

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00178108.</p> <p>Complaint IN00178108 - Substantiated. Federal/State deficiencies related to the allegations are cited at F224 and F226.</p> <p>Survey dates: July 21 and 22, 2015</p> <p>Facility number: 000485 Provider number: 155655 AIM number: 100291190</p> <p>Census bed type: SNF/NF: 171 Residential: 118 Total: 289</p> <p>Census payor type: Medicare: 11 Medicaid: 125 Other: 153 Total: 289</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0224	483.13(c)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS=D Bldg. 00	<p>PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the mistreatment of residents did not occur in regards to misuse of personal funds for 1 of 4 residents reviewed for mistreatment. (Residents B)</p> <p>Findings Include:</p> <p>The clinical record of Resident B was reviewed on 7/21/15 at 9:50 a.m. Diagnoses included, but were not limited to, dementia with delusions, cerebrovascular accident, dysphagia, depression, glaucoma and congestive heart failure. The quarterly Minimum Data Set (MDS), dated 5/14/15, indicated Resident B was severely cognitively impaired.</p> <p>During review of the Indiana State Department of Health Incident Report Form dated 7/16/15, the newly appointed guardian for Resident B informed the Executive Director, on 7/9/15, two checks in the combined amount of \$7000.00 had been written from Resident</p>	F 0224	<p>The filing of this plan of correction does not constitute an admission that the alleged deficiencies exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulation and continue to provide quality care. We respectfully request a desk review. A guardian for resident B was secured and resident B's funds are monitored by the guardian. All other residents were audited for POA/guardianship and none were found that did not have a responsible party to monitor resident funds. All staff educated on Abuse/Misappropriation of resident funds Policy. The policy entitled "Resident Personal Funds" has been amended to include that if the resident/POA is not able to physically come up and withdraw the money, money can be delivered to the resident/POA, but will require two employees to deliver and sign off that the money was received by the resident/POA. Furthermore, any outings paid out of the RTA will require a list of residents attending the outing and require two employee signatures. All new admits will be reviewed for</p>	07/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2015	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>B's account. The checks had the word "pharmacy" written next to the bank statement. The Executive Director notified the pharmacy and verified there had been no payment to Resident B's account since 3/14. The Executive Director and the Administrator spoke with Employee #1 who wrote and cashed the checks. Employee #1 had no proof the checks were written for a medication bill. Employee #1 was immediately suspended pending an investigation.</p> <p>Review of the investigation, provided by the Executive Director on 7/21/15 at 10:50 a.m., indicated, through the investigation, it was determined Resident B could not have signed the checks as she was incapable of signing them. No proof could be found the money went towards a pharmacy bill. It was determined that both checks had been written and cashed for Employee #1's personal use. Employee #1 failed to show up for 2 meetings with the facility. The employee was terminated and the local police were notified.</p> <p>During an interview on 7/21/15 at 1:25 p.m., the Associate Administrator indicated the incident was still under investigation. She indicated the facility has determined no other resident funds were misappropriated. She indicated the</p>		<p>responsible party upon admission and with any changes reviewed daily by the SSD/Designee on regular business days for 30 days, weekly for 3 months, monthly for 6 months, and ongoing thereafter until 100% of the threshold is achieved. The QAPI committee, chaired by the Administrator, will oversee compliance with the SSD/Designee having responsibility reporting. The systemic changes will be completed July31, 2015.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>money would be replaced, but unsure who would replace the money.</p> <p>On 7/22/15 at 10:10 a.m., the Social Worker Coordinator indicated staff persons were to have a witness when either accepting money or removing money from a resident's account. She indicated when her staff purchased items for a resident, they were supposed to get an initial from the resident for the items purchased. She indicated Resident B did not have any family and had not appointed a Power of Attorney (POA) or guardian until recently.</p> <p>During an interview on 7/22/15 at 10:25 a.m., the Billing Coordinator indicated all of Resident B's mail was going to Employee #1. Several attempts had been made to appoint a guardian for Resident B. She indicated Employee #1 delayed the process. The Billing Coordinator indicated as she looked over Resident B's balance, she knew she would have to soon apply for Medicaid. In April, the Billing Coordinator approached the Executive Director to have a local attorney start the process of appointing a guardian.</p> <p>The Billing Coordinator indicated the attorney and facility had since appointed the facility's pastor to be the guardian of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident B.</p> <p>Review of Resident B's contact sheet indicated a financial responsible guardian has been appointed.</p> <p>Review of a current, undated facility policy, provided by the Associate Administrator on 7/22/15 at 8:15 a.m., titled "ABUSE, NEGLECT AND MISAPPROPRIATION OF RESIDENT PROPERTY" indicated the following:</p> <p>"Policy This facility's policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all stated [sic] and federal regulations. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals.</p> <p>Purpose This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of allegation of mistreatment, neglect,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0226 SS=D Bldg. 00	<p>abuse, including injuries of unknown source, unusual occurrences and misappropriation of resident property.</p> <p>...Policy Interpretation and Implementation</p> <p>...6. The facility shall prevent abuse by providing...identify, correct and intervene in situations in which abuse, neglect or misappropriations of resident property is likely to occur...</p> <p>...15. Depending on the situation, the facility may need to contact the local police department, Adult Protective Services...."</p> <p>This Federal tag related to Complaint IN00178108.</p> <p>3.1-28(a)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their policy related to the misappropriation of resident funds for 1 of 4 residents reviewed. (Residents B)</p>	F 0226	The filing of this plan of correction does not constitute an admission that the alleged deficiencies exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulation and	07/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2015	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Findings Include:</p> <p>The clinical record of Resident B was reviewed on 7/21/15 at 9:50 a.m. Diagnoses included, but were not limited to, dementia with delusions, cerebrovascular accident, dysphagia, depression, glaucoma and congestive heart failure. The quarterly Minimum Data Set assessment (MDS), dated 5/14/15, indicated Resident B was severely cognitively impaired.</p> <p>During review of the Indiana State Department of Health Incident Report Form, dated 7/16/15, the newly appointed guardian for Resident B informed the Executive Director, on 7/9/15, two checks in the combined amount of \$7000.00 had been written from Resident B's account. The checks had the word "pharmacy" written next to the bank statement. The Executive Director notified the pharmacy and verified there had been no payment to Resident B's account since 3/14. The Executive Director and the Administrator spoke with Employee #1 who wrote and cashed the checks. Employee #1 had no proof the checks were written for a medication bill. Employee #1 was immediately suspended pending an investigation.</p> <p>Review of the investigation, provided by</p>		<p>continue to provide quality care. We respectfully request a desk review.</p> <p>A guardian for resident B was secured and resident B's funds are monitored by the guardian. All other residents were audited for POA/guardianship and none were found that did not have a responsible party to monitor resident funds. The systemic changes will be completed July 31, 2015.</p> <p>All staff educated on Abuse/Misappropriation of resident funds Policy. The policy entitled "Resident Personal Funds" has been amended to include that if the resident/POA is not able to physically come up and withdraw the money, money can be delivered to the resident/POA, but will require two employees to deliver and sign off that the money was received by the resident/POA. Furthermore, any outings paid out of the RTA will require a list of residents attending the outing and require two employee signatures.</p> <p>All new admits will be reviewed for responsible party upon admission and with any changes reviewed daily by the SSD/Designee on regular business days for 30 days, weekly for 3 months, monthly for 6 months, and ongoing thereafter until 100% of the threshold is achieved. The QAPI committee, chaired by the Administrator, will oversee compliance with the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2015
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the Executive Director on 7/21/15 at 10:50 a.m., indicated through the investigation, it was determined Resident B could not have signed the checks as she was incapable of signing them. No proof could be found the money went towards a pharmacy bill. It was determined that both checks had been written and cashed for Employee #1's personal use. Employee #1 failed to show up for 2 meetings with the facility. The employee was terminated and the local police were notified.</p> <p>During an interview on 7/21/15 at 1:25 p.m., the Associate Administrator indicated the incident was still under investigation. She indicated the facility had determined no other resident funds were misappropriated. She indicated the money would be replaced, but unsure who would replace the money.</p> <p>On 7/22/15 at 10:10 a.m., the Social Worker Coordinator indicated staff persons were to have a witness when either accepting money or removing money from a resident's account. She indicated when her staff purchased items for a resident, they were supposed to get an initial from the resident for the items purchased. She indicated Resident B did not have any family and had not appointed a Power of Attorney (POA) or</p>		SSD/Designee having responsibility reporting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2015	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>guardian until recently.</p> <p>During an interview on 7/22/15 at 10:25 a.m., the Billing Coordinator indicated all of Resident B's mail was going to employee #1. Several attempts had been made to appoint a guardian for Resident B. She indicated Employee #1 delayed the process. The Billing Coordinator indicated as she looked over Resident B's balance, she knew she would have to soon apply for Medicaid. In April, the Billing Coordinator approached the Executive Director to have a local attorney start the process of appointing a guardian.</p> <p>The Billing Coordinator indicated the attorney and facility had since appointed the facility's pastor to be the guardian of Resident B.</p> <p>Review of Resident B's contact sheet, a financial responsible guardian had been appointed.</p> <p>Review of a current, undated facility policy, provided by the Associate Administrator on 7/22/15 at 8:15 a.m., titled "ABUSE, NEGLECT AND MISAPPROPRIATION OF RESIDENT PROPERTY" indicated the following:</p> <p>"Policy</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>This facility's policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all stated [sic] and federal regulations. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals.</p> <p>Purpose This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of allegation of mistreatment, neglect, abuse, including injuries of unknown source, unusual occurrences and misappropriation of resident property.</p> <p>...Policy Interpretation and Implementation ...6. The facility shall prevent abuse by providing...identify, correct and intervene in situations in which abuse, neglect or misappropriations of resident property is likely to occur... ...15. Depending on the situation, the facility may need to contact the local police department, Adult Protective</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2015
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Services...." This Federal tag related to Complaint IN00178108. 3.1-28(a)				