STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING 00 B. WING	01/18/2023

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BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00399012. Complaint IN00399012 - Substantiated. Federal/state deficiencies related to the allegations are cited at F686 . Unrelated deficiencies are cited. Survey dates: January 17 and 18, 2023. Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census Bed Type: SNF/NF: 100 SNF: 10 Total: 110 Census Payor Type: Medicare: 18 Medicaid: 80 Other: 12 Total: 110 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 24, 2023.	F 0000	1-26-2023 IDOH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Provider number :155005 AIM number :100270840 Facility number: 000005 Re: Complaint Survey IN00399012. Beaumont Rehabilitation and Healthcare Center 1345 N Madison Ave Anderson, IN 46011 Survey Event ID Z46611 Dear Ms. Buroker: On January 18, a Complaint Survey (IN00399012) was conducted by the Division of Long-Term Care, Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review to confirm that the facility has achieved substantial compliance with the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian McKamie	HFA	01/27/2023

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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			applicable requirements as of the date set forth in the Plan of Correction of 1-30-2023. Please feel free to call me with any further questions at 1-765-644-2888 Respectfully submitted, Brian McKamie, HFA	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law,			

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	including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report injuries from a fall that required a hospital intervention for 1 of 1 resident reviewed for reporting to the State Agency (Resident C). Findings include: Resident C's clinical record was reviewed on 1/17/23 at 11:22 a.m. Diagnoses included cognitive communication deficit, muscle weakness, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, history of falling, and epilepsy, unspecified, not intractable, without status epilepticus. A nurses note, dated 10/17/22 at 10:57 p.m., indicated Resident C was found on the floor in front of the wheelchair and the bed with a wound to his forehead, a laceration 3 cm (centimeters) long x 2 cm wide x 0.1 cm deep and a blood pool in front of him. 911, the medical group, DON, and Unit Manager were notified. He was sent to the emergency room. A nurses note, dated 10/18/22 at 12:46 a.m., indicated he was admitted to ICU (Intensive Care Unit) due to a right contusion of the right hemisphere, as well as UTI (Urinary Tract Infection). The DON was notified. A nurses note, dated 10/22/22 at 4:29 p.m., indicated he returned to the facility from the local hospital. He continued on an antibiotic and started on an anticonvulsant. There was a new order to hold his blood thinners until 11/3/22 due to the head injury. He had a laceration to his right	F 0609	F 609 Reporting of Alleged Violations The facility respectively requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Immediate actions taken for those residents identified: • Resident C identified no longer resides within the facility. • Identified areas of concern related to 10-17-2022 event was reported. • Facility education provided on reporting requirements. 2. How the facility identified other residents: • An audit was conducted over the past 60 of risk management, grievances, and 24-hour clinical reviews to identify any other areas of concern that may have met reporting requirements. No other resident was affected.	01/30/2023

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	forehead and had four sutures, to be removed in 10 days. During an interview with the Administrator, on 1/17/23 at 1:42 p.m., he provided the incident paperwork that was reported to IDOH (Indiana Department of Health) on 1/17/23 and indicated the incident was not reported at the time of 10/17/22. He was on vacation, the DON was at an offsite meeting, and the person responsible for reporting was also out of town. Review of a current facility policy, from IDOH for reporting to the State Agency with the effective dates of 12/8/22 - 12/8/23 and provided by the AIT (Administrator in Training), on 1/18/23 at 1:35 p.m., indicated the following: "...B. Types of Incidents Reportable Under Federal and State Rules...10. Major accidents a. Required to report examples included but are not limited to..." 3.1-28(e)		3. Measures put into place/ System changes: • Education was provided on Policy and Procedure related to reporting requirements and access to reporting domain(gateway) was provided to additional staff should the Executive Director of Director of Nursing be unavailable to report. • The Director of Clinical Services will be notified of any reportable event, assistance with reporting will be provided as required. • Events will be reported per reporting guidelines. • Review of the 24-hour report during scheduled IDT meetings to identify reportable events. • Issues identified will be immediately addressed with additional education and or disciplinary action. 4. How the corrective actions will be monitored: • The responsible party for this plan of correction is the Executive Director/Director of Nursing/designee. • Events will be audited and reviewed daily during morning/clinical meetings via the IDT team to review the 24-hour report to determine if anything had occurred that may meet the reporting requirements. • Facility staff will immediately notify the Executive Director should an event occur that	

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			requires reporting. • Identified areas of concern will be reported per guidelines and additional education provided as required. • Staff will be educated on abuse upon hire, annually and as needed with a focus on reporting requirements. • Audits will continue 5 times weekly for 6 months and or until 100% compliance has been achieved for 3 consecutive months, at which time the QA committee will review to identify any trends or patterns and make recommendations to revise the plan of correction. 5. Date of Correction 1-30-2023	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			

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	Based on observation, interview, and record review, the facility failed to implement interventions for a resident with two SDTIs (Suspected Deep Tissue Injuries) for 2 of 3 residents reviewed for facility-acquired pressure ulcers (Resident B). Findings include: Resident B's clinical record was reviewed on 1/17/23 at 9:22 a.m. Diagnoses included seizures, other malaise, and bipolar disorder, current episode mixed, major depressive disorder, recurrent severe without psychotic features and weakness. Her current orders included the following: a. Multi-vitamin daily started on 11/10/22. b. Ensure twice daily for wound healing started on 1/6/23. c. Santyl Ointment apply to right buttocks topically one time a day for wound cleanse with wound cleaner, pat dry, skin prep wound edges, apply Santyl to wound bed, cover with bordered foam dressing, change daily and PRN (as needed) soilage/dislodgement and apply to right buttock topically every 12 hours as needed for wound healing, for soilage or dislodgement started on 1/9/23. d. House barrier cream to coccyx/sacrum every shift for wound prevention started on 1/8/23. e. Coat entire left and right heel and right fifth toe head with skin prep every shift for wound healing started on 12/30/22.	F 0686	F686 D TX/SVCS to Treat Pressure Areas 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: • Resident B no longer resides in the facility. 2) How the facility identified other residents: • Any residents identified with pressure areas residing in the facility had the potential to be affected. • Residents will be monitored through the 24-hour report process and reviewed at stand-up meetings. • An audit was completed on those residents identified to have Pressure and Non-Pressure skin areas.	01/30/2023

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	f. Offloading boots to bilateral feet at all times for wound prevention started on 1/8/23. An 11/21/22, admission, MDS (Minimum Data Set) indicated she was cognitively intact. She required extensive assistance for bed mobility, dressing, toilet use and personal hygiene. She required total assistance for transfers. She was at risk for developing pressure ulcers. She had pressure reducing devices to her bed and chair. She used a wheelchair for mobility. A pressure ulcer risk assessment, dated 11/30/22, indicated she was at a high risk for developing pressure ulcers. Her current care plans included: She had potential for impaired skin integrity related to (blank) initiated on 11/9/22. Her interventions, initiated on 11/9/22, were pressure redistribution mattress to bed and provide diet as ordered. She had actual pressure ulcers on her left heel, right heel, right ear, and buttock. She required assist of two with turning and repositioning initiated on 12/29/22 and revised on 1/9/23. Her goal was the wound(s) would show signs of improvement through next review. The interventions included provide offloading of ulcer site initiated on 12/29/22. She was non-compliant with ADL (Activities of Daily Living) care, repositioning, calling for assistance and allowing staff assistance She refused care initiated on 1/9/23. Her goal was that she would verbalize understanding of consequences of non-compliance through review date. Her interventions were initiated on 1/9/23		• Orders and treatments were clarified. • Care plans were reviewed for accuracy. • Any identified issues were immediately addressed. • Conversation held with Wound NP to discuss increased communication and order review. 3) Measures put into place/ System changes: • Nursing staff will be educated on Wound Policy, which includes care planning, physician orders and documentation requirements. • Any resident with Pressure or Non-Pressure areas will be reviewed by the Registered Dietician. • DON/ Unit managers will review physician/NP notes to ensure orders are identified. • Review of the 24-hout summary daily during scheduled clinical meeting per the DNS/designee to identify residents that may have had a change of condition related to skin issues, notification of physician and family/responsible party has occurred. • Unit Managers will audit 5 residents weekly that have pressure areas to determine orders, treatments/ interventions are present, and documentation is completed. • The Wound Care Policy was reviewed.	

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	and included accept residents right to refuse, and show respect for resident's decisions, discuss with resident his/her objections, reasons, fears, ideas, give positive feedback and reinforcement for resident's compliance, inform resident about risks of non-compliance and offer as many alternatives as possible for resident to choose from. The Matrix for Providers, provided by the wound nurse, on 1/17/23 at 9:58 a.m., indicated Resident B had a SDTI (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) to her right and left heel, a Stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.) to her ear and an untraceable pressure ulcer (Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.) to her right buttock. A nurses note, dated 12/12/22 at 10:12 a.m., indicated Resident B had a DTI area to her right heel that measured 3.6 cm (centimeters) L (long) x 1.4 cm W (wide) and to her left heel which measured 1 cm L x 0.7 cm W. The skin was intact. Skin prep and Prevalon boots were applied. The PCP and wound nurse were notified and waiting on any new orders. A NP (Nurse Practitioner) note, dated 12/16/22 at 7:55 a.m., indicated new DTI had developed since her last visit to the facility. Prevalon boots were in		4) How the corrective actions will be monitored: • The responsible party for this plan of correction is the Director of Nursing with Executive Director oversight. • The results of audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months at which time the QA committee will identify any trends and patterns and make recommendations to revise the plan of correction if indicated. 5) Date of compliance: 1-30-23	

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	place. The assessment/plan was skin prep every shift and offload heels. A new skin concern pressure assessment, dated 12/29/22, indicated she had a facility acquired SDTI to her right heel that measured 2 cm L x 3.7 cm W, and was the first observation of the pressure area. The current interventions that were in place were air/specialty mattress, turning and repositioning, incontinence care and barrier cream as needed. Her predisposing risk factors were complex medical conditions and refusal of care. A new skin concern pressure assessment, dated 12/29/22 at 11:01 a.m., indicated she had a facility acquired SDTI to her left heel which measured 1 cm L x 1.2 cm W, and was the first observation of the pressure area. There were no current interventions documented. She had another new skin concern pressure assessment, dated 12/29/22 at 11:19 a.m., to indicate the SDTI to her left heel measured 1.5 cm L x 1.3 cm W. A NP note, dated 12/30/22 at 10:45 a.m., indicated Prevalon boots were in place. The assessment/plan was skin prep every shift and offload heels. A NP note, dated 1/6/23 at 8:10 a.m., indicated Prevalon boots were in place. The assessment/plan was skin prep every shift and offload heels. A NP note, dated 1/13/23 at 12:13 p.m., indicated Prevalon boots were in place. The assessment/plan was skin prep every shift and offload heels. During an interview with the Wound Nurse, and the AIT (Administrator in Training) present, on			

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	1/18/23 at 9:21 a.m., she indicated Resident B didn't eat a whole lot, she did not like to be on her left side and like to lay on her right side if they could get her to turn. She was "super content" to lay in her bed. She would work the offloading boots off of her feet. She refused to go to therapy. She was on a low air loss mattress and offloading boots prior to the areas on her heels. The wound NP saw her weekly. She was started on Ensure for wound healing. The AIT indicated she did not see an intervention started on or around 12/12/22 or 12/16/22. According to the MAR (Medication Administration Record) skin prep was started on 12/30. During an interview with the AIT, on 1/18/23 at 11:17 a.m., she indicated that skin prep was considered a nursing measure and an order did not have to be put into the computer. As a nurse, they would just know to apply the skin prep without prompting from the medical record. During an interview with LPN 23, on 1/18/23 at 11:20 a.m., she indicated she would not put skin prep on a resident without an order. She would get the order from the doctor first. During an interview with LPN 45, on 1/18/23 at 11:26 a.m., she indicated if she had found a resident with a SDTI, she would check the treatments to see if the resident already had an order. She would measure the wound and call the doctor, the unit manager and the wound nurse. She would not put anything on the wound without an order. During an interview with LPN 20, on 1/18/23 at 1:43 p.m., she indicated skin prep was a nursing measure for a SDTI. She would also check with the NP to make sure that it was an appropriate			

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	treatment for the resident and then put the order in so the next nurse would know. During an interview with LPN 33, on 1/18/23 at 1:45 p.m., she indicated for a SDTI, she might use skin prep or heel boots, but she would contact the doctor or wound nurse. The next nurse would know about the treatment during report and there would be an order for skin prep or heel boots. During an interview with CNA 22, on 1/18/23 at 1:48 p.m., she indicated she would know if a resident had pressure relieving boots if they were already in the resident's room and if they were not in place, she would put them on the resident. The nurse would relay to her, what interventions were in place for the resident. During an interview with LPN 17, on 1/18/23 at 1:55 p.m., she indicated she was not aware if skin prep was a nursing measure. She knew some facilities had standing orders, but was not aware of it at this facility. She would get an order from the doctor or NP and put the order into the computer. Review of current, 1/2022 facility policy titled, "Procedure: Skin Assessment: New Onset and Ongoing Until Healed," provided by the AIT on 1/18/23 at 1:35 p.m., indicated the following: "...4. The Charge Nurse will ensure that the order is implemented and review the need for new interventions to the current care plan. 5. The IDT (Interdisciplinary Team) will ensure the plan of care is updated... 7. Areas identified after admission will be documented on the applicable skin assessment Pressure...." Review of a current, 1/2022 facility policy titled, "Procedure: Wound Interventions," provided by			

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	the AIT on 1/18/23 at 1:35 p.m., indicated the following: "7...Routine Care/Interventions may include but are not limited to...preventative measures such as the application of skin prepping...." This Federal Tag relates to complaint IN00399012. 3.1-40(1) 3.1-40(2)			