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

PRINTED: 12/22/2022 FORM APPROVED OMB NO. 0938-0391

			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155005	B. WING			R-C 12/21/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	CODE	121.	21/2022
				1345 N MADISON AVE			
BEAUMONT REHABILITATION AND HEALTHCARE CENTER				ANDERSON, IN 46011	DERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	((EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 0	00}			
	Paper compliance to the Investigation of Complaint IN00395685 completed on December 8, 2022.						
	Review Date: December 21, 2022						
	Facility Number: 000005						
	Provider Number: 155005 AIM Number: 100270840						
	was found to be in co 483, Subpart B and 4	tion and Healthcare Center ompliance with 42 CFR Part 10 IAC 16.2-3.1, in regard to e review to the Complaint					
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.