STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Rehabilitation and Healthcare Center	1345 N Madison Ave Anderson, IN 46011

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. A. Based on record review and interview, the facility failed to notify the State Ombudsman of resident transfers to the hospital for 3 of 5 residents reviewed for hospitalization. (Resident 83, Resident 120, and Resident 44) B. Based on record review and interview, the facility failed to provide the transfer/discharge notification and bed hold policy to the resident/representative when the resident was discharged for 2 of 5 residents reviewed for hospitalization. (Resident 18 and Resident 44) Findings include: A1. Resident 83's clinical record was reviewed on 9/18/25 at 12:42 p.m. Diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation and acute and chronic respiratory failure with hypoxia. A 7/18/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. A 2/16/25, progress note indicated Resident 83 was sent out to the hospital due to shortness of breath. All necessary parties were made aware. A 2/17/25, progress note indicated the resident was admitted to the hospital for pneumonia. A 2/19/25, progress noted indicated the resident returned to the facility from the hospital. Review of the facility Monthly Transfer Report to the Ombudsman for February 2025 lacked Resident 83's discharge to the hospital on 2/16/25. A2. Resident 120's clinical record was reviewed on 9/17/25 at 10:09 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), generalized anxiety disorder, and fibromyalgia. A 7/25/25, discharge, MDS assessment indicated the resident discharged with a return anticipated. A 7/20/25 social services note indicated the resident was severely cognitively impaired. A 7/25/25 nurse's note. indicated the resident was sent to the emergency room (ER) after rolling out of bed and striking her head. Review of the Monthly Transfer Report to the Ombudsman for July 2025 lacked Resident 120's discharge to the hospital on 7/25/25. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A3. Resident 44's clinical record was reviewed on 9/16/25 at 3:59 p.m. Diagnoses included hypertension, epilepsy. and anxiety disorder. A 6/13/25, quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. A 5/25/25, nurse's note indicated the resident was sent to the emergency room due to complaints of difficulty breathing. A 5/25/25, discharge MDS assessment indicated the resident discharged with a return anticipated. A 5/29/25, entry MDS assessment indicated the resident returned to the facility. Review of the Monthly Transfer Report to the Ombudsman for May 2025 lacked Resident 44's discharge to the hospital on 5/25/25. During an interview, on 9/18/25 at 1:15 p.m., the Social Services Assistant indicated he kept a monthly log of discharges. He gathered the discharged residents information from the discharge/transfer report. He emailed himself the completed log and then uploaded the log onto the Ombudsman notification website. There was a confirmation number provided when the log was uploaded but he didn't keep the information. He would contact the Ombudsman office to obtain verification of the information he sent. He completed this task at the beginning of every month. During an interview on 9/19/25 at 10:13 a.m., the SSD indicated the Social Services Assistant submitted the monthly transfer/discharge notifications to the State Ombudsman. On 9/19/25 at 10:42 a.m., the Social Services Assistant indicated the Monthly Transfer Report to the Ombudsman for February 2025 included all the residents' transfer/discharge notifications provided to the Ombudsman for February 2025. Resident 83's discharge for 2/16/25 was not included on the log. On 9/19/25 at 10:59 a.m., the Social Services Assistant indicated the facility lacked any further Ombudsman notification information. During a follow-up interview, on 9/19/25 at 11:23 a.m., the Social Services Assistant indicated Resident 44 should have been included on his monthly discharge log for May 2025. A current facility policy, effective 9/11/23, titled, Notice of Transfer or Discharge, provided by the SSD on 9/19/25 at 10:11 a.m., indicated the following: .The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman . B1. Resident 44's clinical record was reviewed on 9/16/25 at 3:59 p.m. Diagnoses included hypertension, epilepsy. and anxiety disorder. A 6/13/25, quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. A 5/25/25, nurse's note indicated the resident was sent to the emergency room due to complaints of difficulty breathing. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 5/25/25, discharge MDS assessment indicated the resident discharged with a return anticipated. A 5/29/25, entry MDS assessment indicated the resident returned to the facility. The clinical record lacked documentation that the resident or resident's representative was provided with a copy of the bed hold policy and notice of transfer. B2. Resident 44's clinical record was reviewed on 9/16/25 at 3:59 p.m. Diagnoses included hypertension, epilepsy. and anxiety disorder. A 6/13/25, quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. A 5/25/25, nurse's note indicated the resident was sent to the emergency room due to complaints of difficulty breathing. A 5/25/25, discharge MDS assessment indicated the resident discharged with a return anticipated. A 5/29/25, entry MDS assessment indicated the resident returned to the facility. The clinical record lacked documentation that the resident or resident's representative was provided with a copy of the bed hold policy and notice of transfer. During an interview on 9/18/25 at 10:07 a.m., LPN 8 indicated for transfers/discharges the nursing staff were required to print and provide a copy of the bed hold policy and transfer form to the emergency services staff when they arrived to transport the resident to the hospital. The resident's representative was notified of the transfer via telephone. No paperwork was provided to the resident or the resident's representative when they were transferred to the hospital. During an interview, on 9/18/25 at 4:20 p.m., the SSD indicated she was present when Resident 44 was discharged on 5/25/25. She remembered personally providing the Emergency Medical Technician (EMT) with the Bed Hold policy and Notice of Transfer or Discharge. During a follow-up interview, on 9/19/25 at 10:21 a.m., the SSD indicated the facility policy did not tell who the discharge/transfer and bed hold forms should be provided to at the time of discharge. She provided the paperwork to the EMTs and assumed the resident would be given the documents upon arrival to the hospital. On 9/19/25 at 11:00 a.m., the SSD indicated the resident/resident's representative should have been provided with a copy of the bed hold policy and transfer/discharge form when residents were transferred or mailed to them in the event of an emergency. When residents were cognitively impaired, the bed hold policy and transfer discharge form should have been provided to the resident's representative. On 9/19/25 at 11:28 a.m., the SSD indicated the facility was unable to provide any information to indicate the resident representative received copies of the bed hold policy and the notice of transfer/discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, effective 9/11/23, titled, Notice of Transfer or Discharge, provided by the SSD on 9/19/25 at 10:11 a.m., indicated the following: It is the policy of the facility to notify the resident and/or their legal guardian or representative before transfer and/or discharge according to state and federal regulations . II. Notice must be made as soon as practicable before transfer or discharge except in such cases when it is unplanned or deemed an emergency .d. An immediate transfer or discharge is required by the resident's urgent medical needs .f. The facility will complete a Notice of Transfer Form and explain to the resident/representative at the time of the transfer and then a copy of the notice shall be mailed to the resident representative on the next business day . A current facility policy, effective 9/11/23, titled, Bed Hold Policy Notice, provided by the SSD on 9/19/25 at 10:11 a.m., indicated the following: .A copy of the facility Bed-Hold Policy will be provided to all residents and/or resident representatives at the time of admission. Additionally, notice will be provided to the resident, and if applicable the resident's representative at the time of the transfer, or in cases of emergency transfer, a verbal notification will be provided within 24 hours and a copy of the Bed-Hold Policy will be mailed to the resident representative the next business day . 3.1-12 (a)(4) 3.1-12(a)(6)(A)(i) 3.1-12 (a)(26)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure timely completion of a required Level I Preadmission Screening and Resident Review (PASARR) assessment for 1 of 2 residents reviewed for PASARR. (Resident 6) Findings include:Resident 6's clinical record was reviewed on 9/17/25 at 10:20 a.m. Diagnoses included hypokalemia, stage 3 chronic kidney disease, and acute kidney failure. His admission date was 8/6/25. His discharge date was 9/15/25. Review of a Level of Care Screen Outcome, dated 7/31/25, indicated short term approval for intermediate nursing care for the duration of 30 days. The end date was 8/30/25. Review of a Level I PASARR Screen Outcome, dated 7/31/25 indicated the exempted hospital discharge allowed for a 30 day duration without further PASRR evaluation. If more time was required, the nursing facility must submit a new Level 1 screen. This must be completed by or before the 30th day after admission to the nursing facility. During an interview, on 9/18/25 at 3:30 p.m., the Social Service Assistant (SSA) indicated Resident 6's current Level 1 had an end date of 8/31/25. He needed to look for additional documentation and/or screenings for this resident. During an interview, on 9/18/25 at 3:58 p.m., the SSA indicated the facility utilized an online system to prompt for additional screenings that were due or required. This system had stopped updating appropriately in the last few weeks. The corporate office was aware of the program errors and everyone was trying to remain current with screenings. Resident 6 should have had an additional Level 1 when it was discovered his stay would be longer than the approved duration listed in the original Level 1 screening. During an interview, on 9/18/25 at 4:01 p.m., the Social Service Director (SSD) indicated the SSA utilized an online system to streamline and track the screenings required for residents. This system had not been updating appropriately and this issues was forwarded to the management staff. The social services department was doing it's best to keep up to date and current with all screenings. Resident 6 should've had an additional Level 1 since he did not discharge in the 30 day period. An undated current facility policy, titled, PASRR Completion Policy, provided by the Administrator on 9/19/25 at 10:32 a.m., indicated the following: The facility will make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed .3. SSD is accountable for monitoring the process of completing the necessary paperwork for the admission. 4. SSD will maintain copies of the LOC and/or PASSRR in the social services resident file.3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. A. Based on observation, interview, and record review, the facility failed to prepare, serve, and distribute food under safe sanitary conditions regarding food temperatures at the time of service. This deficient practice had the potential to impact 116 of 116 residents who resided in the facility.B. Based on observation, interview, and record review, the facility failed to ensure sanitation of cookware in the three-compartment sink. This deficient practice had the potential to impact 116 of 116 residents who resided in the facility.Findings include:A. During the initial kitchen tour on 9/15/25 at 10:00 a.m., the three-compartment sink was observed to have food particles in sink 1 (the wash sink), utensils in sink 2 (the rinse sink), and utensils and pans in sink 3 (the sanitizing sink). The Dietary Manager tested the sanitizing sink for the concentration of the sanitizing liquid. The test strip registered zero sanitizing agent. The Dietary Manager indicated the water was too cold and would not activate the sanitizer when it was cold. The water temperature booster had not been working properly. Dietary staff should wait until water was at least at room temperature to begin the sanitation process. All dishware washed in the three-compartment sink would need to be re-washed and re-sanitized.During an observation of the three-compartment sink on 9/17/25 at 12:48 p.m., the wash sink had food particles, utensils were in the rinse sink, and utensils and pans in the sanitizing sink. To the left of the sink, two roasting pans, which were covered with water droplets, were stored upright to dry. The Dietary Manager tested the sanitizing solution in the sanitizing sink/sink 3. The solution registered zero sanitizing agent. The Dietary Manager indicated the water was too cold to register the solution. A current, 4/20, facility policy titled, Cleaning Dishes- Manual Dishwashing, which was provided by the Regional Dietary Director in 9/17/26 at 1:22 p.m., indicated: Sink 3: SanitizeSanitize Dishes:1. Measure the appropriate amount of sanitizing chemical into the appropriate amount of water.Water should be 75 to 100 [degrees] F [Fahrenheit]. 2. Test the sanitizing solution in the sink using the manufacturer's test strips to assure appropriate levels. A current, 4/21, facility policy titled, Chlorine Solutions, which was provided by the Regional Dietary Director in 9/17/26 at 1:22 p.m., indicated: Manual Washing Using Chemicals to SanitizeAn exposure time of at least 10 seconds of a chlorine solution of 50 mg/L that has a pH of 10.B. During an observation of lunch meal service on 9/15/25 from 11:56 a.m. to 12:10 p.m., [NAME] 13 began serving meal trays without taking temperatures of the food items on the steam table. There were 10 separate food items on the steam table. The cook served 11 meal trays without taking any food temperatures. Following the service of the eleventh meal tray, [NAME] 13 was interviewed and indicated he did not take food temperatures at the point of service on the steam table. He instead had taken food temperatures at the oven/stove prior to the food being put in the steam table and held until service. He did not record the food temperatures on the log. He instead remembered the temperatures of all the items and recorded them when the meal was done. He indicated temperatures should be recorded when taken.Review of facility Daily Food Temperature Sheets for 9/1/25 to 9/15/25 Lunch (15 days and 44 meals), provided by the Regional Dietary Director on 9/15/25 at 3:19 p.m., indicated the following dates and meals which lacked documented food temperatures: 9/4/25 Dinner, 9/8/25 Dinner had only regular textured foods recorded, no pureed foods were documented, 9/8/25 Breakfast and Lunch, 9/12/25 Dinner, and 9/15/25 lunch.During an interview on 9/19/2025 at 10:55 a.m., the Dietary Manager indicated all 116 of the facility's 116 residents received meals prepared in the facility's kitchen.A current, undated, facility policy titled, Food Temperatures, which was provided by the Regional Dietary Director in 9/17/26 at 1:22 p.m., indicated: All hot food must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 [degrees] F.3.1-21(i)(1)3.1-21(i)(3)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies regarding Enhanced Barrier Precautions (EBP). Finding includes: Review of the Summary Statement of Deficiencies for the facility's last annual recertification and licensure survey, completed on 7/2/24, indicated the facility had deficiencies related to failure to follow infection control guidelines related to EBP.During an interview, on 9/19/25 at 12:41 p.m., the Administration indicated the Quality Assessment and Assurance (QAA) committee met quarterly to review current facility concerns. The QAA committee utilized an online program to assist with streamlining the process, assessing trends, and documentation of these meetings. The current nursing topics were changes in Minimum Data Set (MDS) regulations. The Administrator indicated the facility did not have any current QAPI or Performance Improvement Plans (PIP) in place for isolation procedures such as Enhanced Barrier Precautions (EBP).Repeat concerns regarding infection control were cited during the 9/19/25 survey as follows:Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed during a dressing change for 1 of 2 residents reviewed for EBP. (Resident 19)A facility policy, dated 10/1/23, titled, Quality Assurance and Performance Improvement Program Policy, provided by the Administrator following entrance conference on 9/15/25 indicated the following: .C. The Facility shall demonstrate compliance with the federal regulations governing QAPI programs and QAA committees through: a. Evidence of systems and reports demonstrating identification, reporting, investigation, analysis, and prevention of adverse events. B. Data collection and analysis at regular intervals. C. Documentation demonstrating development implantation and evaluation of corrective actions or performance improvement activities.Cross reference F880.3.1-52(b)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed during a dressing change for 1 of 2 residents reviewed for EBP. (Resident 19)Finding includes:On 9/15/25 at 10:47 a.m. Resident 19 was seated in a wheelchair watching television while the housekeeper mopped the floor of her room. No EBP signage or personal protective equipment (PPE) cart was observed. Resident 19's record was reviewed on 9/18/25 at 1:38 p.m. Medical diagnoses included major depressive disorder, acquired deformity of left and right lower leg, and polyneuropathy (complex nerve pain). Current physician orders included, surgical site right lower extremity cleanse with normal saline or wound wash, and apply silver alginate. Apply skin protectant film to peri wound then cover with dressing and secure daily. A nurse practitioner's note, dated 9/4/25 at 9:38 a.m., indicated the resident had a wound to her right shin with slough (moist, soft, non-viable tissue) on the surface easily penetrated to the underlying bone with a Q-tip.During a wound observation on 9/19/25 at 8:46 a.m., LPN 15 gathered supplies and entered Resident 19's room after performing hand hygiene with alcohol-based hand rub (ABHR). He did not don a gown prior to entering the room. The LPN donned gloves, created a barrier on the resident's bed for supplies, and removed the previous dressing with gloves hands. During dressing removal, his scrub pants were observed touching the left side of the resident's bed multiple times. He performed hand hygiene, donned new gloves, and applied a new dressing to the area. During the application of the new dressing, LPN 15's scrub pants again touched the left side of the resident's bed. Hand hygiene was performed and the work area was cleaned up. During an observation outside of the resident's room, on 9/19/25 9:01 a.m., an EBP sign was observed across the hall from the resident's room. The sign indicated ENHANCED BARRIER PRECAUTIONS, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound care: any skin opening requiring a dressing. During an interview, on 9/19/25 at 9:02 a.m., LPN 15 indicated he did not wear a gown during the dressing change because Resident 19 did not require EBP. An order would have been placed in the electronic medical record (EMR) and signage placed outside of the resident's room. During an interview, on 9/19/25 at 9:59 a.m., the DON indicated staff were expected to implement EBP. Residents requiring EBP were placed on Certified Nurse Aide (CNA) assignment sheets and residents with wounds were communicated to staff directly. Resident 19 was not placed on EBP, and staff were not informed she required EBP during care.A Centers for Disease Control (CDC) document dated 11/15/22 from cdc. gov/infection-control/media/pdfs/Webinar-EBPinNH-Nov2022-Slides-508.pdf and reviewed on 9/22/25 at 9:36 a.m. indicated the following: .What are High-Contact Resident Care Activities? .Wound Care Generally defined at the care of any skin opening requiring a dressing.Use EBP when performing high-contact resident care activities and for residents who meet criteria for the use of EBP, includes the use of gown and gloves.3. 1-18(b)(2)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to provide COVID-19 vaccines per the Center for Disease and Control (CDC) guidance for 1 of 5 residents reviewed for immunizations. (Resident 44)Findings includes: Resident 44's clinical record was reviewed on 9/17/25 at 1:53 p.m. Diagnoses included essential hypertension, epilepsy, and anxiety disorder. A 1/22/25, physician's order indicated Resident 44 may have all age appropriate and pertinent vaccinations. A 6/13/25, quarterly, Minimum Data Set (MDS) assessment indicated Resident 44 was cognitively intact. Review of the resident's vaccinations included the following: The resident had no historical administration of the Pneumococcal vaccine. A 2/25/25, Vaccine Consent Form, indicated Resident 44 was educated and consented to the appropriate pneumococcal vaccination. The clinical record lacked further documentation of the pneumococcal vaccination. During an interview, on 9/19/25 at 11:50 a.m., LPN 18 indicated she was just recently asked to oversee the vaccination records. She was unable to locate any documentation indicating that Resident 44 received a pneumococcal vaccination. When a resident consented to a vaccination, the facility could request the vaccinations from the pharmacy for administration. The facility had a planned vaccine clinic for this coming October and pneumococcal vaccines would be given. On 9/19/25 at 11:50 a.m., the DON indicated she was unable to provide documentation that Resident 44 had received the appropriate vaccination. A current facility policy, effective 10/31/24, titled, Pneumococcal Vaccination Policy, provided by the Administrator on 9/19/15 at 1:19 p.m. indicated the following: . 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized .#. Prior to offering the pneumococcal immunization, each resident or resident's representative will receive education regarding the benefits and potential side effects of the immunization with the education being documented in the clinical record .5. A consent for shall be signed prior to the administration of the vaccine and filed in the individual's medical record . 3.1-18(b)(2)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to provide COVID-19 vaccines per the Center for Disease and Control (CDC) guidance for 1 of 5 residents reviewed for immunizations. (Resident 44)Findings includes: Resident 44's clinical record was reviewed on 9/17/25 at 1:53 p.m. Diagnoses included essential hypertension, epilepsy, and anxiety disorder. A 1/22/25, physician's order indicated Resident 44 may have all age appropriate and pertinent vaccinations. A 6/13/25, quarterly, Minimum Data Set (MDS) assessment indicated Resident 44 was cognitively intact. Review of the resident's vaccinations included the following: The resident had a historical administration of the COVID-19 vaccination on 1/26/21 and 2/23/21. A 2/25/25, Vaccine Consent Form, indicated Resident 44 was educated and consented to the appropriate COVID-19 vaccination. The clinical record lacked further documentation of the COVID-19 vaccination. During an interview, on 9/19/25 at 11:50 a.m., LPN 18 indicated she was just recently asked to oversee the vaccination records. She indicated she was unable to locate any documentation indicating that Resident 44 received the COVID-19 vaccination. When a resident consents to a vaccination, the facility can request the vaccinations from the pharmacy. On 9/19/25 at 11:50 a.m., the DON indicated she was unable to provide documentation that Resident 44 had received a recent COVID-19 vaccination. A current policy, effective 10/31/24, titled, COVID-19 Vaccination Policy, provided by the Administrator on 9/19/15 at 1:19 p.m. indicated the following: . 1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against COVID-19 disease in accordance with national standards of practice .13. The facility may administer the vaccine directly or the vaccine may be administrated indirectly through and arrangement with a pharmacy provider or local health department .14. The facility will educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of such .21. The resident's medical record will include documentation of the following: .b. Each dose of the vaccine administered to the resident . 3. 1-18(b)(5)