STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155655	A. BUILDING 00 B. WING	04/18/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00427809, IN00431274, and IN00431817. Complaint IN00427809 - No deficiencies related to the allegations are cited. Complaint IN00431274 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00431817 - Federal/State deficiencies related to the allegations are cited at F744. Survey dates: April 16, 17, and 18, 2024 Facility number: 000485 Provider number: 155655 AIM number: 100291190 Census Bed Type: SNF/NF: 165 Total: 165 Census Payor Type: Medicare: 6 Medicaid: 99 Other: 60 Total: 165 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 26, 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. We respectfully request desk review of this Plan of Correction.	
F 0744 SS=G Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katie Robinson	Administrator	05/03/2024

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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	appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure services for effective supervision were provided to ensure a pencil sharpener was not left unattended and within the reach of a cognitively impaired resident with dementia for 1 of 3 residents reviewed for dementia care. This deficient practice resulted in Resident B ingesting the sharpener blade and required hospitalization for surgical removal. Findings include: On 4/16/24 at 11:10 a.m., Resident B was observed in A wheelchair at a table in the common area, with a staff member sitting next to her. On 4/18/24 at 12:07 p.m., Resident B was observed in a wheelchair with her head down and her eyes closed, in the dining room. A staff member was assisting another resident at the same table. Resident B's clinical record was reviewed on 4/16/24 at 10:47 a.m. Diagnoses included, but were not limited to, Alzheimer's disease with early onset, dementia in other disease classified elsewhere, moderate, with agitation, psychotic disorder with delusions due to known physiological condition, and unspecified mood (affective) disorder. A 3/14/24, significant change Minimum Data Set (MDS) assessment, indicated the resident was rarely/never understood. There were no behaviors exhibited. Extensive assistance of two staff members was required for bed mobility, transfers, and toilet use. Extensive assistance of one staff	F 0744	Peabody Retirement Community has a policy whereby our Residents who are diagnosed with dementia receive the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 1. Affected resident was in common area when noted to be chewing on non-food item. Nurse unable to locate sharpener believed to have been attached to the object resident was chewing on. Nurse and CNA searched resident head-to-toe, as well as wheelchair and area on unit where resident had been seated and were unable to locate object. NP notified and assessed resident, noting no injuries or signs/symptoms of pain, discomfort, or distress. Order received to transfer to Emergency Room for further evaluation and treatment. Resident transported via EMS to Parkview Wabash ER where Xray revealed metal in stomach. The affected resident was then transported to Parkview Regional Medical Center where object was extracted. Resident returned to facility that same day with no new orders. Nurse received report from PRMC nurse and performed assessment of	04/19/2024

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	member was required for eating. The current physician's orders included, but were not limited to, divalproex sodium (mood stabilizer) 250 mg twice daily, citalopram hydrobromide (treat depression) 20 mg daily, and olanzapine (treat mental disorders) 2.5 mg daily. A nurses note, dated 4/3/24 at 10:13 a.m., indicated Resident B was coloring in the common area during activities programming when a CNA noticed the resident was chewing on something. The CNA called for the nurse to assist. The resident had placed a small pencil sharpener in her mouth and was chewing on it. Using the finger sweep method, the nurse was able to effectively remove the majority of the plastic fragments from the resident's mouth, along with a small screw that held the sharpener blade in place. A moist oral swab was used to remove smaller fragments. The resident was not asked to swish and spit due to her baseline chronic confusion. The sharpener blade was unaccounted for after the oral cavity had been cleared of foreign objects. Staff searched the resident's clothing, pockets, wheelchair, and the floor within her vicinity. The blade was not found. The Nurse Practitioner (NP) was called, and new orders were given for a STAT (immediately) chest x-ray and a Kidneys, Ureter and Bladder (KUB) x-ray. The resident drank a cup of apple juice without difficulty and denied pain when swallowing or gastrointestinal upset. She had no signs of bleeding from her mouth. The NP assessed her and advised staff to continue to monitor pending x-rays. Her vital signs were obtained. A call was placed for the estimated time of arrival for the mobile x-ray, and they indicated it would be several hours before they could arrive at the facility. The unit manager and the Administrator decided she should be seen in the		resident. No signs/symptoms of distress, pain, or discomfort noted and resident at baseline. Resident placed on alert charting. IDT to meet and review. 2)A sweep of all other units was performed for any other potentially hazardous objects. All residents on same unit as affected resident received skin checks to ensure no other potentially unknown injuries. Reminders were sent out to resident families regarding safety considerations when bringing items into the facility for their loved ones. 3)All Staff re-educated on Safety considerations regarding potentially hazardous items as well as Abuse/Neglect policy. 4 4) DON, or designee, will review all units for potentially hazardous items weekly for 4 weeks, then monthly for 5 months. The results of these audits will be reported to QAPI. Any negative findings will result in another month of auditing until 100% compliance is achieved. 5	

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	ER to prevent unnecessary complications. Emergency Medical Services were called and she left the facility at 12:15 p.m. A 4/3/24 physician's order indicated may send to the emergency room (ER) for evaluation and treatment for the ingestion of a foreign object. A hospital X-ray report, completed on 4/3/24 at 1:57 p.m., indicated there was an area of metallic density that measured 2.3 centimeters projected into the left upper quadrant of the stomach and a concern for a foreign body was identified. The radiology report for the findings from an upper GI endoscopy (exam completed with a tube with a camera on it, inserted into the mouth and throat, then through the stomach and upper intestine) performed on 4/3/24 at 5:03 p.m., indicated a new diagnosis of esophagitis (irritation of the esophagus) with no bleeding was received. The entire examined stomach and small intestine was normal. Removal of the blade from the pencil sharpener was accomplished with a retrieval net, from the lower portion of stomach. A nurses note, dated 4/3/24 at 11:00 p.m., indicated the resident returned from the hospital. The resident had general anesthesia for the procedure to remove the razor blade from the pencil sharpener. The hospital nurse reported the resident had small cuts in her upper airway and the back of her throat, and her esophagus was okay with no cuts found. She was suctioned with minimum bleeding. The resident could resume her ordered diet as tolerated. No new orders were received. The resident was to be monitored for bleeding. The resident was alert to self, with "word salad" (unorganized speech) when talking. An assessment did not display signs of pain or			

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	discomfort. A plan of care for of unintentional self-injury, related to eating small non-edible objects, with a created date of 4/17/24, indicated the plan was initiated on 4/4/24 with interventions for staff to monitor Resident B while in the area to ensure that small non-edible objects were not placed within her reach, she would be offered items of appropriate size and comparable recreational value, and staff would frequently inspect area where she was and remove any small nonedible objects from her reach. During an interview with the DON, on 4/16/24 at 1:43 p.m., she indicated the facility had on 4/3/24, determined the item in Resident B's mouth looked like a pencil sharpener. The NP was notified, and the facility called for x-ray. The resident was sent out to be evaluated at the ER and providers were able to see a piece of metal. Hospital staff retrieved what appeared to be a blade. When the NP assessed her, there was no injury. The resident returned from the hospital with no new orders and no limitations and did not recall the incident. The facility decided to sweep the area and make the environment as safe as possible. No one at the facility had seen the pencil sharpener prior to the incident, and the facility didn't feel like it was the facility's pencil sharpener. The facility sent out a notice to families on what not to bring in to ensure it didn't happen again. The facility was completing ongoing audits and did a sweep on all the units. There was one other sharpener found on another unit the same day. There was video footage, but the DON did not feel like much could be viewed. During an interview with CNA 8, on 4/16/24 at 1:52 p.m., she indicated Resident B was sitting at a			

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	table in the common area with Agency CNA 11 when CNA 8 had left to take her break. Upon return to the unit, CNA 8 noticed Resident B was "crunching" on a green plastic object in her mouth and went to get the nurse, who was in the nurses station charting on the computer. The nurse put on gloves and got little green pieces of plastic and the screw from the resident's mouth. The CNA realized it was a pencil sharpener, but she and the nurse couldn't locate the blade. They took the resident to her room, took her clothes off, checked the wheelchair, and then sent her to the ER because the only thing missing was the blade. Activities staff normally sat out the box with colored pencils for the resident. The CNA had seen the pencil sharpener before, and it must had been buried in the box with the colored pencils. The resident must have pulled it out and put it in her mouth. The pencil sharpener was not normally in the colored pencil box. Agency CNA 11 was not sitting with the resident when she returned to the unit from break. Resident B was a fall risk and they tried to keep her busy and within sight. During an interview with CNA 4, on 4/17/24 at 9:48 a.m., she indicated she was not working the day Resident B swallowed the pencil sharpener blade, but she had purchased some pencil sharpeners a long time ago and they were stored in a toolbox in the nurse's station. She had not seen any left out. She threw the pencil sharpeners away that were in the nurse's station after Resident B had ingested one. Sometimes they sat with Resident B or watched her from a distance. Usually if she had pencils, the activities aide or someone was with her. The CNA had never seen Resident B put anything in her mouth like that. During an interview with LPN 21, on 4/17/24 at 10:00 a.m., she indicated she was in the nurse's			

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	station charting, when CNA 8 came to her and told her Resident B was chewing on something. The nurse put gloves on and did a finger sweep. CNA 8 recognized what she was chewing on, and it was a hippo-shaped pencil sharpener. There was a similar hippo-shaped pencil sharpener located in the medication cart. The nurse and CNA pulled out a bigger piece of the head of the hippo, some smaller pieces, and the screw, but could not locate blade of the pencil sharpener. The nurse used a mouth swab to clean out the resident's mouth. There was no bleeding. Resident B denied throat pain. The nurse called the NP, who gave the okay to offer drinks, and ordered an x-ray and a KUB. The nurse and CNA had the resident drink apple juice. The NP assessed the resident and she was sent to the hospital. The hospital retrieved the blade and she came back to the facility around 11:00 p.m. that night. Resident B was not known to put things in her mouth. Activities staff had an electric pencil sharpener for the colored pencils. Resident B normally sat and colored with activities, but she was in the common area this day by herself, and the box of colored pencils was next to her. During the interview, LPN 21 retrieved a hippo-shaped pencil sharpener from the top drawer of the medication cart. The body of the pencil sharpener had an open back with a metal blade and a screw holding the blade to the plastic. LPN 21 indicated the pencil sharpener Resident B chewed up was just like this one, except for the color. During the interview, LPN 21 reviewed her handwritten statement completed on 4/3/24. The statement indicated what happened during the incident, and the last line of the statement read "Did not see this item before", written in a different handwriting, and a lighter shade of ink. LPN 21 indicated she did not write that statement.			

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	Observation of video footage, with the DON present on 4/17/24 at 2:04 p.m., indicated CNA 8 propelled Resident B to a table in the common area on 4/3/24 at 8:38 a.m. CNA 8 placed paper and a clear shoe box on the table in front of Resident B and walked away, leaving her alone at the table. At 9:17 a.m., an unidentified staff member approached Resident B, adjusted an unidentified item within the resident's reach on the table, and walked away. At 9:18 a.m., CNA 8 was near the table where Resident B was seated, picking up an unidentified item from the floor. Agency CNA 11 sat down across the table from Resident B, then got up and walked away at 9:20 a.m., leaving Resident B alone at the table. At 9:39 a.m., Resident B used her right hand to pick up an item (not able to fully visualize item due to the quality of the camera footage) off the table and place it in her mouth. At 10:04 a.m., CNA 8 walked by the common area, paused, and walked up to Resident B. She walked away, retrieved gloves, and spoke to the nurse at the nurse's station. CNA 8 looked through the pencil box, then began looking through the resident's clothing and beside her in the wheelchair. The nurse and CNA stood the resident up and checked the wheelchair and sat her back down. The nurse began using a flashlight looking into Resident B's mouth. At 10:11 a.m., the nurse was on the phone and CNA 8 looked through the pencil box again and walked out of sight of the camera. During an interview with Activity Assistant 15, on 4/18/24 at 12:17 p.m., she indicated she didn't put anything in front of Resident B if she couldn't watch her. Years back, the facility may have had manual sharpeners on the unit. The Activity Assistant had been taught not to leave anything sharp out. The facility had an electric sharpener to sharpen colored pencils. The Activity Assistant			

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	had no idea Resident B had put something in her mouth that day. The Activity Assistant was involved in an activity at the fireplace across from the common area where Resident B was sitting at the table. The activity group had anywhere from 12 to 15 residents that day, and the Activity Assistant was totally tuned in to the group. A current facility policy, revised 12/2007, titled "Safety and Supervision of Residents," provided by the Administrator on 4/18/24 at 2:55 p.m., indicated the following: "...Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities...Systems Approach to safety...2. Resident supervision is a core component...The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment...." This citation relates to Complaint IN00431817. 3.1-37(a)			