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 _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY RETIREMENT COMMUNITY	400 W SEVENTH ST NORTH MANCHESTER, IN 46962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00444013 and IN00447236. Complaint IN00444013 - Federal/state deficiencies related to the allegations are cited at F600. Complaint IN00447236 - No deficiencies related to the allegations are cited. Survey date: November 25, 2024 Facility number: 000485 Provider number: 155655 AIM number: 100291190 Census Bed Type: SNF/NF: 164 Residential: 59 Total: 223 Census Payor Type: Medicare: 9 Medicaid: 106 Other: 49 Total: 164 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 5, 2024.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to prevent staff-to-resident verbal abuse of a dependent resident (Resident D) and neglect of a resident (Resident E) from a staff member, CNA 1, for 2 of 3 residents reviewed for abuse. The deficient practice was corrected on September 24, 2024, prior to the date of the survey, and was therefore past noncompliance. Findings include: 1. The clinical record for Resident D was reviewed on 11/25/24 at 10:57 a.m. Diagnoses included dysphagia, cerebral infarction, and glaucoma. The most recent significant change Minimum Data Set (MDS) assessment, dated 8/5/24, was reviewed on 11/25/24 at 10:57 a.m. The MDS indicated Resident D had severe cognitive impairment and was dependent on staff for all activities of daily living. In a written statement, dated 9/24/24, CNA 2 indicated while getting Resident D ready for bed,	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

Resident C indicated CNA 2 had told Resident D to "Shut up, You don't need to talk right now." CNA 1 also told the resident that she would give her permission to talk.

During an interview on 11/25/24 at 12:57 p.m., Resident C indicated on the morning of 9/24/24, CNA 1 had been verbally abusive to Resident C when she came to provide morning care. Resident D indicated CNA 1 told Resident C to "shut up; you don't need to talk right now," and "I will give you permission to talk." Resident D did not report the incident to the facility until 9/29/24. The resident reported the incident to CNA 2.

Neither CNA 1 nor CNA 2 were available for interview during the survey.

2. The clinical record for Resident E was reviewed on 11/25/24 at 11:10 a.m. Diagnoses included intertrochanteric fracture of the right femur, chronic obstructive pulmonary disease, and atrial fibrillation.

The most recent quarterly MDS assessment, dated 9/13/24, was reviewed on 11/25/24 at 11:10 a.m. The MDS indicated Resident E was cognitively intact. The resident was impaired in the lower extremity on one side and required moderate assistance for showering and dressing.

Review of a written statement, dated 9/24/24, indicated CNA 2 indicated while providing care to the resident, Resident E asked for a shower. The resident indicated CNA 1 had told the resident they were "too tired" to provide a shower. CNA 2 provided the resident with a shower.

During an interview on 11/25/24 at 1:48 p.m., the

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F 600	Continued From page 3	F 600		

DON provided the facility investigation regarding the incident. The facility reported CNA 1 to their agency and the appropriate state agency. The DON indicated CNA 1 was no longer allowed to work in the facility.

During an interview on 11/25/24 at 4:46 p.m., the DON indicated resident rights were revived during Resident Council meetings. The DON provided a copy of the resident rights reviewed that indicated the following:
" .... Freedom from Restraint and Abuse You have the right to: .... Be free from verbal, physical, sexual, and mental abuse; corporal punishment; neglect; and involuntary seclusion. ...."

This deficient practice was corrected by 9/24/24 after the facility implemented a systemic plan that included the following actions: assessment of all residents for psychosocial harm, corrective action for the CNA involved in abuse allegation, in-servicing re-education to staff related to resident abuse and neglect, and audits of residents for neglect concerns were completed.

This citation relates to Complaint IN00444013.

3.1-27(b)