PRINTED: 05/06/2024
FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				ON	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPI	LETED
		155005	B. W	ING		04/05	/2024
				CTREET	ADDRESS STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
RΕΔΙΙΜΟ	NIT REHARII ITATI	ION AND HEALTHCARE CENT	FR		I MADISON AVE RSON, IN 46011		
DLAGING	THE INDICITATION			ANDLI	10011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
		ne Investigation of Complaints	F 0	000			
	IN00431055, IN004	431082, and IN00431111.					
	G 11	1055 31 100					
	Complaint IN00431055 - No deficiencies related to						
	the allegations are o	eited.					
	G 1 ' + D100421	1000 F 1 1/G . 1 5					
	_	1082 - Federal/State deficiencies					
		ations are cited at F0609 and					
	F0610.						
	Commissint INIO0421	1111 Fadamal/State deficiencies					
		1111 - Federal/State deficiencies ations are cited at F0609 and					
	F0610.	tions are cited at F0009 and					
	10010.						
	Survey dates: Apri	1.4 and 5, 2024					
	Burvey dates. 71pm	1 1 tilita 3, 202 i					
	Facility number: 00	00005					
	Provider number: 1						
	AIM number: 1002						
	Census Bed Type:						
	SNF/NF: 109						
	SNF: 8						
	Total: 117						
	Census Payor Type	:					
	Medicare: 6						
	Medicaid: 95						
	Other: 16						
	Total: 117						
	TI 1	O 4 O 4 E 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
		reflect State Findings cited in					
	accordance with 41	U IAC 16.2-3.1.					
	Quality ravious com	npleted April 15, 2024.					
	Quality IEVIEW COIL	ipicica Apiii 13, 2024.	ı		1		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIE	TITLE	(X6) DATE	
Mary Clark	DON		04/22/2024

Any defiency statement 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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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 04/05/2024			ETED	
	ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		1345 N	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)	ΓE	(X5) COMPLETION DATE
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(Reporting of Allege §483.12(c) In resp abuse, neglect, ex the facility must: §483.12(c)(1) Ensiviolations involving exploitation or mis injuries of unknow misappropriation or reported immediat hours after the allegevents that cause or result in serious than 24 hours if the allegation do not in result in serious be administrator of the officials (including Agency and adult state law provides care facilities) in a through established §483.12(c)(4) Repinvestigations to the her designated repofficials in accordatincluding to the State	B)(c)(1)(4) ed Violations conse to allegations of coloitation, or mistreatment, ure that all alleged g abuse, neglect, ctreatment, including n source and of resident property, are cely, but not later than 2 regation is made, if the the allegation involve abuse s bodily injury, or not later e events that cause the nvolve abuse and do not odily injury, to the e facility and to other to the State Survey protective services where for jurisdiction in long-term coordance with State law ed procedures. Fort the results of all the administrator or his or presentative and to other ance with State law, ate Survey Agency, within the incident, and if the s verified appropriate					
	Based on interview failed to report an all of property within re Indiana Department	and record review, the facility llegation of misappropriation equired timeframe to the of Health for 1 of 3 residents propriation. (Resident C)	F 06	509	F 609D Reporting of Alleged Violations The facility respectively requests a desk review for th citation.	is	04/23/2024
	Finding includes:				Preparation, submission, an	d	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	f /	JILDING	00	COMPLE	ETED
		155005	B. WI	NG		04/05/2	2024
				CTREET	ADDRESS OF A STATE FOR SOR		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DEVIINA	VIIT DEUVDII ITAT	ION AND HEALTHCARE CENTER			MADISON AVE		
DEAUIVIC	JINI NEHADILIIAI	ION AND REALINCARE CENTER		ANDER	RSON, IN 46011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	T	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					implementation of this Plan	of	
		al record was reviewed on			Correction does not constitu	ute	
	_	Diagnoses included displaced			an admission of or agreeme		
		acture of the left femur,			with the facts and conclusion	_	
		ter for closed fracture with			set forth in the survey repor	t.	
	1	cohol abuse, difficulty in					
	walking, and weak	ness.			Our Plan of Correction is		
					prepared and executed to		
	An admission Minimum Data Set (MDS)				continuously improve the		
		2/11/24, indicated the resident			quality of care and to compl	-	
	was cognitively int	act.			with all applicable state and		
					federal regulatory		
		ted 3/4/24 at 6:55 p.m.,			requirements.		
		ent was transferred to the					
		y Room for lethargy. The					
		red information on any personal					
	items sent to the ho	ospital with the resident.					
		. 10/4/04 11.00			1. Immediate actions taken f	or	
		ted 3/4/24 at 11:22 p.m.,			those residents identified:		
		ent was admitted to the			Resident C has a phone	e,	
	hospital.				charger, and his glasses.		
	Danie	4/4/24 -+ 4 40			Facility education provide	ded	
	_	w on 4/4/24 at 4:40 p.m.,			on reporting requirements.		
	_	sentative indicated the resident			O Hamaba fa differ intende		
		ility on 2/8/24 with his and his glasses. The resident			2. How the facility identified		
		ed every other day at the			other residents:		
	1 -	ent had his phone and glasses			An audit was conducted over the past 60days of risk	'	
	1	isits prior to his transfer to the			management and grievances		
		g of 3/4/24 via emergency			No other resident was	.	
		EMS). The resident's			affected.		
	,	the resident in the Emergency			ancolou.		
	1 -	here he asked for his phone and			3. Measures put into		
		5/24, the resident representative			place/ System changes:		
	_	lity to pick up the resident's			Education was provided	l on	
		to deliver them to the resident			Policy and Procedure related		
		nen the resident representative			reporting requirements and a		
		ty on 3/5/24, the Administrator			to reporting domain(gateway)		
		ent's glasses and charging cord			provided to additional staff sh		
	for his phone. He t				the Executive Director of Dire		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155005 B. WING 04/05/2024 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE representative he was unable to find the resident's of Nursing be unavailable to report. phone. The resident's representative contacted The Director of Clinical EMS and they indicated the resident did not have Services will be notified of any a phone with him during transport. After reportable event, assistance with inappropriate messages were received by family reporting will be provided as from the residents missing telephone on 3/6/24, required. the resident's representative determined the Events will be reported per phone was stolen. On 3/6/24, the resident's reporting guidelines. representative contacted the Administrator via Review of the 24-hour report phone and told him the phone was stolen from the during scheduled IDT meetings to facility when the resident was sent to the hospital. identify reportable events. The Administrator indicated the staff member on Issues identified will be duty during the resident's transfer reported the immediately addressed with resident's phone was sent to the hospital with the additional education and or resident. Between 3/6/24 and 3/22/24, the facility disciplinary action. had not provided an update on an investigation, nor let the resident's representative know what 4. How the corrective actions they planned to do about the resident's stolen will be monitored: phone. The phone was not returned, nor The responsible party for replaced, by the facility. As a result, the family this plan of correction is the contacted the phone service provider and tracked Executive Director/Director of the resident's stolen phone. A police report was Nursing/designee. initiated and the device was tracked to the Events will be audited and residence of CNA 3 on 3/22/24. On 3/22/24, the reviewed daily during resident's representative contacted the facility and morning/clinical meetings via the indicated the police were involved and the phone IDT team to review the 24-hour had been tracked to CNA 3's residence. The report to determine if anything had Administrator indicated the staff member was occurred that may meet the removed from duty pending an investigation. reporting requirements. Facility staff will Review of the facility completed investigation on immediately notify the Executive 4/4/24 at 2:07 p.m., indicated the resident's phone Director should an event occur was reported lost on 3/4/24 during the resident's that requires or may require hospital transfer. The alleged misappropriation reporting. was reported to the Indiana Department of Health Identified areas of concern on 3/22/24. The report lacked detail of will be reported per guidelines and communication held between the Administrator additional education provided as and the resident representative alleging the phone required. had changed from lost to stolen prior to 3/22/24. Staff will be educated on abuse upon hire, annually and as

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		155005	B. WING		04/05/2024
			CTREET	ADDRESS CITY STATE ZID COD	
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD	
DEALINAC	NIT DELLA DIL ITA TI	ON AND LIEAL THOADS OSNITED		MADISON AVE	
BEAUMO	INT REHABILITATI	ON AND HEALTHCARE CENTER	ANDER	RSON, IN 46011	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Review of the polic	e report on 4/5/24 at 9:56 a.m.,		needed with a focus on report	ing
	provided by the Pol	ice Department, indicated the		requirements.	
	police went to CNA	3's residence and began a		Audits will continue 5 tim	nes
	theft investigation of	of the resident's phone.		weekly for 6 months and or ur	til
				100% compliance has been	
	During an interview	on 4/5/24 at 3:22 p.m., the		achieved for 3 consecutive	
	Administrator indic	ated the resident was		months, at which time the QA	
	transferred to the ho	ospital on 3/4/24 due to a		committee will review to identi	fy
	change in condition	. The resident's		any trends or patterns and ma	ke
	representative came	to the facility on 3/5/24 to		recommendations to revise the	e
	pick up the resident	's glasses and phone. The		plan of correction.	
	Administrator found	d the resident's glasses and			
	phone charger, but l	he was unable to find the		5. Date of Correction	
	phone. He told the	resident representative they		4-23-2024	
	-	with the residents when they			
		out he would ask a staff who			
		nt on 3/4/24 what happened to			
	_	e. He asked CNA 3 because he			
		resident transferred to the			
	-	reported the phone was sent			
		Ie did not complete the facility			
	reportable incident	-			
		ntil he was contacted by the			
		ve on 3/22/24, when the police			
		the phone was tracked to CNA			
	3's residence.				
	_	on 4/5/24 at 4:31 p.m., the			
		ated he received a call from the			
	•	ive on 3/6/24. The resident			
	_	ated the phone had been			
		lity and the family had received			
		ages from the resident's stolen			
	_	n the facility became aware			
		tion of misappropriation of			
		ity should have reported the			
	allegation of misapp	propriation on 3/6/24.			
	A assumant for -:1:4	alian marriand 6/12/19 4:41-4	1		
		olicy, revised 6/13/18, titled	1		
	Abuse Prevention	and Reporting - Indiana,"	1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	PROVIDER 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 CY 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
	indicated the follow resident has the right neglect, misappropriand exploitation Talleged violations in exploitation or mist unknown source and property, are reported than 2 hours after the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in long the events that the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours after the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if	on 4/5/24 at 1:27 p.m., ring: "Guidelines: The at to be free from abuse, riation of resident property, riming of Reporting: All avolving abuse, neglect, reatment, including injuries of d misappropriation of resident ed immediately, but not later at allegation is made, if the et allegation involve abuse or dily injury; or not later than 24 that cause the allegation do and do not result in serious the administrator of the efficials (including to the ey and adult protective et law provides for jurisdiction cilities) in accordance with stablished procedures. The the ISDH Incident Reporting					
F 0610 SS=D Bldg. 00	§483.12(c) In resp	nt/Correct Alleged Violation conse to allegations of oploitation, or mistreatment,					
	violations are thore §483.12(c)(3) Pre-	ve evidence that all alleged oughly investigated. vent further potential abuse, on, or mistreatment while in progress.					

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	PROVIDER OR SUPPLIED	ON AND HEALTHCARE CENTER		1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE RSON, 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
	investigations to the her designated reofficials in accordincluding to the S 5 working days of alleged violation is corrective action in Based on interview failed to thoroughly misappropriation or residents reviewed (Resident C) Finding includes: During an interview Administrator was complete investigate abuse/misapproprial last 30 days. Resident C's clinical 4/4/24 at 1:12 p.m. intertrochanteric from subsequent encount routine healing, allowed walking, and weaks An admission Minital assessment, dated 2 was cognitively into assistance for trans. A Nurse's Note, dated indicated the resident hospital Emergency clinical record lacks.	and record review, the facility investigate an allegation of fresident property for 1 of 3 for misappropriation. If you on 4/4/24 at 10:42 a.m., the requested to provide the tion files for any ution investigations held in the all record was reviewed on Diagnoses included displaced acture of the left femur, ter for closed fracture with ohol abuse, difficulty in	F 06	510	F 610D Investigate/Prevent/Correct Alleged Violation The facility respectively requests a desk review for t citation. Preparation, submission, ar implementation of this Plan Correction does not constitut an admission of or agreeme with the facts and conclusion set forth in the survey report Our Plan of Correction is prepared and executed to continuously improve the quality of care and to compl with all applicable state and federal regulatory requirements 1. Immediate actions taken for those residents identified: Resident C did not displicated ill effects related to the investigation. allegation of misappropriation	nd of ute nt ons t. y	04/23/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 04/05/2024
	PROVIDER OR SUPPLIEI ONT REHABILITAT	RION AND HEALTHCARE CENTE	1345 N	ADDRESS, CITY, STATE, ZIP COD N MADISON AVE RSON, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	indicated the reside	ted 3/4/24 at 11:22 p.m., ent was admitted to the		resident property. Resident C has a phone	е.
	Administrator was the complete facility. Review of the facil 4/4/24 at 2:07 p.m. began on 3/22/24. reported lost on 3/4 hospital transfer. To communication hel and the resident rephad changed from 1 The investigation in interview with the had reported the all 3/22/24, an interviev 3/22/24, an interviev via telephone on 3/ misappropriation of on 3/23/24, and two on 3/28/24. The information of the staff member During an interview Resident C's representative visit facility. The reside every day during via hospital the evening medical services (E	ity completed investigation on a indicated the investigation. The resident's phone was 1/24 during the resident's. The report lacked detail of the discontinuous detail discontinuous detail discontin		2. How the facility identified other residents: Current residents have potential to be affected. No other resident was identified to have been affect Audit conducted of last days of grievances and risk management to identify if any misappropriation may have occurred. 3. Measures put into place/ System changes: The NHA was educated the policy and procedure of thoroughly investigating allegations of misappropriation resident property. Facility education was provided on Policy and Procedure detailed to timely reporting requirements. All potential allegations be reported to the RDO and limmediately for review to ensithorough investigation has be initiated and conducted. Events will be reported reporting guidelines. Review of the 24-hour mand Grievances during schedult in the policy and grievances during schedult.	ed. 60 / d on on of edure will RNC sure a een per report duled
	_	here he asked for his phone and		events.	-

his glasses. On 3/5/24, the resident representative

Issues identified will be

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	F PROVIDER OR SUPPLIES	RION AND HEALTHCARE CENTER	₹	1345 N	ADDRESS, CITY, STATE, ZIP COD MADISON AVE RSON, IN 46011		
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TAG	stopped by the faci glasses and phone in the hospital. Wharrived at the facilit provided the reside for his phone. He to representative he we phone. The resident EMS and they indicate a phone with him do in the resident's representative control phone and told him facility when the resident's phone was stolen. The Administrator duty during the resident's phone was resident. Between had not provided an nor let the resident' they planned to do phone. The phone replaced, by the fact contacted the phone the resident's representative and the deresidence of CNA are sident's represent indicated the police had been tracked to Administrator indicated the police had been tracked to Administrator indicated by the Popolice went to CNA police went to CNA pol	R LSC IDENTIFYING INFORMATION lity to pick up the resident's to deliver them to the resident then the resident representative try on 3/5/24, the Administrator nt's glasses and charging cord		TAG	immediately addressed with additional education and or disciplinary action. 4. How the corrective actions will be monitored: The responsible party fo this plan of correction is the Executive Director/Director of Nursing/designee. Events will be audited at reviewed daily during morning/clinical meetings via to IDT team to review the 24-hour report to determine if anything occurred that may meet the reporting requirements. Facility staff will immediately notify the Execution Director should an event occut that requires or may require reporting. Identified areas of concewill be reported per guidelines additional education provided required. Staff will be educated or abuse upon hire, annually and needed with a focus on report requirements. Audits will continue 5 time weekly for 6 months and or una 100% compliance has been achieved for 3 consecutive months, at which time the QA committee will review to identification any trends or patterns and may recommendations to revise the plan of correction.	the ur had ve r and as ing hes hill	DATE

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	facility, indicated C resident's unit from	dule for 3/4/24, provided by the CNA 3 was assigned to the 2:00 p.m. to 10:00 p.m. the t was transferred to the			5. Date of Correction 4-23-2024		
	Administrator indic surveillance up and misappropriation be	or on 4/5/24 at 8:51 a.m., the sated they did not have running during the alleged etween 3/4/24 to 3/6/24, so he de surveillance footage in his					
	DON indicated she	on 4/5/24 at 10:18 a.m., the would check into the lack of the facility's investigation.					
	Confidential intervi survey and indicate	ews were held during the d the following:					
	questions regarding suspicions of misap	-					
	questions regarding suspicions of misap members, requested nor included in an i	ated they were not asked any residents' missing items, propriation by other staff to provide any statements, investigation of the last month until today.					
	questions regarding suspicions of misap	ated they were not asked any residents' missing items, oppropriation by other staff I to provide any statements, nvestigation of					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/05/2024
	ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	1345 N	ADDRESS, 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 the last month.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Employee #7 indicated questions regarding suspicions of misap members, requested nor included in an immisappropriation in Employee #5 indicated questions regarding suspicions of misap members, requested nor included in an immisappropriation in During an interview Administrator indicated in the investigation hand-written staff in signatures, were professed and thought it was stand on the left sid the hospital about a and thought it was significant in the investigation hand-written staff in signatures, were professed and indicated his phone and charge take his phone, but stand on the left sid the hospital about a and thought it was sight stand. He ask from the facility and was without a phone His phone was not in facility had not compare the supplementation of the facility had not compare the supplementation of the su	residents' missing items, propriation by other staff I to provide any statements, nvestigation of the last month. Ited they were not asked any residents' missing items, propriation by other staff I to provide any statements,			
	Administrator indic	on 4/5/24 at 3:22 p.m., the ated the resident was ospital on 3/4/24 due to a			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155005	B. WI	NG		04/05/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	t .			MADISON AVE		
BFAUMO	NT REHABII ITATI	ON AND HEALTHCARE CENTER			SON, IN 46011		
	T		1				
(X4) ID		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	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	change in condition						
	1 -	to the facility on 3/5/24 to					
	1	's glasses and phone. The					
		d the resident's glasses and					
		he was unable to find the					
	_	resident representative he					
		who was with the resident on					
		e status the resident's phone.					
		ecause he was there when the					
		erred. The CNA reported the					
	_	n the resident. He did not start ralleged misappropriation					
	until he was contacted by the family representative on 3/22/24 when she told him the						
	1 -	l and the phone was tracked to					
	CNA 3's residence.	and the phone was tracked to					
	CIVA 3's residence.						
	During an interview	on 4/5/24 at 4:12 p.m., the					
	_	ated investigations of					
		tion should include interviews					
		arties, interviews of other					
	_	views with other staff members					
		time of the alleged event and					
	worked with the all	_					
		5 1 1					
	A current facility po	olicy, revised 6/13/18, titled					
		and Reporting - Indiana,"					
		N on 4/5/24 at 1:27 p.m.,					
		ving: "Guidelines: The					
		nt to be free from abuse,					
	_	riation of resident property,					
		nvestigation Procedures: The					
	_	tor will, at minimum, attempt to					
		n who reported the incident,					
	anyone likely to have	ve direct knowledge of the					
		ident, if interviewable. Any					
		hat have been submitted will					
	be reviewed, along	with any pertinent medical					
		cuments. Residents to whom					
	the accused has reg	ularly provided care, and					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/06/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155005	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/05/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	worked, will be inte any one has witness exploitation, mistres resident property by	om the accused has regularly erviewed to determine whether sed any prior abuse, neglect, atment or misappropriation of the accused individual" to Complaints IN00431082				

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