STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155655	A. BUILDING -- B. WING	09/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/23/24 Facility Number: 000485 Provider Number: 155655 AIM Number: 100291190 At this Emergency Preparedness survey, Peabody Retirement Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 192 certified beds. At the time of the survey, the census was 165. Quality Review completed on 09/25/24	E 0000	Preparation and/or execution of this plan does not constitute admission or agreement by Peabody Retirement Community that a deficiency exists. This plan is also not to be construed as an admission of fault by Peabody Retirement Community or its employees who draft this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. We respectfully request desk review of this Plan of Correction.	
E 0007 SS=E Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(EP Program Patient Population Based on interview, the facility failed to ensure the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.73(a)(3). This deficient practice could affect residents, staff and visitors in the dialysis treatment area. Findings include: Based on interview with the Director of Facility	E 0007	Peabody Retirement Community has a policy on maintaining Emergency Policy and Procedure in accordance with all regulatory requirements, including those receiving dialysis and the services provided in the dialysis treatment area. 1 Emergency Policy and Procedure were reviewed and adopted by the QAPI Committee. 2 The Emergency Policy and Procedure will be maintained in an accessible location for all staff in	10/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katie Robinson	Administrator	10/08/2024

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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	Services and Assistant Administrator from 10:35 a.m. to 11:35 a.m. on 09/23/24, the Emergency Preparedness (EP) plan failed to address persons at-risk or the type of services the LTC facility has the ability to provide in an emergency. During interview the Director of Facility Services stated the facility's emergency preparedness plan did not address patients receiving dialysis or the services provided in the dialysis treatment area. This finding was reviewed with the Director of Facility Services at the exit conference.		the dialysis treatment area. 3 The Facility Operations Director, Assistant Administrator, and Administrator were educated on this requirement. 4 The Facility Operations Director, or designee, will audit to confirm Emergency Policy and Procedure is maintained in this area and address needs of the population 1x/month x 6 months. Results of these audits will be forwarded to QAPI. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	
K 0000 Bldg. 04	A Preoccupancy Survey for remodeling of three former resident rooms (128, 129, and 130) into a dialysis treatment area with 9 treatment stations and supporting nurse station and the renovation of rooms 125, 126, and 136 in the Smock Memory Enhancement Center locked building to allow two (2) licensed comprehensive beds in each room was conducted by the Indiana Department of Health in accordance with 42 CFR 483 Subpart B. Survey Date: 09/23/24 Facility Number: 000485 Provider Number: 155655 AIM Number: 100291190 At this preoccupancy survey, Peabody Retirement Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483 Subpart B and	K 0000	Preparation and/or execution of this plan does not constitute admission or agreement by Peabody Retirement Community that a deficiency exists. This plan is also not to be construed as an admission of fault by Peabody Retirement Community or its employees who draft this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. We respectfully request desk review of this Plan of Correction.	

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	155655	A. BUILDING 04 B. WING	09/23/2024

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	410 IAC 16.2. The facility has 192 certified beds. At the time of the survey, the census was 165. Quality Review completed on 09/25/24			
K 0211 SS=E Bldg. 04	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure means of egress in 1 of 1 dialysis treatment areas was continuously maintained free of obstructions. LSC 19.2.1 states every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. LSC 7.1.5.1 Means of egress shall be designed and maintained to provide headroom in accordance with other sections of this Code, and such headroom shall be not less than 7 ft 6 in., with projections from the ceiling not less than 6 ft 8 in. with a tolerance of 3/4 in., above the finished floor, unless otherwise specified by any of the following: (1) In existing buildings, the ceiling height shall be not less than 7 ft from the floor, with projections from the ceiling not less than 6 ft 8 in. nominal above the floor. This deficient practice affects residents, staff and visitors in the dialysis treatment area. Findings include: Based on observation and interview with the Director of Facility Services and Assistant Administrator from 10:35 a.m. to 11:35 a.m. on 09/23/24, the dialysis treatment area contained 3 televisions which measured 6 ft. from the floor. Based on interview at the time of observation, the Director of Facility Services stated they should be able to move the televisions higher to allow required clearance.	K 0211	Peabody Retirement Community has a policy on maintaining a means of egress in accordance with all regulatory requirements, including ensuring proper square footage. 1 The ceiling mounted TV's in the Dialysis Den were repositioned to provide a minimum of 6'8" of clearance from the floor 2 No other areas affected by this practice. 3 The Facility Operations Director was educated on this requirement. 4 The Facility Operations Director, or designee, will audit the clearance between the floor and the ceiling mounted TV's 1x/month x 6 months. Results of these audits will be forwarded to QAPI. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	10/04/2024

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	These findings were reviewed with the Director of Facility Services at the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 04	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 3 of 3 rooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Further NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states suspended horizontal obstructions more than thirty inches in length shall maintain a minimum vertical distance below the sprinkler deflector of 18 inches. Section 8.6.5.2.2.1 states, in light hazard occupancies, privacy curtains shall not be considered obstructions where all of the following are met: (1) The curtains are supported by fabric mesh on ceiling track. (2) Openings in the mesh are equal to 70 percent or greater. (3) The mesh extends a minimum of 22 inches down from the ceiling. This deficient practice could affect 6 residents, staff and visitors. Finding includes: Based on observation and interview with the	K 0353	Peabody Retirement Community has a policy on maintaining our facility in accordance with all regulatory requirements, including ensuring privacy curtain compliance. 1 The privacy curtains for rooms 125, 126, and 136 were replaced with curtains that meet the requirements of NFPA standards. 2 No other areas affected by this practice. 3 The Facility Operations Director was educated on this requirement. 4 The Facility Operations Director, or designee, will audit the privacy curtains 1x/month x 6 months to ensure they meet compliance. Results of these audits will be forwarded to QAPI. Any negative findings will add an additional month of auditing until 100% compliance is achieved.	10/04/2024

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	Director of Facility Services and Assistant Administrator from 10:35 a.m. to 11:35 a.m. on 09/23/24, the privacy curtains in the resident rooms 125, 126, and 136 in the Smock Memory Enhancement Center were hung from a track attached to the ceiling. The privacy curtains were supported by fabric mesh; however, the openings in the mesh were less than 70 percent. Based on interview at the time of the observations, the Director of Facility Services stated they were new privacy curtains. This finding was reviewed with the Director of Facility Services at the exit conference. 3.1-19(b)			