications was done by the nurses. During an interview, on 3/11/22 at 11:51 a.m., the DON indicated psychotropic side effect monitoring was documented on the electronic medication administration record. During an interview, on 3/11/22 at 2:21 p.m., RN 23 was unable to find psychotropic side effect monitoring, she did not find it on the electronic medication administration record or in the physician orders. Review of a current facility policy, titled MONITORING FOR ANTI-PSYCHOTIC MEDICATION SIDE EFFECTS, with a revised date of 9/09 and provided by the DON on 3/16/22 at 11:18 a.m., indicated It is the policy of [NAME] Retirement Community to monitor each resident on anti-psychotic medication(s) for adverse side effects, to maintain the resident at their highest functional and emotional status 3.1-48(a)(3)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 Based on record review and interview, the facility failed to ensure resident's did not receive a dosage increase without indication for 2 of 7 residents reviewed for unnecessary medications (Resident 1 and Resident 79). Findings include: 1. Resident 1's clinical record was reviewed on 3/16/22 at 9:22 a.m. Diagnoses included, but were not limited to, anxiety disorder, unspecified dementia without behavioral disturbance, major depressive disorder, recurrent, moderate, cognitive communication deficit, other symptoms and signs involving cognitive functions and awareness, and insomnia. Her current orders included, but were not limited to, buspirone (treat anxiety) 10 mg (milligram) three times daily, trazadone (treat insomnia) 50 mg daily, duloxetine (treat depression) delayed release sprinkle 60 mg daily and gabapentin (treat pain) 300 mg three times daily. A quarterly MDS (Minimum Data Set), dated 2/26/22, indicated she was severely cognitively impaired. She had physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) daily. She had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) that occurred 4 to 6 days. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred daily. She rejected evaluation or care daily and she wandered daily. Her care plans included, but were not limited to the following: She had the potential to be verbally aggressive related to dementia, and poor impulse control. She may yell at staff or other residents, initiated on 5/24/21. Her goal was that she would demonstrate effective coping skills through the review date. Her interventions, initiated on 5/24/21, included administer medications as ordered, monitor/document for side effects and effectiveness, give the resident as many choices as possible about care and activities. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She had the potential to be physically aggressive (hitting, slapping, grabbing staff) related to dementia, initiated on 1/21/22. Her goal was that she would not harm self or others through the review date. Her interventions, initiated on 1/21/22 included, but were not limited to, administer medications as ordered, monitor/document for side effects and effectiveness, analyze times of day, places, circumstances, triggers, and what de-escalated behavior and document, assess and address for contributing sensory deficits, assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Communication: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, give the resident as many choices as possible about care and activities, monitor/document/report PRN (as needed) any sign and symptoms of resident posing danger to self and others, psychiatric/psychogeriatric consult as indicated. She used anti-anxiety medication Buspar related to anxiety disorder, initiated on 6/25/21. Her goal was that she would be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Her interventions, initiated on 6/25/21, included, but were not limited to, administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift, educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Buspar, monitor the resident every shift for safety. She took anti-anxiety medication which were associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. unexpected side effects: mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Monitor/record occurrence of targeted behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc .) and document per facility protocol. She used an antidepressant medication Cymbalta related to pain & Trazadone related to insomnia, initiated on 5/18/21. Her goal was that she would be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Her interventions, initiated on 5/18/21, included administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift and monitor/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL (Activities of Daily Living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth or dry eyes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She was at risk for decline in psychosocial wellbeing related to resident to resident altercations. On 6/5/21, she was hit/scratched by a female peer during a verbal argument. This was an unwitnessed altercation reported by another resident. On 2/23/22, she wandered into other resident's room, staff heard yelling, entered room and found both residents hitting each other. On 3/10/22, she hit another resident with lint roller. Her goal was that she would not have indications of psychosocial well being problem by/through review date. Her interventions included, but were not limited to, allow resident to express their emotions/feelings about incident, initiated on 6/5/21, encourage her to visit in common area, initiated on 6/7/21, high risk walking rounds, initiated on 6/5/21, psychiatric NP (Nurse Practitioner) to assess for behaviors of wandering, agitation and aggression, when conflict arises initiated on 3/11/22, remove residents to a calm safe environment and allow to vent/share feelings, initiated on 6/5/21. Her progress notes indicated, but was not limited to, the following: On 1/3/22 on 1:44 p.m., IDT met to review behaviors during period of 12/136/21 - 12/26/21 of intrusive wandering, agitation with redirection, combative towards staff, refused medications, refused meals, verbal aggression. The immediate interventions were to redirect to own room/common area, snacks/drinks, activities, one on one support which were unsuccessful. The psychiatric NP assessed with new order for Buspar. The resident appeared to have days and nights mixed up as resident slept most of the day and was awake at night. The care plan was reviewed and current. On 1/5/22 at 3:00 p.m., a psychiatric provider note, indicated an acute visit, per staff request, for insomnia. The NP would also provide emotional support of medical and mental concerns of the patient as needed. The NP would evaluate and record pertinent diagnostics, medications, vital signs, solicit staff and/or family input as available. Staff would report resident having increased restlessness and agitation. The plan was to start trazadone 12.5 mg a bedtime and staff to monitor for signs and symptoms of sleep disturbance or maladjustment to medication being started. On 1/10/22 at 2:02 p.m., IDT met to review recent behaviors during week of 12/27/21-1/2-22. She had behaviors of intrusive wandering, agitation, verbal and physical aggression, and refused care. Immediate interventions included redirecting her to her own room, offer snacks and drinks, redirected to an activity, which were unsuccessful. She was referred to psychiatric NP with increase in buspar and new order for trazadone for insomnia. The care plan was reviewed and current. On 1/11/22 at 10:40 a.m., a psychiatric provider note, indicated an acute visit, per staff request, the resident was combative with staff, not sleeping at night, and refused appointments/medications/care. Nursing indicated that medication changes had not helped yet. They noted that Trazadone addition had not helped with resident's insomnia. The NP would evaluate and record pertinent diagnostics, medications, vital signs, solicit staff and/or family's input as available. The staff reported the resident had increased restlessness and agitation. The plan was to discontinue trazadone 12.5 mg at bedtime and start Trazadone 25 mg at bedtime. The staff was to monitor for signs and symptoms of sleep disturbance or maladjustment to medication being started. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/22 at 1:28 a.m., she had been restless and agitated all shift, going into other resident's rooms and attempted to wake them up, when other resident did not respond due to sleeping, she would then run over to the bed in an attempt to wake up, she had not physically touched any other resident's that shift, staff had closely monitored her all shift and redirected, she slapped and yelled at staff and stated they needed to wake up and go. She had refused medications all shift with three attempts. She was unable to successfully be redirected or distracted. She showed no signs of pain, she was continent of bowel and bladder. She had snacked through out the shift, while the writer offered her juice in her room, she came up behind writer and slapped across the back. She threw personals around in the room, staff was outside door and monitored for safety and safety of others, the NP was called with new orders for buspar 20 mg and Trazadone 25 mg one time STAT (immediately). On 1/20/22 at 3:30 p.m., a psychiatric provider note, indicated an acute visit, per staff request, for resident insomnia, refused appointments, refused medications, and care. They noted delusions were worsening. The NP would evaluate and record pertinent diagnostics, medications, vital signs, solicit staff and/or family input as available. The staff reported resident had increased restlessness and agitation. The plan was to discontinue Trazadone 25 mg daily and start Trazadone 50 mg daily, with staff to monitor for sign and symptoms of sleep disturbance or maladjustment to medication being started. On 1/24/22 at 3:25 p.m., IDT met to review behaviors from 1/10-1/16/22 of agitation, physical aggression, intrusive wandering, verbal aggression,restlessness, insomnia and refusing care and medication. The immediate interventions included redirected her to her own room or common area, offered snacks/drinks, one on one support all of which were only effective for short periods of time. The psychiatric NP was notified and a new order given for increased trazadone and Buspar. The care plans were reviewed and current. On 2/18/22 at 3:07 p.m., IDT met to review behaviors from 1/24/22 through 2/13/22 of agitation, combative with care, intrusive wandering, took others things, took toilet apart and flooded the bathroom. Immediate interventions were to redirect her to her own room or common area, switchcare givers, re-approach at later time. The psychiatric NP referral with new order to change times of medication administration. The care plan was reviewed and was current. On 2/23/22 at 3:43 p.m., staff heard yelling coming from a resident's room, staff entered room and found she had wandered into another residents room and both residents were hitting each other. Residents were immediately separated and placed on high risk walking rounds. Stop sign placed across other resident's door to deter her from wandering in. The care plan was updated. On 2/24/22 at 9:05 a.m., IDT met to review resident to resident altercation from 2/23/22 in which resident had entered another resident's room, staff heard yelling and upon entry, found residents hitting each other. Residents were immediately separated and Resident 1 was removed from the room. The other resident had abrasions to left forearm. A stop sign was placed across other resident's doorway to deter her from wandering into other's rooms. On 3/1/22 at 3:10 p.m., IDT met to review behaviors from 2/14/22 - 2/20/22 of aggressive with care, intrusive wandering and she took others things. Physical aggression during when redirection attempted. The immediate interventions were to attempt to redirect to common area or own room, approach at later time to retrieve other's belongings, offer snack/drink which are occasionally successful. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/7/22 on 4:37 p.m., IDT met to review behaviors from 2/21/22 - 2/27/22 of hitting, punching, spitting, kicking staff, cursing at staff, disrobing in the common area, attempted to urinate on the floor in another resident's room, resident to resident altercation in which resident was in another's room and hit the other resident. The immediate interventions were to separate her from other resident, redirected her to a quiet area and reproached for care. The psychiatric NP notified and assessed with no new orders. The care plan was reviewed and current. On 3/10/22 at 10:10 p.m., there was yelling that came from a resident's room. Resident 1 was observed hitting another resident in the leg with a lint roller. She was asked to stop hitting the other resident and she replied I hate that b----. She also tried to take the other resident's rolling walker and became very aggressive when the writer tried to stop her from taking it. The writer let her take the walker in order to allow space between the two resident's. The walker was found in the common area. Resident 1 was redirected to her room without incident. On 3/12/22 at 2:49 p.m., a psychiatric provider note, indicated an acute visit per staff request for an incident that took place on 3/10/22. She had hit another resident with a lint roller. The staff reported she had increased restlessness and agitation. The plan was to increase buspirone to 10 mg three times daily which would help treat anxiety by easing symptoms of restlessness, irritability, and difficult concentrating. Discontinue buspirone 5 mg twice daily and 10 mg at bedtime and start buspirone 10 mg three times daily. Staff was to monitor for changes in moods, behaviors, sleep, and appetite. During an interview, on 3/16/22 at 1:43 p.m., the SSD (Social Service Director) indicated she was not sure why made that decision was made to increase her buspirone, it was the psychiatric NP. They have GDR (Gradual Dose Reduction) meetings monthly and review psychotropic and increased or new behaviors and had not reviewed her yet. The NP came in on a Saturday and saw the resident. The NP would rather increase medication than start a new one, to prevent poly pharmacy. It is ultimately up to the prescriber. 35283 2. On 3/8/22 at 2:16 p.m., Resident 79 was seated in her wheelchair at a table in the unit common area. Activity Aide 31 was seated next to her. On 3/8/22 at 2:30 p.m., she was saying she wanted to get up; Activity Aide 31 was encouraging her to sit still. On 3/9/22 at 10:43 a.m., she was up walking away from the activity group in the common area. LPN 51 went to assist her and asked her to sit in a chair near the fireplace sitting area. On 3/9/22 at 1:10 p.m., she was seated at a table in the common area with a baby doll during a small group activity. On 3/10/22 at 8:51 a.m., she was seated in her wheelchair in the common area with her head in her hands. On 3/10/22 at 9:20 a.m., she remained in her wheelchair near an activity group, holding her head up with her fingers in her eyes. (continued on next page)

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	155655	A. Building B. Wing	03/17/2022

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/22 at 3:06 p.m., the resident left her wheelchair in the common area and began walking. CNA 53 assisted her to a chair in the lounge area near the fireplace. The CNA walked away and then the resident got up and walked to a chair across the lounge area and sat down with two other residents. On 3/11/22 at 8:35 a.m., she was up walking around the unit with CNA 39, looking for her spouse. On 3/11/22 at 9:32 a.m., she was up walking toward the medication carts. LPN 37 assisted her back to her wheelchair near a small group of residents and walked away. On 3/15/22 at 9:36 a.m., she was seated in a recliner in the common area, asleep, with a pillow on her lap. Resident 79's clinical record was reviewed on 3/8/22 at 9:50 a.m. Diagnoses included, but were not limited to, (1/27/22) fracture of unspecified part of neck of right femur, major depressive disorder, transient ischemic attack (TIA), restlessness and agitation, psychotic disorder with delusions, dysphagia, unsteadiness on feet, age-related physical debility, and Alzheimer's disease. She had current physician orders for, but not limited to, sertraline (anti-depressant) 50 mg daily, nortriptylline (anti-depressant) 25 mg at HS for insomnia and neuropathic pain secondary to hip fracture, tramadol (opiate pain medication) 50 mg every six hours as needed for pain, acetaminophen (analgesic) 325 mg two tablets three times daily, quetiapine (anti-psychotic) 25 mg 0.5 tablet (12.5 mg) at bedtime, and alprazolam (anti-anxiety) 1 mg twice daily. A 12/17/21, annual, Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired. She experienced hallucinations and delusions, and had behaviors not directed at herself or other for 1-3 days of the assessment period. They did not interfere with her daily functioning, nor those of other people. A 1/31/22, 5 day, MDS indicated she was severely cognitively impaired. She had no hallucinations or delusions and wandered daily. She had a current, 2/10/22, care plan problem of exhibited behavior of confusion/distress as evidenced by calling her family members and them asking about her husband, wanting to go home, stating her husband has given her money, being unable to find her husband, and wanting to go home. Interventions included call representative, reminisce, remind her that her husband's ashes are in her room. She had a current, 1/26/21 care plan problem of verbal and/or physical aggression towards staff. Interventions included, but were not limited to, medications, assess needs, intervene as needed, guide away from situation, and engage in conversation. She had a current, 1/19/22, care plan problem of elopement risk. Interventions included, but were not limited to, distract with activities the resident prefers such as [left blank], high-risk walking rounds, offer a snack, call her spouse, and redirection. She had a current, 1/21/22, care plan problem of anti-psychotic medication use. Interventions included, but were not limited to, medications, monitor for adverse reactions, and record delusions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She had a current, 6/29/21, care plan for leisure/activity interests. She enjoyed being around animals such as pets, it was not very important to her to do things with groups of people, her favorite activities included TV and to go outside for fresh air, she may enjoy spending time in her room and would be offered 1:1 visits from staff. Review of progress notes indicated the following: On 1/1/22, she was looking for her babies and her husband, and had been up at least 15 times. A snack calmed her for a few minutes. She was opening windows in her room, then saying she didn't open them. She attempted to get her leg over a half-door on the unit, attempting to open a window. Attempts were made to redirect her with conversation but were unsuccessful. She continued on increased alprazolam. She came out of her room repeatedly with no pants on at 11:05 p.m. On 1/2/22, she was looking for her husband and the little boy that was there earlier. She continued to search for a way out of the facility. She calmed after 1:1 and support of staff. On 1/3/22, the Interdisciplinary Team (IDT) met to review behaviors during the period of 12/13-12/26/21 of exit seeking (attempting to open windows, banging on doors demanding to be let out, asking to go home), delusions (looking for children she thinks were in her room, husband waiting for her at home), slamming doors, increased confusion and verbal aggression. Immediate interventions were to redirect to own room, redirect to an activity, offer snacks/drinks, 1:1 conversation/support which is usually successful for short periods. The Psychiatric Nurse Practitioner (NP) assessed her, with a new order for increased alprazolam. Her care plan was reviewed and found to be current. On 1/5/22, a Psychiatric NP note indicated the resident had been experiencing anxiety, wandering, and exit-seeking since January 2021. A 1/5/22 Social Services note indicated her family took the urn containing her spouse's ashes home. On 1/5/22, she had been restless and delusional, and had taken items out of her room and then said she had no idea how they got out here and someone had stolen them. On 1/7/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. On 1/10/22, the IDT met to review her behaviors for the week of 12/27 - 1/2/22. She continued with exit-seeking, delusions there were children around, her husband was waiting for her, and tearfulness. Immediate interventions were 1:1 support, snack, and redirection to her room. A 1/11/22 Psychiatric NP note indicated she was seen for paranoid thoughts and starting to speak in word salad. A new order for buspirone 5 mg at bedtime for anxiety. On 1/11/22, she was looking for her keys, stating her kids were out in the freezing cold and no one cared. 1:1 support was not successful and she began throwing items off of the medication cart. An order was received for a one-time dose of buspirone 15 mg and the resident accepted the medication on the second attempt of offering it. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/12/22, the resident's representative was notified of the new order for buspirone and indicated the resident had been on the medication in the past without success. She requested the NP be notified of this. On 1/12/22, she was noted to have a shuffling gait. On 1/13/22, she attempted to climb the half-door and open the windows. She was looking for her husband and her babies. She continued to look for her keys and packing up her personal items. On 1/13/22, the resident was transferred to a different room and nursing unit, when the secured unit was moved within the facility. On 1/14/22, she was involved in an altercation with another resident, where they yelled at each other and she pushed the other resident's forehead. They were immediately separated, and the resident calmed. On 1/16/22, she continued to look for her husband, wandering and exit-seeking. On 1/19/22, she was looking for her grandmother. On 1/20/22, she was seen by the Psychiatric NP per staff request for the altercation with the other resident, throwing belongings out the window, and continued delusions. A new order was received for quetiapine 12.5 mg daily and she was to continue on sertraline 100 mg daily, alprazolam 1 mg twice daily, and buspirone 5 mg at bedtime. On 1/21/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. On 1/22/22, she continued with packing her belongings and exit-seeking. Redirection continued at times. On 1/24/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. On 1/24/22, she tripped on another resident's wheelchair and sustained a hip fracture. On 1/27/22, she returned to the facility at 3:40 p.m., following surgical repair of her hip fracture. She fell twice after her return, with the second fall requiring a transfer to the emergency department. On 1/28/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. On 1/28/22, she fell , requiring a transfer to the emergency department. Her representative was concerned about her anxiety and wanted the Psychiatric NP notified to have the buspirone discontinued, as they felt it was not working. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/22, a Nurse Practitioner note indicated she continued to exit-seek. The buspirone was discontinued, sertraline was reduced to 50 mg daily, and nortriptylline was initiated for sleep and pain. On 1/31/22, she was yelling at staff to find her car and her husband. Review of January CNA behavior monitoring indicated her interventions were remove from situation, calm environment, meaningful activity, reapproach, 1:1, food or drink, toilet, and provide comfort such as massage or repositioning. There were no individualized interventions included. A 1/31/22 NP note indicated she had several falls over the weekend. On 2/18/22, the IDT met to review behaviors from 1/24 - 2/13/22 of yelling out, agitation, exit seeking, and refusing care. Immediate interventions were to offer reassurance, redirect to her room and allow time and space for her to calm, which was successful. Her care plan was reviewed and found to be current. On 2/19/22, she had been agitated and yelling out, going in and out of other resident rooms, taking other resident's belongings, yelling, and cursing at staff, stating that she was going to her mom's and continued to exit-seek. Staff was unable to redirect, she refused to sit in her wheelchair and insisted on wandering about the unit. On 3/7/22, she became combative with staff when they attempted to direct her to her room, as she was in the hallway undressed. She calmed when they entered her room. On 3/8/22, she was placed on the facility bowel movement protocol, as she had not had a BM in 72 hours. On 3/11/22, she was found to have a urinary tract infection. A 3/14/22 nutrition note indicated her average meal consumption in the previous 7 days was 43% Her current weight reflected a significant loss of 8.7% x 1 month, 11.3% x 3 months and 13.4% x 6 months. Her BMI was below goal range. During an interview, on 3/11/22 at 9:07 a.m., RN 37 indicated agency staff obtained information about the residents from report and reviewing the clinical record at the start of the shift. During an interview, on 3/11/22 at 10:22 a.m., CNA 39 indicated behaviors were documented in the clinical record with some interventions listed for each resident, but she wasn't sure what Resident 79's specific interventions were. She was very difficult to redirect and calm. During an interview, on 3/11/22 at 1:50 p.m., the Social Services Director (SSD) indicated the resident's spouse had recently passed away and she didn't recall that. Interventions for her were reassurance, 1:1, and try to get her involved in activities and keep her with the group of friends in the common area. She had been started on quetiapine for agitation and aggression and also for delusional thoughts her husband was still here or at the bar drinking, and she had seen some kids running around. Care plans were reviewed with the MDS schedule. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/14/22 at 9:59 a.m., CNA 52 indicated Resident 79 would become frustrated from wanting to walk. Staff encouraged her to remain seated and to stay busy with activities. During an interview, on 3/15/22 at 10:19 a.m., the SSD indicated medication initiation and adjustments would be up to the Psychiatric NP. The facility sent her an acute list weekly for new or worsening behaviors and had her assess the residents. The resident had been on anxiety medication and an anti-depressant, but they were ineffective, and her behavior was out of control. She was seeing kids running around and thought her husband was at the bar to the point she would grab her purse, wanting to go find him. Review of a current facility policy, titled Psychoactive Medication Management, dated 9/21/11 and provided by the DON on 3/16/22 at 10:52 a.m., indicated the following: Thee use of psychoactive medications will only be implemented for the treatment of the resident's medical symptoms, not for discipline or convenience. [NAME] Retirement Community will implement PRC systems for monitoring of side effects, adverse reactions, adverse consequences and behavioral symptoms that negatively impact the resident or others . Care plans will address use of psychoactive medication and method to monitor for effectiveness. Social Service Coordinators to track using pharmacy info, consults with nurse practitioner/physician .The team will develop an interdisciplinary approach to care planning mood and behaviors through medication management. Care plans will address use of psychoactive medication, reason for use, and method to monitor for side effects and effectiveness Cross-reference F 689. 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(b)(2)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45122 Based on observation, interview, and record review, the facility failed to ensure a medication administration rate under 5% with 35 opportunities of medication administration observed, and 4 of the 35 medications were not administered correctly or in accordance with physician's orders (Residents 30 and 55). Findings include: On 3/10/22 at 10:12 a.m., RN 43 prepared Resident 30's medication (divalproex delayed release 125 mg tablet) by crushing the tablet and placing in chocolate pudding. The package containing the medication indicated do not crush. In an interview, during the observation, RN 43 indicated she typically crushes the medication for this resident. The medication was given, crushed in chocolate pudding, to the resident. On 3/10/22 10:21 a.m., RN 43 prepared Resident 55's medication. She crushed the following medications clonidine 0.1 mg, hydralazine 25 mg, and tramadol 50 mg and placed in chocolate pudding. The medication was given, crushed in chocolate pudding, to the resident. On 3/10/22 at 11:01 a.m., Resident 30's medication orders were reviewed. She had a physician's order for Depakote tablet delayed release 125 mg (divalproex sodium) give 125 mg by mouth three times a day related to unspecified dementia with behavioral disturbance. Do not crush. The physician's orders lacked a crush medications order. On 3/10/22 at 11:03 a.m. Resident 55's medication orders were reviewed. She had physician's orders for clonidine 0.1 mg, give 1 tablet by mouth two times a day for hypertension, hydralazine 25 mg, give 1 tablet two times a day for hypertension, tramadol 50 mg, give 1 tablet by mouth three times a day for pain in lower back. The physician's orders lacked a crush medications order. During an interview, on 3/10/22 at 11:14 a.m., RN 43 indicated she had changed Resident 30's order to divalproex sprinkle as this was more appropriate. She indicated she generally crushes medication for Resident 55. She indicated she was getting an order to crush Resident 55's medication. Review, on 3/18/22 at 10:06 a.m., of a professional website, Institute for Safe Medication Practices, updated 2/21/20, https://www.ismp.org/recommendations/do-not-crush, indicated divalproex should not be crushed. Review of a current facility policy, titled Administering Medications and provided by the DON, on 3/11/22 at 3:15 p.m., indicated .Medications must be administered in accordance with orders . 3.1-48(c)(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40461 Based on interview and record review, the facility did not ensure dietary staff had the appropriate cooking abilities to provide meals in a palatable manner, for 6 of 6 residents that attended the Resident Council meeting, (Residents 17, 115, 38, 94, 51, and 53). Findings Include: During a tour of the kitchen, on 3/7/22 at 9:40 a.m., accompanied by the Production Manager, the grease vat had black/dark brown grease, burnt debris was visible in the grease as well as on the surface leading into the grease vat. He indicated the grease was changed every Tuesday and hash browns had been made for breakfast. During an interview, on 3/7/22 at 11:36 a.m., Resident 38 indicated residents could no longer receive onion rings because dietary staff always burnt them and the facility had stopped serving macaroni and cheese because the staff didn't know how to fix them. During an interview, on 3/8/22 at 9:41 a.m., Resident 94 indicated his food was burnt a lot, especially shrimp and meatballs. He never received his food warm from the kitchen. 1/3 of his meals were either brought in by family or staff that worked at the facility. During a Resident Council meeting, on 3/9/22 at 3:05 p.m., the residents that were present had indicated food was burnt, macaroni and cheese was no longer available, and meals were not served at a consistent time. During an interview, on 3/10/22 at 11:57 a.m., the Dietary Inventory Manager indicated it was hard to get macaroni and cheese and onion rings in on the supply trucks. Sometimes they had to make macaroni and cheese from scratch for the assisted living portion of the facility, the staff cooking in healthcare didn't have a cook that knew how to make it, and the onion rings were getting burnt too often. During an interview, on 3/11/22 at 9:21 a.m., the Dietary Manager indicated staff were younger, there was less staff, and they had different skill sets that didn't include cooking. Review of a Position Description for a cook, with an effective date of 1/2014 and provided by the Dietary Manager on 3/16/22 at 2:09 p.m., indicated .DUTIES AND RESPONSIBILITIES To perform this job successfully, an individual must be able to perform each essential duty satisfactorily .2. Insures meals are palpable and attractive when served 3. Follows time schedule for coordination of meal preparation and service This Federal Tag relates to Complaint IN00371468. 3.1-21(h)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40461 Based on observation, record review and interview, the facility failed to ensure food in refrigerators, freezers, and dry storage areas were stored in a sanitary manner. Findings include: During a tour of the kitchen, on 3/7/22 at 9:40 a.m., accompanied by the Production Manager, the following were observed: a. The meat refrigerator included four boxes stacked on top of each other on the floor, he indicated staff had not had time to take the supplies out of the box and place on the shelves in the refrigerator. b. A dry food storage area, identified as a loading dock, included boxes stored on the floor, the boxes included, but were not limited to, pudding cups and canned goods. An area at the far right corner of the ceiling had areas of water damage with cracked and chipped ceiling surface, he indicated he hadn't noticed it leaking anymore. He indicated stock arrived on Tuesday and Fridays and should be put away within one day of arrival. c. Refrigerator 4 included boxes, that contained food items, stacked on top of each other on the floor, he indicated stock had not been put away. d. Freezer 3 contained food items that included, but were not limited to, chicken and ice cream, boxes were stacked on top of each other on the floor. e. Another dry food storage area, included, but was not limited to, two open boxes of bananas on the floor, he indicated the bananas were aged and needed to be discarded. An area above a food storage shelf had areas of water damage with cracked and chipped ceiling surface, he indicated it needed to be re-plastered. From the RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENTS, effective November 13, 2004 form the website: https://www.in.gov/health/food-protection/files/410_iac_7-24.pdf, indicated .Food storage . (2) Where it is not exposed to splash, dust, or other contamination. (3) At least six (6) inches above the floor. (4) in a manner to prevent overcrowding .Food storage; prohibited areas Sec.178. (a) Food may not be stored as follows: .(2) Under the following: .(B) Leaking water lines, .under lines on which water had condensed 3.1-21(i)(2)(3)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35283 Based on observation, record review, and interview, the facility failed to comprehensively complete and review the Facility Assessment to ensure resident needs and staffing ratios were evaluated to meet the needs of residents. Findings include: Review of the current, 2/21/22, Facility Assessment, was completed on 3/17/22 at 8:46 a.m. The assessment indicated the following: The assessment was scheduled for QAPI review on 3/9/22. Admission of residents diagnosed with psychiatric/mood disorders were accepted, and the Administrator and Social Services department were to ensure the mental health provider agreement, behavior management, and in-service education was completed, with resources available and no action steps were required. Mental health and behavior practices included, but were not limited to, managing the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identification and implementation of interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, and intellectual or developmental disabilities. The Facility Assessment did not address staffing needs based on resident acuity and identified seven residents with cognitive needs and 21 with reduced physical function. Review of the facility census, upon entrance to the facility on [DATE], indicated a total of 40 residents resided on the secured units. During an interview, on 3/17/22 at 10:12 a.m., the Administrator confirmed the facility assessment had been left blank where the determination and review of individual staff assignments for coordination and continuity of care were to be addressed. She indicated the number of residents with cognitive needs and reduced physical function had been pulled from current MDS assessment information, and would only include those residents who had an assessment during a specific time period. Cross reference F725. Cross reference F744.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35283 Based on observation, interview, and record review, the facility failed to ensure systematic issues related to resident care were identified, in which quality assessment and assurance activities were necessary, as evidenced by the severity of deficiencies cited and to ensure quality assurance procedures were followed and plans of action implemented to prevent deficiencies from re-occurring. Findings include: During an interview, on 3/17/22 at 10:12 a.m., the Administrator indicated the facility QA committee had met last on 3/9/22. The committee had tasks assigned for review on a schedule, such as falls, call light response, pressure wounds, reportables, documentation, and laboratory results. There were different thresh holds to trigger quality improvement studies and plans. They had a goal to reduce falls by 5% each month and to keep pressure wounds under the State average. They did not currently have any actions plans in place. During an interview, on 3/17/22 at 11:27 a.m., the Administrator indicated some of the tasks reviewed by the QA committee included, but were not limited to, daily review of documentation during the work week and monthly reviews of abuse, infection control, and incontinence care. Review of a current facility policy, titled Quality Assurance and Performance Improvement (QAPI) Committee, dated July 2016 and provided by the Administrator following the Entrance Conference on 3/7/22, indicated the following: .The primary goals of the QAPI Committee are to: 1. Establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services; 2. Promote the consistent use of facility systems and processes during provision of care and services .4. Support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problems .6. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals .The QAPI Committee shall help various departments/committees/disciplines/individuals develop and implement plans of correction and monitoring approaches. These plans and approaches should include specific time frames for implementation and follow-up Cross reference F600. Cross reference F725. Cross reference F744. Cross Reference F689. 3.1-52(b)(2)

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	03/17/2022

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40461 Based on observation, record review and interview, the facility failed to ensure the blood glucose meters were used and stored hygienically and failed to ensure hand hygiene standards were followed, for 1 of 2 blood glucose observations (QMA 44). Findings include: During an observation of blood glucose testing, on 3/10/22 at 11:07 a.m., QMA 44 removed a blood glucose meter from the top drawer of the medication cart, there was no barrier between the glucose meter and the drawer. She obtained a test strip, lancet, alcohol prep pad, gloves and entered a resident's room. She sat the supplies on top of the resident's bed, donned gloves, wiped the resident's finger with an alcohol prep pad and pricked her finger with the lancet. There had not been enough blood pulled up from the test strip for the blood glucose reading. She doffed the gloves, gathered the glucose meter and used lancet and exited the resident's room. She returned to the medication cart, placed the glucose meter on top of the medication cart, obtained another test strip, an alcohol prep pad, gloves and lancet and returned to the resident who was now on an exercise bike in the hallway with therapy. She placed the blood glucose meter on a ledge along the wall, donned gloves, wiped the resident's finger with an alcohol prep pad, pricked her finger with the lancet, then placed the used lancet on a ledge beside the exercise bike. The glucose reading had been obtained, doffed her gloves, gathered supplies and returned to the medication cart. She placed the blood glucose meter on top of the medication cart, opened the top drawer and placed the meter inside the drawer. No hand hygiene had been observed during the observation. During an interview, on 3/11/22 at 11:02 a.m., QMA 3 indicated a barrier would need to be between the glucose meter and any other surface, the meter would need to be disinfected after use, most glucose meters would be in their own case when not in use. Review of a current facility policy, titled Obtaining Fingerstick Glucose Level, with a revised date of October 2011 and provided by the Administrator on 3/17/22 at 4:28 p.m., indicated .Steps in the Procedure .18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice .19. Remove gloves and discard into designated container. 20. Wash hands 3.1-18(b)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 40461 Based on observation, record review and interview, the facility failed to ensure additional precautions had been implemented to mitigate the spread of COVID-19 for staff who were not fully vaccinated, for 3 of 9 staff members reviewed for vaccinations (LPN 3, QMA 9, RN 14). Findings include: During an interview, on 3/9/22 at 9:11 a.m., LPN 3 was wearing a surgical mask, she indicated she was not vaccinated, had a religious exemption, got tested on ce a week, sometimes twice, and had not received information related to additional mitigation strategies. During an interview, on 3/9/22 at 1:25 p.m., QMA 9 was wearing a surgical mask, she indicated she was not vaccinated, had a religious exemption, got tested on ce a week and had not been told of any additional strategies that were required for her to work at the facility. During an interview, on 3/11/22 at 10:08 a.m., the DON indicated unvaccinated staff had to wear surgical masks and test twice a week. During and interview, on 3/10/22 at 10:37 a.m., RN 14 was wearing a surgical mask, she indicated she was not vaccinated, had a medical exemption, was tested on ce a week and had not been told about additional strategies that would be required. Review of the COVID-19 Staff Vaccination Status for Providers indicated the total number of staff employed was 299, the number of staff fully vaccinated was 215, the number of partially vaccinated staff was 20, the number of staff with a pending exemption was 10, and the number of staff that had been granted an exemption was 54. Review of a current facility policy, titled COVID-19 VACCINE POLICIES AND PROCEDURES, undated and provided by the Assistant Director of nursing on 3/11/22 at 10:32 a.m., indicted .Additional Precautions and Contingency Plans for Unvaccinated Staff * Staff who receive an exemption to the COVID-19 vaccine with be subject to additional precautions to mitigate the transmission and spread of COVID-19, which includes: * Staff that have been given a religious or medical exemption will be tested weekly. * All staff that do not have either the first shot by February 14th and the second shot by March 15th, or doesn't have a pending or approved exemption will be terminate From the CDC (Centers for Disease Control and Prevention) COVID Data Tracker website, https://covid.cdc.gov/covid-data-tracker/#county-view, on 3/5/22 Wabash County's community transmission was high. From the Long-Term Care and Skilled Nursing Facility, Attachment A, QSO 22-09-ALL .S483.80(i)(3)(iii): Requires facilities to ensure those staff who are not yet fully vaccinated, or who have a pending or been granted an exemption, or who have a temporary delay as recommended by the CDC, adhere to additional precautions that are intended to mitigate the spread of COVID-19. 3.1-8(a)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 40241 Based on record review and interview, the facility failed to ensure resident rights, abuse training and dementia was completed for 5 of 9 employee files reviewed for required training (CNA 81, CNA 85, CNA 87, and LPN 89). Findings include: The employee files were reviewed on 3/13/22 at 2:00 p.m. and indicated the following: 1. CNA 81, CNA 85, CNA 87's new employee files lacked abuse training. 2. LPN 89's employee file lacked annual abuse training. During an interview with the HR Director, on 3/14/22 at 9:45 a.m. she indicated they were working on putting a system in place, there was a four month gap between the last HR manger and herself.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40241 Based on record review and interview the facility failed to ensure required inservices were completed for 6 of 9 employee files reviewed for required inservicing (CNA 81, CNA 85, CNA 87, CNA 82, QMA 86 and CNA 90). Findings include: The employee files were reviewed, on 3/13/22 at 2:00 p.m., and indicated the following: a. CNA 81, CNA 85, CNA 87's new employee files lacked resident rights, dementia and abuse training. b. CNA 82's employee file lacked 2 hours of annual dementia training. c. QMA 86's employee file lacked 0.5 hours of annual dementia training. d. CNA 90's employee file lacked annual dementia training. During an interview with the HR Director, on 3/14/22 at 9:45 a.m. she indicated they were working on putting a system in place, there was a 4 month gap between the last HR manger and herself. 3.1-14(h)