STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUMONT REHABILITATION AND HEALTHCARE CENTER	**1345 N MADISON AVE ANDERSON, IN 46011**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00425098, IN00425807, IN00426281, and IN00426363. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00424249 completed on December 28, 2023. Complaint IN00425098 - No deficiencies related to the allegations are cited. Complaint IN00425807 - No deficiencies related to the allegations are cited. Complaint IN00426281 - No deficiencies related to the allegations are cited. Complaint IN00426363 - No deficiencies related to the allegations are cited. Complaint IN00424249 - Corrected. Survey dates: January 18 & 19, 2024 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census Bed Type: SNF/NF: 116 SNF: 10 Total: 126 Census Payor Type: Medicare: 10 Medicaid: 103 Other: 13	F 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUMONT REHABILITATION AND HEALTHCARE CENTER	**1345 N MADISON AVE ANDERSON, IN 46011**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	Continued From page 1 Total: 126 Beaumont Rehabilitation and Healthcare Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00425098, IN00425807, IN00426281, and IN00426363. Quality review completed January 24, 2024.	F 000		