PRINTED: 08/01/2024

			THE TEST			
EPARTMENT OF HEALTH AND HUMAN SERVICES FO						
ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 0938-039			
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 07/15/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1345 N MADISON AVE BEAUMONT REHABILITATION AND HEALTHCARE CENTER ANDERSON, IN 46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 The facility requests paper conducted by the Indiana Department of Health in compliance for this citation. accordance with 42 CFR 483.73. This Plan of Correction is the center's credible allegation of Survey Date: 07/15/24 compliance. Preparation and/or execution of Facility Number: 000005 this plan of correction does not Provider Number: 155005 constitute admission or agreement AIM Number: 100270840 by the provider of the truth of the facts alleged or conclusions set At this Emergency Preparedness survey, forth in the statement of Beaumont Rehabilitation and Healthcare Center deficiencies. The plan of was found not in compliance with Emergency correction is prepared and/or Preparedness Requirements for Medicare and executed solely because it is Medicaid Participating Providers and Suppliers, 42 required by the provisions of CFR 483.73. The facility has a capacity of 200 and federal and state law. had a census of 122 at the time of this survey. Quality Review completed on 07/18/24 E 0039 403.748(d)(2), 416.54(d)(2), 418.113(d)(2), SS=F 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), Bldg. --483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) **EP Testing Requirements** §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d) (2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:

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

TITLE (X6) DATE

Goran Prentoski Administrator 07/30/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155005		A. BUILDING B. WING			COMPLETED 07/15/2024	
		.50000	<i>D.</i> "	_		07/13/		
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD MADISON AVE			
BEAUMO	ONT REHABILITATI	ON AND HEALTHCARE CENTE	R		SON, IN 46011			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY 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	
	. ,	acility] must conduct						
		he emergency plan ility] must do all of the						
	following:	ility] must do all of the						
	(i) Participate in a full-scale exercise that is							
	community-based							
	1 ' '	nunity-based exercise is						
		nduct a facility-based						
		e every 2 years; or ility] experiences an actual						
		ade emergency that requires						
	activation of the emergency plan, the [facility]							
		gaging in its next required						
	1 -	or individual, facility-based						
		e following the onset of the						
	actual event.							
	1 ' '	ditional exercise at least						
		posite the year the full-scale cise under paragraph (d)(2)						
		s conducted, that may						
		limited to the following:						
		scale exercise that is						
	community-based	or individual, facility-based						
	functional exercise							
	(B) A mock disast							
		ercise or workshop that is						
	discussion using a	and includes a group						
		emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er							
		acility's] response to and						
		ntation of all drills, tabletop						
		nergency events, and revise						
	the [tacɪlity's] eme	rgency plan, as needed.						
	*[For Hospices at	418.113(d):]						
	(2) Testing for ho	spices that provide care in						

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	TEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDIN 155005 B. WING		JILDING	E CONSTRUCTION G		(X3) DATE SURVEY COMPLETED 07/15/2024	
	ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		1345 N	NDDRESS, 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 B CROSS-REFERENCED TO THE APPROPE		(X5) COMPLETION DATE
	conduct exercises plan at least annuate following: (i) Participate in a community based (A) When a commande exercises for the emergency exempt from engascale community-facility-based functional exercises of the emergency exempt from engascale community-facility-based functional exercises of this section is conclude, but is not (A) A second full-community-based functional exercises (B) A mock disast (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an erection of the exercises to test the per year. The hose (i) Participate in a that is community-based in a that is community-based community-based functional exercises to test the preparation of the exercises to test the exercises t	cunity based exercise is not cot an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is ging in its next required full based exercise or individual tional exercise following the gency event. Iditional exercise every 2 ee year the full-scale or enuder paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based ee; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed cared questions designed mergency plan. Spices that provide inpatient hospice must conduct exercise exercise exercise in annual full-scale exercise.					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005		UILDING	NSTRUCTION	(X3) DATE COMPL 07/15/	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 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)	ATE	(X5) COMPLETION DATE
	facility-based fund (B) If the hospice man-made emerg of the emergency exempt from enga full-scale commun functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full- community-based functional exercise. (B) A mock disas (C) A tabletop ex facilitator that inclusing a narrated, emergency scena statements, direct questions designe emergency plan. (iii) Analyze the h maintain documer exercises, and em the hospice's eme *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu	dditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ted messages, or prepared ed to challenge an sospice's response to and intation of all drills, tabletop inergency events and revise ergency plan, as needed. 441.184(d), Hospitals at a t §485.625(d):] PRTF, Hospital, CAH] must a to test the emergency ar. The [PRTF, Hospital, erfollowing: an annual full-scale exercise					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/15/2024		
	PROVIDER OR SUPPLIER	R ION AND HEALTHCARE CENTER		1345 N	DDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011	•	
DL/ (OIVIC	·		`	ANDLIN			
(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 APPROPRI	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(B) If the [PRTF, I	Hospital, CAH] experiences					
	an actual natural	or man-made emergency					
		ation of the emergency					
		is exempt from engaging in					
	-	ull-scale community based					
		ty-based functional exercise					
	_	et of the emergency event.					
	, ,	an [additional] annual					
		at may include, but is not					
	limited to the follo	•					
	, ,	scale exercise that is					
	community-based						
	-	ctional exercise; or					
	, ,	ock disaster drill; or					
		o exercise or workshop that					
	-	or and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
	to challenge an e	pared questions designed					
	_	he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
	-	cility's] emergency plan, as					
	needed.	omity of chilorgonoy plant, as					
	*[For PACE at §40	60.84(d):1					
	-	PACE organization must					
	, ,	s to test the emergency					
	plan at least annu						
	organization must	_					
	-	an annual full-scale exercise					
	that is community						
	-	nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					
	facility-based fund	ctional exercise; or					
	(B) If the PACE ex	xperiences an actual natural					
	or man-made eme	ergency that requires					
	activation of the e	mergency plan, the PACE					

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	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155005		UILDING	NSTRUCTION	COMPL 07/15/	ETED
	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
	full-scale community facility-based functional exercises of this section is community-based based functional exercises of this section is community-based based functional exercises functional exercises functional exercises functional exercises functional exercises functional exercises, and exercises, and exercises, and exercises, and exercises, and exercises functional exercises functional exercises, and exercises functional	the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: escale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. PACE's response to and nation of all drills, tabletop hergency events and revise gency plan, as needed. Les at §483.73(d):] ity] must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, he following: an annual full-scale exercise based; or nunity-based exercise is not loct an annual individual,					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BU	A. BUILDING B. WING			COMPLETED 07/15/2024	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD MADISON AVE			
BEAUMO	NT REHABILITATI	ON AND HEALTHCARE CENTER	₹	ANDER	SON, IN 46011			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
		le community-based or					2.112	
		based functional exercise						
	-	et of the emergency event.						
	-	dditional annual exercise						
	` '	but is not limited to the						
	following:							
	(A) A second full-	scale exercise that is						
	community-based	or an individual, facility						
	based functional e	exercise; or						
	(B) A mock disas							
	, ,	ercise or workshop that is						
	led by a facilitator	- ·						
	discussion, using							
	-	emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er	LTC facility] facility's						
		naintain documentation of						
		exercises, and emergency						
	·	e the [LTC facility] facility's						
	emergency plan, a							
	*[For ICF/IIDs at §	5483.475(d)1:						
	-	CF/IID must conduct						
	` '	he emergency plan at least						
		e ICF/IID must do the						
	following:							
	(i) Participate in a	n annual full-scale exercise						
	that is community	-based; or						
		nunity-based exercise is not						
		ct an annual individual,						
	•	ctional exercise; or.						
		experiences an actual						
		ade emergency that requires						
		mergency plan, the ICF/IID						
		gaging in its next required						
		nity-based or individual, ctional exercise following the						
	onset of the emer							
		gonoy event.						

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Facility ID: 000005

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	MENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155005	A. BUILDING B. WING	construction 	COMPLETED 07/15/2024	
	OF PROVIDER OR SUPPLIED MONT REHABILITAT	ON AND HEALTHCARE CENTE	1345	T ADDRESS, CITY, STATE, ZIP C N MADISON AVE ERSON, IN 46011	OD	
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE PPROPRIATE COMP	X5) LETION ATE
TAG	(ii) Conduct an acthat may include, following: (A) A second full-community-based facility-based fund (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an elementary (iii) Analyze the IC maintain documer exercises, and enthe ICF/IID's emethe ICF/IID's eme	Iditional annual exercise but is not limited to the scale exercise that is for an individual, ctional exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. CF/IID's response to and intation of all drills, tabletop inergency events, and revise rgency plan, as needed. 34.102] e HHA must conduct the emergency plan at e HHA must do the full-scale exercise that is it; or community-based exercise conduct an annual based functional exercise A experiences an actual adde emergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the	TAG	DEFICIENCY	DA	<u>IE</u>

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Event ID:

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Facility ID: 000005

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	r í	UILDING	NSTRUCTION		SURVEY LETED 5/2024		
	ROVIDER OR SUPPLIEF	RION 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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX CROSS-REFERENCED TO THE APPROPF TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		N BE PRIATE	(X5) COMPLETION DATE		
	of this section is of include, but is not (A) A second community-based facility-based function (B) A mock d (C) A tabletong is led by a facilitate discussion, using clinically-relevant set of problem state messages, or preto challenge an ere (iii) Analyze the H maintain documer exercises, and enter the HHA's emerged (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statement prepared question emergency plan. I actual natural or in requires activation OPO is exempt for required testing exercises, and emergency (ii) Analyze the Ol maintain documer exercises, and emergency secrecises, and emergency contains a communication of the emergency (iii) Analyze the Ol maintain documer exercises, and emergency activation of the emergency (iii) Analyze the Ol maintain documer exercises, and emergency activation of the emergency (iii) Analyze the Ol maintain documer exercises, and emergency activation of the emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises, and emergency (iii) Analyze the Ol maintain documer exercises (iiii) Analyze the Ol maintain documer exercises (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	conducted, that may limited to the following: full-scale exercise that is or an individual, ctional exercise; or isaster drill; or exercise or workshop that for and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ints, directed messages, or ins designed to challenge an lift the OPO experiences an man-made emergency plan, the ome engaging in its next exercise following the onset							

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Event ID:

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Facility ID: 000005

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		155005	B. WI	NG	_	07/15	/2024
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	C		1345 N	MADISON AVE		
BEAUMO	ONT REHABILITATI	ON AND HEALTHCARE CENTER		ANDER	RSON, IN 46011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	exercises to test to RNHCI must do the RNHCI must do the (i) Conduct a paper at least annually, group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain documer exercises, and enter the RNHCI's emel Based on record restailed to conduct explan at least twice punannounced staff or procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community facility-based function in the emergency perform engaging its in community-based of the emergency perform engaging its in community-based of the conset of the actual (ii) Conduct an addinclude, but is not least A second full-scale functional a. A second full-scale functional and the onset of the actual and the conset of the conset of the actual and the conset of the actual and the conset of the actual and the conset of the conset of the actual and the conset of the conset of the actual and the conset of the conset of the conset of the actual and the conset of the cons	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise rgency plan, as needed. view and interview, the facility tercises to test the emergency er year, including drills using the emergency or year, including drills using the emergency or ity-based exercise is not an annual individual, ional exercise. Ey experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale or individual, facility-based I exercise for I year following tal event. itional exercise that may imited to the following: the exercise that is or an individual, facility-based	E 00	039	E039 EP Testing Requirement 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 of form 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: All residents that reside at the	of ot ment the et	08/04/2024

T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2024	
ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE RSON, IN 46011		
SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR C. A tabletop exercifacilitator that incluated an arrated, clinically and a set of problem messages, or preparchallenge an emergination of the control of th	ON AND HEALTHCARE CENTER STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION se or workshop that is led by a des a group discussion, using relevant emergency scenario, a statements, directed ed questions designed to ency plan. C facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants. The Director, an annual mat is community-based was report by build affect all occupants The Director, an annual mat is community-based or an individual, fronal exercise, a mock disaster exercise or workshop that is led includes a group discussion, mically relevant emergency of problem statements, for prepared questions ge an emergency plan was not time of this survey. Based on ime of record review, the or advised that he had the anned for an upcoming date, t had an opportunity to c.	1345 N	MADISON AVE	to icient ty wed	
held on 07/15/24 at	ssed at the exit conference 2:25 p.m. with the Executive sintenance Director present.				

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	A. BUILDING <u>01</u> C			(3) DATE SURVEY COMPLETED 07/15/2024	
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COD MADISON AVE RSON, IN 46011	01710	2021	
(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 0000 Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/15 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety C Rehabilitation and H not in compliance w Participation in Mec Subpart 483.90(a), I 2012 edition of the I Association (NFPA) Chapter 19, Existing 410 IAC 16.2. This one-story facility Type V (111) constructions and detectors in the residuation to the corridors and detectors and detectors in the residuation to the corridors and detectors are correctly and detectors are correctly as a correctly and detectors are correctly as a correctly and detectors are correctly as a correctl	200005 55005 70840 Code survey, Beaumont Healthcare Center was found with Requirements for Hicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC), g Health Care Occupancies and Ity was determined to be of fruction and was fully ility has a fire alarm system in in the corridors, areas open battery-operated smoke dent sleeping rooms. The ty of 200 and had a census of its survey. residents have customary ered. All areas providing the sprinklered.	K 0000	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 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.	t ment the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/15/2024		
NAME OF PROVIDER OR SUPPLIER BEAUMONT REHABILITATION AND HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE							
(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)	.ΤΕ	(X5) COMPLETION DATE
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the National Electric Continual Fire Alarm Records of system and testing are ready 1.3, 9.6.1.5, Nor Based on observation failed to maintain that it had accurate accordance with the 2012 edition, Section 2010 edition 2010 edition 2010 edition 2010 edi	n - Testing and n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. FPA 70, NFPA 72 on and interview, the facility ne fire alarm system to assure time and date information in e requirements of NFPA 101- ons 19.3.4 and 9.6 and NFPA 72 ions 14.1, 14.1.1. This deficient t all residents, staff, and	K 0.		K345 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 this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions of 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: All residents that reside at the community have the potential be affected by the alleged defi	of ment the et	08/04/2024

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		A. BUILDING B. WING	01	COMPLETED 07/15/2024				
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
		2:25 p.m. with the Executive intenance Director present.		practice 3) Measures put into place/ System changes: Facility has updated the fire all control panel to ensure the codate & time was displayed. Find panel is actively operating accordingly. 4) How the corrective actions will be monitored: The Maintenance Director/designee will audit the panel 3 times per week to ensproper date, time and operation Audits will be reviewed in Quance Assurance Meeting monthly formonths or until 100% compliating achieved. The QA Committed will identify any trends or patter and make recommendations to revise the plan of correction actindicated.	e fire e fire ure on. dity or 6 nce eee erns o			
K 0374 SS=E Bldg. 01	Barrie Subdivision of Buil Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that re Nonrated protectiv are permitted. Doo fixed fire window a are self-closing or require latching, ai in the direction of a	esists fire for 20 minutes. The plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not are not required to swing egress travel. Door opening m clear width of 32 inches						

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i '					(X3) DATE	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPL			ETED	
		155005	B. WING 07/15/2024				
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			MADISON AVE		
BEAUMO	NT REHABILITATI	ON AND HEALTHCARE CENTER			RSON, IN 46011		
(V4) ID	CLIMMADY	STATEMENT OF DEFICIENCIE	1		<u> </u>		(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	19.3.7.6, 19.3.7.8			IAU			DATE
	· ·	ation and interview, the facility	K 0	27/	K374 Subdivision of Building	,	08/04/2024
	1	f 4 sets of smoke barrier doors	K U	3/4	Spaces- Smoke Barriers.	9	06/04/2024
		novement of smoke for at least			The facility requests paper		
		0.3.7.8 requires doors in smoke			compliance for this citation.		
		ly with LSC Section 8.5.4. LSC			This Plan of Correction is the		
	-	ors in smoke barrier shall close			center's credible allegation of		
	•	only the minimum clearance			compliance.		
		r operation. This deficient			Preparation and/or execution	of	
		at as many as 44 residents, 4			this plan of correction does no		
	staff and 2 visitors				constitute admission or agree		
		•			by the provider of the truth of		
	Findings include:				facts alleged or conclusions s		
	C				forth in the statement of		
	Based on observation	ons made on 07/15/24 at 1:05		deficiencies. The plan of			
	p.m. during a tour o	of the facility with the		correction is prepared and/or			
	Maintenance Direct	or, the set of smoke barrier			executed solely because it is		
	doors on the 300 Ha	all nearest to Resident room			required by the provisions of		
		completely when the door was			federal and state law.		
	-	rate occasions. Each time			1)Immediate actions taken fo	or	
	-	ere was a two-inch gap			those residents identified		
		when closed to their fullest.			No individuals were found to b	e	
		at the time of the observation,		affected by the finding.			
		rector acknowledged these			2)How the facility identified		
		t close completely, adding that			other residents:		
		loors looked at as soon as			44 residents that reside at the		
	possible.				community, 4 staff and 2 visito		
	m : :, ::	1 (4 2 2			had the potential to be affected by		
		assed at the exit conference			the alleged deficient practice		
		2:25 p.m. with the Executive			3) Measures put into place/		
	Director and the Ma	aintenance Director present.			System changes:		
	2.1.10(1)				Facility has ensured that all		
	3.1-19(b)				smoke doors within the facility		
	2) Pagad am aba	ation and interview the facility			in good working order and clo	se	
	1	ation and interview, the facility f 8 sets of corridor doors would			appropriately.	•	
		ke resistant barrier. This			A door closing coordinator wa		
		ould affect as many as 44			placed onto the doors leading	ເບ	
	_	d 2 visitors within the facility.			the Family Tree Dining Area. 4)How the corrective actions		
	residents, 4 stail all	a 2 visitors within the facility.			will be monitored:	•	
			I		will be illufficuled:		1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		r í	ILDING	01	COMPL 07/15/	ETED	
NAME OF PROVIDER OR SUPPLIER BEAUMONT REHABILITATION 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 APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	p.m. during a tour of Maintenance Directed doors leading to the of doors each swing south door equipped aforementioned dood door closing coordin equipped with an assmoke resistant barritime of observation, acknowledged the asset was not equipped coordinator to ensur astragal closes last a barrier and stated the to the door set as soon. This item was discussed in the door of t	ons made on 07/15/24 at 12:20 If the facility with the or, the set of smoke barrier "Family Tree Dining area" set in the same direction with the I with an astragal. The r set was not equipped with a nator to ensure the door tragal closes last and forms a ier. Based on interview at the the Maintenance Director forementioned corridor door d with a door closing the the door equipped with an and forms a smoke resistant at he would have one added on as possible. ssed at the exit conference 2:25 p.m. with the Executive intenance Director present.			The Maintenance Director/designee will audit factors smoke doors weekly to ensure proper closing procedure. At will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliar is achieved. The QA Committe will identify any trends or patter and make recommendations to revise the plan of correction as indicated.	udits r 6 nce ee rns	
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dri and unexpected tir conditions, at leas The staff is familia aware that drills ar routine. Where dri 9:00 PM and 6:00	t quarterly on each shift. r with procedures and is re part of established ills are conducted between					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/15/2024 155005 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1345 N MADISON AVE BEAUMONT REHABILITATION AND HEALTHCARE CENTER ANDERSON, IN 46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility K 0712 K712 Fire Drills 08/04/2024 failed to ensure 2 of 12 fire drills included the The facility requests paper verification of transmission of the fire alarm signal compliance for this citation. to the monitoring station in fire drills conducted This Plan of Correction is the between 6:00 a.m. and 9:00 p.m. for the last 4 center's credible allegation of quarters. LSC 19.7.1.4 requires fire drills in health compliance. care occupancies shall include the transmission of Preparation and/or execution of a fire alarm signal and simulation of emergency fire this plan of correction does not conditions. This deficient practice affects all constitute admission or agreement residents in the facility as well as staff and by the provider of the truth of the visitors. facts alleged or conclusions set forth in the statement of Findings include: deficiencies. The plan of correction is prepared and/or Based on record review of the documentation executed solely because it is entitled "Fire Drill Report" with the Maintenance required by the provisions of Director on 07/15/24 at 9:50 a.m., the fire drill forms federal and state law. had lines for the documentation to indicate the 1)Immediate actions taken for transmission of the fire alarm signal was reached those residents identified at the monitoring company. Based on the fire drills No individuals were found to be presented for review at the time of this survey, affected by the finding. both the March 25th, 2024 and the September 2)How the facility identified 20th, 2023 night shift fire drills lacked verification other residents: of the transmission of the fire alarm signal at the All individuals had the potential to monitoring company. Based on an interview at the be affected by the alleged deficient time of record review, the Maintenance Director practice advices that he was unaware he forgot to 3) Measures put into place/ document this item and stated that he would be System changes: more dilligent in the future with documenting this Facility has ensured verification of item on the fire drill report form. transmission of the fire alarm signal to the monitoring station This item was discussed at the exit conference with the monitoring company. held on 07/15/24 at 2:25 p.m. with the Executive 4)How the corrective actions Director and the Maintenance Director present. will be monitored:

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3.1-19(b)

3.1-51(c)

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The Maintenance

Director/designee will ensure

documentation and verification of fire alarm signal transmission to the monitoring system during

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/15/2024		
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		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	routinely scheduled fire drills. Documentation from these dril will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliant is achieved. The QA Committ will identify any trends or pattern and make recommendations to revise the plan of correction as indicated.	or 6 nce ee erns	DATE	
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib used or stored and location, and such signs that read NC posted with the int smoking. (2) In health care of smoking is prohibit prominently placed secondary signs with smoking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the pasupervision. (5) Ashtrays of no	ns shall be adopted and less than the following be prohibited in any room, ment where flammable le gases, or oxygen is do in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ted and signs are do at all major entrances, with language that prohibits be required. Intents classified as not be prohibited. Into f 18.7.4(3) shall not attent is under direct incombustible material and be provided in all areas						

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(6) Metal containers with self-closing cover

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005 A. BUILDING B. WING O1 O7/15/2024 STREET ADDRESS, CITY, STATE, ZIP COD 1345 N MADISON AVE ANDERSON, IN 46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDED NOT REPORTED OF COMPLETED 07/15/2024	
NAME OF PROVIDER OR SUPPLIER BEAUMONT REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP COD 1345 N MADISON AVE ANDERSON, IN 46011	
NAME OF PROVIDER OR SUPPLIER BEAUMONT REHABILITATION AND HEALTHCARE CENTER 1345 N MADISON AVE ANDERSON, IN 46011	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID	
PROVIDER'S PLAN OF CORRECTION	(X5)
	PLETION
	ATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005		r í	JILDING	nstruction 01	(X3) DATE COMPL 07/15 /	ETED	
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD MADISON AVE		
BEAUMO	ONT REHABILITATI	ON AND HEALTHCARE CENTER	₹	ANDER	SON, IN 46011		
(X4) ID PREFIX TAG	(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
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are re-	ent - Power Cords and ent - Power Cords and patient care vicinity are only			Director/designee will audit the smoking areas to ensure cigar disposal containers are free frounnecessary trash 5 times per week. Documentation from these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and ma recommendations to revise the plan of correction as indicated.	ette om n v ke	

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f ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED		
		155005	B. WING 07/15/2024					
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	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
	` `				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
TAG	installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3 (Based on observation failed to ensure 1 of using flexible cords wiring. LSC 9.1.2 requipment shall be a National Electrical Article 400.8 requir permitted, flexible coused as a substitute This deficient practice residents, 4 staff, and Findings include: Based on observation a.m. to 2:16 p.m. duthe Maintenance Dinoticed: a) at 11:50 a.m. the strip with a mini frie plugged into it b) at 12:10 p.m. the office had a power sinto it Based on interview observation, the Maintenance Dinotice acknowledged each that staff is aware pallowed but that it is need to be held as a This item was disculated in 17/15/24 at	ons made on 07/15/24 at 11:14 uring a tour of the facility with rector, the following was Marketing office had a power dge and a microwave oven Assistant Director of Nursing's strip with a mini fridge plugged at the time of each intenance Director use of a power strip adding ower strip usage is not eemed an in-service would	K 0	920	K920 Electrical Equipment- Power Cord and Extension Cords 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 no constitute admission or agree by the provider of the truth of the facts alleged or conclusions of 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 individuals were found to be affected by the finding. 2)How the facility identified other residents: All residents have the potential be affected by this finding. 3) Measures put into place/ System changes: Marketing office Power Cord removed. Assistant Director of Nursing's power strip was removed. An entire house audit was completed to ensure no non-approved power cords we present. Any located were ei	of of ot ment the et or oe al to was	DATE 08/04/2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI. AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155005			X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/15/2024		
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
					removed or replaced with hos grade power cords. 4)How the corrective actions will be monitored: The Maintenance Director/designee will audit 5 random areas 3 times per wee ensure no non-hospital grade power extension cords are present. Documentation from these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved The QA Committee will identifiany trends or patterns and material recommendations to revise the plan of correction as indicated.	ek to m in y ike e		

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