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| | 155655 | A. BUILDING 00<br>B. WING | 06/07/2024 |

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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 the Investigation of Complaints IN00434570, IN00434656, and IN00435415. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy.<br><br>Complaint IN00434570 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00434656 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00435415 - Federal/state deficiencies related to the allegations are cited at F689 and F609.<br><br>Survey dates: June 5, 6, and 7, 2024.<br><br>Facility number: 000485<br>Provider number: 155655<br>AIM number: 100291190<br><br>Census Bed Type:<br>SNF/NF: 159<br>Total: 159<br><br>Census Payor Type:<br>Medicare: 5<br>Medicaid: 93<br>Other: 61<br>Total: 159<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed June 11, 2024 | 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. | |

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

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| F 0609 SS=D Bldg. 00 | 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br>Reporting of Alleged Violations<br><br>Based on interviews and record review, the facility failed to report accurate information regarding an elopement for 1 of 1 facility reported incidents reviewed for elopement (Resident B).<br><br>Findings include:<br><br>A Facility Reported Incident indicated the following:<br>The actual or identified date and time of the incident was 5/23/24 at 9:30 p.m. Resident B was admitted to the facility on 5/17/24 for rehab services. Upon admission he was identified as moderately cognitively impaired, and he was an elopement risk. A discussion with the family regarding his risk for elopement resulted in the family declining a need for his placement on a secured unit. On 5/24/24 at 6:10 a.m., CNA 7 went into Resident B's room to check on him, discovered he was not in his room, and she alerted LPN 16. Resident B was located outside of the facility and returned without incident. The clinician and the family were notified and in agreement to relocate Resident B to a room within a secured unit. There was no physical, mental or emotional injury observed. The follow up report added on 5/28/24, indicated he continued to adjust well to his new unit. His family remained supportive to his plan of care. There was no latent physical injury or emotional distress observed.<br><br>A late entry nurse note, dated 5/24/24 at 6:10 a.m. and created on 5/24/24 at 8:10 p.m., indicated CNA 7 reported that Resident B was not in his room during a.m. rounds. Staff immediately initiated unit sweep and were unable to locate him. The phone tree was initiated per facility protocol. The sweep | F 0609 | Peabody Retirement Community has a policy in place that we follow all State and Federal guidance for reporting violations.<br>1 The report was made at the time of the incident. Additional details were made available to the surveyor upon request during her investigation.<br>2 Future reportable violations have the potential to be affected.<br>3 The Administrator, Director of Nursing, and Assistant Administrator inserviced on reportable guidelines.<br>4 The Administrator will audit each reportable incident x 6 months to ensure all guidelines are followed. Results of these audits will be forwarded to QAPI. Any negative findings will add an additional month of auditing until 100% compliance is achieved. | 06/14/2024 |

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| | was widened to facility and grounds. The 911 dispatch was called, and the local police department was notified. Staff located him at 7:05 a.m. in a cabin shelter at a local park, approximately one-half mile from the facility. Resident B came willingly with staff back to the facility. Once he was back on the unit, a head-to-toe assessment was performed. There were no injuries noted. He did not report emotional distress and apologized for worrying everyone. He reported he had left to find two churches. He was relocated to a secured unit.<br><br>An observation of the video footage, on 6/5/24 at 3:19 p.m., with the DON and the Administrator present indicated the following:<br><br>On 5/23/24 at 10:29 p.m., Resident B was seen exiting his room without his walker. He was wearing a pullover sweatshirt, pants and tennis shoes. He ambulated from his room to the double doors of the Rehab Unit. He pushed the door open on the right and exited the unit at 10:30 p.m.<br><br>At 10:31 p.m., he ambulated down the hall from the Rehab Unit through the rotunda towards the Assisted Living area. He was out of the camera view at 10:33 p.m.<br><br>At 10:34 p.m., he ambulated to the Assisted Living door (door 8) and exited the facility.<br><br>On 5/24/24 at 6:09 a.m., CNA 7 was observed entering Resident B's room, then the CNA exited the room and walked towards the nurses station.<br><br>On 5/24/24 at 7:09 a.m., Resident B was in the foyer at the rotunda accompanied by Floor Technician 34 and Maintenance Employee 25. Resident B was assisted into a wheelchair and | | | |

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| | was escorted to the Rehab Unit.<br><br>During an interview with Resident B's family member, on 6/5/24 at 12:35 p.m., it was indicated Resident B had not had problems leaving his home unattended. The facility had not asked the family about admitting Resident B to a secured unit and they had not declined for him to be admitted to a secured unit prior to him being admited to the rehab unit, but they knew eventually he would be going to a memory care unit somewhere.<br><br>During an interview with the DON and with the Administrator present, on 6/7/24 at 1:58 p.m., the DON indicated she didn't normally complete the Facility Reported Incidents, when she reported the elopement, she didn't have all the information yet and she knew it just needed it reported to the state agency. The Administrator indicated the facility reported incident wasn't intentionally meant to be misleading.<br><br>A policy was requested during the interview for reporting and the Administrator indicated they normally followed the guidance for reporting.<br><br>This citation relates to Complaint IN00435415.<br><br>3.1-28(c) | | | |
| F 0689<br>SS=J<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>Based on observation, interview, and record review, the facility failed to ensure a resident who was cognitively impaired and assessed as an elopement risk, was observed overnight and provided with care checks. This deficient practice resulted in the resident eloping from the facility | F 0689 | Past Non-Compliance was achieved for this citation, so no Plan of Correction will be submitted. | 06/14/2024 |

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| | and being unaccounted for overnight for 1 of 3 residents reviewed for elopements. (Resident B)<br><br>The Immediate Jeopardy began on 5/23/24 when the facility failed to ensure a resident who was cognitively impaired and assessed as an elopement risk, was observed overnight and provided with care checks. The resident eloped from the facility on 5/23/24 at 10:34 p.m. and being unaccounted for overnight until 5/24/24 at 7:09 a.m. when he was found in a local park approximately one-half mile from the facility. The resident complained of being cold and had been incontinent of bowel when he was located by a staff member. The Administrator was notified of the Immediate Jeopardy at 4:59 p.m. on 6/5/24. The Immediate Jeopardy was removed, and the deficient practice corrected on 5/24/24, prior to the start of the survey and was therefore Past Noncompliance.<br><br>Findings include:<br><br>Resident B's clinical record was reviewed on 6/5/24 at 10:19 a.m. Diagnoses included metabolic encephalopathy, repeated falls, unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, delirium due to known physiological condition, post-traumatic stress disorder, difficulty in walking, weakness, other lack of coordination, and need for assistance at home and no other household member able to render care.<br><br>Physician's orders included relocate him to a secured unit now (5/24/24), admit to a secured unit (6/4/24), Prozac (treat depression) 10 mg (milligram) daily, apixaban (treat atrial fibrillation) 5 mg twice daily, and metoprolol succinate (treat | | | |

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| | high blood pressure) 50 mg daily.<br><br>An admission Minimum Data Set (MDS) assessment, dated 5/23/24, indicated he was moderately cognitively impaired. He required extensive assistance from one staff member for bed mobility and toileting. He required limited assistance from one staff member for transfers. He was frequently incontinent of bowel and bladder.<br><br>An elopement risk assessment, dated 5/17/24, indicated he was at risk for elopement and an elopement care plan was initiated. The care plan indicated he was at risk for elopement related to impaired cognition/safety awareness. His goal was he would remain safe through the next review. His interventions included distracting him from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, etc., offer resident the restroom, and redirect him to areas appropriate for him.<br><br>An elopement risk assessment, dated 5/19/24, indicated he was at risk for elopement and an elopement care plan was initiated. The care plan indicated he was at risk for elopement related to impaired cognition/safety awareness. His goal was he would remain safe through the next review. His interventions included distracting him from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, etc., offering him the restroom, and redirect him to areas appropriate for him.<br><br>He had a current care plan for elopement risk/wanderer related to disoriented to place, history of attempts to leave facility unattended (5/24/24). His goal was to not leave the facility unattended through the review (5/24/24). His interventions included distracting him from | | | |

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| | wandering by offering pleasant diversions, structured activities, food, conversation, television, books he preferred (5/24/24), identify a pattern of wandering: Is wandering purposeful, aimless, or escapist? Is he looking for something? Does it indicate the need for more exercise? Intervene as appropriate (5/24/24), monitor for fatigue and weight loss (5/24/24), he resided on secure unit due to wandering and confusion (5/24/24).<br><br>He had a current care plan for having a behavior problem related to his desire to return to his home. He tended to exit seek and linger by the exit doors to his current neighborhood. He may speak about returning to his home where his wife was waiting on him. (His wife had passed.) (5/31/24). His interventions included administering medications as ordered. Monitor/document for side effects and effectiveness (5/31/24), anticipate and meet his needs (5/31/24), caregivers to provided opportunity for positive interaction, and attention. Stop and talk with him as passing by (5/31/24), if reasonable, discuss his behavior, explain/reinforce why the behavior was inappropriate and/or unacceptable to him (5/31/24), intervene as necessary to protect the rights and safety of others, approach/speak to him in a calm manner, divert attention and remove him from the situation and take him to an alternate location as needed (5/31/24), offer one on one activity, conversation of interest, snack and/or beverage (5/31/24), praise him for any indication of his progress/improvement in his behavior (5/31/24), provide a program of activities that is of interest and accommodates his status (5/31/24).<br><br>Review of nurses' notes indicated the following:<br><br>A late entry nurse note, dated 5/24/24 at 6:10 a.m. | | | |

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| | and created on 5/24/24 at 8:10 p.m., indicated CNA 7 reported that Resident B was not in his room during a.m. rounds. Staff immediately initiated unit sweep and were unable to locate him. The phone tree was initiated per facility protocol. The sweep was widened to facility and grounds. The 911 dispatch was called, and the local police department was notified. Staff located him at 7:05 a.m. in a cabin shelter at a local park, approximately one-half mile from the facility. Resident B came willingly with staff back to the facility. Once he was back on the unit, a head-to-toe assessment was performed. There were no injuries noted. He did not report emotional distress and apologized for worrying everyone. He reported he had left to find two churches. He was relocated to a secured unit.<br><br>An observation of the video footage, on 6/5/24 at 3:19 p.m., with the DON and the Administrator present indicated the following:<br><br>On 5/23/24 at 10:29 p.m., Resident B was seen exiting his room without his walker. He was wearing a pullover sweatshirt, pants and tennis shoes. He ambulated from his room to the double doors of the Rehab Unit. He pushed the door open on the right and exited the unit at 10:30 p.m.<br><br>At 10:31 p.m., he ambulated down the hall from the Rehab Unit through the rotunda towards the Assisted Living area. He was out of the camera view at 10:33 p.m.<br><br>At 10:34 p.m., he ambulated to the Assisted Living door (door 8) and exited the facility.<br><br>On 5/24/24 at 6:09 a.m., CNA 7 was observed entering Resident B's room, then the CNA exited the room and walked towards the nurses station. | | | |

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On 5/24/24 at 7:09 a.m., Resident B was in the foyer at the rotunda accompanied by Floor Technician 34 and Maintenance Employee 25. Resident B was assisted into a wheelchair and was escorted to the Rehab Unit.

During an interview at the time of the video observation, the DON indicated she had watched the video, and during the time of Resident B being out of the facility CNA 6, who was responsible for him, did not enter his room the entire night and his door remained partially open. The CNA did enter the room next to Resident B's room. It was the facility's expectation that staff completed walking rounds at shift change.

Review of the website www.wunderground.com for historical weather, indicated on 5/23/24 at 10:54 p.m. the temperature was 70 degrees Fahrenheit. On 5/24/24 at 12:54 a.m., it was 67 degrees Fahrenheit. On 5/24/24 at 6:54 a.m., it was 58 degrees Fahrenheit.

During an interview with LPN 16 and with Nurse Manager 52 present, on 6/5/24 at 11:21 a.m., LPN 16 indicated she arrived to work at 6:00 a.m. on 5/24/24. CNA 7 completed resident rounds at 6:10 a.m. and Resident B was not in his room. She started the phone chain per facility protocol. They looked through the Rehab Unit and the whole building was looking for him. The grounds employees and the nursing aides were outside looking for him. The resident was found by Maintenance Employee 34 and Floor Technician 24 at a local park in a little log cabin just after 7:00 a.m. Resident B was driven back to the facility and escorted in a wheelchair back to the unit and kept apologizing to her for leaving. The resident didn't seem to have any emotional distress and he

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| | said he was trying to find two churches. The son indicated to her that he had worked in a grocery store between two churches. Nurse Manager 52 indicated Resident B left through the double doors of the unit, passed the main entrance (door 9), straight to the Assisted Living door (door 8) and left the building at 10:30 p.m. on 5/23/24. An Agency Nurse was on duty that night and CNA 6 was assigned to him. CNA 6 had not checked on the resident during the night and her reasoning was that he was independent, and he didn't want her in his room. LPN 16 indicated Resident B was supposed to ambulate with a walker but didn't have the walker with him. She last saw him around 9:30 p.m. on 5/23/24, he was ambulating in the hallway, and she reminded him to use his walker and he told her that he was stretching his legs. She had left the facility around 11:30 p.m., on 5/23/24.<br><br>During an interview with CNA 7, on 6/5/24 at 1:22 p.m., she indicated she gave CNA 6 report at 6:00 p.m. on 5/23/24 and told her that Resident B had some confusion towards the end of her shift. She had asked him to go to supper and he declined and told her that he had not eaten breakfast or lunch, which he had, because she took him to the dining room. On 5/24/24 at 6:00 a.m., she came to work, and she normally did walking rounds with the other aide during shift change, but they didn't that day. CNA 6 told her Resident B didn't like her. The resident shut the door in her face and wouldn't let her do his care. CNA 7 went to Resident B's room and noticed he was gone, so she checked a couple of other resident's rooms, whose doors were open, thinking he went in the wrong room. Then she went to the nurses station and reported him missing to the nurse. They checked every single room, the closets, and under the beds. Some staff went outside and checked | | | |

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| | around the building. She stayed in the Rehab Unit and when he returned, he was cold to touch, and he had been incontinent of bowel. He was wearing a pair of black dry-fit pants and a sweatshirt with a t-shirt underneath it. He also had shoes and socks on. She didn't know he was at risk for elopement.<br><br>During an interview with Agency Nurse 15, on 6/5/24 at 1:53 p.m., she indicated it was her first time working at the facility and did not know any of the residents. It was not reported to her that he was an elopement risk. He toileted himself, so she didn't have to check on him every two hours to make sure he was clean. She thought she saw him before midnight on 5/23/24.<br><br>During an interview with Maintenance Employee 25, on 6/5/24 at 2:03 p.m., he indicated he was told there was a missing resident on the day Resident B was found to be missing. He drove the facility's complex first, the nearby cemetery and then the nearby recreation area. He drove through the local park and as he was driving back out onto the street he looked right, then left. Something white caught his eye in the children's cabin at the park. He and Floor Technician 34 had walked up to the cabin at the same time. The floor technician called the facility to tell them that Resident B was located. Maintenance Employee 25 went to the cabin and put his head in the door and asked Resident B his name and if he was alright. He was shivering and indicated he was cold. Resident B took his hand and assisted him into his truck, turned the heat on for him, and drove him back to the facility. Resident B indicated to him he was visiting the church and something about his son. Resident B was dressed in a sweatshirt, pants, and tennis shoes. They brought him back to the facility and escorted him in a wheelchair to the | | | |

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| | Rehab Unit.<br><br>During an interview with CNA 6, on 6/5/24 at 2:47 p.m., she indicated she couldn't remember what time she had seen Resident B in his room on 5/23/24. She had only passed ice water to the residents who asked for it. She didn't believe she checked on him that night because he was usually okay. He had shut the door on her and she didn't see him the rest of the night. He toileted himself and she assumed he was continent. She had completed walking rounds with CNA 7 on the evening of 5/23/24 or the morning of 5/24/24 and she didn't remember CNA 7 saying Resident B was confused at the end of CNA 7's shift on 5/23/24. Normally she would check on the residents and open the door. She didn't know why she didn't check on him. She thought she had a lot in on her mind that day. She still felt terrible about it.<br><br>On 6/6/24 at 8:58 a.m., CNA 6's employee file was reviewed and indicated the following:<br><br>A form titled, "Resident Services Coordinator Department Specific Orientation," dated 4/19/24 and initialed by CNA 6, indicated the following: " ...26. Before leaving for the day do walking rounds and give detailed report on all residents to your replacement ..."<br><br>A form titled, "Position Description," dated and signed by CNA 6 on 3/29/24, indicated the following: " ...Principal duties ...2. Monitor residents throughout the day without interfering with their privacy ..."<br><br>During an interview with the Administrator, on 6/7/24 at 1:41 p.m., she indicated it was a standard of care to check on the residents every two hours | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155655 | A. BUILDING 00<br>B. WING | 06/07/2024 |

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

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| | or more frequently if needed, it depended on the resident.<br><br>A current facility policy, titled "Safety and Supervision of Residents," provided by the DON, on 6/6/24 at 9:40 a.m., indicated the following: "...Our facility strives to make the environment as free from accidents hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities...."<br><br>A current facility policy, titled "Wandering and Elopements," provided by the DON, on 6/6/24 at 9:42 a.m., indicated the following: "...1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety."<br><br>The Past Noncompliance Immediate Jeopardy began on 5/23/24. Immediate Jeopardy was removed and corrected by 5/24/24 after the facility inserviced all staff on two-hour care checks, on systemic change of identifying residents who were an elopement, the elopement and abuse/neglect policies. Colored background name plates for residents who are at risk for elopement, ribbons on electronic health records noted for those residents who are an elopement risk and documentation for safety checks for residents who were at risk for elopement and resided on an unsecured unit were implemented. Audits were to be conducted to ensure elopement assessments were completed with new admissions and appropriate interventions were in place weekly for six months.<br><br>This citation relates to Complaint IN00435415.<br><br>3.1-45(a)(2) | | | |

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