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	08/01/2025

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

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement interventions of two staff for bed mobility for a dependent resident (Resident B) to prevent a fall from bed when the resident rolled from the bed during care and struck their head on a nightstand, resulting in a major head injury and hospitalization in the Intensive Care Unit (ICU). (Resident B) This deficient practice was corrected on 7/29/25, prior to the start of the survey, and was therefore past noncompliance. Findings include:Resident B's clinical record was reviewed on 7/30/2025 at 10:00 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes, dementia, stage 2 chronic kidney disease, atherosclerotic heart disease, anxiety, depressive disorder, hydrocephalus (buildup of fluid in brain) and aortocoronary bypass. Resident B admitted to the facility on [DATE] from another skilled facility.Review of the admission observation, dated 7/17/2025, indicated the resident required partial to moderate assistance for rolling left to right.A care plan, dated 7/17/2025, indicated the resident required two-person assistance for bathing and dressing. The resident required a mechanical lift for transfers and a wheelchair for mobility.An admission fall risk assessment, dated 7/17/2025, indicated the resident was alert and oriented to person, place and time. The resident had no falls within the past 30 days. The resident was chair bound and was not able to perform function for gait/balance. A physical therapy evaluation and treatment plan, dated 7/21/2025, indicated the resident was dependent for bed mobility. An occupational therapy evaluation and plan of treatment, dated 7/21/2025, indicated the resident was dependent for bed mobility.A facility self-reported incident, dated 7/26/2025, indicated during care, a CNA assisted Resident B in positioning onto her side. The resident rolled off the bed and her head made contact with the nightstand located next to the bed. The resident appeared to have a change in her level of consciousness. The charge nurse was called, and the resident was sent to the hospital for evaluation and treatment. A small laceration to the back of the head with a scant amount of blood was noted. Upon arrival, the resident was noted to have new onset of atrial fibrillation with RVR (rapid ventricular response) and was placed in observation. A progress note, dated 7/25/2025 at 7:48 p.m., indicated the resident was accidentally rolled out of the bed. She hit her head on the dresser next to the bed. 911 was called and the resident was sent to the hospital. The incident was witnessed by the aide in the room (CNA 3) and the resident was unconscious for a couple of minutes.A progress note, dated 7/26/2025 at 5:21 p.m., indicated when the aide was assisting the resident, the resident got too close to the side of the bed and rolled onto the floor, hitting her head on the dresser. She had a bump on the left front side of her head and a small opening on the back of her head with some bleeding. Pressure was applied to stop the bleeding. She was also placed on her side and was assessed. Neurological assessment was completed and she was alert and oriented to person and time.The facility investigation of the fall included a written statement, dated 7/25/2025, from CNA 3 who indicated that while she provided incontinence care to Resident B, she rolled the resident onto her side and continued with the care. During the process, the resident unexpectantly rolled further and fell from the bed and hit her head. A written statement, dated 7/25/2025, from LPN 1 indicated she heard CNA 3 yell from Resident B's room. When she arrived, the resident was on the floor and was unconscious for a few minutes. The resident was turned to her side and pressure was applied to the back of her head due to bleeding. The resident was able to communicate after a few minutes. Vital signs included temperature 98.3, blood pressure 147/78, heart rate 102 beats per minute and respirations 22 per minute. The resident had an oxygen saturation of 94% and complained of head pain where her head had been struck. 911 was called and the resident was transported to the hospital for evaluation and treatment. A head CT (radiology study), dated 7/25/2025, indicated a small amount of traumatic left frontal subarachnoid hemorrhage (bleeding in space between brain and membrane). No subdural or epidural (other layers of the skull and brain) hematoma. No parenchymal hemorrhage. Ventricles are stable in size. No skull fracture. IMPRESSION: 1. Small amount of traumatic left frontal subarachnoid hemorrhage. No skull fracture.The Emergency Department provider note, dated 7/25/2025, indicated Resident B presented with complaints of a fall at the nursing home, hitting the back of her head on the nightstand. She stated she was not sure why she fell. She was normally non-ambulatory and used a wheelchair. Reported she had a headache. Denied lightheadedness or dizziness. Denied dyspnea (shortness of breath). Denied chest pain. Denied nausea or vomiting. She was without fever, tachycardic (rapid heart rate) with heart rate in the 100s, normotensive (normal blood pressure), with oxygen saturation stable on room air. Head CT demonstrated a small amount of traumatic left