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	12/08/2022

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 Investigation of Complaints IN00395685 and IN00393526. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00395685 - Substantiated. Federal/State deficiencies related to the allegation are cited at F607. Complaint IN00393526 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: December 7 and 8, 2022 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census Bed Type: SNF/NF: 99 SNF: 10 Total: 109 Census Payor Type: Medicare: 18 Medicaid: 81 Other: 10 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 13, 2022.	F 0000	12-20-22 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 IN00395685, IN00393526, IN00395685 and Covid-19 Focused Infection Control Survey. Beaumont Rehabilitation and Healthcare Center 1345 N Madison Ave Anderson, IN 46011 Survey Event ID Z46611 Dear Ms. Buroker: On December 7th and 8th of 2022, a Complaint Survey (IN00395685, IN00393526, IN00395685 and Covid-19 Focused Infection Control Survey) 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian McKamie	HFA	12/15/2022

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			compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 12-20-2022 Please feel free to call me with any further questions at 1-765-644-2888 Respectfully submitted, Brian McKamie, HFA	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following			

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	elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on interview and record review, the facility failed to ensure staff (CNA 2) immediately reported suspected verbal abuse and/or mistreatment of residents (Resident C, G and H) to the Administrator. Findings include: 1. The clinical record for Resident C was reviewed on 12/7/2022 at 1:20 p.m. Diagnoses included, but were not limited to, COVID 19, diabetes type 2, cerebrovascular infarction and acute kidney failure. 2. The clinical record for Resident G was reviewed on 12/8/2022 at 10:00 a.m. Diagnoses included, but were not limited to, aphasia, cerebral palsy, cerebrovascular accident, hemiplegia/hemiparesis, and depression. 3. The clinical record for Resident H was reviewed on 12/8/2022 at 10:28 a.m. Diagnoses included, but were not limited to, arthritis, urinary tract infection, and anemia. During a review of a facility investigation for abuse, CNA (Certified Nursing Aide) 2 indicated on 11/24/2022 he witnessed RN 1 being verbally abusive to Resident G and Resident H. In a written statement, CNA 2 indicated RN 1 told both residents to "shut up" and ignored their call	F 0607	F-607D Development/Implement Abuse/Neglect Policies 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: Residents identified to have been affected were interviewed by social services and no psychosocial issues were identified. C.N.A #2 received 1-1 education on reporting requirements. Education initiated immediately with facility staff on abuse policy and procedure with focus on immediate notification of Executive	12/20/2022

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	lights. The statement was dated 11/28/2022, four days after the incident. During an interview, on 12/8/2022 at 11:23 a.m., CNA 2 indicated they reported to the Administrator the allegation of abuse on 11/28/2022, after they witnessed a repeated behavior by RN 1 involving Resident C. During an interview, on 12/8/2022 at 12:00 p.m., the Administrator indicated CNA 2 informed him of the allegations on 11/28/2022. Review of a current undated policy, provided by the Infection Preventionist on 12/7/2022 at 11:03 a.m., titled "Abuse, Neglect, and Misappropriation of Resident Property" indicated the following: "... Policy Interpretation and Implementation...1. The staff will not commit verbal, mental, sexual or physical abuse, including punishment or involuntary seclusion. ... 8. The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source are reported immediate to the Administrator of the facility and to other officials in accordance with state law through established procedures (Including to the State survey and certification agency). The Administrator and/or other officials shall notify ISDH in accordance with ISDH Guidelines...." This Federal tag relates to complaint IN00395685. 3.1-28(c)		Director. 2. How the facility identified other residents: Any resident that was cared for by RN #1 had the potential to be affected, however no other resident was identified when interviews were conducted by Social Services director/Director of Nursing/designee RN#1 no longer employed by facility 3. Measures put into place/ System changes: Facility staff educated on components of F607 Develop/Implement Abuse/Neglect Policies with special focus placed on timely notification of Executive Director. 4. How the corrective actions will be monitored: The responsible party for this plan of correction is the Executive Director/Director of Nursing/designee who will interview three residents weekly related to abuse. Three facility staff will be interviewed weekly to include all shifts to determine understanding of abuse reporting guidelines. Identified areas of concern will be immediately reported per guidelines and additional education provided as required.	

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			Staff will be educated on abuse upon hire, annually and as needed. Abuse audits will be reviewed during scheduled morning meetings and monthly during Quality Assurance. Audits will continue three 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 12-20-2022	