STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155655	A. BUILDING 00 B. WING	03/28/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00402752. This visit included a State Residential Licensure Survey. Complaint IN00402752 - No deficiencies related to the allegations are cited. Survey dates: March 21, 22, 23, 24, 27 & 28, 2023 Facility number: 000485 Provider number: 155655 AIM number: 100291190 Census Bed Type: SNF/NF: 136 Residential: 62 Total: 198 Census Payor Type: Medicare: 11 Medicaid: 83 Other: 42 Total: 136 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 4, 2023.	F 0000	Preparation and/or execution of this plan does not constitute admission or agreement by Peabody Retirement Community that a deficiency exists. This plan is also not to be construed as an admission of fault by Peabody Retirement Community or its employees who draft this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. We respectfully request desk review of this Plan of Correction.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katie Robinson	Administrator	04/17/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and interview, the facility staff failed to serve residents in a dignified manner during observation of 1 of 4 dining rooms observed for dining services.	F 0550	Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents shall be cared for in a manner that	04/27/2023

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	(Resident 3) Findings include: During an observation of the Healthcare 2nd floor dining room, on 3/23/23 at 11:11 a.m., residents were observed seated at tables, each having been served beverages and a dessert cup. Staff members began to take orders from residents. Resident 3 was observed seated alone, at a table for two. A table next to her had eight residents seated. At 11:16 a.m., three residents from the table of eight were served special orders of a hamburger and onion rings. At 11:28 a.m., the remaining residents at the table of eight had been served. At 11:39 a.m., Resident 3 became visibly upset and left the dining room, indicating to CNA 11 that she would not stay there, sitting alone without food, any longer. During an interview with Resident 3 in her room at 3/23/23 at 12:17 p.m., she was observed crying. She felt the staff and residents would snub her. She was always seated at a table alone, and was one of the last to be served. She had not felt welcomed in the dining rooms. She rarely received what she ordered. During the interview, a staff member delivered the resident's lunch tray. The resident's meal ticket indicated a peanut butter and jelly sandwich, onion rings, fruit crisp, water, and coffee. Her order was accurate, except the plate had french fries instead of onion rings. No beverages were on the tray. She indicated she was not hungry and asked the staff to take the tray away. She would be eating in her room going		promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem which includes being served in a welcoming, dignified manner during meal services as well as honoring choices. 1. One Resident, Resident 3, was affected by this alleged deficient practice. Resident 3 was interviewed at the time of notification of the event as the 2567 outlines and weekly thereafter on seating location and meal selection choices. Resident maintains there was not an issue and declined changing seating location in the dining room. Resident 3 has since returned to the dining room for meal services. 2. All residents who reside within the facility have the potential to be affected by the alleged deficient practice. All cognitively intact residents interviewed on meal service preferences which include seating arrangements and meal choices. All non-cognitively intact residents reviewed for meal consumption and anticipated preferences based on representative feedback. Individual care records amended accordingly. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents shall be	

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	forward; she would not return to the dining room. Further observations on 3/24/23, 3/27/23, and 3/28/23 were made in which she had refused to go to the dining room for meals. During an interview on 3/27/23 at 10:17 a.m., SSD 20 indicated Resident 3 had voiced no concerns to her. She recalled the resident had awhile ago entered the dining room and all of the seats were full. The resident had indicated she felt everyone was staring at her, so she turned around and left the dining room. SSD 20 indicated the resident used food as a means of controlling her environment. She not aware of the resident becoming upset during dining service on 3/23/23. During an interview on 3/27/23 at 10:42 a.m., the ADON indicated Resident 3 was a fragile person and she had been unaware the resident had been upset during dining service. Resident 3's clinical record was reviewed on 3/22/23 at 2:40 p.m. Diagnoses included heart failure, diabetes mellitus type II, depression, and dementia. A significant change Minimum Data Set (MDS) assessment, dated 2/2/23, indicated the resident was cognitively intact, required supervision/set-up for meals, felt bad about herself and thought of being better off dead for several days during the assessment period. A health care plan, revised 1/4/23, indicated the resident may refuse to eat related to dining times and frustration. Intervention included resident's triggers for refusing to eat were delays in food arrival, provide hot food and on time meals, and empower the resident by allowing choices in meal		cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem which includes being served in a dignified manner during meal services and honoring choices. All staff, including agency, in-serviced on aforementioned policy emphasizing Residents to be served in a welcoming, dignified manner during meal services and choices honored. 4. Social Services, or Designee, will audit dining services alternating meals one (1) time a day, three (3) days a week, for four (4) weeks, then alternating meals one (1) time a day, three (3) times a week for an additional five (5) months to ensure Residents are being served in a welcoming, dignified manner during meal services and choices honored. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	

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	time, menu selection, dining location. A current facility policy, revised February 2021, titled, "Dignity," left on the conference table on 3/24/23 at 9:00 a.m., included the following: "...Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem...." 3.1-3(a)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to			

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	participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to honor the preference for a resident's preferred time to wake in the mornings for 1 of 1 residents reviewed for choices. (Resident 36) Findings include: During an interview on 3/21/23 at 2:21 p.m., Resident 36 indicated he was not being assisted in mornings to prepare for the day. He woke up around 4:00 a.m. and preferred to get out of bed. The staff on night shift would often ignore his request to get cleaned up and dressed. Resident 36's clinical record was review on 3/24/23 at 12:08 p.m. Diagnoses included anemia, rectal cancer, major depression, and history of stroke. An annual Minimum Data Set (MDS) assessment, dated 2/24/23, indicated the resident was cognitively intact, had no verbal or physical behaviors, no rejection of care, and required extensive assistance of staff for bed mobility, transfer, dressing and hygiene. A health care plan, initiated 2/23/22, indicated a daily preference to choose his own bedtime and wake up naturally. The goal was the resident's daily preferences would be honored by staff. Interventions included to provide necessary resources to ensure daily preferences were able to be met. During an interview on 3/27/23 at 10:02 a.m., CNA 22 indicated Resident 36 liked to get up around 4:00 a.m. The resident had been involved in	F 0561	Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents are entitled to exercise their rights and privileges to the fullest extent possible and further we will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity which includes daily preference to choose his/her own hour of sleep and wake times. 1. One Resident, Resident 36, was affected by this alleged deficient practice. Resident 36 was interviewed on preferred hour of sleep and wake times which can fluctuate. Individual care record amended accordingly. 2. All Residents who reside within the facility have the potential to be affected by the alleged deficient practice. All cognitively intact Residents interviewed on daily preference of sleep and wake times. All non-cognitively intact Residents reviewed for daily preference of naturally occurring sleep and wake times. Individual care records amended accordingly. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents are entitled	04/27/2023

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	disagreements with some of the night shift CNAs and would not receive assistance to get up. When the resident had not been assisted, the day shift would assist him first thing at between 6:10 a.m. and 6:15 a.m. This occurred approximately two times a week, depending on who had worked the previous shift. During an interview on 3/27/23 at 10:39 a.m., the ADON indicated she was unaware of the issue with the resident's wake time. He had complained to her about one month ago about not getting assistance at 4:00 a.m., and she had addressed it at that time. She was unaware the situation was still occurring. A current facility policy, revised August 2009, titled "Resident Rights," provided by LPN 10 on 3/28/23 at 11:11 a.m., indicated the following: "...Policy and Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all resident of this facility....2. Residents are entitled to exercise their rights and privileges to the fullest extent possible. 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity...." 3.1-3(u)(1) 3.1-3(v)(1)		to exercise their rights and privileges to the fullest extent possible and further we will make every effort to assist each Resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity which includes daily preference to choose his/her own hour of sleep and wake times. All staff in-serviced, including agency, on aforementioned policy emphasizing daily preference to choose his/her own hour of sleep and wake times. 4. DON, or Designee, will audit seven (7) random Residents three (3) days a week, for four (4) weeks, then seven (7) random Residents one (1) time a week for an additional five (5) months to ensure Residents preferred wake times are honored. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	
F 0574 SS=E Bldg. 00	483.10(g)(4)(i)-(vi) Required Notices and Contact Information §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each			

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	resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system			

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	(as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.			
	Based on observation, interview, and record review, the facility failed to provide Long Term Care Ombudsman contact information to the Resident Council upon request for 6 of 7 Resident Council attendees. Findings include: During an interview on 3/23/23 at 2:46 p.m., the Resident Council meeting attendees indicated they did not know what the ombudsman was, or who it was. Six of seven of the Resident Council attendees had requested the number of the ombudsman, but it had not been provided. A review of the 1/17/23 Resident Council minutes on 3/23/23 at 12:30 p.m., provided by the DON,	F 0574	Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents are entitled to exercise their rights and privileges to the fullest extent possible including communicating with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations, etc.) regarding any matter. 1. Six of seven of the Resident Council attendees were identified as affected by this alleged deficient practice. Out of abundance of caution, all current	04/27/2023

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	indicated the Resident Council had requested updated ombudsman documents. A review of the 1/17/23 Resident Council follow up record, on 3/27/23 at 2:01 p.m., provided by the DON, indicated the new number for the ombudsman was given to the residents who had wanted it. During an interview on 3/27/23 at 2:22 p.m., the Activity Director indicated she had typed out a paper with the local ombudsman's contact number and had given it to the residents at the Resident Council meeting who had wanted it. A copy of the paper provided to the residents who requested the local ombudsman contact information, provided by the Activity Director on 3/28/23 at 9:51 a.m., lacked the local ombudsman's name. The phone number provided was not the correct information for the local ombudsman. During an observation on 3/28/23 at 10:06 a.m., the local Ombudsman's name and contact number listed on a telephone and address directory, in the Hawthorne Heights and Tulip Place entrance areas, were incorrect. During an interview at the time of the observation, Social Service Designee 3 confirmed the Ombudsman's name was incorrect. She was uncertain who was responsible for updating the directory. A current policy, dated 8/2009, provided by LPN 10 on 3/28/23 at 11:11 a.m., titled "Resident Rights," indicated the following: " ...Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ...Voice grievances and have the facility respond to those grievances ...."		Resident Council attendees were provided with a written record of the new Ombudsman name and contact information, including a brief description of his position, as the 2567 did not indicate Resident identifier numbers. In addition, our new Ombudsman, Dana Neer, has been invited to attend a facility Resident council meeting. 2. All Residents who reside within the facility have the potential to be affected by the alleged deficient practice. All cognitively intact Residents provided with a written record of the new Ombudsman name and contact information including a brief description of his position. All non-cognitively intact Residents representatives provided with a written record of the new Ombudsman name and contact information, including a brief description of his position, via mail. The Hawthorn Heights and Tulip place directory was updated with accurate information immediately upon notification of occurrence. The remaining posted locations were audited and are accurate. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents are entitled to exercise their rights and privileges to the fullest extent possible including communicating with outside agencies (e.g., local,	

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	3.1-4(j)(3)(C)		state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations, etc.) regarding any matter. All staff, including agency, in-serviced on aforementioned policy. Activity Manager and Social Services in-serviced on Resident Council requests and accuracy of community contact posting respectively. 4. SS, or Designee, will audit postings for accuracy of community contact information one (1) time a week for six (6) months and Administrator, or Designee, will audit responses to Resident Council members requested information for accuracy one (1) time a month for 6 months. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status			

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	(that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). A. Based on observation, interview, and record	F 0580	Peabody Retirement Community	04/27/2023

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	155655	A. BUILDING 00 B. WING	03/28/2023

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	review, the facility failed to timely notify the physician and family of a significant change in condition for 1 of 5 resident's reviewed for respiratory care. (Resident 58) B. Based on record review and interview, the facility failed to ensure the physician was notified of dietary recommendations for a resident with weight loss for 1 of 9 residents reviewed for nutrition. (Resident 28) Finding includes: During an observation on 3/21/23 at 3:40 p.m., Resident 58 was in bed on her back, with her eye closed and her mouth open. Her lips and tongue were cracked and very dry. Upon a knock and entry to the resident's room, the resident opened her eyes. Her mouth was very dry, and after multiple attempts to form words with a dry mouth, she spoke her name. She was confused and asked the date over and over again. Oral care supplies were not observed at the resident's bedside. Resident 58's clinical record was reviewed on 3/22/23 at 3:24 p.m. Diagnoses included pneumonia, unspecified organism and need for assistance with personal care. Current orders included occupational therapy five times per week for four weeks (3/2/23), physical therapy five times per week for four weeks (3/2/23), and assess pain level every shift. The clinical record lacked indication of comfort care, palliative care, or hospice services. An order for acetaminophen (pain) 500 milligrams (mg), one tablet by mouth every morning and at bedtime was started on 3/1/23, and discontinued		Health and Rehabilitation has a policy whereby our Resident's representatives and clinicians are notified with significant changes including a change in the Resident's physical, mental, or psychosocial status that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. Peabody Retirement Community Health and Rehabilitation also has a policy whereby nutritional assessments are a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the Resident at risk for or with impaired nutrition. 1. Resident 58, their medical records (i.e. Progress notes) and orders reviewed. Resident 58's representative, was notified of said change in her condition. Facetime contact was arranged to promote emotional comfort for both the family and Resident 58. Resident 58 clinicians were updated. Resident 28, their medical records (i.e. Progress notes) and orders reviewed. Resident representative was notified of said change in weight. Dietician notified of said change in condition and reviewed resident. Clinician notified of Dieticians recommendation. 2. All Residents who reside within the facility have the potential to be affected by the	

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	on 3/9/23. An order for acetaminophen (pain) 325 mg, 2 tablets by mouth every 4 hours as needed, was started on 3/9/23. An admission Minimum Data Set (MDS), dated 3/6/23, indicated the resident was cognitively intact with no change in the resident's mental status from baseline. She required supervision with set up help only for eating. She required extensive assistance for bed mobility, dressing, toileting, and personal hygiene. She used a wheelchair for mobility. She did not have a condition or chronic disease that may result in a life expectancy of less than six months. A care plan for pneumonia was dated 3/1/23. Interventions included the following: encourage good fluid intake as well as good nutrition and adequate rest; monitor and document for changes in mental status, stupor, and signs or symptoms of congestive heart failure; monitor, document, and report to the provider for tachypnea, hypoxia, confusion, or disorientation; and monitor vital signs per order and protocol. A care plan, dated 3/1/23, indicated the resident was at risk for pain related to colitis and pneumonia. Interventions included the following: anticipate the resident's need for pain relief and respond immediately to any complaint of pain; monitor, record, and report to the nurse any signs or symptoms of non-verbal pain such as changes in breathing, grunting, moans, yelling out, silence; monitor, record, and report to the nurse any loss of appetite, refusal to eat and weight loss; observe and report changes in usual routine, decrease in functional abilities, and withdrawal or resistance to care; provide the resident and family		alleged deficient practice. All current Residents, their medical records (i.e. Progress notes), orders and weights reviewed for significant loss of 5% in 30 days and 10% in 180 days. The dietician was provided the information gathered and reviewed. Clinician and family members updated with any significant changes and dietary recommendations as they occurred. Individual Resident's plan of care amended as applicable. Vendor contacted and calibrated all scales for accuracy of weight measurement on 3/28/23. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby Resident's representatives and clinicians are notified with significant changes including a change in the Resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. All licensed staff, including agency, in-serviced on aforementioned policy. In addition, Peabody Retirement Community Health and Rehabilitation also has a policy whereby nutritional assessments are a systematic, multidisciplinary process that includes gathering and interpreting data and using	

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	with information about pain and options available for pain management; discuss and record preferences. A care plan, dated 3/6/23, indicated the resident elected a do not resuscitate code status. Interventions included the following: notify the physician and power of attorney of changes in the resident's condition and involve family in discussion. A care plan, dated 3/6/23, indicated the resident had preferences. Interventions included, have her family involved in discussions about her care. A care plan, dated 3/7/23, indicated the resident was at risk for dehydration or potential fluid deficit related to pneumonia. Interventions included the following: monitor and document intake and output as per facility policy; monitor, document, and report any signs or symptoms of dehydration such as decreased or no urine output, cracked lips, furrowed tongue, new onset of confusion, fatigue and weakness, and dry or sunken eyes. A care plan, dated 3/6/23, indicated the resident had an activity of living self-care performance deficit related to colitis and pneumonia. Interventions included, discuss with the resident and family any concerns related to decline in function. A Provider Note, dated 3/1/23, indicated a care plan meeting would be arranged to discuss hospice or comfort care. The resident was alert and oriented to person, place, and time. A care plan note, dated 3/2/23, indicated the resident, family, and interdisciplinary team met for		that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. All interdisciplinary team members and nursing staff, including agency, in-serviced on aforementioned policy. All certified nurse aides, including agency, in-serviced on obtaining weights for ongoing review including return demonstration. 4. Director of Nursing, or Designee, will audit Residents and their medical records for significant changes, including weight loss, and for correlating Resident representative and clinician notification of seven (7) random residents five (5) times a week for four (4) weeks then one (1) time a week for five (5) additional months. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	

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	a care plan meeting. The resident was agreeable to therapy evaluations. It was explained to family and the resident about the resident's improvement with cognition and alertness. She seemed to be moving towards her prior self. Family was glad the resident was doing better and willing to cooperate with therapy. A Provider Note, dated 3/8/23, indicated if the resident continued to decline, she would be appropriate for a referral to palliative care/hospice. A Provider Note, dated 3/12/23, indicated the resident was awake and alert. If the resident continued to decline, she would be appropriate for a referral to palliative care/hospice. A Social Service Note, dated 3/20/23, indicated the family was made aware of the resident's planned move from the rehabilitation unit later in the week and transition to a long term stay. A review of the resident's fluid intakes indicated a significant decrease to 60 milliliters (ml) of fluid intake on 3/20/23 for the 24 hour period, and no fluid intake on 3/21/23. The clinical record lacked documentation of family and provider notification of further decline. During an observation on 3/22/23 at 4:23 p.m., the resident was position in her bed on her left side with her eyes closed, and breathed with her mouth open. Her eyes remained closed when her door was knocked on and when her name was spoken twice at the bedside. No visitors were present. During an observation on 3/23/23 at 11:27 a.m., the resident was asleep in her bed, with her mouth open and it was observed to be very dry. She did not open her eyes or respond when the door was			

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	knocked on and when her name was spoken at bedside. Her respirations were 35 breaths per minute and audible. Oxygen was not in use during the observation. No visitors were present. During an interview, at the time of observation, on 3/23/23 at 11:42 a.m., CNA 6 exited the resident's room and indicated the resident had not taken anything by mouth, had rapid respirations, and was unresponsive during care. This was not normal for the resident. During an interview on 3/23/23/ at 12:18 p.m., CNA 6 indicated she had also provided care for the resident on 3/22/23. The resident had not been herself on 3/22/23, as she did not eat or drink and had to have her mouth swabbed, which was unusual for her. On 3/22/23, the resident remained in bed all day and moaned during repositioning. The nurses had been aware the resident was not herself on 3/22/23. She had provided care approximately a week and a half prior to 3/22/23, and the resident had significantly declined since then. At that time, the resident got up in her chair with assistance and ate and drank on her own, after her meal was set up. During an interview on 3/23/22 at 2:27 p.m., LPN 5 indicated the resident did not have a palliative care or comfort care order. She indicated she also provided the resident's care on 3/18/23. The resident got out of bed on 3/18/23, though it was unusual that she was only up for a few minutes on that date. She indicated the resident now had a significant decline and was actively passing. She did not have any orders for comfort measures. During an interview on 3/23/23 at 2:57 p.m., Social Service Designee (SSD) 3 indicated the resident's family lived out of state and she had not			

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	discussed palliative care or hospice options with the family to date because they wanted her to do therapy so she could return to assisted living. When she last spoke with them, they was aware of the plan for the resident to move to Tulip Place Unit for skilled care later this week. During an interview on 3/23/23 at 3:06 p.m., LPN 5 indicated she also cared for the resident on 3/22/23 and the resident was not herself. They would typically offer comfort measure to the family when the resident was unable to make their own decisions. She was not aware of any offer to the family for comfort care or palliative care. The resident was not coherent to accept or decline medications. During an interview on 3/23/23 at 3:16 p.m., LPN 5 indicated she had not notified the medical provider prior to 3/23/23, of the resident's further decline in condition. At the time of the interview, the resident was observed on her back in bed with shallow gurgling respirations at 34 breaths per minute and periods of apnea. A Nurse's Note, dated 3/23/23 at 6:00 p.m., indicated the resident had expired. During an interview on 3/27/23 at 4:41 p.m., the DON indicated a sudden change in the resident's fluid and food intake, not adequate to sustain life, was a significant change and warranted immediate physician notification in resident who lacked orders for palliative or hospice care. Physician and family notifications should have been documented with a significant change in condition. Further documentation was not provided prior to the survey exit on 3/28/23.			

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A policy, last revised 4/16/09, titled "PHYSICIAN NOTIFICATION OF CHANGE IN RESIDENT'S MEDICAL CONDITION," provided by the DON on 3/24/23 at 4:07 p.m., indicated the following: "POLICY: It is the policy of Peabody Retirement Community to notify a resident's physician of changes in the resident's medical condition that impact the resident's health status. PROCEDURE: Upon notice of a resident's change of condition, a licensed nurse will complete an assessment of the resident... The licensed nurse will document the findings in the nurse's notes of the resident's chart... 4. If...the resident either worsens or is experiencing discomfort, the physician is to be notified at that time. 5. The licensed nurse will document in the nurses notes the use and effectiveness of PRN [as needed] medications, nursing measures, and when and how a physician was notified...."

B. Resident 28's clinical record was reviewed on 3/24/23 at 12:48 p.m. Diagnoses included right hip fracture, type 2 diabetes mellitus, and malignant neoplasm of the rectum.

Physician's orders included to obtain weekly weight on Friday - reweigh if 5% difference than previous weight (3/17/23), protein supplement give 30 ml (milliliters) every morning and at bedtime (1/31/23), and CCHO (controlled carbohydrate) diet, regular texture, thin consistency 50-gram fat restriction (1/10/23).

A current care plan problem indicated a potential for alteration of nutrition and weight status changes related to diabetes mellitus and recent admission to facility (1/18/23). Interventions included: obtain and evaluate weights upon admission, as ordered/per policy, and/or at

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	minimum monthly, notify physician, dietitian, and family of any significant changes (1/18/2023), and review per weight/skin meeting (1/18/2023). The resident's Weight Summary report indicated the following weights: 1/12/23 - 202 pounds 2/12/23 - 198 pounds 3/2/23 - 153 pounds 3/2/23 - 152.6 pounds A 2/20/23 Nutrition At Risk Assessment completed by the dietician indicated a weekly weight was needed. A 2/28/23 Nutrition At Risk Assessment completed by the dietician indicated a weekly weight was needed. A 3/9/23 Nutrition At Risk Assessment completed by the dietician indicated a weekly weight was needed. A 3/14/23 Nutrition At Risk Assessment completed by the dietician indicated a weekly weight was needed. The Medication Administration Record (MAR) for March lacked weekly weights on 3/17/23 and 3/24/23. A Nutrition/Dietary Note, dated 2/20/23 at 8:01 p.m., indicated a recommendation to obtain a weekly weight order, record amount of supplement consumed, and start a wound care nutrition supplement. A Nurses Note, dated 3/2/23 at 1:44 p.m., indicated the resident was weighed three times to ensure			

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	correct weight. The previous weights had not subtracted the wheelchair weight. The resident's clinical record lacked physician/NP notification documentation of the recommendations of the dietician. During an interview on 3/27/23 at 9:44 a.m., LPN 19 indicated she did not know where weights might be recorded other than the resident's electronic medical record. During an interview on 3/27/23 at 9:46 a.m., Unit Manager LPN 10 indicated the weights were usually put in the electronic medical record by the nurses. The CNAs obtained the weights and reported them to the nurse. The weights could have been documented on paper and not yet been placed in the electronic medical record. The dietician was included in a Nutrition At Risk (NAR) meeting. During the meeting, the dietician recommendations were discussed and the nurse on the floor or the clinical manager put in the orders. The clinical manager was responsible to follow up on those recommendations. During an interview on 3/27/23 at 10:06 a.m., QMA 7 indicated she had looked at the electronic medical record to see the weights that were needed. She entered weights in the MAR because she was a QMA. The nurse gave the CNAs the list of residents who needed weights for the day. The CNAs wrote the weights down on paper and gave them to the nurse. She did not believe the CNAs would be able to see on the electronic record what weights were required. During an interview on 3/27/23 at 10:21 a.m., CNA 18 indicated the nurse told him the resident weights needed for each day. He obtained those			

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	weights and gave them to the nurse. He did not know where additional weights may be documented if not in the resident's electronic medical record. During an interview on 3/27/23 at 11: 46 a.m., LPN 21 indicated the nurse informed the CNAs on what weights were to be obtained each day. She was uncertain who followed up on dietician recommendations. She believed management was responsible for follow up unless the dietician came to the nurse specifically with a recommendation to relay to the physician or nurse practitioner (NP). During an interview on 3/27/23 at 3:07 p.m., Unit Manager 10 indicated another staff member had attended the NAR meeting for Resident 28. She was uncertain on the recommendation for the wound care supplement, as this recommendation was prior to her starting her position as the unit manager. The resident should have been started on weekly weights. During an interview on 3/27/23 at 3:32 p.m., the DON indicated the resident's weekly weights may have been documented in a weight book. The weights should have been placed in the electronic medical record as the dietician or physician would not have had access to the weights elsewhere. During an interview on 3/28/23 at 10:10 a.m., Unit Manager 10 indicated she was unable to locate in the resident's clinical record where the NP had been notified about initiating the wound care supplement or weekly weights from the 2/20/23 recommendations. The NP had been notified recently and declined to initiate the supplement, as the resident frequently declined his other high protein supplement. The resident's most recent			

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	weights had been located and placed in the electronic medical record. A review of the weight summary, performed during the interview, indicated the resident's weight on 3/17/23 was 183.9 pounds and on 3/27/23 was 183.0 pounds. The Unit Manager LPN 10 indicated the weight on 3/2/23 of 153 pounds was incorrect. The scales had needed to be recalibrated and were now working correctly. A current policy, dated 12/2011, provided by Unit Manager LPN 10 on 3/28/23 at 10:10 a.m., titled "Nutritional Assessment," indicated " ...nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition ...." 3.1-5(a)(2) 3.1-22(b)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure communication between the hospice company and the facility staff for 2 of 3 residents reviewed for end of life services (Resident 36 and 42).	F 0684	Peabody Retirement Community Health and Rehabilitation has a Hospice policy whereby quality of care is a fundamental principle that applies to all treatment and care provided to facility Residents	04/27/2023

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	Findings include: 1. The clinical record for Resident 36 was reviewed on 3/24/23 at 12:08 p.m. Diagnoses included anemia, rectal cancer, and history of stroke. A current physicians order, dated 1/17/23, indicated the resident was to be evaluated and treated for palliative care. A health care plan, dated 3/10/23, indicated the resident had elected palliative care services related to his diagnosis of cancer. The provider was to visit once a month. Interventions included, to coordinate with hospice agency to ensure resident's psychosocial needs were addressed to obtain the maximum quality of life possible. During an interview, on 3/24/23 at 3:16 p.m., the SSD (Social Service Designee) 16 indicated there was not a hospice service binder for Resident 36. During an interview, on 3/27/23 at 2:45 p.m., the DON indicated there should had been a binder with communication with the provider regarding the resident's care for end of life services. A plan of care for the end of life services and coordination between provider and the facility should had been included in the resident's binder. 2. The clinical record for Resident 42 was reviewed on 3/24/23 at 9:23 a.m. Diagnoses included dementia, cerebral atherosclerosis, malnutrition, and heart disease. A current physician's order, dated 1/6/23, indicated to admit to hospice for services with a diagnosis of cerebral atherosclerosis resulting in a life expectancy of less than six months.		ensuring Residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the Residents' choices. 1. Resident 36, hospice notified, and binder is in place to meet the Resident's personal care and nursing needs in coordination with the hospice representative. Included in the hospice binders is the hospice provider coordinated care plans for said Residents receiving hospice services that include services provided in order to maintain the Resident's highest practicable physical, mental and psychosocial well-being. Resident 42, hospice notified, and binder is in place to meet the Resident's personal care and nursing needs in coordination with the hospice representative. Included in the hospice binders is the hospice provider coordinated care plans for said Residents receiving hospice services that include services provided in order to maintain the Resident's highest practicable physical, mental and psychosocial well-being. 2. All six Residents who reside within the facility and receive hospice services, have the potential to be affected by the alleged deficient practice. All current hospice Residents reviewed. Each of the hospice companies notified and binders	

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	A health care plan, initiated on 1/4/23, indicated the resident and/or power of attorney had elected a hospice provider for services related to cerebral atherosclerosis. Interventions included, coordination with the hospice agency to ensure resident's psychosocial needs were addressed to obtain the maximum quality of life possible. On 3/24/23 at 3:08 p.m., the hospice binder was reviewed and lacked a plan of care or provider documentation regarding visits with the resident. The binder contained three sign in sheets of provider staff who visited the resident. During an interview, on 3/27/23 at 2:47 p.m., the DON indicated the binder should contain the plan of care and documentation of provider staff visits. She was unsure why the documentation had not been provided and placed in the binder. A current facility policy, revised July 2017 and titled, "Hospice Program," provided by the DON, on 3/27/23 at 3:02 p.m., indicated the following: "Policy Interpretation and Implementation...10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative...d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day...13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by outside facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being."		are in place to meet the Resident's personal care and nursing needs in coordination with the hospice representative. Included in the hospice binders is the hospice provider coordinated care plans for said Residents receiving hospice services that include the most recent services provided in order to maintain the Resident's highest practicable physical, mental and psychosocial well-being. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby quality of care is a fundamental principle that applies to all treatment and care provided to facility residents ensuring residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. All staff, including agency, Interdisciplinary Team, and Hospice Providers in-serviced on said policy with emphasis on with emphases on hospice/end of life care and hospice binders. 4. SS, or Designee, will audit hospice binders for presence and appropriate content one (1) time a week for six (6) months. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is	

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	3.1-37(a)		achieved.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to complete routine assessments of stage IV pressure ulcer to determine worsening and failed to ensure wound care was provided in a sanitary manner for 1 of 3 residents reviewed for pressure ulcers. (Resident 98) Finding includes: During an interview, at the time of observation on 3/21/23 at 3:13 p.m., Resident 98 indicated he had admitted to the facility with a pressure ulcer on his buttocks. He was in bed and positioned on his back during the observation. Resident 98's clinical record was reviewed on 3/22/23 at 3:31 p.m. Diagnoses included, unspecified paraplegia, acquired absence of right leg above the knee, acquired absence of left leg	F 0686	Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents receive care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and/or a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 1. Resident 98 medical record reviewed. Resident 98 is a Veteran's Administration (VA)	04/27/2023

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	above the knee, malnutrition, and neuromuscular dysfunction of the bladder. A wound vacuum order, dated 1/27/23, included to cleanse wound with normal saline and pat dry. Apply skin barrier preparation to the surrounding area. May use hydrocolloid ring as needed around the wound. Place one piece of black foam within the wound bed. Place the device and secure with the dressing drape. Connect to low continuous suction at 125 mmHg (millimeters of mercury) every day shift on Monday, Wednesday, and Friday for the sacrum wound. A wound clinic order indicated the next appointment was scheduled for 3/28/23 at 2:30 p.m. Review of weekly skin assessments indicated the last skin assessment was completed on 3/8/23. The stage four (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer was worsening, and measured 5 cm (centimeters) long x 3.4 cm wide x 2 cm depth. An admission Minimum Data Set (MDS) assessment, dated 12/27/22, indicated the resident was cognitively intact. Rejection of care behavior was not exhibited. The resident required limited assistance for bed mobility, extensive assistance for dressing and toileting, and supervision for transfers. A wheelchair was required for mobility. The resident had an indwelling urinary catheter and an ostomy for bowels. He was at risk for pressure ulcers and had a stage IV pressure ulcer present on admission. Skin interventions included a pressure reducing device for the bed, pressure ulcer care, and application of medications to areas other than the feet.		patient and chooses to have wound services followed at VA. Resident had an appointment with VA services for wound care last on 2/21/23 where he seen Cindy Nanavaty, FNP, CWOCN at Roudebush VA Medical Center where she performed wound debridement. Records obtained and reconciled. Nurse RN 4 was re-educated on wound care with emphasis on maintaining sterility and hand hygiene. 2. Currently eight (8) Residents who reside within the facility and have an ordered dressing change have the potential to be affected by the alleged deficient practice. All eight (8) Residents, their medical records (i.e. Progress notes, DX, diagnostics), orders and wound assessments reviewed. All wound assessments are present, and no residents have an unexpected worsening of wounds identified or symptoms of infection. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents receive care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and/or a resident with pressure ulcers receives necessary treatment and services,	

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	A current care plan, dated 1/3/23, indicated the resident was at risk for skin impairment related to paraplegia, right above the knee amputation, and left above the knee amputation. Interventions included, encourage/assist the resident to reposition every 2-3 hours and as needed and perform weekly skin assessments and as needed. A care plan, dated 12/23/22, indicated the resident admitted with a stage IV pressure ulcer to the sacrum related to immobility. Interventions indicated to administer the treatment as ordered, measure the wound area weekly, monitor for any change in condition, monitor for any signs or symptoms of infection until healed, and notify the provider as needed. During an interview on 3/24/23 at 11:54 a.m., RN 4 indicated the resident's sacrum wound dressing change was done on Monday, Wednesday, and Friday each week. During a wound care observation on 3/24/23 at 12:06 p.m., RN 4 used gloved hands and removed the existing wound vacuum drape. He doffed his gloves but did not perform hand hygiene prior to donning his clean gloves. After the wound was cleansed and dried, RN 4 measured the wound at 6.5 cm long x 3.1 cm wide x 4 cm depth. He indicated the sacral pressure ulcer was a stage IV pressure ulcer with some tunneling. RN 4's bandage scissors were under the the clean barrier and against the over-bed table. The scissors were not cleaned. RN 4 used the bandage scissors to cut the foam. He applied the foam to the stage IV wound base. After the foam was cut, the bandage scissors were placed against the disposable bed pad on the bed that was partially under the resident. The bed pad had a small yellow stain on it, near the scissors. He opened the drape and		consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. All licensed staff, including agency, in-serviced on aforementioned policy and return demonstration performed successfully. 4. Director of Nursing, or Designee, will audit all Residents with wounds for completed assessments one (1) time a week for six (6) months. In addition, the Director of Nursing, or Designee, will audit quality of dressing changes one (1) time a week for four (4) weeks then one (1) time a month for an additional 5 months. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	

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	placed it securely across the foam and surrounded the stage IV pressure ulcer. He picked up the bandage scissors off of the soiled bed pad and used them to cut the hole in the drape directly above the sponge in the wound bed. Hand hygiene was not performed and the scissors were not cleaned after he touched the bed pad. The bandage scissors were not cleaned prior to placing the scissors in his pocket before he exited the resident's room. During an interview on 3/24/23 at 12:18 p.m., RN 4 indicated he had placed the bandage scissors into his pocket prior to exiting the resident's room and planned to clean them when he got to the nurse's station. He should have used hand hygiene after he removed the old dressing and before donning new gloves. The bandage scissors should not have been placed on contaminated surfaces before they were used to cut the materials for the new dressing. This was a risk for contamination. The weekly wound assessments were assigned to the ADON. The regular dressing changes completed on Monday, Wednesday, and Friday were not required to have wound measurements. He referenced the weekly wound assessments to determine if the wound had a change in condition. During an interview on 3/24/23 at 12:31 p.m., RN 4 indicated the resident's last weekly skin assessment in the clinical record was dated 3/8/23. They should have been completed each week. The measurements of the stage IV sacral wound had significantly increased in size compared to the last assessment. He did not know of any other area in the clinical record to find the weekly wound assessments. RN 4 was unable to provide measurements from the last wound clinic progress note on 3/14/23.			

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	During an interview on 3/27/23 at 4:51 p.m., the DON indicated wound assessments with measurements should have been documented in the clinical record weekly. She thought the ADON had it documented elsewhere. During an interview on 3/27/23 at 5:01 p.m., the ADON indicated she was behind on her wound documentation. She had not scanned the paper notes into the clinical record but had shredded them. The nurses who completed the regular dressing changes did not have a reference for the wound measurement. Without the wound assessments, one may not be able to identify a decline in the wound. Further documentation was not provided prior to survey exit on 3/28/23. A current facility policy, revised October 2010, titled "Wound Care," provided by the DON on 3/28/23 at 11:48 a.m., indicated the following: "...Purpose... The purpose of this procedure is to provide guidelines for the care of wounds to promote healing... Steps in the Procedure 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hand thoroughly. 6. Put on gloves... 14. Be certain all clean items are on clean field... 21. Wipe reusable supplies with alcohol as indicated... Return reusable supplies to resident's drawer in treatment cart... Documentation... The following information should be recorded in the			

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	resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound... Reporting...2. Report other information in accordance with facility policy and professional standards of practice...." 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to implement fall interventions to prevent further falls for 1 of 5 residents reviewed for accidents. (Resident 17) Finding includes: Resident 17's clinical record was reviewed on 3/22/23 at 3:40 p.m. Diagnosis included weakness, difficulty walking, not elsewhere classified, other lack of coordination, need for assistance with personal care, pain and repeated falls. Current medications included the following:	F 0689	Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident 17, clinical record (i.e. progress notes, DX), orders and plan of care interventions reviewed. Intervention of strips at bedside and strips in front of	04/27/2023

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	aspirin 81 milligrams (mg) once daily and morphine sulfate (pain medication) 30 mg extended release 1 tab in the morning and 1 tab at bedtime. An admission Minimum Data Set (MDS) assessment dated 2/6/23 indicated the resident was cognitively intact. Behaviors were not exhibited. The resident required limited assistance for transfers, locomotion on the unit, walking in room, toileting , and personal hygiene. She required supervision x 1 assistance for bed mobility. She required a walker for mobility. She was frequently incontinent of urine and always incontinent of bowel. She had no falls since the last admission or prior assessment. A current care plan, dated 2/3/23, indicated the resident had an activity of daily living self-care performance deficit related to altered mental status. Interventions included, staff to assist as needed with bed mobility toileting and transfers, staff to assist as needed with dressing and grooming, monitor, document, and report any changes as needed, any potential for improvement, reasons for self- care deficit, and expected course of decline in function. A current care plan, revised on 3/20/23, indicated the resident was at risk for falls related to altered mental status and recent falls. Interventions included the following: be sure the call light is in reach and the resident was encouraged to use it for assistance. The resident needs prompt response to all requests for assistance (2/3/23), ensure the resident is wearing proper non slip footwear when ambulating or mobilizing in the wheelchair (2/3/23), non slip strips in front of recliner and beside bed (3/15/23), non slip strips in front of toilet (3/2/23), sign on walker for reminder to call for assist (3/21/23).		recliner were immediately replaced upon notice. 2. All residents who reside within the facility have the potential to be affected by the alleged deficient practice. All Residents, their medical records (i.e. Progress notes, DX, diagnostics), orders and plan of care interventions reviewed. A facility wide sweep of fall interventions conducted to ensure proper interventions in place at point of care and complied on a device list. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. All staff, including agency, in-serviced on aforementioned policy emphasizing steps to inform management of missing interventions. 4. Director of Nursing, or Designee, will audit Residents fall interventions are in place at point of care on seven (7) random Residents three (3) times a week for four (4) weeks; then seven (7) random Residents one (1) time a week for five (5) additional months. Results of these audits will be forwarded to Qapi. Any negative	

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	Review of the Fall Risk Assessment, dated 3/15/23, indicated the resident was at high risk for falls. A fall incident progress note, dated 3/14/23 at 3:00 p.m., indicated the resident was found on the floor in her room after she attempted to walk to her recliner in normal socks. This resulted in a bruise to her right elbow which measured 17 centimeters (cm) long x 8 cm wide. An Interdisciplinary Team (IDT) Note, dated 3/15/23 at 11:15 a.m., indicated the following new interventions: non-skid strips were placed in front of the resident's recliner and in front of the resident's bed, non-skid socks placed on the resident, and medication was reassessed for dosing, and laboratory and radiology was ordered with an x-ray to the resident's right elbow. A fall incident progress note, dated 3/18/23 at 1:45 p.m., indicated the resident was found on the floor in her room beside the bed. No injuries were noted. An Interdisciplinary Team (IDT) Note, dated 3/20/23 at 7:58 a.m., indicated the following new interventions: obtained lab work as ordered to determine any physiological root cause, and a repeated intervention of non-skid strips to be placed in front of the resident's bed. During an interview at the time of observation on 3/21/23 at 2:41 p.m., the resident sat on the side of her bed with her rollator walker in front of her. A sign was noted on the walker to call for assistance. The resident had bruising on her right and left forearms near her elbows. She indicated she had fallen and bruised her forearms, though		findings will add an additional month of auditing until 100% compliance is achieved.	

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	she was uncertain of the exact date. During an observation on 3/22/23 at 4:17 p.m. the resident's room lacked any non-skid strips on the floor in front of the recliner, nor in front of the bed. The resident was seated in her recliner during the observation. During an observation on 3/23/23 at 10:56 a.m., the resident rested in bed with her eyes closed. There were no non-skid strips beside the bed, nor in front of the recliner. During an observation on 3/24/23 at 3:28 p.m., the resident was in bed with her blanket over her. Her wheelchair was within reach at the beside with the right wheel locked and the left wheel unlocked. She had her eyes partially open. There were no non-skid strips on the floor at bedside, nor in front of the resident's recliner. During an observation on 3/27/23 at 10:56 a.m., the resident sat on the side of the bed with her feet on the floor watching television. There were no non-skid strips on the floor beside the resident's bed, nor in front of the recliner. During an interview at the time of observation on 3/27/23 at 11:42 a.m., LPN 23 indicated the only non-skids strips in the resident's room were located in the bathroom, in front of the toilet. During an interview on 3/27/23 at 4:24 p.m., the DON indicated staff were required to initiate and implement an immediate fall intervention when a resident fell, to prevent further falls. An Interdisciplinary Team met to determine if any additional interventions needed put into place. During an interview on 3/27/23 at 4:34 p.m., LPN			

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	10 indicated she thought the non-skid strips on the resident's floor in front of the bed and recliner were removed during mopping. She indicated this should have been identified during rounding and corrected immediately. A current policy, revised March 2011, titled "FALL PREVENTION and MANAGEMENT PROGRAM," provided by the DON on 3/24/23 at 4:07 p.m., indicated the following: "...POLICY: It is the policy of Peabody Retirement Community to ensure a safe environment while promoting the highest level of independence and quality of life... PURPOSE: A Fall Prevention Program is used to provide a safe environment for all residents of the Health Care Facility. This program is designed to identify residents at risk of falls; define interventions for the prevention of falls; implement Quality Assurance measures to monitor progress; and provide ongoing staff education... Assessment and Care Planning: The initial Care Plan will be followed (altered as necessary)... At the time a CAA for falls will be completed if triggered and appropriate interventions will be implemented in the Care Plan... Quality Assurance... 3. A Risk Team will review falls weekly to prevent reoccurrence and/or prevent injury..." 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with			

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	155655	A. BUILDING 00 B. WING	03/28/2023

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	professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was stored in a sanitary manner for 1 of 5 residents reviewed for respiratory care. (Resident 111) Finding includes: During an observation on 3/21/23 at 11:48 a.m., the resident's nebulizer mask and tubing was stored without a cover, directly against the end table in the resident's room beside the recliner. A barrier was not on the end table. The nebulizer mask and tubing lacked a date. Resident 111's clinical record was reviewed on 3/22/23 at 3:02 p.m. Diagnoses included chronic obstructive pulmonary disease (COPD) and unspecified dementia, severe, with psychotic disturbance. Medications included albuterol sulfate nebulization solution (respiratory medication) 2.5 milligram (mg)/3 milliliter (ml) 0.083% inhaled once daily via nebulizer. A quarterly Minimum Data Set (MDS) assessment, dated 12/21/22, indicated the resident had severe cognitive impairment. A current care plan, dated 6/28/22, indicated the resident had impaired cognitive function due to dementia. Interventions included the following: administer medications as ordered and monitor/document for side effects and effectiveness.	F 0695	Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents who require respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences. 1. Resident 111, clinical record (i.e. progress notes, DX), orders and plan of care interventions reviewed. New respiratory equipment and bag delivered. 2. All eight (8) Residents who reside within the facility and receive respiratory services have the potential to be affected by the alleged deficient practice. All eight (8) Residents, their medical records (i.e. Progress notes, DX, diagnostics), orders and plan of care interventions reviewed. A facility wide sweep of respiratory equipment conducted, masks cleaned with date and bag provided. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents who require respiratory care, including tracheostomy care and tracheal suctioning, is provided such care,	04/27/2023

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	A current COPD care plan, revised on 8/1/22, indicated the resident was at risk for shortness of breath. Interventions included the following: give aerosol or brochodialators (respiratory medication) as ordered, monitor and document any side effects and effectiveness, and monitor for any signs or symptoms of respiratory infection. During an observation on 3/23/23 at 9:56 a.m., the resident's nebulizer mask and tubing was against the end table in the resident's room, without a bag or barrier. The mask and tubing lacked a date. During an observation on 3/24/23 at 11:08 a.m., the resident's nebulizer mask and tubing was against the end table in the resident's room, without a bag or barrier. During an observation at the time of interview on 3/24/23 at 11:31 a.m., CNA 9 indicated the nebulizer mask and tubing had been left on the resident's end table without a barrier and should have been stored in a bag. Nebulizer treatments were administered by the nurse. All staff were aware it had to be placed in a bag to avoid cross contamination. This was a risk for infection. During an interview on 3/24/23 at 11:40 a.m., LPN 8 indicated it was not appropriate to store a nebulizer mask and tubing without a barrier on the resident's end table. She had administered the resident's nebulizer treatment on 3/24/23 after breakfast. She failed to place the nebulizer mask and tubing in a bag when the treatment ended. This was a risk for contamination. During an interview on 3/27/23 at 4:37 p.m., the DON indicated a date was required on the tubing		consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences. All staff, including agency, in-serviced on aforementioned policy emphasizing respiratory equipment is to be stored in a sanitary manner. 4. Director of Nursing, or Designee, will audit Residents receiving respiratory services that respiratory equipment is dated and stored in a sanitary manner one (1) time a week for six (6) months. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	

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	for respiratory equipment. A nebulizer mask required a barrier or bag to prevent contact with surfaces during storage for infection prevention. A current policy, dated 2/1/01, titled "NEBULIZED MIST INHALATION TREATMENT," provided by the DON on 3/24/23 at 4:07 p.m., indicated the following: "PURPOSE: To deliver microscopic moisture droplets into the lower respiratory tract, to sooth irritated mucous membranes, and to aid in removal of thick secretions from the lower respiratory tract... PROCEDURE: 1. Wash hands... 9. Remain with the resident sufficiently long enough to ensure technique and use of all medication. If resident cannot hold nebulizer or removes mask, stay with the resident to assist in treatment... 10. At the completion of the treatment, assess lung sounds and respirations and record, assist the resident with mouth care, and make comfortable. 11. Disassemble the nebulizer... Rinse nebulizer and mouthpiece with water. Allow to air dry on paper towel or clean terry towel. Cover while air-drying with paper or terry towel at bedside. When nebulizer is dry, place in plastic bag by nebulizer compressor. 12. Wash hands...." 3.1-47(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals			

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	§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure insulin pens were labeled with the dates opened and the dates of expiration for 2 of 4 medication carts reviewed for medication storage and labeling (medication carts 1 and 2 on Hawthorn Heights). Findings include: During an observation of medication cart 2, accompanied by QMA 13, on 3/27/23 at 11:34 a.m., the following was observed: a. A Humalog (short-acting insulin) KwikPen had been opened, the date it was dispensed to the facility was not indicated, nor the date it was opened or the date it would expire. b. A Lantus (long-acting insulin) SoloStar Pen had been opened, the date the it was dispensed to the facility was not indicated, nor the date it was opened or the date it would expire.	F 0761	Peabody Retirement Community Health and Rehabilitation has a policy whereby the labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 1. Upon notice, the insulin mentioned in the 2567 delivery date confirmed and dated with open and expiration date accordingly. No ill effects noted to correlating Residents as none of the insulins were given outside of the expiration date parameters as delivery was less than twenty – eight (28) days when identified.	04/27/2023

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	During an observation of medication cart 1, accompanied by QMA 13, on 3/27/23 at 11:36 a.m., the following was observed: a. A Lantus SoloStar Pen had been opened and it did not indicate the date it was opened or the date it would expire. b. Two Lispro (short-acting insulin) KwikPens had been opened and it did not indicate the date it was opened or the date it would expire. c. A Basaglar (long-acting insulin) KwikPen had been opened, it did not indicate the date it was opened or the date it would expire. During an interview, on 3/27/23 at 11:30 a.m., RN 12 indicated she could not find the dates that indicated when the Humalog KwikPen or the Lantus SoloStar Pen, observed in medication cart 2, had arrived from the pharmacy, each of insulin pens would be considered expired 28 days after they were opened. Review of a current facility policy, titled "Labeling of Medication Containers," with a revised date of April 2007 and provided by the DON, on 3/27/23 at 12:36 p.m., indicated "...1. Medication labels must be legible at all times...2. Labels for individual containers shall include all necessary information, such as...f. The date that the medication was dispensed...h. The expiration date when applicable...." 3.1-25(j) 3.1-25(k)(6)		2. All Residents who reside within the facility and who receive medication that require an open and expiration date have the potential to be affected by the alleged deficient practice. A facility wide sweep of medication that require an open and expiration date conducted, all with open and expiration dates present. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby the labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. All staff, including agency, in-serviced on aforementioned policy emphasizing 1. Medication labels must be legible at all times. 2. Labels for individual containers shall include all necessary information, such as the date that the medication was dispensed and the expiration date when applicable. 4. Director of Nursing, or Designee, will audit all medication carts for medication requiring an open date and expiration date three (3) days a week for four (4) weeks then one (1) time a week for an additional five (5) months. Results of these audits will be	

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			forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure foods were handled in a sanitary manner during 1 of 5 dining room observations for meal services. Findings include: During an observation, on 3/23/23 at 10:55 a.m., Cook 15 prepared two plates of chef salads for residents and the following was observed:	F 0812	Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents food will be stored, prepared, distributed and served in accordance with professional standards for food service safety. 1. Residents served by staff identified as 15 in 2567 were assessed with no ill effects noted	04/27/2023

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	a. He opened a bag of shredded cheese, reached his bare hand into the bag, pulled out a handful of shredded cheese, and added it to the two plates of Chef salads. b. He retrieved a boiled egg from a dish with his bare hands, he placed the egg on the cutting counter, sliced the egg, scooped up the cut egg and added it to the two Chef salads. c. He retrieved a tomato with his bare hands, he placed the tomato on the cutting counter, cut up the tomato, scooped up the cut tomato and added it to the two Chef salads. During an interview, on 3/27/23 at 11:46 a.m., Cook 15 indicated his bare hands should not have come into direct contact with the food and the food service gloves needed to be worn when handling food. Review of a current facility policy, titled "Food Preparation and Service," with a revised date of July 2014 and provided by the DON, on 3/27/23 at 2:42 p.m., indicated the following: "...Food service employees shall prepare and serve food in a manner that complies with safe food handling practices...Food Preparation Area...5. Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of food-borne illness...Food Service/Distribution...6. Bare hand contact with food is prohibited. Gloves must be worn when handling food directly...." 3.1-21(i)(3)		as a result of this alleged deficient practice. 2. All Residents with oral consumption have the potential to be affected by the alleged deficient practice. A facility wide sweep of food preparation performed with immediate re-education conducted. Residents' food prepared in accordance with professional standards. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby our Residents food will be stored, prepared, distributed and served in accordance with professional standards for food service safety. All staff, including agency, in-serviced on aforementioned policy emphasizing glove use and hand hygiene. 4. Dining Manager, or Designee, will audit dining services food stored, prepared, distributed and served in accordance with professional standards for food service safety alternating dining rooms alternating meals three (3) times a week for six (6) months. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			

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	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to handle a catheter drainage bag in a sanitary manner to prevent infection for 1 of 1 residents reviewed for catheters (Resident 69). Findings include: During an observation, on 3/21/23 at 2:59 p.m., Resident 69 was observed seated in his recliner.	F 0880	Peabody Retirement Community Health and Rehabilitation has an infection prevention and control program (IPCP) that includes handling a catheter drainage bag in a sanitary manner to prevent infection for those Residents who receive catheter care. 1. Resident 69, clinical record (i.e. progress notes, DX), orders	04/27/2023

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	His catheter drainage bag was hooked to a pouch on the right side of his recliner and was resting on the floor. On 3/23/23 at 10:18 a.m., he was observed seated in his recliner with his catheter drainage bag attached to small trashcan to the right of his recliner. His catheter drainage bag was resting on the floor. During an observation with CNA 11, on 3/28/23 at 10:11 a.m., he was observed seated in his recliner. His catheter drainage bag was hooked on the side of a small trashcan and rested on the floor. CNA 11 indicated the catheter drainage bag should not have rested on the floor. Resident 69's clinical record was reviewed, on 3/24/23 at 11:03 a.m. Diagnoses included, obstructive uropathy, cerebral palsy, and urinary retention. A current care plan, revised on 1/24/23, indicated the resident had an indwelling catheter with a diagnosis of urinary retention, neurogenic bladder, obstructive uropathy, and history of urinary tract infections and sepsis. A quarterly Minimum Data Set (MDS) assessment, dated 1/9/23, indicated the resident was cognitively intact. He was totally dependent on staff for transfers. He had an indwelling catheter. He was administered an antibiotic for seven of the seven days during the assessment period. He had septicemia and urinary tract infections in past 30 days. During an interview, on 3/28/23 at 11:37 a.m., the DON indicated a catheter bag should be positioned off of the floor at all times.		and plan of care interventions reviewed. Catheter drainage bag replaced, and external catheter bag provided upon notice of event. No ill effects resulted for alleged deficient practice. 2. All Residents who reside within the facility and receive catheter care have the potential to be affected by the alleged deficient practice. Currently eight (8) Residents receiving catheter care have the potential to be affected. A facility wide sweep of catheter care conducted to ensure proper infection prevention measures performed. No breaches in catheter handling observed. Infection Control Assessment and Response (ICAR) assessment conducted by Pam Bennett on 4/6/2023 which resulted in no noted breaches of infection control systems. A Directed Plan of Correction (DPOC) has been completed and includes: a. a root cause analysis of the deficiency b. infection control facility assessment c. staff education of policy on handling catheters in a sanitary manner d. competency check off e. daily monitoring of staff adherence to policy. 3. As mentioned, Peabody Retirement Community Health and has an infection prevention and control program (IPCP) that	

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	A current facility policy, revised October 2010, titled, "Catheter Care, Urinary," provided by the DON, on 3/28/23 at 11:48 a.m., indicated the following: "Purpose. The purpose of this procedure is to prevent catheter-associated urinary tract infections...Infection Control...2. b. Be sure the catheter tubing and drainage bag are kept off the floor ...." 3.1-41(a)(2)		includes handling a catheter drainage bag in a sanitary manner to prevent infection for those Residents who receive catheter care. All staff, including agency, in-serviced on aforementioned policy emphasizing handling a catheter drainage bag in a sanitary manner to prevent infection. 4. Director of Nursing, or Designee, will audit Residents who receive catheter care on handling of catheter four (4) random residents three (3) times a week for four (4) weeks; then four (4) random residents one (1) time a week for five (5) additional months. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (5) Needs of specialized populations served. (6) Care of cognitively impaired residents (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours	F 9999	Peabody Retirement Community Health and Rehabilitation has a policy whereby our staff who have regular contact with Residents shall have a minimum of six (6) hours of dementia-specific training within (6) months of initial employment and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired Residents and to gain understanding of the current standards of care for Residents with dementia.	04/27/2023

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	155655	A. BUILDING 00 B. WING	03/28/2023

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

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	annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure required annual dementia education was completed for 2 of 5 employees reviewed for required annual training (CNA 11 and RN 4). Findings include: Employee records, provided on 3/21/23, were reviewed on 3/22/23 at 11:28 a.m. and indicated the following: CNA 11's file lacked three hours of annual dementia training and RN 4's file lacked three hours of annual dementia training. During an interview, on 3/27/23 at 11:16 a.m., the DON indicated she was unable to provide additional information on the CNA's inservice training. A current policy, dated 6/14/11, provided by the DON on 3/24/23 at 12:25 p.m., titled "Indiana State Department of Health, Health Care Quality and Regulatory Commission Alzheimer's and Dementia Care Rules, Comprehensive Care Facilities (Nursing Homes)", indicated the following: "...staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within (6) months of initial employment and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain		1. Staff member 4 and 11, dementia training is currently up to date consisting of a minimum of six (6) hours of dementia-specific training within (6) months of initial employment and three (3) hours annually. 2. All Residents who reside within the facility have the potential to be affected by the alleged deficient practice. All staff, including staff member 4 and 11, dementia training is up to date consisting of a minimum of six (6) hours of dementia-specific training within (6) months of initial employment and three (3) hours annually. 3. As mentioned, Peabody Retirement Community Health and Rehabilitation has a policy whereby our staff who have regular contact with Residents shall have a minimum of six (6) hours of dementia-specific training within (6) months of initial employment and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired Residents and to gain understanding of the current standards of care for Residents with dementia. All staff, including agency, in-serviced on aforementioned policy emphasizing the required training hours of dementia – specific training. 4. Human Resources, or Designee, will audit Dementia	

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	understanding of the current standards of care for residents with dementia...."		training hours one (1) time a week for 6 months. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey and Investigation of Complaint IN00402752. This visit included a Recertification and State Licensure Survey. Complaint IN00402752 - No deficiencies related to the allegations are cited. Survey dates: March 21, 22, 23, 24, 27 & 28, 2023 Facility number: 000485 Residential Census: 62 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.	R 0000	Preparation and/or execution of this plan does not constitute admission or agreement by Peabody Retirement Community that a deficiency exists. This plan is also not to be construed as an admission of fault by Peabody Retirement Community or its employees who draft this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. We respectfully request desk review of this Plan of Correction.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If			

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	fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a minimum of one awake staff member certified in cardiopulmonary resuscitation (CPR) was on site for 14 of 21 shifts reviewed for staffing. Findings include: The staffing schedule for 3/21/23 through 3/28/23, provided by the DON on 3/21/23 at 11:52 a.m., was reviewed on 3/28/23 at 12:01 p.m. Fourteen of 21 shifts lacked a CPR - certified staff member. During an interview, on 3/28/23 at 1:12 p.m., the Residential Director indicated many of the staff had completed online CPR certifications, without a return demonstration component, as she had believed she had read a newsletter from the Indiana Department of Health which indicated this was acceptable during the pandemic. During an interview, on 3/28/23 at 2:36 p.m., the Residential Director indicated she was unable to locate a copy of the above-mentioned newsletter. During an interview, on 3/28/23 at 3:09 p.m., the	R 0117	Peabody Retirement Community Health and Rehabilitation has a policy whereby licensed personnel obtain and/or maintain American Red Cross or American Heart Association certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR). 1. No Peabody Retirement Community Health and Rehabilitation Residents have experienced a negative outcome related to the alleged deficient practice. 2. All residents who reside within the facility have the potential to be affected by the alleged deficient practice. All licensed personnel, including agency, Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) certifications reviewed for both required components. Daily schedule reviewed to ensure licensed	04/27/2023

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	Residential Director indicated the facility did not have a policy about CPR certifications for staff members.		personnel with Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) certifications containing both components present on schedule at all times. 3. Peabody Retirement Community Health and Rehabilitation has a policy whereby key personnel with certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) are always on site. Re-education provided to all key personnel on said policy emphasizing both components of classroom and return demonstration be required. An inhouse Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) training session through the American Red Cross, which contain both required components, scheduled on April 26, 2023 for both licensed staff, including agency staff, requiring recertification and interested non-licensed personnel. Any licensed personnel not meeting the in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) will be removed from the schedule. 4. Director of Nursing, or Designee, will audit the daily schedule for four (4) weeks, then once (1) a week for an additional five (5) months to ensure the presence of licensed employees certified in Basic Life Support (BLS)/Cardiopulmonary	

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			Resuscitation (CPR) containing both components are scheduled at all times. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	