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	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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 Complaints IN00399161, IN00399658, IN00400108, and IN00402205. Complaint IN00399161 - Federal/state deficiencies related to the allegations are cited at F812. Complaint IN00399658 - No deficiencies related to the allegations are cited. Complaint IN00400108 - Federal/state deficiencies related to the allegations are cited at F584. Complaint IN00402205 - No deficiencies related to the allegations are cited. Survey dates: March 6 & 7, 2023 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census Bed Type: SNF/NF: 109 SNF: 11 Total: 120 Census Payor Type: Medicare: 11 Medicaid: 90 Other: 19 Total: 120 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 10, 2023.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian McKamie	HFA	03/17/2023

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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F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a			

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	temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to maintain the kitchen door frames in a safe manner, failed to secure a personal refrigerator placed on a five drawer dresser in a resident room, and failed to maintain wall coverings in resident rooms in good repair. Findings include: 1. During an initial walk-through of the kitchen, on 3/6/23 at 9:21 a.m., the metal door frame by the dishroom was observed to be rotting, approximately 10 inches up from the floor. The door frame had visible rust, with loose flaking noted, and the frame was loosened from the wall. The hallway door frame was observed to be rusted almost completely through at floor level, and continuing up approximately five inches. During an interview, on 3/7/23 at 11:27 a.m., the Administrator indicated he had become aware of the rusted door frames a couple weeks ago. Someone had come to provide a quote for replacement, but he had not heard back from them. He had no documentation from the potential provider. 2. During an initial walk-through of the facility, on 3/6/23 at 9:21 a.m., a personal refrigerator was observed in Room 409, next to the bed by the window. The refrigerator was placed on top of a five drawer dresser. The refrigerator and dresser top were approximately the same width, and neither were secured to the wall. This led to potential for the refrigerator to be pulled off the dresser when opened.	F 0584	**F 584D** **Safe/Clean/Comfortable/Homelike Environment** **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 identified to have been affected. Quotes received for purchase of metal doorframe identified by the dish room and hallway. Installation scheduled upon arrival. RM 409 -Personal refrigerator secured and dresser were secured to the wall. RM 406, 407 and 415 identified wallpaper was repaired.	03/24/2023

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	During a walk through with the Administrator, on 3/7/23 at 10:47 a.m., the refrigerator in room 409 was observed. The Administrator confirmed it was not secured to the wall, and was easily moveable on the dresser top. 3. During the same walk-through with the Administrator, on 3/7/23 at 10:47 a.m., rooms 406, 407, and 415 had wallpaper observed peeling away from the wall around the heating and air wall unit, under the windows. The Administrator indicated he was unaware of the peeling wallpaper. No policies were provided by the facility prior to exit. This Federal tag relates to complaint IN00400108. 3.1-19(a)(4)		**2)How the facility identified other resident:** No resident was identified to have been affected related to identification of needed facility repairs. Facility wide walk through was completed by Administrator, Maintenance Director, and Housekeeping Supervisor to identify facility repairs. Audit was conducted of residents with refrigerators located off the floor for safety and security. Any identified were secured appropriately. **3)Measures put into place/ System changes:** Maintenance added identified needed facility repairs to Preventative Maintenance. Log and with Administrator assistance prioritized needed repairs. Administrator will review daily during stand-up meeting scheduled facility maintenance repairs. Preventative Maintenance log will be reviewed and initialed weekly for completed repairs for 6 weeks. Educated staff to notify their supervisor should any resident voice concerns regarding Maintenance (repairs). Angel Rounds will be completed 5 times weekly per departmental managers to identify any areas of needed repair and reviewed in	

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			scheduled stand-up meeting. **4)How the corrective actions will be monitored:** The responsible party for this plan of correction is the joint effort of the Administrator/Maintenance Director/and Housekeeping Supervisor who will round together 2 times weekly. Identified areas are placed on a Preventative Maintenance log for follow up. The results of these audits will be reviewed in QAPI monthly for 6 months and or until 90% compliance is achieved for 3 consecutive months. The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 3-24-2023**	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent			

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	facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure canned foods were stored in a safe manner and failed to maintain a sanitary environment for plating resident servings during observations of the facility kitchen. Findings include: During the initial tour of the kitchen on 3/6/23 at 9:21 a.m., the dry food storage area included the following; 1. A six pound and 12 ounce can of sweet potatoes had a dent in the seam of the lid. 2. A can without a label had a dent in the seam near the lid. 3. A 105 ounce can of diced mixed fruit had a dent in the seam. During an interview, on 3/6/23 at 9:40 a.m., the Dietary Manager indicated dented cans should not be used, should be removed from the food storage area, and they did not have a policy related to dented cans. 4. During a follow-up tour of the kitchen, on 3/7/23	F 0812	F 812 E Food Procurement, Store/Prepare/Serve-Sanitary 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 identified to have been affected. Dented cans were discarded. The kitchen was cleaned, pest control accomplished.	03/24/2023

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	at 10:42 a.m., Cook 7 placed cut pieces of sheet cake onto individual serving plates. An uncovered trash receptacle was adjacent to her and gnats swarmed over the trash receptacle. The Dietary Manager indicated, at the time of the observation, he was aware of the gnats. Review of a current facility policy, titled, "Housekeeping Guidelines," undated and provided by the Administrator on 3/7/23 at 11:25 a.m., indicated the following: "...4. Pest control service will be monitored by the housekeeping personnel, and pesticides used will be in compliance with federal, state, and local laws. Housekeeping personnel shall report any problems or needs concerning pest control to the Administrator and contact will be made to the outside service...." No additional information was provided prior to exit. This Federal tag relates to complaint IN00399161. 3.1-19(f)(4)		**2) How the facility identified other residents:** Any resident residing in the facility had the potential to have been affected, however no resident was identified. **3) Measures put into place/ System changes:** Food Procurement, Storage/Prep/Serve-Sanitary policy. education to Dietary staff. Environmental Services/designee will observe/ monitor pests during daily facility rounding with specific attention to dietary/kitchen. Identified concerns will be immediately reported to the administrator and pest control notified as required. **4) How the corrective actions will be monitored:** The responsible party for this plan of correction is the Dietary manager with Executive Director oversight. Audits will be conducted weekly per dietary manager/designee to ensure no food cans are dented and labels are present. Identified areas of concern will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

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			The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance**: 3-24-2023	