| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155655 | A. BUILDING 00<br>B. WING | 04/09/2025 |

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| PEABODY RETIREMENT COMMUNITY | 400 W SEVENTH ST<br>NORTH MANCHESTER, IN 46962 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.<br><br>Survey dates: April 2, 3, 4, 7, 8, and 9, 2025<br><br>Facility number: 000485<br>Provider number: 155655<br>AIM number: 100291190<br><br>Census Bed Type:<br>SNF/NF: 175<br>Residential: 52<br>Total: 227<br><br>Census Payor Type:<br>Medicare: 6<br>Medicaid: 116<br>Other: 53<br>Total: 175<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed April 17, 2025. | 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.<br>We respectfully request desk review of this Plan of Correction. | |
| F 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br><br>Based on observation, record review, and interview, the facility failed to promote resident dignity by failing to provide prompt care for bowel incontinence for 1 of 1 resident reviewed for dignity. (Resident 71)<br><br>Finding includes: | F 0550 | Peabody Retirement Community Health and Rehabilitation has a policy on following Resident Rights and ensuring all residents are treated with dignity. It is our policy that all residents receive treatment and care in accordance with professional standards of | 05/09/2025 |

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

Katie Robinson | Administrator | 05/01/2025

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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| | Confidential interviews were conducted during the course of the survey.<br><br>During the confidential interview, the interviewee indicated Resident 71 had been assisted into a wheelchair and out of his room that day. The resident indicated he had been having a bowel movement as he left the room. He was not permitted to return to his room because his room was being sprayed for pests. The room had been sprayed about an hour ago. The resident had been in the common area since he had left his room. The staff members were aware the resident was soiled, but did not know what to do and did not know how to help him get changed as they were not permitted to return to the resident's room due to the exterminator's spray.<br><br>During an interview on 4/7/25 at 2:36 p.m., Resident 71 indicated his room had been treated today for pests, and he had to stay out of his room. He was very incontinent. He had an incontinent episode as soon as he left his room. He was sitting in feces, and no one knew what to do to help him since his room was unavailable.<br><br>On 4/7/25 at 2:41 p.m., Resident 71 sat in a wheelchair in the common area of the unit with a mechanical lift net under him. He indicated he still needed to be assisted with incontinence care. During the interview, QMA 11 in the hall near the common area, and CNA 12 was documenting on a kiosk a short distance away from the resident.<br><br>During an interview on 4/7/25 at 2:43 p.m., QMA 11 indicated Resident 71's room was being cleaned, and an exterminator had sprayed in his room. She was uncertain where she should take the resident to be given incontinence care as there were no empty rooms on the unit. She was going | | practice, the comprehensive person-centered care plan, and the Residents' choices.<br>1 Resident 71 was provided with continent care.<br>2 All residents have the possibility to be affected by the alleged deficient practice.<br>3 All staff members re-educated regarding Resident Rights and prompt incontinent care when needed.<br>4 Director of Nursing, or Designee, will audit 8 residents receiving incontinence care one (1) time a week for four (4) weeks then one (1) time a month for five (5) months. Results of these audits will be forwarded to QAPI. The QAPI Committee reserves the right to modify or extend auditing based on findings.<br>5 Date of compliance: 5/9/2025 | |

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| | to find the supervisor and ask what she should do.<br><br>During an interview on 4/7/25 at 2:44 p.m., CNA 12 indicated she thought Resident 71's room had been sprayed about an hour ago. She did not know what she was supposed to do since there was not anywhere to take the resident for incontinence care or toileting.<br><br>During an interview on 4/7/25 at 2:58 p.m., Unit Manager 4 indicated the resident had recently had Clostridioides difficile (an infection of bowel causing severe diarrhea) and had an issue with pests in his room. He could now go back to his room because it had been over two hours since his room had been sprayed. The staff should have taken the resident to an empty room or notified her (Unit Manager 4) so she could have directed them where the resident could go for toileting needs.<br><br>During an observation on 4/7/25 at 3:00 p.m., CNA 12 indicated to Resident 71 that she needed to make his bed first, then she would assist him with changing his pants. The resident remained in the common area, seated in a wheelchair.<br><br>On 4/7/25 at 3:04 p.m., CNA 12 assisted the resident to his room.<br><br>During an observation on 4/7/25 at 3:12 p.m., QMA 11 and CNA 12 lowered the resident into his bed using the mechanical lift. The resident had feces on and between his buttocks, extending from his scrotum up to a bandage on his sacral/coccyx area.<br><br>During an interview on 4/7/25 at 4:13 p.m., the DON indicated she would expect incontinence | | | |

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| | care to be provided immediately for a resident known to have been incontinent. When the resident's room was sprayed, the plan had been for the resident to be taken to an empty room or taken to a private room in the therapy room.<br><br>Resident 71's clinical record was reviewed on 4/8/25 at 9:56 a.m. Diagnoses included depression, bipolar disorder, paraplegia, and enterocolitis (inflammation of both the small and large intestines) due to Clostridium difficile (also known as Clostridioides difficile) not specified as recurrent.<br><br>Current physician's orders included bupropion (antidepressant) extended release 200 milligrams (mg) daily, fluoxetine (antidepressant) 20 mg daily, trazodone (antidepressant) 75 mg daily, and quetiapine fumarate (antidepressant) 50 mg daily.<br><br>An admission Minimum Data Set (MDS) assessment, dated 2/27/25, indicated the resident was cognitively intact. The resident felt down/depressed/hopeless for two to six days of the 14-day assessment period. He was dependent on staff for toileting, bathing, dressing of his lower body, chair to bed/bed to chair transfers, and tub/shower transfers. He required substantial/maximal assistance with rolling from left to right in bed and moving from sitting to lying position. The resident was always incontinent of bowel.<br><br>During an interview on 4/8/25 at 3:45 p.m., RN 16 indicated a resident who was incontinent of bowel or bladder should be provided incontinence care right away.<br><br>During an interview on 4/8/25 at 4:53 p.m., Unit Manager 4 indicated a resident should not be left | | | |

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| | sitting in a soiled incontinence brief.<br><br>A current facility policy, revised 2/2021, titled "Dignity," provided by the DON on 4/8/25 at 8:56 a.m., indicated the following: " ...Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist resident; for example: ... promptly responding to a resident's request for toileting assistance ...."<br><br>3.1-3(t) | | | |
| F 0554 SS=D Bldg. 00 | 483.10(c)(7)<br>Resident Self-Admin Meds-Clinically Approp<br><br>Based on observation, interview, and record review, the facility failed to ensure residents who self-administered medications were assessed for safety for 2 of 2 residents reviewed for medication self-administration. (Residents 31 and 14)<br><br>Findings include:<br><br>1. During an interview on 4/2/25 at 3:09 p.m., a medication cup sat on Resident 31's bedside table. She indicated the cup contained applesauce and her medications. A large, red-colored pill and white colored pills were observed in the cup. The resident indicated the pills had to dissolve in the applesauce before she could swallow them. Staff left the medications with her because the pills took a long time to dissolve.<br><br>Resident 31's clinical record was reviewed on 4/8/25 at 4:19 p.m. Diagnoses included atrial fibrillation, major depressive disorder, anxiety disorder, heart failure, and acute kidney failure.<br><br>Current physician's orders included levothyroxine | F 0554 | Peabody Retirement Community Health and Rehabilitation has a policy on medication administration. It is our policy that all residents receive their medication in accordance with professional standards of practice, the comprehensive person-centered care plan, and the Residents' preference.<br>1 Staff swept Resident 14's and Resident 31's rooms to ensure there were no medications left at bedside or unsecured in their rooms.<br>2 All residents who require assistance with their medication administration have the potential to be affected by the alleged deficient practice.<br>3 Licensed Nurses re-educated on Medication Administration Policy and Procedure. | 05/09/2025 |

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| | sodium 75 micrograms (mcg) (thyroid medication), one tablet in the evening, gabapentin 100 mg (seizure or nerve pain medication), two capsules twice a day, mechanical soft diet, no salt added, thin consistency, no bacon, sausage, hot dogs, or ham, and an 1800 milliliter (mL) fluid restriction.<br><br>The clinical record lacked a physician's order for self-administration of medications.<br><br>A Medication Self-Administration Safety Screen, dated 2/27/25 at 6:35 p.m., indicated Resident 31 was able to correctly read the label and/or identify each medication, required assistance to identify what condition each medication treated, the time/frequency medications were to be administered, and to open the medication packages or containers. The Interdisciplinary Team (IDT) review summary indicated medications were to be administered by nursing staff. The resident was not safe to self-administer medications.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 2/28/25, indicated the resident was moderately cognitively impaired, had no difficulty swallowing, and received a mechanically altered diet.<br><br>The clinical record lacked a care plan for medication self-administration.<br><br>During an interview on 4/8/24 at 3:41 p.m., QMA 25 indicated Resident 31 preferred her medications to sit in applesauce until dissolved. The resident did not want the medications crushed before adding to the applesauce. Some days, the resident would refuse to take the medications until they dissolved. QMA 25's practice was to return the medication cup containing the applesauce and | | 4 Director of Nursing, or Designee, will audit medication administration for 8 residents one (1) time per week for four (4) weeks and then one (1) time a month for five (5) months. Results of these audits will be forwarded to QAPI. The QAPI Committee reserves the right to modify or extend auditing based on findings. | |

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| | "floated" medications to the medication cart, where she would put the cup in the drawer under the resident's name. After the medications were dissolved, she would take them back to Resident 31. She never left medications in the room with the resident.<br><br>During an interview on 4/8/25 at 3:48 p.m., RN 26 indicated the resident would sometimes try to take the medications without dissolving them in applesauce. The medications should not be left with the resident. RN 26 would occasionally dissolve the medications in applesauce before taking them to Resident 31. The resident's Self-Administration Assessment Safety Screen indicated staff needed to be present for medication administration.<br><br>2. During an observation on 4/3/25 at 9:52 a.m., QMA 27 indicated another staff member reported medication on the floor in Resident 14's room. QMA 27 went to the resident's room, picked up a medication cup from the bedside table, picked up pills from the floor, and put the pills in the medication cup. Resident 14 requested the pills but the QMA told her the pills had been on the floor and she could not have them. The QMA removed the pills and cup from the room.<br><br>During an interview, immediately following the observation, QMA 27 indicated medications should not be left in resident rooms. She was unsure if the resident dropped the pills. The resident received 11 pills in the morning. The medication cup contained two white pills.<br><br>Resident 14's clinical record was reviewed on 4/9/25 at 9:46 a.m. Diagnoses included heart failure, anemia, overactive bladder, and osteoarthritis. | | | |

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| | Current physician's orders included aspirin 81 mg delayed release, give one tablet by mouth daily for heart health, cetirizine 10 mg, give one tablet daily for allergies, furosemide 40 mg, give one tablet daily for pulmonary edema, gabapentin 100 mg, give one capsule by mouth one time a day for neuropathy, glucosamine-chondroitin 750-600 mg, give one tablet by mouth daily, linaclotide 72 mcg, give in the morning for constipation, potassium 20 milliequivalents (mEq), give in the morning for hypokalemia (low potassium), primidone 50 mg, give three tablets daily for benign familial tremor, vitamin D3 1000 units, give two capsules daily for osteoporosis, guaifenesin 600 mg, give every morning and at bedtime for ongoing productive cough for ten days, and hydrocodone-acetaminophen 5-325, give one tablet three times a day for chronic pain.<br><br>A quarterly MDS assessment, dated 2/18/25, indicated the resident was moderately cognitively impaired, had no difficulty swallowing, and received a regular diet.<br><br>A current care plan, initiated on 11/14/24, indicated the resident was at risk for pain related to a pressure area on her buttocks, polymyalgia rheumatica (an inflammatory condition), osteoarthritis, and chronic pain. Interventions included administration of analgesia according to physician's order, evaluate the effectiveness of pain interventions, identify, record, and treat the resident's conditions which might increase pain or discomfort.<br><br>A current care plan, initiated 2/23/25, indicated the resident was on pain medication. Interventions included administration of analgesic medications as ordered by physician, monitor/document side | | | |

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| | effects and effectiveness every shift.<br><br>The clinical record lacked a care plan for medication self-administration.<br><br>The clinical record lacked a Medication Self-Administration Safety Screen.<br><br>A current facility policy, titled "Administering Medications", provided by the Director of Nursing (DON) on 4/8/25 at 4:26 p.m., indicated the following: "Medications are administered in a safe and timely manner, and as prescribed." The "Policy Interpretation and Implementation" indicated the following: "1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so...7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified...27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely...."<br><br>3.1-11(a) | | | |
| F 0684 SS=D Bldg. 00 | 483.25<br>Quality of Care<br><br>Based on interview and record review, the facility failed to monitor bowel movements and initiate the facility's bowel protocol for a resident with constipation for 1 of 1 resident reviewed for constipation. (Resident 40)<br><br>Finding includes:<br><br>During an interview on 4/7/25 at 1:57 p.m., | F 0684 | Peabody Retirement Community Health and Rehabilitation has a policy on providing interventions for all residents with constipation. It is our policy that all residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and | 05/09/2025 |

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| | Resident 40 indicated her bowels moved that day, but it was very hard. It had been about three days since her bowels last moved. She hoped the constipation was getting better.<br><br>Resident 40's clinical record was reviewed on 4/7/25 at 4:34 p.m. Diagnoses included Parkinson's disease, constipation, generalized anxiety disorder, unspecified dementia, iron deficiency anemia, and difficulty walking.<br><br>A current physician's order included bisacodyl rectal suppository 10 mg insert one suppository rectally as needed for constipation daily,<br><br>An admission Minimum Data Set (MDS) assessment, dated 12/16/24, indicated the resident was moderately cognitively impaired, used a manual wheelchair, required set-up assistance for eating, toileting, and oral hygiene. She could walk 10 feet with supervision. The resident was always continent of bowel.<br><br>A current care plan, initiated on 12/10/24, indicated the resident was at risk for bladder and bowel incontinence related to dementia and pain. Interventions included encourage fluids during the day to promote a prompted voiding response, monitor and document intake and output according to facility policy, and establish voiding patterns.<br><br>A current care plan, initiated on 12/10/24, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to her diagnoses of Parkinson's disease, a history of falls, degenerative disc disease, arthritis, scoliosis, and dementia. The intervention was to toilet the resident as needed. | | the Residents' choices.<br>1 Resident 40's medical records were reviewed and her clinician notified. New order received for routine medication to address resident's complaint.<br>2 All residents have the possibility to be affected by the alleged deficient practice.<br>3 Licensed Nurses re-educated on Bowel tracking and intervention Policy and Procedure.<br>4 Director of Nursing, or Designee, will audit bowel movement charting for 8 residents one (1) time per week x 4 weeks and then one (1) time per month for five (5) months. Results of these audits will be forwarded to QAPI. The QAPI Committee reserves the right to modify or extend auditing based on findings. | |

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| | A current care plan, dated 12/10/24, indicated the resident had a diagnosis of constipation. Interventions included follow the facility bowel protocol for bowel management, monitor/document/report, as needed, signs and symptoms of complications related to constipation, a change in mental status, new onset confusion, sleepiness, inability to maintain posture, agitation, bradycardia (slow heart rate), abdominal distension, vomiting, small loose stools, fecal smearing, bowel sounds, diaphoresis (sweating), abdominal tenderness, guarding, rigidity, or fecal compaction.<br><br>During an interview with CNA 19 on 4/8/25 at 12:14 p.m., she indicated Resident 40 required limited assistance for toileting and assistance with personal hygiene after a bowel movement. The resident had experienced constipation for some time. CNA 19 thought the resident's constipation had improved. The resident's medication helped with the constipation. Any problems with constipation or diarrhea were to be charted in the resident's electronic health record and reported to the nurse. She reported Resident 40's constipation concerns to RN 16 approximately three weeks ago.<br><br>During an interview with RN 16 on 4/8/25 at 12:23 p.m., she indicated the staff told her about Resident 40's constipation but could not recall when. Nurses were able look up the residents' bowel patterns in the electronic health record. Staff could also report concerns directly to the nurses. If a resident had no bowel movements for three days, nursing could request an order for prune juice, magnesium hydroxide (laxative), polyethylene glycol 3350 (laxative), or senna (laxative/stool softener). All nurses should monitor for bowel concerns during their shift. They should run a bowel report, then follow the | | | |

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| | bowel protocol. Resident 40 had a diagnosis of dementia and might not remember to tell staff she was constipated. RN 16 could not locate documentation to indicate the resident received anything for constipation between 3/10/25 and 4/8/25. If the constipation was not documented in the clinical record, staff would not know whether the bowel protocol was utilized for the resident since 3/10/25. The last time the bowel protocol was utilized for Resident 40 was December 2024. The resident should have received bowel protocol interventions between 3/10/25 and 4/8/25, especially since the resident had no bowel movements for more than three days.<br><br>A bowel elimination record, dated 3/10/25 through 4/7/25 and provided by RN 16 on 4/8/25 at 12:46 p.m., indicated the resident did not have any bowel movements between 3/16/25 through 3/18/25, and 3/24/25 through 3/31/25.<br><br>During an interview with Unit Manager 3 on 4/8/25 at 3:36 p.m., she indicated CNA staff should chart bowel movements every shift, whether the resident had a bowel movement or not. The nurses, every shift, should have monitored when a resident did not have a bowel movement in a 72-hour period or more. When the 72 hours (or more) had passed, the bowel protocol should have been followed, sooner if the constipation had been reported to nursing. Failure to follow the bowel protocol increased the risk for impaction or bowel perforation.<br><br>A current facility policy, dated 12/2009, titled "Monitoring of Bowel Movements", provided by the DON on 4/8/25 at 2:49 p.m., indicated the following: "It is the policy of (the facility) to monitor bowel function of all residents routinely and as needed for signs of constipation...2. All | | | |

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| | BM's will be documented in the kiosk or on paper in the resident medical record every shift. 3. A Bowel Movement (BM) report will be run nightly on the 6:00 p.m. to 6:00 a.m. shift from the kiosk that will reflect the previous 72 hours bowel activity. 4. The BM report will be audited for each resident to identify any resident who has had either no BM or a small BM within the previous 72 hours for further intervention. 5. Any resident identified as having no BM or only one small BM within the previous 72 hours will have a complete assessment including but not limited to palpation of abdomen, auscultation of bowel sounds, and any signs or symptoms of discomfort noted and documented. After assessment completed the resident will be offered prune juice or PRN (as needed) medication as ordered...."<br><br>3.1-37(a)(2)(C) | | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>A. Based on observation, record review, and interview, the facility failed to implement interventions to promote the healing of a pressure injury for 1 of 4 residents reviewed for pressure injuries. (Resident 71)<br><br>B. Based on observation, record review, and interview, the facility failed to utilize infection prevention and control strategies to promote the healing of a pressure injury for 1 of 4 residents reviewed for pressure injuries. (Resident 153)<br><br>Findings include:<br><br>A.1. Confidential interviews were conducted during the course of the survey. | 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/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.<br>1 A. Resident 71, who was previously admitted with a pressure area, clinical record (i.e. progress notes, DX), orders and | 05/09/2025 |

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| | During the confidential interview, the interviewee indicated Resident 71 had been assisted into a wheelchair and out of his room that day. The resident indicated he had been having a bowel movement as he left the room. He was not permitted to return to his room because his room was being sprayed for pests. The room had been sprayed about an hour ago. The resident had been in the common area since he had left his room. The staff members were aware the resident was soiled, but did not know what to do and did not know how to help him get changed as they were not permitted to return to the resident's room due to the exterminator's spray.<br><br>During an interview on 4/7/25 at 2:36 p.m., Resident 71 indicated his room had been treated today for pests, and he had to stay out of his room. He was very incontinent. He had an incontinent episode as soon as he left his room. He was sitting in feces, and no one knew what to do to help him since his room was unavailable.<br><br>On 4/7/25 at 2:41 p.m., Resident 71 sat in a wheelchair in the common area of the unit with a mechanical lift net under him. He indicated he still needed to be assisted with incontinence care. During the interview, QMA 11 in the hall near the common area, and CNA 12 was documenting on a kiosk a short distance away from the resident.<br><br>During an interview on 4/7/25 at 2:43 p.m., QMA 11 indicated Resident 71's room was being cleaned, and an exterminator had sprayed in his room. She was uncertain where she should take the resident to be given incontinence care as there were no empty rooms on the unit. She was going to find the supervisor and ask what she should do. | | plan of care interventions reviewed and amended.<br><br>B. Resident 153, who was previously admitted with a pressure area, clinical record (i.e. progress notes, DX), orders and plan of care interventions reviewed and amended.<br>2. Currently ten (10) residents have an ordered dressing change for a pressure ulcer have the potential to be affected by the alleged deficient practice. All ten (10) Residents, their medical records (i.e. Progress notes, DX, diagnostics), orders, Kardex and wound assessments reviewed. All wound assessments are present, Kardex accurate and no residents have an unexpected worsening of wounds identified or symptoms of infection.<br>3. All licensed nurses re-educated on Wound Care policy and professional standards of practice to promote healing.<br>4 Director of Nursing, or Designee, will audit Nurse performance of wound dressing change on all Residents with pressure wounds one (1) time per week for four (4) weeks then one (1) time a month for five (5) months, then one (1) time per quarter for two (2) quarters. Results of these audits will be forwarded to QAPI. The QAPI Committee reserves the right to modify or extend auditing based | |

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| | During an interview on 4/7/25 at 2:44 p.m., CNA 12 indicated she thought Resident 71's room had been sprayed about an hour ago. She did not know what she was supposed to do since there was not anywhere to take the resident for incontinence care or toileting.<br><br>During an interview on 4/7/25 at 2:58 p.m., Unit Manager 4 indicated the resident had recently had Clostridioides difficile (an infection of bowel causing severe diarrhea) and had an issue with pests in his room. He could now go back to his room because it had been over two hours since his room had been sprayed. The staff should have taken the resident to an empty room or notified her (Unit Manager 4) so she could have directed them where the resident could go for toileting needs.<br><br>During an observation on 4/7/25 at 3:00 p.m., CNA 12 indicated to Resident 71 that she needed to make his bed first, then she would assist him with changing his pants. The resident remained in the common area, seated in a wheelchair.<br><br>On 4/7/25 at 3:04 p.m., CNA 12 assisted the resident to his room.<br><br>During an observation on 4/7/25 at 3:12 p.m., QMA 11 and CNA 12 lowered the resident into his bed using the mechanical lift. The resident had feces on and between his buttocks, extending from his scrotum up to a bandage on his sacral/coccyx area. The resident's inner buttocks were reddened.<br><br>During an observation on 4/7/25 at 3:54 p.m., LPN 13 removed the soiled dressing from the resident's sacral/coccyx area. LPN 13 cleaned the feces from the pressure injury and the surrounding area. The | | on findings. | |

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| | skin surrounding the pressure injury was reddened. The pressure injury was slightly smaller than the size of a dime. The depth was approximately the diameter of a triple A battery. LPN 13 packed the wound with the Dakin's moistened gauze and applied a bandage to the pressure injury.<br><br>During an interview on 4/7/25 at 4:13 p.m., the DON indicated she expected incontinence care to be provided immediately for a resident known to have been incontinent. When the resident's room was sprayed, the plan had been for the resident to be taken to an empty room or taken to a private room in the therapy department. He was only supposed to be out of the room for two hours.<br><br>Resident 71's clinical record was reviewed on 4/8/25 at 9:56 a.m. Diagnoses included paraplegia, and enterocolitis (inflammation of both the small and large intestines) due to Clostridium difficile (also known as Clostridioides difficile) not specified as recurrent.<br><br>A current physician's order included cleanse the sacrum with mild soap and water, pat dry, skin prep peri wound, apply ¼ strength Dakin's solution (wound treatment) to dampened gauze cotton roll, and cover with abdominal gauze bandage and paper tape daily for wound care and as needed.<br><br>An admission Minimum Data Set (MDS) assessment, dated 2/27/25, indicated the resident was cognitively intact. He was dependent on staff for toileting, bathing, dressing of his lower body, chair to bed/bed to chair transfers, and tub/shower transfers. He required substantial/maximal assistance with rolling from left to right in bed and moving from sitting to | | | |

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| | lying position. The resident was always incontinent of bowel. He was at risk for pressure ulcers. He had one unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer, present on admission, with the wound bed covered by slough (non-viable yellow, tan, gray, green or brown tissue) or eschar (dead or devitalized tissue that is hard or soft in texture). Skin interventions included a pressure reducing device for his chair and bed.<br><br>A care plan problem indicated the resident was at risk for skin impairment related to paraplegic, new suprapubic catheter, multiple wounds, C-diff in isolation, anticoagulant and aspirin regimen was initiated and revised on 2/19/25. An intervention was to provide incontinence care after each incontinent episode.<br><br>A weekly wound assessment, dated 4/2/25 at 2:26 p.m., indicated the resident had a stage 3 (full-thickness skin loss where subcutaneous fat is visible, but bone, tendon, or muscle is not exposed) pressure injury measuring 1.5 centimeters (cm) long by 1.5 cm wide by 1 cm deep and had 0.5 cm of undermining (the tissue under the wound edges becomes eroded or separated, creating a pocket or a "shelf" beneath the skin at the wound's edge). The pressure injury had a small amount of serosanguineous (mixture of clear, watery fluid and blood) drainage. The overall impression of the visible tissue was that the pressure injury was unchanged since the prior week.<br><br>A weekly wound assessment, dated 4/8/25 at 10:30 a.m., indicated the resident had a stage 3 pressure injury measuring 1.5 centimeters (cm) | | | |

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| | long by 1.5 cm wide by 1 cm deep and had 0.5 cm of undermining around entire wound edge. A new tunnel (channel underneath the skin surface) measuring 1.5 cm was at the top of the pressure injury. The pressure injury had a moderate amount of purulent drainage. The overall impression of the visible tissue was that the pressure injury was worsened since the prior week.<br><br>During an interview on 4/8/25 at 4:13 p.m., RN 16 indicated a resident who was incontinent of bowel or bladder should be provided incontinence care right away. Sitting in feces could increase the risk of infection to a pressure injury.<br><br>During an interview on 4/8/25 at 4:53 p.m., Unit Manager 4 indicated a resident should not be left sitting in a soiled incontinence brief and could have an increased risk of infection for a resident with a pressure injury.<br><br>A current facility policy, revised 4/2020 and titled "Prevention of Pressure Injuries," provided by the DON on 4/8/25 at 2:49 p.m., indicated the following: " ...Skin Care ...Clean promptly after episodes of incontinence ...."B1. During an observation on 4/3/25 at 12:02 p.m., Resident 153 was seated in a wheelchair in his room. The outline of a dressing was observed on the resident's right heel under his sock. The resident indicated he had a hole in his right heel with a dressing over it. There was no pressure relief intervention observed under the resident's feet. A green pressure relief boot was observed on the floor near the foot of the bed.<br><br>Resident 153's clinical record was reviewed on 4/4/25 at 10:52 a.m. Diagnoses included a fracture of an unspecified part of the neck of the right femur, subsequent encounter for closed fracture | | | |

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with routine healing.

A current physician's order, dated 3/25/25, indicated to cleanse the right heel every day shift for wound care with mild soap and water, pat dry, apply calcium alginate (wound dressing) to the wound bed, and cover with a foam dressing. A provider notification was required for adverse changes.

A quarterly Minimum Data Set (MDS) assessment, dated 2/11/25, indicated the resident was cognitively intact. He required partial assistance from staff for lower body dressing and transfers. He required substantial assistance to don and doff footwear. The resident was at risk for pressure ulcers. He had one unstageable pressure ulcer, present on admission, with the wound bed covered by slough or eschar. Skin interventions included a pressure-reducing device for his bed and pressure ulcer care.

A current care plan, initiated 11/1/24, indicated the resident was at risk for skin impairment related to a recent fall with a right hip fracture with surgical repair and a right heel wound. Interventions included pressure-relieving boots placed on the resident's feet as he allowed (11/6/25) and medications provided as ordered (11/1/24).

A current care plan, initiated 11/5/24, indicated the resident had an unstageable pressure injury to his right heel upon admission. Interventions included wound measurement weekly (11/5/24) and administer the wound treatment as ordered (11/5/24).

An admission nurse's note, dated 10/31/24 at 2:23 p.m., indicated the resident had a wound to his right heel measuring 5.0 centimeters (cm) by 5.5

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| | cm. No depth or type of wound was included.<br><br>A weekly wound assessment, dated 11/5/24, indicated the resident had an unstageable pressure ulcer to the right heel, present on admission. The wound measured 3.5 cm in length by 6 cm in width. The depth was unknown.<br><br>During a wound observation on 4/4/25 from 1:56 p.m. to 2:14 p.m., RN 23 entered the resident's room and donned a gown and gloves. RN 23 did not perform hand hygiene. She placed the wound care supplies directly against the overbed table without a barrier or cleaning it. The resident had a soft open-toed shoe on his right foot that was removed by RN 23 with both gloved hands as she touched the sole of the shoe. With the same gloves, she removed the dressing to the resident's right heel, dated 4/2/25, which contained a small amount of yellow with blood tinged drainage on the dressing. The wound was open around the edges with a large, scabbed area to the center of the wound. RN 23 doffed the gloves, performed hand hygiene, and donned clean gloves. She opened a package from the overbed table, then turned on the faucet and placed soap and water on the gauze. She then used it to cleanse the wound and discarded the gauze. She doffed her gloves, performed hand hygiene, and donned clean gloves. She picked up another gauze package from the overbed table with her gloved hands, opened it, and used it to pat the wound dry. She measured the right heel wound at 2.5 cm length by 3.7 cm width. x 0.1 cm depth on the medial side of the right heel. RN 23 confirmed the date on the previous dressing was two days ago and indicated the depth of the wound could not be determined due to the scab. She applied the calcium alginate and foam dressing retrieved from the overbed table. | | | |

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During an interview on 4/4/25 at 2:16 p.m., RN 23 indicated she had not used a barrier on the overbed table or cleaned it prior to placing wound supplies directly against it. She had not performed hand hygiene after she removed the resident's shoe and prior to the beginning of the wound care observation. These practices were a potential opportunity for contamination of the resident's pressure injury site.

During an interview on 4/8/25 at 3:20 p.m., Clinical Nurse Specialist 17 indicated it was not appropriate infection control practice when wound supplies were placed on a surface that had not been cleaned or had a clean barrier. The supplies should not have been opened from a dirty surface and used for wound care. This was a risk for wound contamination.

A current facility policy, dated 2001, titled "Dressings, Dry/Clean," provided by the DON on 4/7/25 at 9:25 a.m., indicated the following: "Purpose... The purpose of this procedure is to provide guidelines for the application of dry, clean dressings... Equipment and Supplies... The following equipment and supplies will be necessary when performing this procedure. 1. Clean dressing(s)... 5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in the Procedure... 1. Clean the beside stand. Establish a clean field. 2. Place the clean equipment on the clean field. Arrange the supplies so they can be easily reached...4. Position resident and adjust clothing to provide access to affected area. 5. Wash and dry your hands thoroughly. 6. Put on clean gloves. Loosen tape and remove soiled dressing... 11. Using clean technique, open other products (i.e., prescribed dressing; dry, clean gauze). 12. Wash

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| | and dry your hands thoroughly. Put on clean gloves... 15. Cleanse the wound with ordered cleanser...."<br><br>3.1-40(a)(2) | | | |
| F 0812<br>SS=E<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>Based on observation and interview, the facility failed to prepare and distribute food in a safe and sanitary manner. This deficient practice has the potential to affect 46 of 46 residents who receive meals from the Transitional Care Unit and Tulip Place kitchenette.<br><br>Finding includes:<br><br>During a meal service observation on 4/4/25 at 11:30 a.m., Dietary Cook 8 donned gloves and utilized utensils to scoop food items onto plates, warmed up a cooked hamburger on the griddle, picked up the mustard container with his gloved hands, and applied mustard to the hamburger. While wearing the same gloves, Dietary Cook 8 removed an egg roll from inside a warmer and placed it onto a resident's plate. He prepared four more resident's plates dipping up the stir fry and rice with utensils and placing the egg rolls on the plates with his gloved hands. He doffed his gloves, washed his hands with soap and water, and donned new gloves. Dietary Cook 8 used his gloved hand to place a plate on the serving board. He used the same gloved hand to remove an egg roll from inside the warmer and placed it on a plate. Using the same gloves, he walked to the freezer, opened the freezer door, reached inside, and retrieved frozen chicken tenders with his gloved hands. He walked back to the fryer and placed the frozen chicken tenders he was holding | F 0812 | Peabody Retirement Community has a policy regarding Sanitary Food Distribution and prevention of food-borne illness.<br>1 The Cook observed was immediately educated on the policy and proper hand hygiene and food handling.<br>2 All other residents in the neighborhoods served by the kitchen have the potential to be affected.<br>3 All Dietary employees were re-educated on the Preventing Foodborne Illness – Food Handling Policy and Procedure.<br>4 The Administrator or designee will audit three (3) meal services per week for four (4) weeks, and then three (3) meal services for five (5) months to ensure compliance with the policy. Results of these audits will be forwarded to QAPI. The QAPI Committee reserves the right to modify or extend auditing based on findings. | 05/09/2025 |

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| | in his gloved hands into the fryer.<br><br>During a meal service observation on 4/4/25 at 11:47 a.m., Dietary Cook 8 was wearing gloves. He opened the steam oven top and placed a piece of cheese onto a cooking hamburger patty. Wearing the same gloves, he retrieved a plate, placed an egg roll onto the plate, and then opened the plastic wrapping of a package of buns. He removed one bun from the package. On the bottom portion of the bun, he placed a piece of lettuce picked up the ketchup container adding ketchup to the sandwich. He checked the temperature of the items in the fryer nearby with a thermometer. Using the same gloves, he lifted the fryer basket and dumped out the chicken tenders onto a plate. He opened the warming oven and retrieved gravy. He placed a bun on top of the hamburger sandwich. He removed his gloves and washed his hands with soap and water. He removed his gloves and washed his hands with soap and water. He went to the freezer and removed a box of egg rolls, which he placed on a table. He donned new gloves and opened the microwave. Wearing the same gloves, he took the temperature of the soup, placed the bowl back into the microwave and reset the time. He cleaned the thermometer, used a spatula and flipped the egg on the griddle. He opened a loaf of bread, removed two slices with his soiled gloves, then picked up the mayonnaise container and added mayonnaise. Dietary Cook 8 removed the soup from the microwave with his gloved hands. He placed the egg onto the bread with a spatula and with his gloved hands picked up slice of tomato and the top piece of bread to complete the sandwich. He retrieved two egg rolls with the same gloved hands from the box on the table and placed them into two different fryer baskets. He removed his gloves and washed his hands with | | | |

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| | soap and water. He donned a new pair of gloves. The Dietary Manager arrived and handed Dietary Cook 8 tongs to use when serving the egg rolls.<br><br>During an observation on 4/4/25 at 12:13 p.m., Dietary Cook 8 utilized the tongs to serve the egg rolls. Using gloves, he removed a peanut butter and jelly sandwich from a refrigerator and placed it on a plate. He opened a package of hot dog buns and removed a bun with the same gloved hands. He then picked up the mustard container, added the mustard to the bun, and utilized the tongs to place the hot dog onto the bun. He removed a hamburger bun from the bag using the same gloves. Next, he retrieved a cheese sandwich from the refrigerator with his gloved hands and placed it on the griddle. He opened another can of soup with his gloved hands and placed it into the microwave. Dietary Cook 8 removed a hamburger bun from the package with his gloved hands and placed on a plate.<br><br>During an interview on 4/4/25 at 12:45 p.m., Dietary Cook 8 indicated he would change his gloves if he touched something that was not food safe. He was permitted to touch all the ready-to-eat items with his gloves. If the handles in the kitchen were clean, he touched them with his gloves too.<br><br>During an interview on 4/4/25 at 12:47 p.m., the Dietary Manager indicated the staff were not supposed to touch food items with gloved hands unless the gloves were clean. The staff needed to change their gloves to touch other items. She instructed her staff to utilize tongs when serving meals and not wear gloves.<br><br>A current facility policy, revised 7/2014, titled "Preventing Foodborne Illness - Food Handling," | | | |

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| | provided by the DON on 4/7/25 at 3:45 p.m., indicated the following: " ...Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized ...."<br><br>3.1-21(i)(3) | | | |
| F 0865 SS=D Bldg. 00 | 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)( QAPI Prgm/Plan, Disclosure/Good Faith Attmpt<br>Based on record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies.<br><br>Finding includes:<br><br>1. Review of the Summary Statement of Deficiencies, for the facility's last annual Recertification and State Licensure Survey completed on 5/1/24, indicated the facility failed to provide monitoring of a pressure injury and failed to develop and implement interventions to promote the healing of pressure injuries. The plan of correction indicated, "...the DON or designee, will audit four (4) resident's dressing changes one (1) time a week for four (4) weeks then one (1) time a month for five (5) months for potential infection related to contamination for example, glove use and hand hygiene - Before handling clean or soiled dressings, gauze pads, - After handling used dressings, contaminated equipment, - After contact with objects in the immediate vicinity of the resident. Results of these audits will be forwarded to QAPI. Any negative findings will add an additional month of auditing until 100% compliance is achieved...."<br><br>Repeat concerns regarding failure to develop and | F 0865 | Peabody Retirement Community Health and Rehabilitation has a QAPI program and plan that provides for a mechanism to identify areas of risk or noncompliance. It is our policy that all residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the Residents' choices and that the facility will review its internal practices to identify and correct quality concerns.<br>1 The facility developed an Action Plan for promoting pressure ulcer healing and proper dressing changes to prevent recurrence of the previous deficiency.<br>2 All residents have the potential to be indirectly affected by the alleged deficient practice.<br>3 QAPI Committee members were educated on the regulations related to QAPI and on the topics of Root Cause Analysis and development of Action Plans with measurable outcomes and target end dates. | 05/09/2025 |

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| | implement interventions to promote the healing of pressure injuries were cited during the April 7, 2025, survey as follows: Based on observation, record review, and interview, the facility failed to implement interventions to promote the healing of a pressure injury for 1 of 4 residents reviewed for pressure injuries. (Resident 71)<br><br>2. Review of the Summary Statement of Deficiencies, for the facility's last annual Recertification and State Licensure Survey completed on 5/1/24, indicated the facility failed to utilize infection prevention and control strategies to prevent contamination of wounds during wound care. The plan of correction indicated, "...The Director of Nursing (DON) or designee, will audit all residents with pressure wounds for interventions, assessments, quality of dressing changes and healing one (1) time a week for four (4) weeks then one (1) time a month for five (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...."<br><br>Repeated concerns regarding failure to utilize infection prevention and control strategies to prevent contamination of wounds during wound care were cited April 7, 2025, survey as follows: Based on observation, record review, and interview, the facility failed to utilize infection prevention and control strategies to promote the healing of a pressure injury for 1 of 4 residents reviewed for pressure injuries. (Resident 153)<br><br>During an interview, on 4/9/25 at 12:17 p.m., the Administrator and DON indicated the QAPI meetings happened no less than quarterly, and sometimes on a monthly basis. The QAPI meeting covered previously identified areas of concern | | 4 The Administrator, or Designee, will audit QAPI Action Plans, progress, and Plan revisions each month to ensure continuous performance improvement. Results of these audits will be forwarded to QAPI. The QAPI Committee reserves the right to modify or extend auditing based on findings. | |

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| | and specific set areas based on the facilities calendar. The previously cited concerns would be reviewed through the timeframe listed on the Plan of Correction (POC). The DON indicated she had started a Performance Improvement Plan (PIP) related to pressure ulcers after the previous survey, but was unable to locate the appropriate supportive documentation.<br><br>An undated, current facility policy, titled, "Quality Assurance and Performance Improvement (QAPI) Plan", provided by the Administrator shortly after entrance conference on 4/2/25, indicated the following: "...The purpose of QAPI in our organization is to take a proactive approach to continually improving the way we care for and interact with our residents, team members, and other care partners so that we may realize our mission and to be the premier provider of Residential, Skilled Long Term, and Short-Term Rehabilitation services in the area...The QAPI plan will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved. The QAPI plan will ensure care and services delivered meet accepted standards of quality, identify problems and opportunities for improvement, and ensure progress toward correction or improvement is achieved and sustained..."<br><br>Cross reference F686.<br><br>3.1-52(b)(2) | | | |
| F 0880 SS=E Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br><br>A. Based on observation, interview and record review, the facility failed to utilize infection prevention and control practices for residents in | F 0880 | Peabody Retirement Community Health and Rehabilitation has a policy whereby we establish an | 05/09/2025 |

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| | droplet precautions for 6 of 9 residents reviewed for infection control. (Residents 369, 15, 109, 147, 29, and 153). This deficiency had the potential to affect 38 of 38 residents with orders for droplet precautions.<br><br>B. Based on observation and interview, the facility failed to ensure infection prevention and control practices were followed during dining services for 3 of 8 residents observed in the Evergreen Park Unit dining room. (Residents 75, 76, and 94)<br><br>Findings include:<br><br>A1. On 4/3/25 at 10:23 a.m., Resident 109's room had a Droplet Precautions sign posted by the door. CNA 20 exited Resident 109's room, leaving the door open. No hand hygiene was performed upon exiting the room. CNA 20 walked to another area of the unit and retrieved a mechanical lift. CNA 20 re-entered Resident 109's room and closed the door. Upon exiting the room, CNA 20 carried a bag of trash to the appropriate trash receptacle. Resident 109 was seated in a wheelchair beside the bed. CNA 20 washed their hands with soap and water. The CNA returned to the resident's room, retrieved the mechanical lift, and walked to another area of the unit. CNA 20 was not wearing eye covering during any part of the observation.<br><br>Resident 109's clinical record was reviewed on 4/9/25 at 1:36 p.m. Diagnoses included unspecified dementia, coronary artery disease, and type 2 diabetes mellitus.<br><br>A current physician's order, dated 3/25/29, indicated droplet precautions, every shift, related to viral syndrome such as coughing and | | infection prevention and control program (IPCP) that includes a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases.<br>1 A. Staff members were immediately re-educated on droplet precautions.<br>B. Staff member provided further education regarding proper infection control processes while assisting residents with eating meals.<br>2. A. At this time, there are no residents currently on droplet precautions.<br>B. Residents who need assistance with dining have the potential to be affected by the alleged deficient practice.<br>3. All staff will be re-educated on Droplet Precaution Policy and Procedure. All nursing staff will be re-educated on proper infection control practices for assisting residents with eating meals.<br>4. Director of Nursing, or Designee, will audit all Resident's with Droplet Precaution orders one (1) time a week for four (4) weeks then one (1) time a month for five (5) months for adherence to policy. Director of Nursing, or Designee, will audit four (4) meal services per week and then (4) meal services per month to ensure staff adherence to policy for assisting residents with feeding. | |

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| | wheezing.<br><br>A 2/28/25, Quarterly Minimum Data Set (MDS) assessment indicated the resident was rarely or never understood. Resident 109 was dependent on staff for bed mobility and transfers.<br><br>A2. During an observation, on 4/3/25 at 2:37 p.m., Resident 15's room had a Droplet Precautions sign posted by the door, noticeable before entry. QMA 11 answered the call light for Resident 15, leaving the door open. QMA 11 entered the resident's room, stood at the resident's bedside and spoke with them for several minutes. QMA 11 exited Resident 15's room. No hand hygiene was performed. QMA 11 was not wearing eye covering during the observation.<br><br>Resident 15's clinical record was reviewed on 4/9/25 at 1:37 p.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus, and morbid obesity.<br><br>A current physician's order, dated 3/25/29, indicated droplet precautions, every shift, related to Influenza A diagnosis.<br><br>A 1/22/25, Quarterly MDS assessment indicated the resident was cognitively intact. Resident 15 required substantial assistance from staff for bed mobility and transfers.<br><br>An isolation precaution care plan, initiated 3/31/25, indicated Resident 15 required droplet isolation for seven (7) days related to a diagnosis of Influenza A. Interventions included all good and services brought to resident's room, droplet precautions as ordered, and resident to remain in private room to prevent spread. | | Results of these audits will be forwarded to QAPI. The QAPI Committee reserves the right to modify or extend auditing based on findings. | |

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| | A3. During an observation, on 4/7/25 at 1:04 p.m., Resident 369's room had a Droplet Precautions sign posted by the door. CNA 21 answered the call light for Resident 369. CNA 21 entered the resident's room and closed the door. CNA 21 was not wearing eye covering during the observation. No hand hygiene was performed upon exiting the room. Resident 369's room had a Droplet Precautions sign posted by the door.<br><br>During an interview, at the time of the observation, CNA 21 indicated since the Personal Protective Equipment (PPE) was not visible at the resident's doorway, she went into the room anyway. If the PPE isn't easily noticeable, she would talk to the nurse manager to get help finding it. CNA 21 indicated she should have done this before she entered the resident's room.<br><br>During an observation, on 4/7/25 at 1:22 p.m., Resident 369's room had a Droplet Precautions sign posted by the door. Dietary Aide 22 entered Resident 369's room. Dietary Aide 22 stood at the resident's bedside and spoke with them for several minutes. No hand hygiene was completed upon exiting the room. Dietary aide 22 was not wearing eye covering during the observation.<br><br>During an interview, at the time of the observation, Dietary Aide 22 indicated the Droplet Isolation sign at the doorway meant staff needed to wear gowns and gloves to prevent the spread of infections when they were working closely with the resident. Since she had talked with the resident, she had not needed to wear any PPE while in the resident's room.<br><br>Resident 369's clinical record was reviewed on 4/7/25 at 12:55 p.m. Diagnoses included type 2 | | | |

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| | diabetes mellitus, morbid obesity, and unspecified cirrhosis of the liver.<br><br>A current physician's order, dated 3/31/25, indicated droplet isolation related to cough, shortness of breath, and respiratory flu symptoms until 4/8/25.<br><br>A care plan, initiated on 3/30/25, indicated Resident 369 required droplet isolation related to signs and symptoms of Influenza A for 7 days. Interventions included to encourage good oral intake, give medications as ordered for fever and pain, and monitor, document, and report signs of dehydration.<br><br>A 3/13/25, Admission MDS indicated the resident was moderately cognitively impaired. Resident 369 required substantial assistance from staff for bed mobility. He was dependent on staff for transfers.<br>A4. During an observation, on 4/4/25 at 9:42 a.m., signage on Resident 147's room indicated the following: "DROPLET PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry ..." The signage had a picture of a person wearing a face shield and a person wearing goggles with an "or" between the pictures. CNA 6 donned a gown, gloves, and placed an N95 mask over her surgical mask. She entered the room and spoke with the resident. She removed her personal protective equipment (PPE) prior to exiting the room. She sanitized her hands and applied a clean surgical mask.<br><br>During an interview, on 4/4/25 at 9:45 a.m., CNA 6 indicated she was supposed to fully apply PPE to enter the resident's room. The facility training had indicated she did not need a face shield for | | | |

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| | Resident 147 nor Resident 29.<br><br>Resident 147's clinical record was reviewed on 4/4/25 at 10:39 a.m. Diagnoses included chronic obstructive pulmonary disease and bronchitis.<br><br>A current physician's order, dated 3/31/25, indicated the resident was to remain in droplet precautions isolation due to a diagnosis of bronchitis until the symptoms resolved or resident was fever free for 48 hours without intervention.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 1/8/25, indicated the resident was severely cognitively impaired. He required substantial/maximal assistance with oral hygiene, toileting, showering/bathing, upper/lower body dressing, personal hygiene, moving from sitting to lying, moving from lying to sitting, and transfers. He was dependent on the staff for putting on/taking off footwear.<br><br>A5. During an observation, on 4/4/25 at 9:48 a.m., a droplet precautions sign was on Resident 29's door. QMA 7 sanitized her hands, donned a gown, gloves, and placed an N95 mask over her surgical mask. She removed her eyeglasses and entered the resident's room. She delivered medications to the resident. She removed her PPE and exited the room, leaving her surgical mask on. She put on her glasses.<br><br>During an interview on 4/4/25 at 9:51 a.m., QMA 7 indicated she was not required to wear the N95 mask, but she did so because she wanted to have extra protection against the respiratory infections. The facility did not require face shields/ eye protection for the droplet rooms, which included Resident 29 and Resident 147. | | | |

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| | During an interview on 4/4/25 at 9:57 a.m., QMA 7 indicated she should have worn a face shield into the residents' rooms with droplet precautions.<br><br>Resident 29's clinical record was reviewed on 4/7/25 at 10:59 a.m. Diagnoses included unspecified asthma, chronic obstructive pulmonary disease, dependence on supplemental oxygen, pneumonia, acute respiratory failure with hypoxia, and shortness of breath.<br><br>Physician's orders included prednisone 40 milligrams (mg) daily for increased cough for five days (3/31/25), amoxicillin 500 mg (antibiotic) two times a day for pneumonia (4/1/25), and azithromycin (antibiotic) 500 mg for one day (started 3/31/25 and discontinued 3/31/25), azithromycin 250 mg daily for four days (4/1/25), oxygen at two to three liters per minute via nasal cannula (3/31/25), and the resident was to remain on droplet precautions until symptom resolution or was fever free without intervention (started 3/31/25, discontinued 4/4/25).<br><br>An admission MDS, dated 1/3/25, indicated the resident was cognitively intact. She required partial/moderate assistance with toileting hygiene, showering/bathing, upper body dressing, and ambulating 10 feet. She required substantial/maximal assistance with lower body dressing, putting on/taking off footwear, rolling in bed, moving from sitting to lying, moving from lying to sitting, moving from sitting to standing, bed to chair/chair to bed transfers, and toilet transfers.<br><br>During an interview on 4/8/25 at 5:07 p.m., the Infection Preventionist indicated eye protection was required to enter rooms with droplet precautions. The staff were expected to read and | | | |

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| | follow the isolation signage on the doors.A6.<br>During an observation on 4/2/25 at 4:52 p.m., CNA 15 approached Resident 153's room, where a droplet isolation sign was in place at the door. The droplet isolation sign indicated everyone was required to perform hand hygiene before entering and when leaving the room. A face shield or goggles was required. The face protection was required to be removed prior to exiting the room. She donned a gown and gloves, and entered the resident's room. CNA 15 already had a surgical mask in place when she approached the resident's room. The mask was not changed when she entered the room and delivered a cup of water to the resident. She wore regular eyeglasses. Eye protection was not worn during the observation. CNA 15 doffed her gown and gloves and exited the room at 4:54 p.m., without removing her surgical mask. She continued to deliver water to random residents' rooms on the Cedar Ridge Unit.<br><br>Resident 153's clinical record was reviewed on 4/4/25 at 10:52 a.m. Diagnoses included influenza due to identified novel Influenza A virus with other respiratory manifestations.<br><br>A physician's order, from 3/27/25 to 4/3/25, indicated the resident was required to remain on droplet precautions isolation due to a diagnosis of Influenza A.<br><br>An isolation precaution care plan, initiated 3/27/25 and discontinued on 4/4/25, indicated the resident required droplet isolation for seven days related to a diagnosis of Influenza A. Interventions included droplet precautions as ordered (3/28/25).<br><br>During an interview on 4/4/25 at 1:17 p.m., CNA 25 indicated staff were required to don a gown, gloves, surgical mask, and a face shield prior to | | | |

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| | the entrance of residents' rooms on droplet precautions.<br><br>During an interview on 4/7/25 at 1:41 p.m., CNA 15 indicated staff were required to don a gown, gloves, face mask, and a face shield prior to the entrance of residents' rooms on droplet precautions. She had not donned a face shield during the observation on 4/2/25 when she delivered ice water to Resident 153. Face shields were readily available and the droplet signs indicated goggles or a face shield was required.<br><br>During an interview on 4/7/25 at 2:36 p.m., the Infection Preventionist (IP) indicated the staff were required to wear a surgical face mask and a face shield or goggles for residents requiring droplet precautions. If the staff were at risk for high contact with the resident, their surroundings, or bodily fluids, they were expected to wear a gown and gloves.<br><br>During an interview on 4/8/25 at 11:23 a.m., the IP (Infection Preventionist) indicated the facility followed the Center for Disease Control (CDC) guidelines for droplet precautions.<br><br>A current facility policy, dated 2001 and titled "Isolation - Categories of Transmission-Based Precautions," provided by the DON on 4/7/25 at 9:25 a.m., indicated the following: " ...Policy Statement... Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents... Policy Interpretation and Implementation... 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on | | | |

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| | the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precautions(s), instructions for use of PPE... Droplet Precautions... 4. Gloves, gown and goggles are worn if there is risk of spraying respiratory secretions...."<br>B1. During a continuous observation on 4/2/25 from 11:35 a.m. to 12:20 p.m., CNA 10 was assisting Resident 75 with his meal. The CNA rested her elbows on the dining room table and used her left index finger to rub her nose. She picked up the resident's fork and assisted him with his meal. She palmed over the top of Resident 75's drinking cup with her right hand and assisted the resident with a drink. She turned to her left and used the same hand to palm the top of Resident 94's bowl. She obtained a spoonful of food, brought it up to her lips, and blew on the food. She indicated that the food was hot and placed the spoonful of food into Resident 94's mouth. The CNA palmed the top of Resident 94's cup and gave the resident a drink. She wiped Resident 94's mouth with a napkin. She turned back to Resident 75 and offered the resident a bite of food. She indicated to Resident 75 the food was not hot because she had blown on it. Resident 75 took a bite of the food. She picked up Resident 94's unused fork, reached across the table, and used the fork to move the remaining food around on Resident 76's plate. She sat the fork down back in front of Resident 94. She stood up and left the table. She approached the kitchenette in the dining room and requested dietary staff to get Resident 76 more onion rings. She retrieved a clean cup, walked over to the refrigerator, and used her hands to open the refrigerator door. She balanced the cup on the refrigerator door and put her finger inside the rim of the cup. She poured | | | |

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| | milk into the cup. She picked up the previously used fork in front of Resident 94 and used it to offer Resident 75 his dessert. She assisted Resident 75 with his meal. She palmed the top of Resident 75's cup and assisted the resident with a drink. CNA 10 did not perform hand hygiene throughout the observation.<br><br>During an interview on 4/8/25 at 12:20 p.m., CNA 24 indicated plates, bowls, and cups were handled from the bottom and the tops of bowls and cups were not touched. Hand hygiene was to be done frequently when in the dining room. Hand hygiene was to be performed after personal clothing, face, and hair was touched. Food was never touched bare handed. Utensils were not shared among residents.<br><br>During an interview on 4/9/25 at 11:09 a.m., the Infection Preventionist indicated staff had been encouraged to carry their own hand sanitizer when they assisted in the dining room. Hand hygiene was to be performed often during individual dining assistance and between multiple residents. Hand hygiene was to be performed when personal clothing, face, or hair were touched. Utensils, cups, or plates were not to be shared among residents. Food was to be cooled naturally, and a replacement plate item obtained if it was too hot and not cooled down timely. Food was not to be touched with bare hands and was not to have been blown on to cool it off. Tableware was to be handled from the underside and the top rim or lip area of cups, and bowls were not to be touched.<br>A current facility policy, revised on March 2022 and provided by the DON on 4/9/25 at 10:00 a.m., titled "Assistance with Meals," indicated the following: "...All Residents:..3. All employees who provide resident assistance with meals will be | | | |

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| | trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling ...."<br><br>3.1-18(a)<br>3.1-18(b)(2)<br>3.1-18(l) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.<br><br>Survey dates: April 2, 3, 4, 7, 8, and 9, 2025<br><br>Facility number: 000485<br><br>Residential Census: 52<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed April 17, 2025. | 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.<br>We respectfully request desk review of this Plan of Correction. | |
| R 0216<br><br>Bldg. 00 | 410 IAC 16.2-5-2(c)(1-4)(d)<br>Evaluation - Noncompliance<br><br>Based on observation, record review, and interview, the facility failed to ensure medications were administered safely and appropriately for 1 of 5 residents reviewed for medication administration. (Resident 48)<br><br>Finding includes:<br><br>During a medication administration observation, | R 0216 | Peabody Retirement Community Health and Rehabilitation has a policy on evaluating all residents for their ability to self-administer medications. It is our policy that all residents receive their medication in accordance with professional standards of practice and needs assessment. | 05/09/2025 |

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| | on 4/9/25 at 10:09 a.m., LPN 2 completed hand hygiene and gathered supplies to provide medication to Resident 48. LPN 2 removed one gabapentin (to treat nerve pain) 400 milligram (mg) capsule from the resident's pharmacy-labeled medication roll. LPN 2 knocked on the resident's door and opened it. LPN 2 called out to the resident and received no answer. LPN 2 left the medication cup, with the capsule inside on the counter top by the door.<br><br>During an interview, at the time of the observation, LPN 2 indicated the resident had an order to allow medications to be left at the bedside.<br><br>Resident 48's clinical record was reviewed on 4/9/25 at 11:01 a.m. Diagnoses included mild dementia in other diseases processes, hypertensive heart disease, and mixed incontinence.<br><br>A physician's order, dated 2/20/23, indicated gabapentin 400 mg, give one capsule four times daily for neuropathy.<br><br>A physician's order, dated 2/20/23, indicated medications may be left at bedside for self-administration every day and evening shift.<br><br>A "Medication Self Administration Safety Screen", dated 2/13/25, indicated Resident 48 may not self administer medications.<br><br>During an interview, on 4/9/25 at 1:55 p.m., LPN 2 indicated residents were evaluated quarterly and with any change of condition to ensure safe self administration. The order was placed after the assessment was completed. | | 1 Staff swept Resident 48's apartment to ensure there were no medications left at bedside or unsecured. Resident 48 received a new evaluation on 4/12/2025 and was found to be safe for self-administration with each med pass.<br>2 All residents who require assistance with their medication administration have the potential to be affected by the alleged deficient practice. All residents who receive their medication from Licensed Nurses or Qualified Medication Aides during med pass were reviewed to ensure no medications were present at bedside.<br>3 Licensed Nurses and Qualified Medication Aides were re-educated on Medication Administration Policy and Procedure.<br>4 Director of Residential Services, or Designee, will audit medication administration for 5 residents one (1) time per week for four (4) weeks and then one (1) time a month for five (5) months. Results of these audits will be forwarded to QAPI. The QAPI Committee reserves the right to modify or extend auditing based on findings. | |

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| | During an interview, on 4/9/25 at 2:00 p.m., the Director of Assisted Living indicated Resident 48's "Medication Self Administration Safety Screen" completed on 2/13/25, had not indicated the resident was able to safely self administer medication. This resident's assessment should have contained additional documentation allowing medications to be left at bedside.<br><br>A facility policy, revised 2/16 and titled, "Assisted Living- Medication Self Administration", provided by the Long Term Care Director of Nursing (DON), indicated the following: "...It is the policy of Peabody Retirement Community to ensure that all Assisted Living residents who wish to self administer their medication in any way is able to do so in a safe manner...." | | | |