PRINTED: 06/07/2023 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				ON	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED	
		155005	B. W	ING		05/09	/2023
NAME OF I	PROVIDER OR SUPPLIE	D	•	STREET	ADDRESS, CITY, STATE, ZIP COD		
					I MADISON AVE		
BEAUMONT REHABILITATION AND HEALTHCARE CENT			.R 	ANDE	RSON, IN 46011		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
□ 0000							
Bldg							
Diag.	An Emergency Pre	paredness Survey was	E 0	200			
		ndiana Department of Health in	LU	300			
	accordance with 42	-					
	Survey Date: 05/09	9/23					
	Facility Number: 0	00005					
	Provider Number:						
	AIM Number: 100						
		Preparedness survey,					
		itation and Healthcare Center					
		ompliance with Emergency					
		irements for Medicare and					
	_	ting Providers and Suppliers, 42 acility has a capacity of 200 and					
		active time of this survey.					
	nad a census of fre	out the time of this survey.					
	Quality Review con	mpleted on 05/15/23					
E 0037	403.748(d)(1), 41	6.54(d)(1), 418.113(d)(1),					
SS=F		2.15(d)(1), 483.475(d)(1),					
Bldg	483.73(d)(1), 484	.102(d)(1), 485.625(d)(1),					
		.727(d)(1), 485.920(d)(1),					
	486.360(d)(1), 49						
	EP Training Prog						
	- , , , , -	416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1),					
	- , , , , -	83.475(d)(1), §484.102(d)(1),					
	. , , , .	485.625(d)(1), §485.727(d)					
	. , , , ,	1), §486.360(d)(1),					
	§491.12(d)(1).						
	+re - DN 0	2400 740 400 + 2442 54					
	_ ·	§403.748, ASCs at §416.54, .15, ICF/IIDs at §483.475,					
		2, "Organizations" under					

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

§485.727, OPOs at §486.360, RHC/FQHCs

TITLE (X6) DATE

Brian McKamie **HFA** 05/25/2023

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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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPL	
		155005	B. W	ING		05/09/	2023
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
			,		MADISON AVE		
	JNI KEHABILITAT	ION AND HEALTHCARE CENTER	`	ANDER	SON, IN 46011		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG		R LSC IDENTIFYING INFORMATION	+	TAG	Barolatery		DATE
	at §491.12:]	rom. The Ifacility's must de					
	all of the following	ram. The [facility] must do					
	(i) Initial training in emergency preparedness						
	(i) initial training in emergency preparedness policies and procedures to all new and						
		viduals providing services					
	_	nt, and volunteers,					
	_	eir expected roles.					
		ency preparedness training					
	at least every 2 ye						
	(iii) Maintain documentation of all emergency						
	preparedness training.						
	(iv) Demonstrate staff knowledge of						
	emergency procedures.						
	(v) If the emergency preparedness policies						
		re significantly updated, the					
		duct training on the					
	updated policies a	-					
		0440 440(1) 1 (4) T ::					
	-	§418.113(d):] (1) Training.					
	-	t do all of the following:					
		n emergency preparedness					
		edures to all new and					
		employees, and individuals					
		s under arrangement,					
		eir expected roles.					
	(ii) Demonstrate s	_					
	emergency proce	gency preparedness training					
	at least every 2 ye						
	1	ears. eview and rehearse its					
	1 ` '	redness plan with hospice					
		ding nonemployee staff),					
		nasis placed on carrying out					
		ecessary to protect patients					
	and others.	because to protoot patients					
		mentation of all emergency					
	(v) Maintain documentation of all emergency preparedness training.						
	(vi) If the emergency preparedness policies						
	, ,	re significantly updated, the					

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Event ID:

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Facility ID: 000005

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PRINTED: 06/07/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155005	B. W	ING		05/09/	/2023
NAME OF I	PROVIDER OR SUPPLIER	}		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					MADISON AVE		
BEAUMO	BEAUMONT REHABILITATION AND HEALTHCARE CENTER			ANDER	SON, IN 46011		
(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
		duct training on the					
	updated policies and						
	procedures.						
	*[For PRTFs at §441.184(d):] (1) Training						
	-	TF must do all of the					
	following:						
	•	n emergency preparedness					
	policies and proce	edures to all new and					
	existing staff, indiv	viduals providing services					
	under arrangemer						
	consistent with the						
		ning, provide emergency					
		ning every 2 years.					
	, ,	staff knowledge of					
	emergency proced						
	' '	mentation of all emergency					
	preparedness trail	· ·					
		cy preparedness policies re significantly updated, the					
	· ·	ict training on the updated					
	policies and proce						
	policies and proce	duics.					
	-	60.84(d):] (1) The PACE					
	organization must	do all of the following:					
		n emergency preparedness					
	1 '	edures to all new and					
	_	viduals providing on-site					
		rangement, contractors,					
	1 '	olunteers, consistent with					
	their expected role						
		ency preparedness training					
	at least every 2 ye						
	, ,	staff knowledge of					
	emergency procedures, including informing						
	participants of what to do, where to go, and						
	whom to contact in case of an emergency. (iv) Maintain documentation of all training.						
	' '	ncy preparedness policies					
		re significantly updated, the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005			UILDING	NSTRUCTION	COMPL 05/09/	ETED	
	ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	₹	1345 N	DDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011		
(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)	TE	(X5) COMPLETION DATE
	PACE must condupolicies and proce	ict training on the updated dures.					
	Training Program. of the following: (i) Initial training in policies and proce existing staff, indivunder arrangemer consistent with the (ii) Provide emergat least annually. (iii) Maintain documpreparedness train (iv) Demonstrate semergency proced* [For CORFs at §4 CORF must do all (i) Provide initial trapparedness polinew and existing services under arraconsistent with the (ii) Provide emergat least every 2 yes (iii) Maintain docum (iv) Demonstrate semergency proced must be oriented a responsibilities regemergency plan wworkday. The train instruction in the losystems and signal equipment.	eir expected role. ency preparedness training mentation of all emergency ning. staff knowledge of dures. 485.68(d):](1) Training. The of the following: aining in emergency cies and procedures to all staff, individuals providing angement, and volunteers, eir expected roles. ency preparedness training ears. mentation of the training. staff knowledge of dures. All new personnel and assigned specific garding the CORF's within 2 weeks of their first ning program must include ocation and use of alarm					
	and procedures ar	re significantly updated, the uct training on the updated					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPL	
		155005	B. WI	NG		05/09/	/2023
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	-	
		ON AND HEALTHCARE CENTER			MADISON AVE SON, IN 46011		
(X4) ID		STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATÉ	DATE
	policies and proce						
	*[For CAHs at §48	85.625(d):] (1) Training					
	-	H must do all of the					
	following:						
	(i) Initial training in	n emergency preparedness					
	policies and proce	edures, including prompt					
	reporting and exti						
		here necessary, evacuation					
	of patients, personnel, and guests, fire prevention, and cooperation with firefighting						
		orities, to all new and					
	-	viduals providing services					
	_	nt, and volunteers,					
		eir expected roles.					
		ency preparedness training					
	at least every 2 ye						
	, ,	mentation of the training.					
		staff knowledge of					
	emergency proce						
		ency preparedness policies re significantly updated, the					
	-	re significantly updated, the ct training on the updated					
	policies and proce						
	policies and proce	Juli 03.					
	*[For CMHCs at 8	485.920(d):] (1) Training.					
		provide initial training in					
		redness policies and					
		new and existing staff,					
		ing services under					
	arrangement, and	l volunteers, consistent with					
	their expected rol	es, and maintain					
	documentation of	the training. The CMHC					
		e staff knowledge of					
		dures. Thereafter, the					
	CMHC must provide emergency						
	preparedness training at least every 2 years.						
		view and interview, the facility	E 00	37	E0037F EP Training Program		05/25/2023
		nnual training for the			The facility requests paper		
	Emergency Prepare	edness Program (EPP). The LTC			compliance for this citation.		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005			(X2) MULTIPI A. BUILDIN B. WING	(X3) DATE SURVEY COMPLETED 05/09/2023		
	PROVIDER OR SUPPLIER		134	EET ADDRESS, CITY, STATE, ZIP COD	•	
DEAUIVIC	INT REHABILITATI	ON AND HEALTHCARE CENTER	AINI	DERSON, IN 46011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPR	LD BE COMPLETION ROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE	
	1	of the following: (i) Initial		This Plan of Correction is		
		cy preparedness policies and		center's credible allegatio	n of	
	_	w and existing staff,		compliance.		
		ng services under arrangement,		Preparation and/or execu		
		sistent with their expected		this plan of correction doe		
		mergency preparedness ually; (iii) Maintain		constitute admission or ac	-	
	_	ll emergency preparedness		by the provider of the truth facts alleged or conclusion		
		nstrate staff knowledge of		forth in the statement of	112 261	
		res in accordance with 42 CFR		deficiencies. The plan of		
		deficient practice could affect		correction is prepared and		
	all residents in the f			executed solely because		
	an residents in the latinty.			required by the provisions		
	Findings include:			federal and state law.		
				1)Immediate actions take	n for	
	Based on records re	eview with the Administrator		those residents identified		
	and Maintenance St	upervisor on 05/09/23 at 11:15		No resident was found to	o be	
	a.m., no documenta	tion of annual EPP within the		affected by the finding.		
	last year and no doo	cumentation to show staff		2)How the facility identifie	ed other	
	could demonstrate l	knowledge of the EPP was		residents:		
	available for review	. Based on an interview at the		Visitors, staff, and resident	ents that	
		ew, the Maintenance Director		reside at the community h	nave the	
		documentation of staff		potential to be affected by	/ the	
	_	ergency Preparedness Plan		alleged practice.		
	within the last year.			3) Measures put into plac	e/	
				System changes:		
		viewed with the Administrator		 Facility has reviewed an 	ıd	
		upervisor during the exit		updated its Emergency		
	conference.			Preparedness Plan.		
	2.1.10(1)			Communication of upda		
	3.1-19(b)			been completed with staff	i and	
				residents as necessary.		
				A Facility Emergency Preparedness Plan		
				Communication binder wi	ll he	
				accessible in the front lob		
				staff, residents, and visito	•	
				reference for updates.	13 G3 G	
				Training on new and exi	isting	
				staff occurs initially within	-	

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	LAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BUILDING B. WING	JNSTRUCTION	COMPL 05/09/	ETED
	ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE RSON, IN 46011		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
E 0039	403.748(d)(2), 416	5.54(d)(2), 418.113(d)(2),		orientation and thereafter as necessary but at a minimum annually. 4)How the corrective action be monitored: • The Maintenance Director/designee will prese Emergency Preparedness completed with new oriente current staff monthly to the Committee during QAPI Me to ensure completion and compliance. • The report will be reviewed Quality Assurance Meeting monthly for 6 months or unt 100% compliance is achieved. • The QA Committee will idea ny trends or patterns and in recommendations to revise plan of correction as indicated. 5) Date of compliance: • 5-30-2023	on the Training es and QAPI etings d in il ed. entify make the	
SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §41 §460.84(d)(2), §48 §483.475(d)(2), §4 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization	2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) ements 8.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d)				

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Event ID:

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Facility ID: 000005

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		l í	UILDING	NSTRUCTION	COMPL 05/09/	ETED	
	F PROVIDER OR SUPPLIEF	ON AND HEALTHCARE CENTER	₹	1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
	(2) Testing. The [f exercises to test t annually. The [fact following: (i) Participate in a community-based (A) When a commont accessible, confunctional exercise (B) If the [fact natural or man-man activation of the exercise is exempt from enderto community-based functional exercise actual event. (ii) Conduct an additional exercise (iii) of this section is include, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise (B) A mock disa	nunity-based exercise is induct a facility-based e every 2 years; or lity] experiences an actual ade emergency that requires mergency plan, the [facility] gaging in its next required or individual, facility-based e following the onset of the ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based e; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. B	IULTIPLE CO UILDING 'ING	NSTRUCTION		LETED 0/2023		
	PROVIDER OR SUPPLIER	RION AND HEALTHCARE CENTE	STREET ADDRESS, CITY, STATE, ZIP COD 1345 N MADISON AVE ANDERSON, IN 46011					
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE	
	the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a commaccessible, condubased functional (B) If the hospice man-made emergof the emergency exempt from engascale community-facility-based functional exercise of the emer (ii) Conduct an advears, opposite the functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an energy of the care directly. The exercises to test to per year. The hospital plants and the conduction of the care directly. The exercises to test to per year. The hospital plants and the conduction of the care directly. The exercises to test to per year. The hospital plants are conducted in the conduction of the care directly. The exercises to test to per year. The hospital plants are conducted in the conducted in t	aspices that provide care in the care that provide care in the care the hospice must as to test the emergency shally. The hospice must do a full-scale exercise that is a every 2 years; or annity based exercise is not not an individual facility exercise every 2 years; or experiences a natural or plan, the hospital is aging in its next required full based exercise or individual extional exercise following the gency event. Inditional exercise every 2 per year the full-scale or the under paragraph (d)(2)(i) conducted, that may be called the following: I as a facility based to a faci						
	(i) Participate in a	an annual full-scale exercise						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	î î			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155005	B. W	NG		05/09	/2023
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					MADISON AVE		
BEAUMO	ONT REHABILITATI	ON AND HEALTHCARE CENTER	<u> </u>	ANDER	SON, IN 46011		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	that is community						
		nunity-based exercise is not					
		ct an annual individual					
		ctional exercise; or					
	, ,	experiences a natural or					
	_	ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
	functional exercise following the onset of the						
	emergency event.						
	' '	dditional annual exercise					
		but is not limited to the					
	following:						
		scale exercise that is					
	-	or a facility based					
	functional exercise						
	(B) A mock disast						
	. ,	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,						
		rio, and a set of problem					
		ed messages, or prepared					
	questions designe	eu to challenge an					
	emergency plan.	ospice's response to and					
	. ,	ntation of all drills, tabletop					
		nergency events and revise					
		•					
	ure nospice's eme	ergency plan, as needed.					
	*[For PRFTs at §4	l41.184(d), Hospitals at					
	§482.15(d), CAHs	•					
	- ' '	PRTF, Hospital, CAH] must					
	. ,	to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the						
	_	an annual full-scale exercise					
	that is community.						

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Event ID:

(A) When a community-based exercise is not

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BUILDING B. WING			COMPLETED 05/09/2023		
	F PROVIDER OR SUPPLIEF	ON AND HEALTHCARE CENTER	₹	1345 N	DDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011		
(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
	facility-based fund (B) If the [PRTF, I an actual natural of that requires active plan, the [facility] its next required for individual, facility following the onse (ii) Conduct a exercise or and the limited to the following the onse facility-based facility-based facility-based facility-based facility-based facility-based facility-based facility-based facility-relevant set of problem state messages, or prepare to challenge an ereceive (iii) Analyze the and maintain docutabletop exercises and revise the [facineeded. *[For PACE at §46 (2) Testing. The Final conduct exercises plan at least annuorganization must (i) Participate in a that is community (A) When a communicacessible, conducted facility-based fundaments.	escale exercise that is or individual, a stional exercise; or ock disaster drill; or ocexercise or workshop that or and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. The [facility's] response to sumentation of all drills, and emergency events cility's] emergency plan, as as as a stement of the emergency plan, as a stement of the emergency events cility's] emergency plan, as a stement of the emergency plan, as a stement of the emergency events of the emergency ev					

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Event ID:

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Facility ID: 000005

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BUILDING B. WING			COMPLETED 05/09/2023			
		ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	₹	1345 N	DDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011		
	(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)	TE	(X5) COMPLETION DATE
		activation of the endis exempt from endis exempt from endis exempt from endis exempt from endisciplination on the emergency of the emergency of the emergency of this section is considered by a facilitation of the endiscommunity of the exempt of the endiscommunity of the emergency produced by a facilitation of the emergency produced by the emergency produ	n additional exercise every he year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: scale exercise that is or individual, a facility exercise; or eer drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed coared questions designed energency plan. ACE's response to and station of all drills, tabletop ergency events and revise gency plan, as needed. s at §483.73(d):] ty] must conduct exercises ency plan at least twice per announced staff drills using coedures. The [LTC facility, ene following: en annual full-scale exercise ebased; or unity-based exercise is not ct an annual individual,					

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Event ID:

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Facility ID: 000005

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BU	A. BUILDING B. WING			COMPLETED 05/09/2023		
		ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTE	R	1345 N	DDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011		
PR	l) ID EFIX 'AG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
		LTC facility is exercived a full-scalindividual, facility-lollowing the onse (ii) Conduct an act that may include, I following: (A) A second full-community-based based functional et (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem staling messages, or prepto challenge an er (iii) Analyze the [Li response to and mall drills, tabletop events, and revise emergency plan, a time following: (i) Testing. The IC exercises to test the twice per year. The following: (i) Participate in an that is community-(A) When a community-(A) When a community-(B) If the ICF/IID et activation of the et is exempt from en	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed. [483.475(d)]: CF/IID must conduct me emergency plan at least et ICF/IID must do the mannual full-scale exercise desaed; or munity-based exercise is not ct an annual individual,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BUILDING B. WING		COMPLETED 05/09/2023			
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1345 N MADISON AVE ANDERSON, IN 46011				
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	onset of the emerging (ii) Conduct an additional that may include, it following: (A) A second full-scommunity-based facility-based function (B) A mock disaste (C) A tabletop exelled by a facilitator discussion, using a clinically-relevant est of problem starmessages, or prepto challenge an endiii) Analyze the IC maintain document exercises, and emithe ICF/IID's emer *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based; (A) When a codis not accessible, of individual, facility-levery 2 years; or. (B) If the HHA natural or man-materization of the endividual exempt from engangul-scale community based functions to the emerging on the emerging of the em	ditional annual exercise but is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or roise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed energency plan. F/IID's response to and station of all drills, tabletop ergency events, and revise gency plan, as needed. 4.102] HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is for community-based exercise conduct an annual based functional exercise. A experiences an actual and emergency plan, the HHA is ging in its next required ity-based or individual, tional exercise following the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155005	B. WI	JILDING		COMPL 05/09/	
		155005	B. WI			05/09/	/2023
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP COD		
TOTAL OF T	NO VIDER OR SOLVER				MADISON AVE		
BEAUMO	BEAUMONT REHABILITATION AND HEALTHCARE CENTER			ANDER	SON, IN 46011		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	1 ' ' ' '	e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c	•					
		limited to the following:					
	, ,	full-scale exercise that is					
	community-based						
		ctional exercise; or isaster drill; or					
	, ,	exercise or workshop that					
	, ,	or and includes a group					
	discussion, using	• ,					
		•					
	clinically-relevant emergency scenario, and a set of problem statements, directed						
	messages, or prepared questions designed						
	to challenge an er						
	_	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	*[For OPOs at §48	-					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the	_					
		er-based, tabletop exercise					
	-	ast annually. A tabletop					
		a facilitator and includes a					
		using a narrated, clinically					
	_	cy scenario, and a set of					
	l '	nts, directed messages, or					
		ns designed to challenge an					
		If the OPO experiences an					
		nan-made emergency that					
		n of the emergency plan, the					
	•	om engaging in its next					
		xercise following the onset					
	of the emergency						
		PO's response to and					
		ntation of all tabletop					
	i exercises, and em	nergency events, and revise	1				I

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BUILDING			COMPL	3) DATE SURVEY COMPLETED 05/09/2023		
		ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1345 N MADISON AVE ANDERSON, IN 46011				
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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
	IAG	the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paper at least annually. It group discussion is narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain documer exercises, and enter the RNHCl's emer Based on record reversible for the exercises. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community-based functions in the emergency plans of the emergency pl	OPO's] emergency plan, as 3.748]: PRINHCI must conduct The emergency plan. The The following: Per-based, tabletop exercise A tabletop exercise is a The ded by a facilitator, using a Therelevant emergency The for problem statements, The senge an emergency plan. The senge an emergency plan. The senge and revise regency events, and revise regency plan, as needed. The wand interview, the facility recreises to test the emergency The sengency events, and revise regency plan, as needed. The wand interview, the facility recreises to test the emergency The facility must do the The sengency exercise is not an annual full-scale exercise that the distributional exercise. The sengency exercise is not an annual individual, the LTC facility is exempt exercise for 1 year following that requires full-scale in a for individual, facility-based are required full-scale in a for individual exercise that may finited to the following:	E 00		E-0039C: EP Testing REG The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does no constitute admission or agreed by the provider of the truth of the facts alleged or conclusions so forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Immediate actions taken for those residents identified: • Emergency Exercise schedu for the next Community Based Disaster Drill.	t ment :he et or	05/25/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED			
		155005	B. WING		05/09/2023	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
				N MADISON AVE		
BEAUMC)N I REHABILITATI ————	ON AND HEALTHCARE CENTER	ANDE	RSON, IN 46011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	(X5)		
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	COMPLETION		
TAG			TAG	DEFICIENCY)	DATE	
	functional exercise.			The Facility will participate in		
	b. A mock disaster			next scheduled Community Ba	ased	
	_	se or workshop that is led by a		Disaster Drill.		
		des a group discussion, using		2. How the facility identified	other	
		y-relevant emergency scenario,		residents:		
	-	n statements, directed		Current residents in the facil		
	challenge an emerg	red questions designed to		have the potential to be affect		
	-	CC facility's response to and		no negative outcomes identifie	ŧu.	
		ation of all drills, tabletop		3. Measures put into place/ System changes:		
		gency events, and revise the		Facility has scheduled		
		gency plan, as needed in		Emergency Exercise test for t	he	
accordance with 42 CFR 483.73(d)(2). This			next scheduled Community ba			
deficient practice could affect all occupants.			drill.	3504		
	F			The facility Emergency		
	Findings include:			Response Committee will		
	S			participate in community wide		
	Based on records re	eview with the Administrator		event/tabletop exercise per		
	and the Maintenanc	e Supervisor on 05/09/23 at		requirements.		
	11:20 a.m., docume	entation for the facility-based		Facility Emergency Operatio	ns	
	exercise conducted	on 02/27/23 and the additional		Plan was reviewed with all		
	actual event on 03/2	28/23 were incomplete. Both	management staff regarding			
		ow if the facility's response		E-039: EP Testing Requireme	ents.	
	was analyzed to ens	sure the EPP policies were		s will		
		interview at the time of		be monitored:		
		Administrator and the		The Emergency Preparedne		
		visor stated no documentation		drill participation will be review	ved	
		ΓC facility's response was		at least quarterly.		
	completed.			Audit findings will be present		
	TELL: C. 1.	t dad Alter		to the QAA Committee month	ly x	
	-	viewed with the Administrator		6 months.		
		upervisor at the exit		• The QAA Committee will rev		
	conference.			findings and determine the ne	ea	
	3 1-10(b)			for further monitoring and/or	`	
	3.1-19(b)			education per the QAA proces Compliance will be determine		
				based on results of audits.	ч	
				5. DOC		
				• 5-30-2023		
				000 2020		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 05/09/2023							
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTE	1345 N	STREET ADDRESS, CITY, STATE, ZIP COD 1345 N MADISON AVE ANDERSON, IN 46011					
(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 CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
K 0000									
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 05/09 Facility Number: 0 Provider Number: 1 AIM Number: 1002 At this Life Safety (Rehabilitation and I not in compliance w Participation in Mes Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2.	00005 55005 70840 Code survey, Beaumont Healthcare Center was found with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC), g Health Care Occupancies and	K 0000						
	sprinklered. The fa with smoke detection to the corridors and detectors in the resi facility has a capaci 116 at the time of the All areas where the	residents have customary ered. All areas providing							

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155005	A. BUILDING B. WING				
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTE	STREET ADDRESS, CITY, STATE, ZIP COD 1345 N MADISON AVE ER ANDERSON, IN 46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	NTE .	(X5) COMPLETION DATE	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress Means of Egress Aisles, passageweischarges, exit loin accordance with of egress is continuously through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure allecontinuously maint 19.2.3.4 (4) states provided that all of met: (a) The wheeled equipment in use in Medical emergency. (c) The wheeled equipment in use ii. Medical emergency iii. Patient lift and to	ays, corridors, exit ays, corridors, and accesses are an Chapter 7, and the means an accesses are an accesses accesses an accesses accesses accesses an accesses accesses an accesses ac	K 0211	K0211: Means of Egress-Gen The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions sforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified • No resident was found to be affected by the finding. 2) How the facility identified ot residents:	of ot ment the et	05/30/2023	

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Based on an observation during a tour of the

facility with the Maintenance Supervisor 05/09/23

between 1:25 p.m. and 3:00 p.m., in all resident

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• Visitors, staff, and residents that

reside at the community have the

potential to be affected by the

alleged deficient practice.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BUILDING 01 B. WING		COMPLETED 05/09/2023	
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	1345 N	ADDRESS, CITY, STATE, ZIP COD I MADISON AVE RSON, IN 46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR halls Personal Prote	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ctive Equipment (PPE) carts	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 3) Measures put into place/	(X5) COMPLETION DATE
	wheels allowing the halls during an emerobserved by rooms Based on interview the Maintenance Su PPE carts are not equed to be replaced The finding was rev	e were not equipped with carts to be moved out of the regency. The PPE carts were 151, 155, 156, 170, and 408. at the time of observations, pervisor stated some of the puipped with wheels and would with a PPE cart with wheels. The with the Administrator is Supervisor during the exit		System changes: PPE carts now have wheels The Maintenance Director has completed and initial audit to ensure all other corridors are of obstruction. How the corrective actions to be monitored: The Maintenance Director/designee has re-educt staff members to ensure corriare free of obstruction. Maintenance Director/design will audit all hallways weekly from this to ensure hallways are free of obstruction. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes until 100% of education has be achieved. The QA Committee will iden any trends or patterns and ma recommendations to revise the plan of correction as indicated. Date of compliance: 5) Date of compliance:	free will cated dors nee for 6 e s or leen tify ake e
K 0324 SS=F Bldg. 01	Ventilation Contro Commercial Cook * residential cookii	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small			

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DEPARTMENT OF HEALTH AND HUN	FORM APPROVEI						
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING 01	COMPLETED			
	155005	B. WI	NG	05/09/2023			
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD					

	NAME OF PROVIDER OR SUPPLIER BEAUMONT REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1345 N MADISON AVE ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
	toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen and 10 residents in the corridor. Findings include: Based on records review with the Maintenance Supervisor (MS) on 05/09/23 at 10:15 a.m., the only documentation of semiannual kitchen fire suppression system inspection available for review was dated 02/17/23. An inspection six	K 0324	Deficiency ID: K _ 0324 K0324: Cooking Facilities The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified • No resident was found to be affected by the finding. 2)How the facility identified other residents:	05/30/2023		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 05/09/2023		LETED		
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	₹	1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0345	months prior to 02/Based on interview the MS stated the conspection on the king on 02/17/23 but did suppression system. This finding was reand MS at the exit of 3.1-19(b) 2. Based on observation facilities that serve cooking facilities at the corridor. This did residents in one smooth facilities in one smooth facilities in the corridor. This did residents in one smooth facilities are the corridor. This did residents in one smooth facilities are the corridor. This did residents in one smooth facilities are the corridor. This did residents in one smooth facilities are the corridor. This did residents in one smooth facilities are the corridor. This did residents in one smooth facilities are the corridor of the smooth facilities are the corridor. This did not smooth facilities are the corridor of the smooth facilities	at the time of record review, ontractor conducted the techen fire suppression system d not inspect the kitchen fire six months prior to 02/17/23. Viewed with the Administrator conference. ation and interview, the facility of 2 corridor doors for cooking 30 or more residents to ensure the protected and not open to efficient practice affects 40 tooke compartments. On during a tour of the facility ce Supervisor on 05/09/23 at the corridor doors from the g on the floor and not allowing a tested. Based on interview at the door would not self close also stated that they were we door and frame to replace wiewed with the Administrator			Visitors, staff, and residents reside at the community have potential to be affected by the alleged practice. Measures put into place/System changes: Semi-Annual Inspection of cooktops with a fire extinguist system was completed 5-15-24)How the corrective actions be monitored: The Maintenance Director/designee will monitor inspections moving forward. The Maintenance Director/designee will bring conditions and future inspections to Quanch Assurance Meeting monthly formonths. The QA Committee will iden any trends or patterns and marecommendations to revise the plan of correction as indicated. Date of compliance: 5-30-35.	ning 2023. will arrent lity or 6 tify take	
SS=F	Fire Alarm System	n - Testing and					

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 05/09/2023	
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTE	1345 N	ADDRESS, CITY, STATE, ZIP COD I MADISON AVE RSON, IN 46011	
(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)	(X5) COMPLETION DATE
Bldg. 01	in accordance with complying with the National Electric C National Fire Alart Records of system and testing are respected in the Sections 19.6.1.5, N Based on record reversible for the Sections 19.3.4.5.1 14.3.1 states that under 14.3.2, visual inspected accordance with the more often if requiringuirisdiction. Table must be visually instead and the section of the fire alarm boxes, he etc.) d. Notification applies. Magnetic hold-op This deficient practifacility. Findings include: During records revisually on documentation was inspection of the fire prior to the annual for the section of the fire prior to the annual for the section of the fire prior to the annual for the section of the fire prior to the annual for the section of the fire prior to the annual for the section of the fire prior to the annual for the section of the fire prior to the annual for the section of the fire prior to the annual for the section of the fire prior to the annual for the section of the fire prior to the annual for the section of the fire prior to the annual for the section of the section of the fire prior to the annual for the section of the section of the fire prior to the annual for the section of the	m is tested and maintained in an approved program a requirements of NFPA 70, Code, and NFPA 72, in and Signaling Code. In acceptance, maintenance adily available. FPA 70, NFPA 72 riew and interview, the facility of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section aless otherwise permitted by citions shall be performed in a schedules in Table 14.3.1, or ed by the authority having 14.3.1 states that the following spected semi-annually: ble signals stors (e.g. duct detectors, manual at detectors, smoke detectors, siances	K 0345	K0345 F: Fire Alarm System - Testing and Maintenance The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreen by the provider of the truth of th facts alleged or conclusions se forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified • No resident was found to be affected by the finding. 2)How the facility identified oth residents: • Any resident had the potential be affected, however no one w identified. 3) Measures put into place/	t nent he et

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records review, the MS stated a visual inspection

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System changes:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/09/2023
NAME OF PROVIDER OR SUPPLIER BEAUMONT REHABILITATION AND HEALTHCARE CENTER			1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE RSON, IN 46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	annual fire alarm in	tem six months prior to the spection was not conducted. viewed with the Administrator conference.		Maintenance director was educated on the requiremen 345 related to the visual inspectations of the semi-annual requirements. 4)How the corrective actions be monitored: The Maintenance Director/designee will monitor/audit those areas the require semi-annual visual monitoring as noted in the 256 months. The report will be reviewed Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieve. The QA Committee will ide any trends or patterns and mecommendations to revise to plan of correction as indicated 5.) DOC- 5-30-2023	ection s will at 567 for in d. ntify nake he
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers shall be postrium wall. Smoke in duct penetration systems where and is installed for smoke to the smoke barrier 19.3.7.3, 8.6.7.1(1	rall be constructed to a cance rating per 8.5. Smoke ermitted to terminate at an edampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005			JILDING	onstruction 01	(X3) DATE COMPI 05/09	ETED		
	PROVIDER OR SUPPLIER	R ION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1345 N MADISON AVE ANDERSON, IN 46011				
			1		, T		art)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
	` ·	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
TAG				TAG	BEIGERETT		DATE	
	system in REMAF	on and interview, the facility	17.0	272	V272, Subdivision of Building		05/20/2022	
		penetrations caused by the	K 0	3/2	K372: Subdivision of Building		05/30/2023	
		d/or conduit through 1 of 5			Spaces- Smoke Barrier Construction			
		s were protected to maintain the			The facility requests paper			
		f each smoke barrier. LSC			compliance for this citation.			
		quires smoke barriers to be			This Plan of Correction is the			
		rdance with LSC Section 8.5			center's credible allegation of			
		nimum ½ hour fire resistive			compliance.			
		1 8.5.2.1 requires smoke barriers			Preparation and/or execution	of		
		om an outside wall to an			this plan of correction does no			
		a floor to a floor, or from a			constitute admission or agree			
	· ·	smoke barrier, or by use of a			by the provider of the truth of			
		of. 8.5.6.2 requires penetrations			facts alleged or conclusions se			
		ays, conduits, pipes, tubes,			forth in the statement of			
		milar items to accommodate			deficiencies. The plan of			
	electrical, mechanic				correction is prepared and/or			
	communications sy	stems that pass through a wall,			executed solely because it is			
	floor, or floor/ceilir	ng assembly constructed as a			required by the provisions of			
	smoke barrier, or th	rough the ceiling membrane of			federal and state law.			
	the roof/ceiling of a	a smoke barrier assembly, shall			1)Immediate actions taken for			
		ystem or material capable of			those residents identified			
		ement of smoke. This deficient			No resident was found to be			
	*	et staff and at least 30 residents			affected by the finding.			
	in two smoke comp	partments.			2)How the facility identified otl	ner		
					residents:			
	Findings include:				Visitors, staff, and residents			
					reside in the community have			
		ons during a tour of the facility			potential to be affected by the			
		nce on 05/09/23 at 2:45 p.m.,			alleged deficient practice.			
		ing of the 500-hall smoke wall			3) Measures put into place/			
		ch gap around a pipe. Based on			System changes:			
		ne of observation, the			The facility has assessed/			
	•	visor agreed there was an			audited identified smoke barri			
	unsealed penetratio	n in the 500-hall smoke wall.			walls to ensure the walls were	!		
	The finding was	viewed with the Administrator			protected to maintain smoke			
	-	ce Supervisor during the exit			resistance.	, the		
	conference.	Le Supervisor during the exit			Any penetrations identified in audit will be corrected.	ıııe		
	conference.				audit will be corrected.	iII		
			1		4)How the corrective actions v	VIII		

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AND PLAN OF CORRECTION IDENTIFY		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	(X2) MULTIPL A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/09/2023	
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	134	EET ADDRESS, CITY, STATE, ZIP COD 5 N MADISON AVE DERSON, IN 46011	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
TAG	3.1-19(b)	R LSC IDENTIFYING INFORMATION	TAG		ect ly for will be mmittee ensure ed in g ntil ved. dentify make e the
K 0511 SS=E Bldg. 01	complies with NFI Code, electrical w complies with NFI Code. Existing ins service provided r 18.5.1.1, 19.5.1.1 Based on observation failed to ensure 2 g (GFCI) devices were protection against e 2011 Edition at 210 Circuit-Interrupter states, ground-fault personnel shall be p	Electric gas or related gas piping PA 54, National Fuel Gas riring and equipment PA 70, National Electric stallations can continue in no hazard to life. , 9.1.1, 9.1.2 on and interview, the facility round fault circuit interrupter re properly maintained for electric shock. NFPA 70, NEC	K 0511	K0511E Utilities- Gas and The facility requests paper compliance for this citation This Plan of Correction is t center's credible allegation compliance. Preparation and/or executi this plan of correction does constitute admission or agi	inche n of ion of is not

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/09/2023
	PROVIDER OR SUPPLIER ONT REHABILITATION AND HEALTHCARE CENTER	1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE RSON, IN 46011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the Gardens Dining Room and any staff in the employee break room.		by the provider of the truth of facts alleged or conclusions s forth in the statement of	
	Findings include: Based on observation with the Maintenance		deficiencies. The plan of correction is prepared and/or executed solely because it is	
	Supervisor on 05/09/23 between 2:10 p.m and 2:45 p.m., when the GFCI electric receptacle in the Gardens Dining Room and the employee break		required by the provisions of federal and state law. 1)Immediate actions taken for	
	room were tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of		those residents identified No resident was found to be affected by the finding.	
	observation, the Maintenance Supervisor agreed the two identified GFCI electric receptacles did not properly work when tested.		2)How the facility identified ot residents: Visitors, staff, and residents	that
	The finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		utilize the Garden Dining Roo and employee break room ha the potential to be affected by practice, however none were	ve
	3.1-19(b)		identified. 3) Measures put into place/ System changes:	
			The facility has assessed junction boxes within the cam to ensure a ground fault circui interrupter (GFCI) to ensure	
			devices were properly mainta to protect against electric sho	
			Any junction boxes found to without covers were immediat corrected.	
			Junction boxes noted in the have been corrected. 4)How the corrective actions to be monitored:	
			The Maintenance Director/designee will random inspect 5 GFCI junction boxes month to ensure electrical cov.	s per

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ì í	ILDING	instruction 01	(X3) DATE (COMPL 05/09/	LETED	
NAME OF PROVIDER OR SUPPLIER BEAUMONT REHABILITATION AND HEALTHCARE CENTER			1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011			
(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)	TE	(X5) COMPLETION DATE
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems Testing Electrical Systems Testing Hospital-grade recolocations and whee anesthesia is adminitial installation, in Additional testing defined by docume Receptacles not lithese locations are exceeding 12 more (LIM), if installed, it less than or equal the LIM test switch activates both visual LIM circuits with a manual test is per than or equal to 12	s - Maintenance and s - Maintenance and septacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not withs. Line isolation monitors are tested at intervals of to 1 month by actuating to per 6.3.2.6.3.6, which wal and audible alarm. For utomated self-testing, this formed at intervals less 2 months. LIM circuits are		TAG	are in proper working order. Completion of inspections wi presented to the QAPI Commit during QAPI Meetings to ensu compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will ident any trends or patterns and ma recommendations to revise the plan of correction as indicated. Date of compliance: 5) Date of compliance: 5-30-2023	ittee re n ify ke e	DATE
	tested per 6.3.3.3	2 after any repair or	1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPL			LETED	
		155005	B. WI	NG		05/09	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			MADISON AVE		
REALIMO	NT REHABII ITATI	ION AND HEALTHCARE CENTER			RSON, IN 46011		
DEMONIC	, The state of the			ANDLI	1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		electric distribution system.					
		tained of required tests and					
	associated repairs						
	_	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)		17.0	014	KO44 Electrical		05/20/2022
		on, record review and	K 09	914	K914-Electrical		05/30/2023
		ty failed to ensure non-hospital			Systems-Maintenance and		
	_	eptacles at resident sleeping			Testing	-4-	
		at least annually. NFPA 99, les Code 2012 Edition, Section			The facility respectively reque desk review for this citation.	รเร	
		eptacles not listed as			This Plan of Correction is the		
		atient bed locations and in			_		
		ep sedation or general			center's credible allegation of compliance.		
		istered, shall be tested at			Preparation and/or execution	of	
		ling 12 months. Additionally,			this plan of correction does no		
		ceptacle Testing in Patient Care			constitute admission or agree		
		physical integrity of each			by the provider of the truth of		
	_	confirmed by visual inspection.			facts alleged or conclusions s		
	1 -	ne grounding circuit in each			forth in the statement of	-	
		e shall be verified. Correct			deficiencies. The plan of		
	1	and neutral connections in			correction is prepared and/or		
		ptacle shall be confirmed; and			executed solely because it is		
	retention force of th	ne grounding blade of each			required by the provisions of		
		e (except locking-type			federal and state law.		
	receptacles) shall be	e not less than 115 grams (4			1.) What corrective action(s) v	vill	
	ounces). This defici	ient practice could affect all			be accomplished for those		
	residents.				residents found to have been		
					affected by the deficient practi	ice?	
	Findings include:				• On or before 5-30-2023, the		
					Maintenance Director will con-		
		ons during a tour of the facility			an audit of all rooms to ensure	_	
		ce Supervisor on 05/09/23			polarity and retention are bein	•	
		and 3 p.m., the facilities resident			tested and that they follow sta	te	
	sleeping rooms con	_			and federal regulations.		
		electrical receptacles. Based			No residents were identified	to	
		at 1:20 p.m., no documentation			have been affected.		
		ow the last time the electrical			2.) How other residents having	-	
	_	ent sleeping rooms were			potential to be affected by the		
	tested. Based on int	terview at the time of the	l		same deficient practice will be)	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	ľ	UILDING	ONSTRUCTION 01	(X3) DATE COMPL 05/09/	LETED
	PROVIDER OR SUPPLIEI	ON AND HEALTHCARE CENTE	R	1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE RSON, IN 46011		
(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 APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Supervisor confirm in the resident sleep hospital-grade and time the annual test. This finding was re and Maintenance D conference. 3.1-19(b)	ords review, the Maintenance ed all the electrical receptacles oing rooms were not stated it is unknown the last ing was completed. viewed with the Administrator birector during the exit			identified and what corrective actions will be taken: • Any residents could be affect by the alleged practice. Regulannual inspections of receptatesting in patient care rooms be conducted. 3.) What measures will be purinto place or what systemic changes will be made to ensuthat the same deficient practice does not recur? • Director of Maintenance/designee will conduct annual inspections or resident rooms and track the polarity and retention of the poutlets including physical intelegand continuity. 4.) How the corrective action (will be monitored to ensure the deficient practice will not recurred; what quality assurance program will be put into place. Audits will be conducted by Director of Maintenance/designee will be brought to Quite the deficient practice will not recurred in the place of the plan of correction as needed. • Results will be brought to Quite the plan of correction as needed. 5.) Date of Correction • 5-30-2023	cted lar cle will it lre ce f ower grity s) e r, : gnee or 90 r and A for r	
K 0918 SS=F	NFPA 101 Electrical Systems	s - Essential Electric Syste					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM			COMPL	ETED
		155005	B. WI	NG		05/09/	2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	Ь	
NAME OF P	ROVIDER OR SUPPLIER	8			MADISON AVE		
BEAUMC	NT REHABILITATI	ON AND HEALTHCARE CENTER			SON, IN 46011		
(X4) ID	SUMMARY	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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Electrical Systems	s - Essential Electric					
	System Maintenar	nce and Testing					
	The generator or	other alternate power					
	source and associ	iated equipment is capable					
	of supplying service	ce within 10 seconds. If the					
	10-second criterio	n is not met during the					
	monthly test, a pro	ocess shall be provided to					
	annually confirm to	his capability for the life					
	safety and critical	branches. Maintenance					
	and testing of the	generator and transfer					
	switches are perfo	ormed in accordance with					
	NFPA 110.						
	Generator sets are	e inspected weekly,					
	exercised under lo	oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	nths for 4 continuous hours.					
	Scheduled test un	der load conditions include					
	a complete simula	ited cold start and					
	automatic or manu	ual transfer of all EES					
	loads, and are cor	nducted by competent					
	•	nance and testing of stored					
	energy power sou	rces (Type 3 EES) are in					
	accordance with N	NFPA 111. Main and feeder					
		e inspected annually, and a					
		dically exercising the					
	-	tablished according to					
	manufacturer requ	uirements. Written records					
	of maintenance ar	nd testing are maintained					
	•	ble. EES electrical panels					
		arked, readily identifiable,					
		n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for r						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		view and interview, the facility	K 09	918	K 918 F Electrical		05/30/2023
		annual fuel quality test was			Systems-Essential Electric		
	-	acility diesel powered			System		
	generator. NFPA 9	9, Health Care Facilities Code,			The Facility respectively reque	ests	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
155005			B. W	ING		05/09/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	ER			MADISON AVE		
 REΔLIM	ONT REHABILITAT	TION AND HEALTHCARE CENTE	R		RSON, IN 46011		
	J. T. T. C. I. A. D. C. I. A. C.	TION / IND TIE/LETTIO/ INC. GENTE		ANDLI	1		T
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ion 6.5.4.1.1.2 states Type 2 EES			desk review for this citation.		
		al System) generator sets shall			Preparation and/or execution		
	_	ested in accordance with			this plan of correction does no		
		3. Section 6.4.4.1.1.3 states			constitute admission or agree		
		be performed in accordance			by the provider of the truth of		
		tandard for Emergency and			facts alleged or conclusions s	et	
		stems, 2010 Edition, Chapter 8.			forth in the statement of		
		n 8.3.8 states a fuel quality test			deficiencies. The plan of		
	_	l at least annually using tests			correction is prepared and/or		
		M standards. This deficient			executed solely because it is		
	practice could affe	ect all residents.			required by the provisions of		
					federal and state law.		
	Findings include:				Immediate actions taken f	or	
	D 1	t da a set .			those residents identified:		
		review with the Maintenance			Executive Director/Maintena		
		on 05/09/23 at 1:10 p.m., no			Director initiated an inspection		
		an annual fuel quality test for			the diesel fuel in the generato		
		or was available for review.			2. How the facility identified	other	
		v at the time of records review,			residents:		
		e was no documentation			Current residents in the facil	-	
		iesel generator annual fuel			have the potential to be affect		
	quality test.				no negative outcomes identifie	ea.	
	This finding was n	arriarrad with the Administrator			3. Measures put into place/		
	and MS at the exit	eviewed with the Administrator			System changes:		
	and wis at the exit	conference.			Cummings completed		
	2 1 10(b)				inspection.		
	3.1-19(b)				Fuel quality tests will be performed at least appually		
					performed at least annually.Written records of maintenar	200	
					and testing are maintained an		
					readily available.	u	
					4. How the corrective actions	s will	
					be monitored:	> 44111	
					Maintenance director/ Execu	ıtive	
					Director will audit monthly to	۷ С	
					ensure that the annual fuel qu	ality	
					test was performed for the fac	-	
					diesel powered generator.	у	
					The Maintenance Director w	ill	
			1		I THE MAINTENANCE DIRECTOR W		1

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	ì í	JILDING	onstruction 01	(X3) DATE COMPL 05/09/	ETED
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011		
(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)	ſΕ	(X5) COMPLETION DATE
					 Reviews of audits will be take QA for review and analysis monthly for 6 months to ensure 100% compliance has been achieved. 5.) DOC 5-30-2023 		

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