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	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEAUMONT REHABILITATION AND HEALTHCARE CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00431055, IN00431082, and IN00431111. Complaint IN00431055 - No deficiencies related to the allegations are cited. Complaint IN00431082 - Federal/State deficiencies related to the allegations are cited at F0609 and F0610. Complaint IN00431111 - Federal/State deficiencies related to the allegations are cited at F0609 and F0610. Survey dates: April 4 and 5, 2024 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census Bed Type: SNF/NF: 109 SNF: 8 Total: 117 Census Payor Type: Medicare: 6 Medicaid: 95 Other: 16 Total: 117 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 15, 2024.	F 0000		

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

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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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report an allegation of misappropriation of property within required timeframe to the Indiana Department of Health for 1 of 3 residents reviewed for misappropriation. (Resident C) Finding includes:	F 0609	**F 609D Reporting of Alleged Violations** **The facility respectively requests a desk review for this citation.** **Preparation, submission, and**	04/23/2024

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	Resident C's clinical record was reviewed on 4/4/24 at 1:12 p.m. Diagnoses included displaced intertrochanteric fracture of the left femur, subsequent encounter for closed fracture with routine healing, alcohol abuse, difficulty in walking, and weakness. An admission Minimum Data Set (MDS) assessment, dated 2/11/24, indicated the resident was cognitively intact. A Nurse's Note, dated 3/4/24 at 6:55 p.m., indicated the resident was transferred to the hospital Emergency Room for lethargy. The clinical record lacked information on any personal items sent to the hospital with the resident. A Nurse's Note, dated 3/4/24 at 11:22 p.m., indicated the resident was admitted to the hospital. During an interview on 4/4/24 at 4:40 p.m., Resident C's representative indicated the resident admitted to the facility on 2/8/24 with his telephone, charger and his glasses. The resident representative visited every other day at the facility. The resident had his phone and glasses every day during visits prior to his transfer to the hospital the evening of 3/4/24 via emergency medical services (EMS). The resident's representative met the resident in the Emergency Room on 3/4/24, where he asked for his phone and his glasses. On 3/5/24, the resident representative stopped by the facility to pick up the resident's glasses and phone to deliver them to the resident in the hospital. When the resident representative arrived at the facility on 3/5/24, the Administrator provided the resident's glasses and charging cord for his phone. He told the resident's		**implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in 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 has a phone, charger, and his glasses. Facility education provided on reporting requirements. **2. How the facility identified other residents:** An audit was conducted over the past 60days of risk management and grievances. No other resident was affected. **3. Measures put into place/ System changes:** Education was provided on Policy and Procedure related to reporting requirements and access to reporting domain(gateway) was provided to additional staff should the Executive Director of Director	

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

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	Review of the police report on 4/5/24 at 9:56 a.m., provided by the Police Department, indicated the police went to CNA 3's residence and began a theft investigation of the resident's phone. During an interview on 4/5/24 at 3:22 p.m., the Administrator indicated the resident was transferred to the hospital on 3/4/24 due to a change in condition. The resident's representative came to the facility on 3/5/24 to pick up the resident's glasses and phone. The Administrator found the resident's glasses and phone charger, but he was unable to find the phone. He told the resident representative they usually send those with the residents when they go to the hospital, but he would ask a staff who was with the resident on 3/4/24 what happened to the resident's phone. He asked CNA 3 because he was there when the resident transferred to the hospital. The CNA reported the phone was sent with the resident. He did not complete the facility reportable incident report for alleged misappropriation until he was contacted by the family representative on 3/22/24, when the police were involved, and the phone was tracked to CNA 3's residence. During an interview on 4/5/24 at 4:31 p.m., the Administrator indicated he received a call from the resident representative on 3/6/24. The resident representative indicated the phone had been stolen from the facility and the family had received inappropriate messages from the resident's stolen phone. That is when the facility became aware there was an allegation of misappropriation of property. The facility should have reported the allegation of misappropriation on 3/6/24. A current facility policy, revised 6/13/18, titled "Abuse Prevention and Reporting - Indiana,"		needed with a focus on reporting requirements. Audits will continue 5 times weekly for 6 months and or until 100% compliance has been achieved for 3 consecutive months, at which time the QA committee will review to identify any trends or patterns and make recommendations to revise the plan of correction. **5. Date of Correction** 4-23-2024	

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	provided by the DON on 4/5/24 at 1:27 p.m., indicated the following: "Guidelines: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation... Timing of Reporting: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures. The facility will follow the ISDH Incident Reporting Policy criteria...." This citation relates to Complaints IN00431082 and IN00431111. 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate an allegation of misappropriation of resident property for 1 of 3 residents reviewed for misappropriation. (Resident C) Finding includes: During an interview on 4/4/24 at 10:42 a.m., the Administrator was requested to provide the complete investigation files for any abuse/misappropriation investigations held in the last 30 days. Resident C's clinical record was reviewed on 4/4/24 at 1:12 p.m. Diagnoses included displaced intertrochanteric fracture of the left femur, subsequent encounter for closed fracture with routine healing, alcohol abuse, difficulty in walking, and weakness. An admission Minimum Data Set (MDS) assessment, dated 2/11/24, indicated the resident was cognitively intact. He required moderate assistance for transfers, toileting, and dressing. A Nurse's Note, dated 3/4/24 at 6:55 p.m., indicated the resident was transferred to the hospital Emergency Room for lethargy. The clinical record lacked information on any personal items sent to the hospital with the resident.	F 0610	**F 610D** **Investigate/Prevent/Correct Alleged Violation** **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 in 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 did not display ill effects related to the investigation. allegation of misappropriation of	04/23/2024

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	A Nurse's Note, dated 3/4/24 at 11:22 p.m., indicated the resident was admitted to the hospital. During an interview on 4/4/24 at 1:45 p.m., the Administrator was requested to provide a copy of the complete facility investigation. Review of the facility completed investigation on 4/4/24 at 2:07 p.m., indicated the investigation began on 3/22/24. The resident's phone was reported lost on 3/4/24 during the resident's hospital transfer. The report lacked detail of the communication held between the Administrator and the resident representative alleging the phone had changed from lost to stolen prior to 3/22/24. The investigation included the following: an interview with the resident's representative who had reported the allegation to the police on 3/22/24, an interview with the police officer on 3/22/24, an interview with the alleged perpetrator via telephone on 3/22/24, an in-service regarding misappropriation of resident property and money on 3/23/24, and twelve other resident interviews on 3/28/24. The investigation lacked interviews of other staff members. During an interview on 4/4/24 at 4:40 p.m., Resident C's representative indicated the resident admitted to the facility on 2/8/24 with his telephone, charger and his glasses. The resident representative visited every other day at the facility. The resident had his phone and glasses every day during visits prior to his transfer to the hospital the evening of 3/4/24 via emergency medical services (EMS). The resident's representative met the resident in the Emergency Room on 3/4/24, where he asked for his phone and his glasses. On 3/5/24, the resident representative		resident property. Resident C has a phone. **2. How the facility identified other residents:** Current residents have the potential to be affected. No other resident was identified to have been affected. Audit conducted of last 60 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 on the policy and procedure of thoroughly investigating allegations of misappropriation of resident property. Facility education was provided on Policy and Procedure related to timely reporting requirements. All potential allegations will be reported to the RDO and RNC immediately for review to ensure a thorough investigation has been initiated and conducted. Events will be reported per reporting guidelines. Review of the 24-hour report and Grievances during scheduled IDT meetings to identify reportable events. Issues identified will be	

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	stopped by the facility to pick up the resident's glasses and phone to deliver them to the resident in the hospital. When the resident representative arrived at the facility on 3/5/24, the Administrator provided the resident's glasses and charging cord for his phone. He told the resident's representative he was unable to find the resident's phone. The resident's representative contacted EMS and they indicated the resident did not have a phone with him during transport. After inappropriate messages were received by family from the residents missing telephone on 3/6/24, the resident's representative determined the phone was stolen. On 3/6/24, the resident's representative contacted the Administrator via phone and told him the phone was stolen from the facility when the resident was sent to the hospital. The Administrator indicated the staff member on duty during the resident's transfer reported the resident's phone was sent to the hospital with the resident. Between 3/6/24 and 3/22/24, the facility had not provided an update on an investigation, nor let the resident's representative know what they planned to do about the resident's stolen phone. The phone was not returned, nor replaced, by the facility. As a result, the family contacted the phone service provider and tracked the resident's stolen phone. A police report was initiated and the device was tracked to the residence of CNA 3 on 3/22/24. On 3/22/24, the resident's representative contacted the facility and indicated the police were involved and the phone had been tracked to CNA 3's residence. The Administrator indicated the staff member was removed from duty pending an investigation. Review of the police report on 4/5/24 at 9:56 a.m., provided by the Police Department, indicated the police went to CNA 3's residence and began a theft investigation of the resident's phone.		immediately addressed with additional education and or disciplinary action. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Executive Director/Director of Nursing/designee. Events will be audited and reviewed daily during morning/clinical meetings via the IDT team to review the 24-hour report to determine if anything had occurred that may meet the reporting requirements. Facility staff will immediately notify the Executive Director should an event occur that requires or may require reporting. Identified areas of concern will be reported per guidelines and additional education provided as required. Staff will be educated on abuse upon hire, annually and as needed with a focus on reporting requirements. Audits will continue 5 times weekly for 6 months and or until 100% compliance has been achieved for 3 consecutive months, at which time the QA committee will review to identify any trends or patterns and make recommendations to revise the plan of correction.	

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	Review of the schedule for 3/4/24, provided by the facility, indicated CNA 3 was assigned to the resident's unit from 2:00 p.m. to 10:00 p.m. the evening the resident was transferred to the hospital. During an interview on 4/5/24 at 8:51 a.m., the Administrator indicated they did not have surveillance up and running during the alleged misappropriation between 3/4/24 to 3/6/24, so he was unable to include surveillance footage in his investigation. During an interview on 4/5/24 at 10:18 a.m., the DON indicated she would check into the lack of staff interviews in the facility's investigation. Confidential interviews were held during the survey and indicated the following: Employee # 8 indicated they were not asked any questions regarding residents' missing items, suspicions of misappropriation by other staff members, requested to provide any statements, nor included in an investigation of misappropriation in the last month. Employee # 9 indicated they were not asked any questions regarding residents' missing items, suspicions of misappropriation by other staff members, requested to provide any statements, nor included in an investigation of misappropriation in the last month until today. Employee #6 indicated they were not asked any questions regarding residents' missing items, suspicions of misappropriation by other staff members, requested to provide any statements, nor included in an investigation of		**5. Date of Correction** 4-23-2024	

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	misappropriation in the last month. Employee #7 indicated they were not asked any questions regarding residents' missing items, suspicions of misappropriation by other staff members, requested to provide any statements, nor included in an investigation of misappropriation in the last month. Employee #5 indicated they were not asked any questions regarding residents' missing items, suspicions of misappropriation by other staff members, requested to provide any statements, nor included in an investigation of misappropriation in the last month until today. During an interview on 4/5/24 at 11:00 p.m., the Administrator indicated staff interviews were not in the investigation file provided. Seven hand-written staff interviews, without staff signatures, were provided at this time and dated 3/28/24. During an interview on 4/5/24 at 12:59 p.m., the resident indicated he admitted to the facility with his phone and charger. He did not see anyone take his phone, but he left his phone on the night stand on the left side of his bed when he went to the hospital about a month ago. He was very sick and thought it was safe to leave his phone on the night stand. He asked his family to get his phone from the facility and she looked everywhere. He was without a phone for approximately 2 weeks. His phone was not returned, nor replaced. The facility had not communicated with him to let him know what they planned to do about his phone. During an interview on 4/5/24 at 3:22 p.m., the Administrator indicated the resident was transferred to the hospital on 3/4/24 due to a			

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BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

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	change in condition. The resident's representative came to the facility on 3/5/24 to pick up the resident's glasses and phone. The Administrator found the resident's glasses and phone charger, but he was unable to find the phone. He told the resident representative he would ask the staff who was with the resident on 3/4/24 regarding the status the resident's phone. He asked CNA 3 because he was there when the resident was transferred. The CNA reported the phone was sent with the resident. He did not start the investigation for alleged misappropriation until he was contacted by the family representative on 3/22/24 when she told him the police was involved and the phone was tracked to CNA 3's residence. During an interview on 4/5/24 at 4:12 p.m., the Administrator indicated investigations of abuse/misappropriation should include interviews with the involved parties, interviews of other residents, and interviews with other staff members who worked at the time of the alleged event and worked with the alleged perpetrator. A current facility policy, revised 6/13/18, titled "Abuse Prevention and Reporting - Indiana," provided by the DON on 4/5/24 at 1:27 p.m., indicated the following: "...Guidelines: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation... Investigation Procedures: The appointed investigator will, at minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and			

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	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual...." This citation relates to Complaints IN00431082 and IN00431111. 3.1-28(d)			