STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPL	ETED
		155655	B. WI	NG		05/23/	2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
554565	V DETIDENTAL A	0.			SEVENTH ST		
PEABOD	Y RETIREMENT C	OMMUNITY		NORTE	H MANCHESTER, IN 46962		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Prep	paredness Survey was	E 00	000	Preparation and/or execution of	of	
	conducted by the In-	diana Department of Health in			this plan does not constitute		
	accordance with 42	-			admission or agreement by		
					Peabody Retirement Commun	ıitv	
	Survey Date: 05/23/	/24			that a deficiency exists. This p	-	
	ř				is also not to be construed as		
	Facility Number: 00	00485			admission of fault by Peabody		
	Provider Number: 1				Retirement Community or its		
	AIM Number: 1002				employees who draft this		
					response and plan of correction	n l	
	At this Emergency Preparedness survey, Peabody				This plan of correction is	***	
		nity was found in compliance			submitted as the facility's cred	ihle	
		eparedness Requirements for			allegation of compliance.	ibic	
		caid Participating Providers			allegation of compliance.		
	and Suppliers, 42 C						
	and Suppliers, 42 C.	1 K 403.73					
	The facility has 192	certified beds. At the time of					
	the survey, the cens						
	the survey, the cens	us was 100.					
	Quality Review con	ducted on 06/03/24					
	Quality Review con	ducted on 00/03/24					
K 0000							l
1, 0000							
Bldg. 02							
2.49. 02	A Life Safety Code	Recertification and State	K 0	200	Preparation and/or execution of	of	ı
	•	ras conducted by the Indiana	K U	JUU	this plan does not constitute	<i>7</i> 1	
	•	th in accordance with 42 CFR			admission or agreement by		
	483.90(a).	in in accordance with 42 Cl K			Peabody Retirement Commun	nity	
	403.70(a).				that a deficiency exists. This p	-	
	Survey Date: 5/23/2	24			is also not to be construed as		
	Sarvey Date. 3/23/2	, I			admission of fault by Peabody		
	Facility Number: 00	00485			Retirement Community or its		
	Provider Number: 1				_		
	AIM Number: 1002				employees who draft this	\n	
	ATIVI INGILIUGI. 1002	.71170			response and plan of correction.		
	At this Life Safety	Code survey, Peabody			This plan of correction is	iblo	
	-	nity was found not in			submitted as the facility's cred	inie	
	Kemement Commu	mry was found not in			allegation of compliance.		

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

(X6) DATE

Katie Robinson Administrator 06/14/2024

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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TITLE

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155655		A. BUI	A. BUILDING 02  B. WING			COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIER			400 W S	DDRESS, CITY, STATE, ZIP COD SEVENTH ST MANCHESTER, IN 46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	I	IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B' CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	compliance with Re Medicare/Medicaid. Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation This facility consist Center South a fully building of Type II Health Care North a Enhancement Center Sprinklered building construction, and (bone story fully spring (000) construction. by hallways and are walls.  Buildings 02, 03, 04	quirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, existing ancies and 410 IAC 16.2.  s of (bldg. 03) Health Care reprinklered two story (111) construction, (bldg. 02) and (bldg. 04) Smock Memory or both are one story fully					
	resident rooms. The	ired smoke detectors in the facility has a capacity of 192 166 at the time of this survey.  ducted on 06/03/24					
K 0353 SS=E Bldg. 02	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and	Maintenance and Testing Maintenance and Testing r and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a Id readily available. System last checked					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155655		A. BUILDING <u>02</u> COM			(X3) DATE COMPI <b>05/23</b> ,	LETED	
	PROVIDER OR SUPPLIER  OY RETIREMENT C		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 400 W SEVENTH ST NORTH MANCHESTER, IN 46962			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	c) Water system  Provide in REMAI coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observation failed to ensure the were not obstructed accordance with NI Installation of Sprin Standard for the Installation of Sprin Standard for the Installation of Wasystems, as require deficient practice of staff in the Evergree Findings include:  Based on observation with the Director of at 1:47 p.m., a drop sprinkler system lost Evergreen Park Nei prevented sprinkler and drop ceiling in Based on interview Director of Facility ceiling prevented provided in the provided provided provided in the provided provided provided provided provided provided in the provided provid	system test  supply source  RKS information on non-required or partial er system.  and NFPA 25 on and interview, the facility spray pattern for sprinklers in 1 of 1 areas of egress in FPA 13, Standard for the akler Systems, and NFPA 25, spection, Testing, and atter-Based Fire Protection d by LSC 19.3.5.1. This build affect 30 residents and en Park neighborhood.  The facility Services on 05/23/24 ceiling was installed under the cated in the egress of the lighborhood. This practice coverage between the floor the aforementioned area. at the time of observation, the Services agreed the drop roper sprinkler coverage.	K 0.		Peabody Retirement Commur Health and Rehabilitation has policy on maintaining our sprir system in accordance with all regulatory requirements, inclu- ensuring the spray pattern of a sprinklers are unobstructed 1 The drop ceiling obstruc- the sprinkler head identified w removed. 2 All other sprinklers were observed to be unobstructed. 3 The Facility Operations Director and all Maintenance Personnel were educated on t requirement. 4 The Facility Operations Director, or designee, will aud sprinkler heads in various locations within the Health Ce 1x/month x 6 months. Results these audits will be forwarded QAPI. Any negative findings w add an additional month of auditing until 100% complianc achieved.	nity a nkler ding all ting as his to of to	06/14/2024
K 0371 SS=F	3.1-19(b)  NFPA 101  Subdivision of Bui	ilding Spaces - Smoke					

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STATEMEN	FOF HEALTH AND HUR MEDICARE & MEDICARE OF OF DEFICIENCIES OF CORRECTION		l í	ULTIPLE CO UILDING	INSTRUCTION 02	FO			
		155655	B. W	ING		05/23	/2024		
NAME OF PROVIDER OR SUPPLIER  PEABODY RETIREMENT COMMUNITY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE				STREET ADDRESS, CITY, STATE, ZIP COD 400 W SEVENTH ST NORTH MANCHESTER, IN 46962					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE		
Bldg. 02	Compartments 2012 EXISTING Smoke barriers sl least two smoke of sleeping floor with capacity. Size of of exceed 22,500 sq								

K 0371

Findings include:

corridors

Detail in REMARKS zone dimensions including length of zones and dead-end

Based on record review, observation, and

interview; the facility failed to provide complete

smoke barriers for 2 of 2 smoke compartments in

accordance with 19.3.7.1. This deficient practice

Building (002) larger than 22,500 square feet in

affects all staff and residents in Building (002).

Based on observations with the Director of Facility Services on 05/23/24 between 11:30 a.m. and 3:00 p.m., the smoke barrier walls by the elevators that separated North-wing 1 and North-wing 2 in building (002) into two smoke compartments were incomplete and could not determined if the barrier walls ran from the roof to the floor and from outside wall to outside wall. Upon inspection of the smoke barrier walls above the drop ceiling by the fire rated smoke doors, it appeared not to fully run from outside wall to outside wall. Based on review of the building construction plans dated 2001 and 2003 with the Director of Facility Services, the square footage for North-wing 1 was listed at 36,645 square feet and North-wing 2 was also listed at 36,645 square

Peabody Retirement Community Health and Rehabilitation has a policy on maintaining our facility and its smoke compartments in accordance with all regulatory requirements, including ensuring proper square footage.

- The plans were obtained from the architect and smoke compartments were located for Health Care Center South (Building 003).
- No other areas affected by this practice.
- The Facility Operations Director was educated on this requirement (see inservice for previous K371 tag).
- The Facility Operations Director, or designee, will audit the smoke compartment wall for HCN, HCS, and ME 1x/month x 6 months. Results of these audits will be forwarded to QAPI. Any negative findings will add an

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155655		î ´	JILDING	nstruction  02	(X3) DATE : COMPL 05/23/	ETED	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD SEVENTH ST		
PEABOD	Y RETIREMENT C	OMMUNITY			MANCHESTER, IN 46962		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION prints of Building 002. Also,		TAG	additional month of auditing u		DATE
	the required smoke into two smoke cominto two smoke comon the plans. Based observation and reconstruction of the plans of	barriers to divide North-wing 1 apartments and North-wing 2 apartments were not identified on interview during ords review, the Director of reed the building plans show forth-wing 2 in Building (002) quare feet and the building fy the required smoke barriers the Director of Facility Services e smoke barriers divided each e compartments and stated a evidence of the location of viewed with the Director of nistrator during the exit			additional month of additing the 100% compliance is achieved audit for previous K371 tag).		
K 0920 SS=D Bldg. 02	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in	d electrical equipment					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155655		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024		
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD SEVENTH ST		
PEABOD	Y RETIREMENT C	OMMUNITY			H MANCHESTER, IN 46962		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	non-patient care reother UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meer 10.2.3.6 (NFPA 99 (NFPA 70), 590.30 Based on observation be determined if 1 compatient care vicinity NFPA 99, Standard edition, defines pation of a health care facinitended to be examinated for the examination of the bed, device that supports examination and tree extends vertically to floor. This deficient resident in Healthcare Findings include:  Based on observation with the Director of between 11:30 a.m. of unknown UL rational Healthcare North programmer of the standard process of the standard p	cooms, power strips meet is. All power strips are precautions. Extension is as a substitute for fixed inc. Extension cords used imoved immediately upon purpose for which it was its the conditions of 10.2.4.  (a), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 (D) (NFPA	K 09		It is the policy of Peabody Retirement Community to maintain compliance with all regulations regarding the appropriate use of power core extension cords, and power st 1 The identified tower in Healthcare South patient root 122 was immediately remove was replaced with 2 power st meeting UL rating requirement The refrigerator in the Social Services office was immediat plugged directly into the wall outlet. 2 No other areas affected this practice. 3 All Department Heads we educated on this requirement previous inservice for K920 ta 4 The Facility Operations Director, or designee, will aud areas (patient rooms and/or offices) 1x/month x 6 months Results of these audits will be forwarded to QAPI. Any negal findings will add an additional month of auditing until 100% compliance is achieved (see	etrips.  m d. It rips nts. ely by vere (see ag). dit 5	06/14/2024

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155655		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIER		400 W	ADDRESS, CITY, STATE, ZIP COD SEVENTH ST H MANCHESTER, IN 46962	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0000	3.1-19(b)				
Bldg. 03	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 5/23/2  Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety of Retirement Commucompliance with Reflect Medicare/Medicaid Life Safety from Fire National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code)  This facility consist Center South a fully building of Type II Health Care North a Enhancement Centes sprinklered building construction, and (bone story fully spring (000) construction.  Buildings 02, 03, 04	200485 255655 291190  Code survey, Peabody 2015 and the 2012 edition of the 2016 and the 2012 edition of the 2016 and 410 IAC 16.2.  So of (bldg. 03) Health Care 2017 aprinklered two story 2018 (111) construction, (bldg. 02) 2018 and (bldg. 04) Smock Memory 2018 are to the story fully	K 0000	Preparation and/or execution of this plan does not constitute admission or agreement by Peabody Retirement Communithat a deficiency exists. This p is also not to be construed as 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 crediallegation of compliance.	nity Ian an on.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155655		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  03	(X3) DATE SURVEY COMPLETED 05/23/2024	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			STREET 400 W NORTH		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
SS=F	resident rooms. The and had a census of Quality Review con NFPA 101 Subdivision of Bu	e facility has a capacity of 192 f 166 at the time of this survey.  Inducted on 06/03/24			
Bldg. 03	Subdivision of Bu Compartments 2012 EXISTING Smoke barriers st least two smoke of sleeping floor with capacity. Size of of exceed 22,500 sq distance from any to a door in the sr 19.3.7.1, 19.3.7.2 Detail in REMARK	nall be provided to form at compartments on every a 30 or more patient bed compartments cannot uare feet or a 200-foot travel point in the compartment noke barrier.			
	interview; the facilismoke barriers for Building (003) larg accordance with 19 affects all staff and Findings include:  Based on observation Facility Services on and 3:00 p.m., the services of an accordance with 19 affects all staff and Findings include:	view, observation, and ity failed to provide complete of 1 smoke compartments in er than 22,500 square feet in .3.7.1. This deficient practice residents in Building (003).  ons with the Director of a 05/23/24 between 11:30 a.m. smoke barrier wall by the since that separated south wing to two smoke compartments of could not determined if the om the roof to the floor and from	K 0371	Peabody Retirement Commun Health and Rehabilitation has a policy on maintaining our facilit and its smoke compartments in accordance with all regulatory requirements, including ensurin proper square footage.  1 The plans were obtained from the architect and smoke compartments were located fo Health Care Center South (Building 003). 2 No other areas affected b this practice. 3 The Facility Operations Director was educated on this	a ty n ng

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outside wall to outside wall. Upon inspection of

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requirement (see inservice for

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155655		A. BUILDING 03  B. WING			COMPLETED 05/23/2024		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD SEVENTH ST		
PEABOD	Y RETIREMENT C	YTINUMMC			MANCHESTER, IN 46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	the fire rated smoke fully run from outside on review of the build dated 2001 and 2000. Services, the square listed at 36,645 square of Building (003). A barriers to divide Socompartments were Based on interview records review, the lagreed the building Building (003) was building prints did in barriers in the wing. Services was not suildivided the wing interpretation of the smoket.	ng was reviewed with the and Administrator during the			previous K371 tag).  4 The Facility Operations Director, or designee, will audi smoke compartment wall for H HCS, and ME 1x/month x 6 months. Results of these audi will be forwarded to QAPI. Any negative findings will add an additional month of auditing ur 100% compliance is achieved audit for previous K371 tag).	CN, ts ,	
K 0920 SS=E Bldg. 03	Extens Electrical Equipme Extension Cords Power strips in a p used for compone patient-care-relate (PCREE) assembl assembled by qua	d electrical equipment					
	the patient care vio	cinity may not be used for personal electronics),					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155655	B. W	NG		05/23/	/2024
NAME OF I	DROVIDED OF CURRING		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF			400 W	SEVENTH ST		
PEABOD	Y RETIREMENT C	OMMUNITY		NORTH	H MANCHESTER, IN 46962		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		m care resident rooms that					
		E. Power strips for PCREE					
	meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms						
		r the patient care rooms r) meet UL 1363. In					
	, ,	rooms, power strips meet					
		ds. All power strips are					
		precautions. Extension					
		d as a substitute for fixed					
		re. Extension cords used					
	_	moved immediately upon					
	completion of the	purpose for which it was					
	installed and mee	ts the conditions of 10.2.4.					
	10.2.3.6 (NFPA 9	9), 10.2.4 (NFPA 99), 400-8					
		(D) (NFPA 70), TIA 12-5					
		vation and interview, it could	K 0920		It is the policy of Peabody		06/14/2024
		f 3 of 3 power strips used in a			Retirement Community to		
		y met UL 1363A or UL60601-1.			maintain compliance with all		
		for Health Care Facilities, 2012			regulations regarding the		
	_	ient care areas as any portion			appropriate use of power cord		
		ility wherein patients are			extension cords, and power st	rıps.	
		nined or treated. Patient care			1 The identified tower in	_	
		as a space, within a location			Healthcare South patient room		
		amination and treatment of 6 feet beyond the normal			122 was immediately removed was replaced with 2 power str		
		chair, table, treadmill, or other			meeting UL rating requiremen	•	
	device that supports				The refrigerator in the Social	w.	
		eatment. A patient care vicinity			Services office was immediate	elv	
		o 7 feet 6 inches above the			plugged directly into the wall	,	
		nt practice could affect 1			outlet.		
		are South room 122.			2 No other areas affected	by	
					this practice.	•	
	Findings include:				3 All Department Heads w	ere	
					educated on this requirement	(see	
		ons during a tour of the facility			previous inservice for K920 tag	g).	
		f Facility Services, on 05/23/24			4 The Facility Operations		
		and 3:00 p.m. three power			Director, or designee, will aud	it 5	
	_	UL rating were powering			areas (patient rooms and/or		
		cheare South patient room 122.			offices) 1x/month x 6 months.		
	At the time of obser	rvation, the resident stated she			Results of these audits will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155655		l í	JILDING	onstruction  03	(X3) DATE : COMPL 05/23/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 400 W SEVENTH ST NORTH MANCHESTER, IN 46962					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)		TE	(X5) COMPLETION DATE	
TAG	personally purchase Amazon.com. This and 20 residents in  This finding was re Facility Services and during the exit configuration of the services and conserved of the services are quires electrically accordance with NFC code. NFPA 70, 20 requires that, unless cords and cables show for fixed wiring of a findings include:  Based on observation of the services compower strips.  This finding was residual control of the services compower strips.	ad the power strips on deficient practice affects staff the Healthcare South.  viewed with the Director of d Administrator on 05/23/2024 derence at 3:00 p.m.  ations and interview with the Services, on 05/23/24 between p.m., a refrigerator (high power as plugged into and supplied trip in an office. LSC 9.1.2 viring and equipment shall be in FPA 70, National Electrical 2011 Edition, Article 400.8 as specifically permitted, flexible all not be used as a substitute a structure.  On and interview, one power a refrigerator (high power draw ocial Service office on the st floor. Based on interview at the tion with the Director of offirmed the improper use of the viewed with the Director of d Administrator on 05/23/2024		TAG	forwarded to QAPI. Any negatindings will add an additional month of auditing until 100% compliance is achieved (see a for previous K920 tag).	ive	DATE	
K 0000	3.1-19(b)							

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STATEMENT OF DEFICIENCIES X1) F		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	04	COMPL	ETED
		155655	B. WI			05/23/	
				_	_		-
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					SEVENTH ST		
PEABOD	Y RETIREMENT C	OMMUNITY		NORTH	I MANCHESTER, IN 46962		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· C	DATE
Bldg. 04							,
_	A Life Safety Code	Recertification and State	K 0	000	Preparation and/or execution o	of	
	Licensure Survey was conducted by the Indiana		•		this plan does not constitute		
	Department of Health in accordance with 42 CFR				admission or agreement by		
	483.90(a).				Peabody Retirement Commun	ity	
					that a deficiency exists. This p	-	
	Survey Date: 5/23/2	4			is also not to be construed as		
	•				admission of fault by Peabody		
	Facility Number: 00	00485			Retirement Community or its		
	Provider Number: 1	55655			employees who draft this		
	AIM Number: 1002	91190			response and plan of correction	n.	
					This plan of correction is		
	At this Life Safety (	Code survey, Peabody			submitted as the facility's cred	ible	
	Retirement Commu	nity was found not in			allegation of compliance.		
	compliance with Re	quirements for Participation in					
	Medicare/Medicaid,	, 42 CFR Subpart 483.90(a),					
	Life Safety from Fir	re and the 2012 edition of the					
	National Fire Protec	ction Association (NFPA) 101,					
	Life Safety Code (L	SC), Chapter 19, existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	THE CONTRACTOR	6411 02) H. H. G					
	-	s of (bldg. 03) Health Care					
	-	sprinklered two story					
		(111) construction, (bldg. 02)					
		and (bldg. 04) Smock Memory or both are one story fully					
	sprinklered building	, ,					
		ldg. 06) Therapy Center is a sklered buildings of Type II					
		All buildings are connected by					
		parated by two-hour fire walls.					
	nanways and are sej	paraced by two-noul file walls.					
	Buildings 02 03 04	have a fire alarm system with					
		corridors, areas open to the					
		ired smoke detectors in the					
		facility has a capacity of 192					
		166 at the time of this survey.					
	and had a census of	100 at the time of this survey.					
	Quality Review con	ducted on 06/03/24					
		3 00.00.21					

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Event ID: YRJ521 Facility ID: 000485

If continuation sheet Page 12 of 14

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155655		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  05/23/2024	
	PROVIDER OR SUPPLIER		400 W	ADDRESS, CITY, STATE, ZIP COD SEVENTH ST H MANCHESTER, IN 46962	
(X4) ID PREFIX TAG K 0000	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  FREFIX  GACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE	
Bldg. 06			K 0000	Preparation and/or execution this plan does not constitute admission or agreement by Peabody Retirement Commuthat a deficiency exists. This is also not to be construed as admission of fault by Peabody Retirement Community or its employees who draft this response and plan of correction is submitted as the facility's creallegation of compliance.	nity plan an y on.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YRJ521

Facility ID: 000485

If continuation sheet

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155655	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP COD 400 W SEVENTH ST NORTH MANCHESTER, IN 46962			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YRJ521 Facility ID: 000485 If continuation sheet Page 14 of 14