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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure hospital discharge orders were accurately transcribed to ensure continuation of treatment for 2 of 3 residents reviewed for new admissions. (Resident B and Resident D)Findings include:1.Resident B's clinical record was reviewed on 6/29/26 at 9:29 a.m. Diagnoses included essential (primary) hypertension, anxiety disorder, depression, and bipolar II disorder.A behavioral health care office note, dated 2/4/26, indicated Resident B's medications included bupropion (antidepressant) 200 milligram (mg) every morning and at noon, and divalproex (anticonvulsant/mood stabilizer) 500 mg in the morning and 1000 mg at bedtime. He was discharged from the hospital to the facility on 3/11/26. Discharge orders included bupropion 450 mg daily, divalproex sodium 500 mg daily, divalproex sodium 250 mg twice daily, and divalproex sodium 1000 mg at bedtime. The March 2026 Medication Administration Record (MAR) indicated divalproex sodium 500 mg at bedtime and divalproex sodium 250 mg twice daily.The clinical record lacked an order for bupropion 450 mg daily, divalproex sodium 500 mg daily, and divalproex sodium 1000 mg at bedtime.A nurse practitioner note, dated 3/12/26 at 12:14 p.m., indicated that he was seen as a new admission and his medications were reviewed.A nurses note, dated 4/17/26 at 5:48 p.m., indicated the resident expressed concerns about a higher dose of divalproex while at another facility and asked if the nurse practitioner needed to change his order. The psychiatric nurse practitioner and the facility nurse practitioner were notified regarding the situation. Multiple times throughout the day, he inquired about a dosage change. Before supper, he became angry that the nurse practitioner had not replied.A nurses note, dated 4/17/26 at 7:05 p.m. indicated a new order was received for divalproex sodium 750 mg twice daily and to monitor for targeted behaviors related to psychotropic medication therapy including quick-to-anger or agitation, mood swings, and verbal aggression.A nurses note, dated 4/18/26 at 10:54 a.m., indicated a new order was verified by the psychiatric nurse practitioner for divalproex sodium 500 mg daily and 1000 mg at bedtime.A nurses note, dated 4/22/26 at 6:00 p.m., indicated he was observed coming out of the dining room and indicated that his meal order was wrong again and he was upset. He became increasingly agitated due to receiving insulin and needing to eat. An aide stepped toward him indicating that he would get the correct meal and bring it to his room. Resident B raised his cane into the air but did not swing or strike with it demonstrating restraint. He indicated that the aide stepped too close to him and thought that it might be aggressive. The aide stepped back and indicated that he was trying to help and went to get the resident's tray. Later, Resident B apologized to staff members for his behavior.A nurses note, dated 4/24/26 at 12:50 a.m., indicated he was very adamant that he would continue to be on his best behavior as he wanted to be able to move to assisted living.A nurses note, dated 4/28/26 at 12:25 a.m., indicated he was very adamant that he would continue to be on his best behavior as he wanted to be able to move to assisted living.A nurse practitioner note, dated 5/6/26 at 9:48 a.m., indicated he was seen for increased behaviors. He reported significant frustration and agitation related to disruptions in his daily routine. He described being upset about food service issues in the dining room, stating he was told he was to be served within 15 minutes per his meal ticket but this has not been occurring. He mentioned that he had received psychiatric care through a local behavioral care office for many years. He (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	described feeling burnt out and physically fed up. He presented with increased behavioral issues and reported significant frustration with facility routines, dietary services, and interactions with staff. A urine dipstick would be obtained to rule out urinary tract infection as a cause of increased behaviors and obtain a follow up with the local behavioral health care office.A behavior note, dated 5/6/26 at 1:45 p.m., indicated he became upset at breakfast when he requested a food item. Staff went to retrieve the item, and he began yelling at staff. A CNA intervened trying to de-escalate the situation. He became more angry and balled up his fist and made threats at the CNA. He left dining room demanding his food be brought to him in his room and for the food to be warm. He was provided a room tray with new food and drinks. He continued to raise his voice and be demanding.A nurses note, dated 5/6/26 at 6:27 p.m., indicated at 8:00 a.m. he was asked if his blood sugar could be obtained. He indicated that his blood sugar needed to be taken first then his food needed to be ready. It was indicated that the nurse would get his blood sugar and would give the insulin before breakfast. He asked if the kitchen was ready and the nurse indicated the they were not sure. He yelled that the nurse was supposed to take care of him and do their d--n job. The nurse educated him to speak respectfully to people and to stop yelling.A nurses note, dated 5/6/26 at 6:38 p.m., indicated at 12:00 p.m., he was yelling in dining room, and observed balling up his fist and threatening to hit a caregiver who was standing in front of a peer resident. He walked out of dining room, to his room and slammed the door. When he was asked what had happened he held his hand up and indicated that he was not talking to anyone until he called his POA.A social service note, dated 5/7/26 at 10:57 a.m., indicated the local behavioral health care office was contacted. An appointment was scheduled for the next day.A local behavioral health care office visit note, dated 5/8/26, indicated order was placed for divalproex blood level to assess current therapeutic range, given recent medication administration inconsistencies. Once laboratory results were available, the resident's medication regimen would be reviewed and adjusted as necessary to ensure therapeutic divalproex levels were achieved and maintained. His bupropion dosage was adjusted to 150 mg twice daily, rather than resuming previous 200 mg twice daily, to safely titrate dose after a period of discontinuation. He was to maintain the divalproex at 500 mg in the morning and 1000 mg at bedtime. An explicit instruction was placed that no changes to his prescribed medications were to be made without prior consultation with the psychiatrist. A current printed list of medications and orders were provided for the facility staff to ensure accurate administration and prevent unauthorized changes. The resident was stable until medications were changed, medications to be restarted at appropriate doses. No changes of any medications were to be made without discussing with the nurse practitioner first.A nurses note, dated 5/27/26 at 5:40 p.m., indicated he was observed yelling and leaving the dining room, indicated that he didn't was his f-king food and a stupid b-ch told him that he had to wait his turn. He angrily walked to his room. A room tray was provided he was slightly calmer but still very upset, he indicated that he went back to his room so he didn't do anything stupid.A behavior note, dated 5/29/26 at 4:54 a.m., indicated he was heard yelling from his room at approximately 11:00 p.m. Upon entering his room, he was in his bathroom with no clothes on yelling and wanting to know where his shower chair was as he preferred a taller shower chair. It was explained that the shower chairs were limited and one at the appropriate height would be found for him. He slammed bathroom door closed and indicated that it was f--king [NAME]-t and why the other person didn't get their own f-king chair. A shower chair was located, he showered, and apologized to staff for yelling.A behavior note, dated 5/30/26 at 3:15 a.m., indicated he was heard screaming I want to talk to the f-king nurse right now! He entered the nurses station and indicated that it was f-king [NAME]-t that they had lost three pairs of his shorts, he wanted them back and described what they looked like. It was explained to him that the staff could not attempt to locate the shorts due to the hour of the night. He left the nurses' station and within a few minutes, he returned with a pair of shorts indicating that was what the missing shorts looked like. He was asked to leave the nurses station, and he drew back both fists and thrusted his body towards the staff member and yelled Come on! He was asked again to leave the nurse's station and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he indicated that he was calling his POA. He was reminded the time of night, and he yelled I don't give a f-k! and went to his room and slammed his door shut, opened the door and slammed the door again.A nurses note, dated 6/8/26 at 4:01 a.m., indicated no behaviors were noted or reported, although, during a conversation with medication administration, he indicated that he had been good the last few days but could put his fist through a glass and not think anything of it. The conversation subject was changed and retired to his room. A social service note, dated 6/19/26 at 3:23 p.m., indicated he spoke about touring another facility, and that no one had given him a clear answer if he was accepted for the facility's assisted living. He was told that he was not accepted and his POA was aware and that was the reason he toured the other facility. The resident expressed frustration and confusion due to the fact that other residents had behaviors and yelled out, and he wanted to know what the difference was. He was told that due to his younger age, physical attributes, his verbal and physical threats were not comparable to the elder community at the facility. He verbalized understanding and thanked writer for explaining it to him in such a way he was able to understand.During an interview, on 6/29/26 at 11:56 a.m., Resident B indicated he had not been given his divalproex correctly nor received his bupropion, causing him to have withdrawal symptoms, which created issues. He was denied the opportunity to move to the facility's assisted living and started looking elsewhere for a place to live. He felt that he was being punished for the facility's mistake with his medication. The facility told his POA that there was a typo and that they could not get ahold of the behavioral office about his medications. This mistake made him feel mad, he was upset, made him use F word, which was not normal for him. He recently had an issue with a nurse and he blew up at the nurse. He got upset like normal people but did not have outbursts like he had been due to not receiving his medication correctly.During an interview, on 6/30/26 at 9:33 a.m. RN 24 indicated that she had completed Resident B's admission to the facility. She normally entered the orders from the hospital into the electronic health record and anything that didn't make sense, she clarified with the nurse practitioner, and a second nurse verified the orders. The nurse manager used to verify the new admission orders, but now the nurse on the next shift verified the orders. The divalproex, bupropion, and the insulin orders were higher dosages and she spoke to the nurse practitioner about the insulin orders but did not document the conversation in the clinical record. She could not recall the nurse practitioners' name nor the nurse who completed the verification on Resident B's medication orders.2. Resident D's clinical record was reviewed on 6/29/26 at 2:51 p.m. Diagnoses included essential (primary) hypertension, chronic kidney disease, Alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, and presence of cardiac pacemaker.Behavioral hospital discharge orders dated 4/22/26 included amlodipine besylate (treat blood pressure) 5 mg daily hold for systolic blood pressure below 100 and heart rate below 60, carvedilol (treat blood pressure) 12.5 mg twice daily and Vitamin D (supplement) 1000 units/25 mcg (micrograms) two tablets daily.The April 2026 MAR indicated amlodipine besylate 5 mg daily, Vitamin D 1000 unit daily, and carvedilol 12.5 mg twice daily, give with food and hold for systolic blood pressure below 100 and pulse below 60.The MAR lacked blood pressure and heart rate perimeters for amlodipine besylate and Vitamin D 1000 units/25 mcg two tablets daily order.The resident's clinical record lacked daily or twice daily blood pressure and heart rate monitoring documentation.During an interview, on 6/30/26 at 10:13 a.m., Nurse Practitioner 7 indicated that she did not complete Resident B or Resident D's admission. She would normally compare the resident's discharge orders from the hospital to what the nurse entered into the computer. She was not a psychiatric nurse practitioner and did not change psychiatric medications, she left that up to the local behavioral health care office. Resident B was very agitated and had explosive behaviors.During an interview, on 6/30/26 at 10:56 a.m., the DON indicated the nurses would use the hospital discharge paperwork and transcribe the medications and new orders. If there were questions, the nurse should reach out to the provider and the second nurse reviews the discharge orders and the medications. The Administrator indicated that the divalproex orders were on multiple lines on the discharge orders, which caused confusion. The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bupropion was on a single line but was not entered. The medication was a very high dose, and later clarification was received from the local behavioral health care office. A notice was entered into the nurse practitioner book for them to review the orders and it got missed. Resident B was denied admission to the facility's assisted living due to behaviors. The incorrect doses of medication could have initially caused Resident B's behaviors, but the medications had now had time to reach the therapeutic levels and he continued to have behaviors.During an interview, on 6/30/26 at 12:16 p.m., the DON indicated the nurses should have converted the units by dividing the units by 40 to get micrograms for the resident's Vitamin D. A Vitamin D level had been drawn shortly after admission and would be redrawn on 7/1/26.During an interview, on 6/30/26 at 1:16 p.m. the DON indicated that Resident D's blood pressure or heart rate was not documented.During an interview, on 6/30/26 2:30 p.m., Unit Manager 33 indicated she assisted with Resident D's admission and entered some of his orders into the electronic health records. She was unable to recall who the admitting nurse was, but during the admission process, if the resident was admitted during day shift, the next shift would either finish the admission process or verify the orders.A current facility policy, revised 10/2010, titled Reconciliation of Medications on Admission, provided by the DON, on 6/30/26 at 12:46 p.m., indicated the following: .Preparation 1. Gather the information needed to reconcile the medication list: Discharge summary from referring facility.General Guidelines.2. Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process.This citation relates to Intake 3041952.