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	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Retirement Community	400 W Seventh St North Manchester, IN 46962

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 Based on observation, interview, and record review, the facility failed to identify effective, individualized interventions to prevent the elopement of a cognitively impaired resident with known elopement risk from a secured unit's bedroom window for 1 of 3 residents reviewed for elopement risk. (Resident C) The deficient practice was corrected on 3/26/24, prior to the start of the survey, and was therefore past noncompliance. Findings include: On 4/16/24 at 10:43 a.m., Resident C was observed sitting on a facility chair, participating in a group activity near the fireplace on the [NAME] Way Unit. On 4/18/24 at 12:12 p.m., the resident was observed leaving the secured unit with family. Resident C's clinical record was reviewed on 4/16/24 at 12:36 p.m. Diagnoses included, but were not limited to, cerebral infarction, metabolic encephalopathy, weakness, other muscle spasm, depression, memory deficit following unspecified cerebrovascular disease, hemiplegia and hemiparesis following cerebral infarction, affecting right dominant side, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Physician's orders included, but were not limited to, nortriptyline (treat depression) 25 mg daily and ziprasidone (antipsychotic) 20 mg twice daily. A 2/21/24, quarterly, MDS assessment indicated he was moderately cognitively impaired. Limited assistance of one staff member was required for bed mobility and transfers. The resident had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, and cursing at others), one to three days during the assessment period. A quarterly elopement risk assessment, dated 8/10/23, indicated the resident was not at risk for an elopement. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note, dated 8/18/23 at 9:30 p.m., and created on 8/19/23 at 10:28 a.m., indicated nursing staff reported Resident C had been exit-seeking multiple times this day and had gone off the unit and was found down near [NAME] Retirement Community (PRC) exit. The staff was able to turn the resident around and have him head back to his room. The resident got outside again this evening and was found on the PRC sidewalk, near the [NAME] high school. Upon interviewing the resident, he said he was trying to hitch hike home to Fort [NAME]. The resident missed home and wanted to go home. It was explained to the resident the dangers of hitchhiking and he indicated people did it all the time, he had done it before, and he was fine. The DON, the Administrator, and Social Services were notified of the situation. It was decided the resident should be moved to a secured unit immediately for his safety due to exit seeking behavior. Upon returning to the unit, staff reported the resident again attempted to leave and walk off the unit, but staff turned him around back to his room. His family reported an attempt to elope from a previous facility. Resident C wore an ankle monitor and was able to figure out how to remove it so he could leave. The resident had a history of elopement at home and walked outside and attempted to go places by himself. The resident had a history of being impulsive and short-tempered, as well as episodes of confusion where he was unable to remember where he was or his children's names. A provider note, dated 8/21/23 at 7:48 a.m., indicated the resident was being examined after a move to the memory unit and was very forgetful and a poor historian. A nurses note, dated 8/22/23 at 10:37 a.m., indicated the IDT team met to review Resident C's behaviors from 8/15/23 through 8/21/23. The resident had an unauthorized departure from facility, and was relocated to a secure unit for safety. He had poor safety awareness and may appear to have full cognitive ability, despite being moderately cognitively impaired. His care plans were updated. A current care plan problem, dated 8/22/23, indicated elopement risk/wanderer, and the resident may want/look for fresh air (8/22/23). Interventions included distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books (8/22/23), offer resident to go outside for fresh air (8/22/23), and to provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes (8/22/23). A nurses note, dated 2/12/24 at 3:31 p.m., indicated it was discussed with family about the resident's current placement on a secured neighborhood. It was shared while on a recent vacation trip to Florida with Resident C, he had been impulsive and slipped out of the house they were staying at when he was left alone for only a couple of minutes, along with several other incidents happening while on vacation. Family confirmed the need for a secure neighborhood. An elopement risk assessment, dated 2/20/24 at 5:33 a.m., indicated the resident was not at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note, dated 3/25/24 at 2:15 p.m., indicated Resident C had told a CNA he wanted to talk with someone. The CNA told the resident the nurse would come speak with him, but the nurse was with another resident at that time. When the nurse started towards Resident C's room, the resident was observed outside the common area windows, walking without an assistive device on the sidewalk outside of the building. A CNA was alerted and the nurse and CNA both went outside to escort the resident back into the building. Resident C was with another staff member outside the door when the CNA and nurse reached him. The resident said he was going inside the facility to speak with someone at the desk. The resident was assisted towards the unit after his walker was obtained. The nurse manager was notified. Staff observed the resident's window was all the way open with the screen removed, and placed perpendicular in the window to keep it open. No injuries were noted, and his vital signs were within normal limits. A nurses note, dated 3/25/24 at 2:40 p.m. and created on 3/26/24 at 1:23 p.m., indicated Resident C had removed the screen from his window and climbed outside. The resident stated that he was tired of fell ow residents coming into his room and the only way to get something done was to do something radical. The resident verbalized he was not leaving the facility. He wanted to go up to the front office to talk with somebody about the residents coming in his room and he wanted a lock on his door. It was explained to the resident that having locks on resident's room doors was not allowed due to safety concerns. The resident indicated he understood, but thought there had to be a way to do it, to have a lock that a pin could be stuck in the handle to unlock it. He was asked what led up to removing the screen and climbing out the window and the resident indicated he came up with the plan the day before (3/24/24). The resident made sure the drop wasn't far from the window to the ground. He put one foot and leg out and then the other and scooted out on his butt. He did not fall; he stood up and walked. He went straight to door 9 (the main entrance to the skilled nursing side of the facility) but someone saw him and brought him back to the unit. If he wanted to leave, he would have gone left or straight to the road and looked for a phone to call someone or for someone to give him a ride or maybe his wife would had come to pick him up. He emphasized that he wanted to talk to someone in the front office about people (residents) coming in his room and when people come in his room it was always his fault, and he must be a jerk. He was also focused on returning to work as a dent repair specialist for automobiles that had [NAME] damage. He wanted to have tools brought into his room and a vehicle hood to practice on. He indicated they had already told him no because the tools could be used as weapons. He emphasized that if he had a lock on his door, he could have his tools and equipment at [NAME] with him. He recalled the event details with ease and did not have to stop the conversation to think of details. An elopement risk assessment, dated 3/25/24, indicated the resident was at a risk for elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry nurses note, dated 3/27/24 at 1:25 p.m. and created on 4/3/24 at 1:26 p.m., indicated the IDT team met to review his behaviors from 3/21/24 through 3/27/24. The resident had fixed delusions of being held against his will for no reason. Family and staff attempted to explain in clear basic terms why he required a secure neighborhood. The resident's behavior escalated to removing a window screen and lifting the window in his room. He remained angry and determined to leave the neighborhood, and was argumentative and manipulative. Abusive language was used toward staff, family, and fell ow residents. The resident was physically aggressive towards fell ow residents and staff. A decision was made by the IDT team on 3/26/24 to send him to the ER for a clinical evaluation due to the refusal of medications and the refusal to eat and a statement he made of until something big happens and I get out of here. He was evaluated at the ER and cleared medically/clinically. The ER physician wrote an order for him to be evaluated by psychiatry and it was determined he needed a further mental health evaluation and stabilization. He was transported to a local behavioral hospital. His care plans were updated and current. A 3/26/24 physician's order indicated to send the resident to the ER for evaluation and treatment of clinical and mental health. He had a current care plan problem, dated 3/26/24, of being at risk for elopement related to impaired cognition/safety awareness. His interventions included distract him from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, etc. (3/26/24), redirect him to areas appropriate for him (3/26/24), and he was to reside in secure unit (3/26/24). During an interview with the DON, on 4/16/24 at 2:06 p.m., she indicated Resident C started out saying someone stole his phone, and as he didn't have one, and the facility called the family to make sure. The resident wanted to talk to someone, and the CNA told the nurse. The CNA went back to the door to the resident's room to see if the nurse was in talking with him. As the nurse was going to the resident's room to talk to him, she saw him out the window walking with staff. The resident had jimmied his window and propped the screen in the window. The resident indicated he was trying to find someone to put a lock on his door and he had been planning the elopement for a while. His lactic acid could had been off to cause the confusion, but he refused to have labs drawn. The resident was progressively getting more agitated, and was transported to a local psychiatric hospital. Resident C was severely cognitively impaired at that time. There was five-minute lapse from the last time the CNA saw him in his room to the time he was seen outside. It was 67 degrees cloudy and breezy, the resident wore tennis shoes, long sleeve shirt, and long pants. The window was repaired. During an interview with CNA 4, on 4/17/24 at 9:48 a.m., she indicated on the day Resident C eloped, the resident very much wanted out and wanted to leave. He was kind of defiant and expressed he wanted to leave and didn't want to be at the facility. That was the resident's typical behavior, but it was more pronounced that day. The CNA felt, to a degree, the resident knew what he was doing. The resident was in his room and she had checked on him. The resident wanted to talk to someone and use the phone. The CNA told the resident the nurse would talk with him. The nurse got called to go do something else. As the nurse was walking towards the resident's room, she saw him outside through the common area windows. The nurse went to see if the resident was in his room. The CNA and the nurse went out the utility room door at the front of the building near the sidewalk where the resident was walking. By the time they got outside, the Housekeeping Supervisor was with him. Staff asked him what he was doing, and he indicated he wanted to talk to someone higher up about leaving. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN 21, on 4/17/24 at 10:00 a.m., she indicated she didn't remember the resident exit-seeking the day he eloped, but he was agitated, and said he was missing a phone, but he didn't have one. The LPN was on her way to talk to the resident when she saw him outside the common area window, walking alone. The resident had on a jacket, a shirt, and shoes that were not tied. The resident didn't have his walker. The nurse was in disbelief that the resident was outside. The nurse went to the resident's room and saw he wasn't in there. The nurse went to another resident's room window to see if she could see Resident C outside. The resident was walking off the sidewalk onto the asphalt and someone was tying his shoes. The resident was talking with the Housekeeping Supervisor when LPN 21 reached them. The resident had eloped from the facility before and that was when he was moved to the secured unit. He did not aimlessly wander and was higher functioning. The resident knew what he was doing, but had no impulse control or safety awareness, and had short-term memory loss. During an interview with Resident C, on 4/17/24 at 10:21 a.m., he indicated he wondered how to get out of the facility. The resident wanted to go home,as this was his work season. The resident knew he was not normal, as he indicated his speech and his right arm had been affected. He walked around to the front of the facility, and they caught him at the front door. He wasn't running away, he just wanted to talk to someone about leaving and going back to work. During the interview, he pointed to the window in his room, and indicated he just lifted the window up like you would a window at home, climbed out of it, and walked around the facility to the front of the building. During an interview with the Housekeeping Supervisor, on 4/17/24 at 10:50 a.m., she indicated while walking down the hall near Resident C's secured unit, Resident C was observed by himself, without his walker, on the asphalt parking lot. When the Housekeeping Supervisor went out to Resident C, the resident indicated he needed to make a phone call to reach out to someone. The Housekeeping Supervisor had not witnessed the resident exit seeking or wanting to leave before. While assisting the resident back into the building, the aide and the nurse came out the soiled utility room exit door and walked with them. During an observation of video footage with the DON present, on 4/17/24 at 1:50 p.m., CNA 4 was observed walking towards Resident C's room on 3/25/24 at 2:18 p.m. She walked past the nurse's station, towards the common area. At 2:24 p.m., CNA 4 looked out the windows at the common area facing the front parking lot of the facility at door 9. At 2:25 p.m., LPN 21 and CNA 4 were observed walking towards the hallway to exit through the utility room door. (The camera footage did not show outside the windows in the parking lot, just inside the [NAME] Way Unit.) The rotunda camera footage showed, at 2:25 p.m., the Housekeeping Supervisor looking out the windows towards the parking lot down the hallway of the DON's office. At 2:26 p.m., the Housekeeping Supervisor exited through the front door and re-entered the building with Resident C, CNA 4, and LPN 21. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of the outside of Resident C's bedroom window (on the 9th Street side of the building) to the front of the building, accompanied by the DON, on 4/18/24 at 11:45 a.m., The DON measured the distance with a digital measuring wheel. The distance from the resident's bedroom window through the river rock stone at the foot of his window, through the grass and to the sidewalk, measured approximately 12 feet. The total distance from the resident's bedroom window, around the outside perimeter of the [NAME] Way unit, to the front of the building via the sidewalk, where the nurse and the CNA noticed him through the common area windows, measured 260 feet. An additional 90 feet was measured to the asphalt parking lot where the Housekeeping Supervisor observed him. It was an additional 103 feet from the asphalt parking lot where the Housekeeping Supervisor observed him to the front door of the facility. It was a total of 453 feet from his bedroom window around the outside perimeter of the [NAME] Way Unit to the front door (door 9) of the facility. An undated current facility policy, titled Nursing/Social Services policies and procedures. Subject: Elopement risk assessment, provided by the DON on 4/17/24 at 4:25 p.m. indicated the following: .Policy: It is the policy of [NAME] Retirement Community to have a system in place to ensure that a resident at risk for elopement is provided with a safe environment .If a resident is determined to be an elopement risk, the Interdisciplinary Team will review and make final determination of elopement risk and review safest and least-restrictive setting. The Interdisciplinary Team will also review and document appropriate findings and interventions in the resident care plan The deficient practice was corrected by 3/26/24 after the facility implemented a systemic plan that included the following actions: assessment of all residents for elopement risks, audited and updated elopement assessments as indicated, developed a stand-alone elopement assessment for residents with incidents, in-servicing education to all staff related to the staff response after a missing resident was identified, and ongoing monitoring by the Quality Assurance and Performance Improvement (QAPI). This citation relates to Complaint IN00431274. 3.1-45(a)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 40241 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 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. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	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 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. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview with LPN 21, on 4/17/24 at 10:00 a.m., she indicated she was in the nurse's 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. 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 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. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Retirement Community	400 W Seventh St North Manchester, IN 46962

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Actual harm Residents Affected - Few	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)