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	11/13/2023

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 IN00421560 and IN00420764. Complaint IN00421560 - No deficiencies related to the allegations are cited. Complaint IN00420764 - Federal/State deficiencies related to the allegations are cited at F744. Survey date: November 13, 2023 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census Bed Type: SNF/NF: 114 SNF: 20 Total: 134 Census Payor Type: Medicare: 9 Medicaid: 114 Other: 11 Total: 134 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 15, 2023.	F 0000	11-20-2023 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 IN00421560, IN00420764 Beaumont Rehabilitation and Healthcare Center 1345 N Madison Ave Anderson, IN 46011 Survey Event ID Z46611 Dear Ms. Buroker: On November 13, a Complaint Survey (IN00421560, IN00420764) 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	Executive Director	11/20/2023

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 12-1-2023. Please feel free to call me with any further questions at 1-765-644-2888 Respectfully submitted, Brian McKamie, HFA	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on interview and record review, the facility failed to document and monitor behaviors and develop and implement a plan of care with targeted behavioral interventions for a cognitively impaired resident for 1 of 3 residents reviewed for behaviors. (Resident C) Findings include: The clinical record for Resident C was reviewed on 11/13/23 at 7:14 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, depressive disorder, and Parkinson's disease. The resident was admitted on 9/21/23. A 9/25/23, admission, Minimum Data Set (MDS) assessment indicated he was severely cognitively impaired. Review of a facility self-reportable, dated 10/30/23, indicated during morning care, Resident C bit	F 0744	F-744 D Treatment and Services/Dementia Care 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 on 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 was assessed, care	12/01/2023

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	CNA 1 on the hand, breaking the skin and causing the hand to bleed. Review of the clinical record indicated lack of documentation and/or monitoring for known behaviors. During an interview on 11/13/23 at 8:08 a.m., LPN 2 indicated the resident reported to her that he was hit by "a big black man". LPN 2 immediately reported the allegation to the Administrator. LPN 2 indicated the resident had been known to be resistant to care by staff. During an interview on 11/13/23 at 9:59 a.m., the Memory Care Social Service Director (SSD) indicated the resident had demonstrated aggressive behaviors towards staff for the past two weeks during a.m. and evening care. These behaviors were noticed prior to the incident with CNA 1. There should have been a care plan in place with interventions. The behaviors should have also been documented in the clinical record to be monitored. During an interview on 11/13/23 at 10:50 a.m., CNA 1 indicated they were providing A.M. care for the resident. During the care, the resident's shirt tangled around their neck. CNA 1 attempted to put a hand between the shirt and the resident's neck when the resident bit their hand, causing it to bleed. During an interview on 11/13/23 at 11:38 a.m., the Director of Nursing indicated all behaviors should be documented in the clinical record. Behaviors should also be monitored on the Medication Administration Record. The facility failed to document and monitor the resident's behaviors. The facility also failed to develop and implement a		plans reviewed and revised specifically related to individualized interventions to de-escalate behaviors and behavior monitoring. • Resident medications were reviewed, and he continues to follow with psyche services. • Care conferences were scheduled for any identified concerns. 2. How the facility identified other residents: • Audit was conducted of facility residents that have dementia with behaviors, care plans were reviewed and updated with interventions to de-escalate identified behaviors. • Special focus was accomplished for memory care units. 3. Measures put into place/ System changes: • Education provided on behavior monitoring documentation. • Education provided on dementia behavior redirection/de-escalation. • Care Plans update to reflect interventions. 4. How the corrective actions will be monitored: • The responsible party for this plan of correction is the Executive Director/ Director of Nursing. • Resident behaviors/documentation will be reviewed daily during morning/clinical meetings.	

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	care plan for the targeted behaviors. A current policy, dated 11/1/21, titled "Incident and Accidents" and provided by the DON on 11/13/23 at 11:38 a.m., indicated the following: ".... An 'incident' is defined as any happening, not consistent with the routine operation of the facility, that does not result in bodily or property damage. Physical or mental mistreatment (abuse - actual or suspected) of a resident is considered an 'incident' whether or not actual injury occurred. An 'accident is defined as any happening, not consistent with the routine operation of the facility that results in bodily injury other than abuse. An incident/accident report will be completed for .... 6. All unexpected events that occur that cause actual or potential harm to a resident or employee ...." A current policy, dated 11/2/21, titled "Behavior and Psychoactive management Program" and provided by the DON on 11/13/23 at 11:38 a.m., indicated the following: " .... Facility's Behavior management Program will consist of: .... 6. Planning and implementing appropriate interventions into the resident's plan of care. ...." A current, undated policy titled "Care Plans Protocol" provided by the DON on 11/13/23 at 11:38 a.m., indicated the following: ".... Establishing and updating Care Plans .... The care plan should be revised on and on-going basis to reflect changes in the resident and the care the resident is receiving. Acute changes and order changes should be addressed on the care plan and are the responsibility of staff nurses to establish, revise, or discontinue care plan goal or interventions (i.e.		• Audits will be conducted by social services 2 times weekly on 3 residents on behaviors and documentation, audits will be reviewed during clinical morning meetings. • Identified issues will result in re-education. • Audits will be reviewed monthly during Quality Assurance and will continue for 6 months or until 95% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Compliance 12-1-2023	

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	acute orders - antibiotic, IV, new drugs, change in orders, change in treatments, fall intervention, etc.) ...." This citation relates to Complaint IN00420764. 3.1-37(a)			