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	04/24/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure immediate, individualized fall interventions were developed to mitigate the risk for further falls for 2 of 3 residents reviewed for accidents. (Resident C and E)Findings include: 1.Resident C's clinical record was reviewed on 4/22/26 at 11:03 a.m. Diagnoses included peripheral vascular disease, acquired absence of other right toe(s), other lack of coordination, weakness, unsteadiness on feet, muscle wasting and atrophy, not elsewhere classiˆed, unspeciˆed site, and cognitive communication deˆcit. A 1/23/26 quarterly Minimum Data Set (MDS) assessment indicated he was cognitively intact. He used a wheelchair for mobility. He had impairments to his bilateral lower extremities. He required set up assistance for bed mobility. He required supervision or touching assistance with upper body dressing. He required partial to moderate assistance with sitting to lying. He required substantial to maximal assistance with toileting and personal hygiene, lower body dressing, footwear, lying to sitting, sitting to stand, and transfers. He had a care plan revised on 4/16/26 for being at risk for falls related to medication use, lack of coordination, generalized weakness, unsteadiness on feet, muscle wasting & atrophy, and history of falls. His interventions included maintain call light within reach (10/13/25), educate on call light use if needed (10/13/25), maintain needed/frequently used items within reach (10/13/25), educate him to call for assist when feeling weak (11/17/25), fall mat at bedside between bed and door (11/19/25), bed against wall to aid in bed boundaries (2/2/26), bolster cover to his bed (1/28/26), keep wheelchair within resident's reach when in bed (4/8/26). Resident C had the following falls: On 1/27/26 at 8:50 p.m., he was found on his knees between his bed and the wall in his room. He indicated he had a dream that he was ˆshing and went to reach for the line and fell out of bed. The immediate interventions were taking his vital signs and helping him to bed. On 1/31/26 at 2:30 a.m., he rolled out of bed and onto the ˆoor. He complained of pain to his left shoulder and sustained a small abrasion to his left hand. He indicated he was sleeping and rolled out of bed. The immediate interventions were placing him back into bed and he had a mat at bedside. On 2/7/26 6:30 p.m., Resident C's roommate indicated that Resident C fell between the wall and the bed. Resident C was observed on his back on the ˆoor and was noted with an empty wine cooler bottle. He indicated that he didn't know what happened. The immediate intervention was assisting him back to bed by three CNAs, neurological checks and a skin assessment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/26 at 4:00 p.m., he was found on his knees, holding himself up using the bedside table and bed. He indicated he was attempting to get into his wheelchair. The immediate intervention was assisting him back into bed and reminded him to use his call light when assistance was needed. On 4/19/26 at 4:15 a.m., he rolled onto the ˆoor from his bed. He indicated that he rolled out of bed and struck his face on the base of his bedside table. He sustained a laceration to the top and bottom of his left eye. The immediate intervention was the laceration was cleansed and covered. During an interview on 4/23/26 at 3:21 p.m., LPN 27 indicated Resident C has had some falls, Resident C thought he could still walk and would get out of bed. Resident C was not complaint with using his call light. The immediate interventions such as obtaining vital signs and picking up the resident from the ˆoor was not an intervention. If LPN 27 was unable to think of an immediate intervention there was a paper with suggested interventions located at the nurses' station. During an interview on 4/23/26 at 5:22 p.m. LPN 47 indicated when a resident fell, immediate interventions included the resident's bed against the wall, neurological checks for unwitnessed falls, low bed, and a floor mat. When she notified the DON, the DON recommended immediate interventions. 2. Resident E's clinical record was reviewed on 4/22/26 at 10:18 a.m. Diagnoses included end stage renal disease, traumatic brain injury, cerebral infarction (stroke), unsteadiness on feet, weakness, and lack of coordination. A 3/31/26 quarterly Minimum Data Set (MDS) assessment indicated Resident E's cogitive status was moderately impaired. He used a wheelchair for mobility. He required substantial to maximal assistance with toileting hygiene, lower body dressing, footwear, personal hygiene, rolling left and right, sitting to standing, and chair or bed to chair transfer. He had a care plan revised on 9/15/25 for being at risk for impaired safety, injury, and falls related to cerebral infarct, traumatic brain injury, weakness, history of falls, mobility, and medications. His interventions included therapy screen (4/7/26), non-skid footwear (6/27/23), remind resident to lock wheelchair prior to transferring (11/18/22), brightly colored tap to be applied to wheelchair brakes (6/26/25), educate on proper transfer (6/27/23), and keep environment clutter free (6/27/23). On 4/4/26 at 8:15 p.m., Resident E sustained a witnessed fall when he stood up unassisted. He stood up and fell into a chair on his roommate's side of the room. The nurse observed Resident E lying on the floor on his right side in the middle of the room. Resident E hit his head during the fall. He sustained two skin tears to his right elbow and complained of right lower extremity pain. Resident E indicated he tried to get into bed unassisted. The immediate interventions were assessed Resident E for injuries, obtained vital signs, initiated neurological checks, the medical doctor and resident's daughter was notified, and an order for an x-ray was obtained. A progress note, dated 4/4/26, indicated Resident E sustained a fall in his room and after he was assessed for injuries, he was assisted to a standing position and transferred to his bed. He complained of right thigh pain once in bed with facial grimacing and guarding noted during range of motion activity. Internal rotation was noted. An interdisciplinary team progress note, dated 4/6/26 at 8:30 a.m., indicated Resident E sustained a witnessed fall in his room. He was attempting to get into bed. A therapy screen was to be done. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/23/26 at 1:55 p.m., LPN 18 indicated an immediate intervention was to be implemented at the time any resident fell. Nursing assessments, such as checking for injuries, obtaining vital signs, and initiating neurological checks, were not considered immediate interventions. Immediate interventions included looking at footwear and toileting needs. The nursing supervisor assisted in appropriate immediate interventions. During an interview, on 4/23/26 at 2:25 p.m., the DON indicated the nursing staff was to implement an intervention immediately at the time of a resident's fall. The interdisciplinary team (IDT) reviewed the implemented intervention on the next business day and the IDT determined if the implemented intervention was appropriate or if the intervention was to be modified. During an interview, on 4/23/26 at 2:43 p.m., the DON provided a therapy screening form dated 4/6/26, which indicated therapy was not recommended. The DON indicated the therapy screening was the only intervention implemented for Resident E's fall on 4/4/26. During an interview, on 4/24/26 at 2:43 p.m., LPN 22 indicated immediate fall interventions were to be implemented at the time of a residents fall. The IDT reviewed the implemented intervention and determined if the intervention was appropriate or needed changed. A current facility policy, dated 10/20/25, titled Falls Management and Fall Risk, provide by Regional Director of Operations, on 4/23/26 at 2:25 p.m., indicated the following Policy/Procedure: 1. Residents will be assessed for risk for fall on admission, with significant change, annually, and as needed (PRN) post fall.8. The falls related care plan will address both prevention of falls as well as when applicable specific interventions in response to an occurrence of a fall.11. If falling occurs despite initial interventions, staff will implement additional or different interventions. This citation relates to Intake 2984573. 410 Indiana Administrative Code (IAC) 16.2-3.1-35(b)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to ensure a resident was not administered medication to increase blood pressure when their blood pressure reading was above physician ordered parameters for 1 of 2 residents reviewed for physician orders. (Resident D) Finding includes: Resident E's clinical record was reviewed on 4/22/26 at 11:00 am. Diagnoses included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and end stage renal (kidney) disease.Current orders included midodrine (increases blood pressure) 10 milligrams, by mouth, two times a day every Monday, Wednesday, and Friday for blood pressure. Hold if systolic (top number) blood pressure is greater than 130 (2/20/26).The clinical record indicated the following:On 2/27/26 the resident's blood pressure was 139/73 millimeters (mm) Hg (mercury). Midodrine was administered.On 3/4/26 the resident's blood pressure was 138/82 mm Hg. Midodrine was administered.On 3/11/26 the resident's blood pressure was 169/93 mm Hg. Midodrine was administered.On 3/25/26 the resident's blood pressure was 132/65 mm Hg. Midodrine was administered.On 4/8/26 the resident's blood pressure was 141/73 mm Hg. Midodrine was administered.On 4/10/26 the resident's blood pressure was 205/100 mm Hg. Midodrine was administered.A current care plan, revised on 3/6/26, indicated Resident D was at risk for medication side effects related to hyperparathyroidism, hypotension (low blood pressure), inflammation, renal failure, chronic obstructive pulmonary disease and anticoagulant use. Interventions included: administer medications as indicated by physician orders (11/20/25).During an interview, on 4/24/26 at 12:57 p.m., the DON reviewed Resident D's midodrine order and administration record. She indicated the order included blood pressure parameters and the electronic administration record indicated midodrine was administered on the identified dates.A current policy, dated 12/1/24, titled Physician Services and Orders, provided by the DON on 4/24/26 at 1:19 p.m., indicated the following: Policy: It is the policy of the facility to ensure that the medical care of each resident is supervised by a physician. The facility will provide care and services related to physician services in accordance with State and Federal regulations. Procedure: 11. All physician orders will be followed as prescribed and if not followed, the reason shall be recorded in the resident's medical record during that shift.410 Indiana Administrative Code (IAC) 16.2-3.1-37(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, observation, and interview, the facility failed to ensure implemented fall interventions were in place to mitigate risk for further falls for 1 of 3 residents reviewed for falls. (Resident E) Finding includes: Resident E's clinical record was reviewed on 4/22/26 at 10:18 a.m. Diagnoses included end stage renal disease, traumatic brain injury, cerebral infarction (stroke), unsteadiness on feet, weakness, and lack of coordination.A 3/31/26 quarterly Minimum Data Set (MDS) assessment indicated Resident E's cognitive status was moderately impaired. He used a wheelchair for mobility. He required substantial to maximal assistance with toileting hygiene, lower body dressing, footwear, personal hygiene, rolling left and right, sitting to standing, and chair or bed to chair transfer.A current fall care plan, revised on 9/15/25, indicated Resident E was at risk for impaired safety, injury, and falls related to a cerebral infarct, traumatic brain injury, weakness, history of falls, mobility, and medications. Interventions included the following: a call for assistance sign placed in room as reminder (12/3/22), non-skid strips on pathway (bedside and in bathroom)(1/26/24), antiroll-back device to wheelchair (3/25/24), brightly colored tape to wheelchair brakes (6/26/25), keep bed in lowest position (6/27/23), lower wheelchair seat to assist with positioning (2/14/23), non-stick strip in place in front of toilet (5/29/24), provide a reacher (2/14/24), educate on proper transfer (6/27/23),call for assistance sign in bathroom (10/2/24), call light within reach, mat to floor at bedside (2/14/24), non-skid footwear (6/27/23), scoop mattress (4/23/25), and toilet riser with handles (1/30/23).A fall risk assessment, dated 1/23/26 at 4:42 p.m., indicated Resident E was at risk for falls.An initial occurrence note, dated 4/4/26 at 8:15 p.m., indicated Resident E sustained a witnessed fall in his room and hit his head. Neurological checks were initiated. The nurse was summoned to the resident's room and found Resident E lying on the floor on his right side. A certified nursing assistant witnessed the fall and reported the resident attempted to stand and fell into a chair on the roommate's side of the room. Resident E indicated he tried to get into bed unassisted. Resident E rated his pain a 5 out of 10 in the right hip. The pain was a new onset. The resident complained of pain with passive range of motion to his right lower extremity and he had sustained two small skin tears to his right elbow.The immediate interventions implemented were to assess Resident E for injuries, obtain vital signs, initiated neurological checks, the medical doctor and resident's daughter was notified, and an order for an x-ray was obtained.A progress note, dated 4/4/26 at 8:38 p.m., indicated after Resident E had sustained a fall in his room. After he was assessed for injuries, he was assisted to a standing position and transferred to his bed. He complained of right thigh pain once in bed with facial grimacing and guarding noted with range of motion activity. Internal rotation was noted. An order for an x-ray was obtained.A fall risk assessment, dated 4/4/26 at 11:43 p.m., indicated Resident E was at risk for falls.An interdisciplinary team progress note, dated 4/6/26 at 8:30 a.m., indicated Resident E sustained a witnessed fall in his room. He was attempting to get into bed. A therapy screen was to be done.During an interview, on 4/23/26 at 9:45 a.m., Resident E was lying in bed. The bed was not in a low position, and the top of the mattress was approximately 34-36 inches from the floor. He indicated he had not fallen recently. A floor mat was on the floor between the right side of the bed and the wall.During an observation, on 4/23/26 at 11:55 a.m., Resident E's room did not have a call for assistance sign posted in the general area of room, non-skid strips were not in place on the floor by Resident E's bed, in the room pathway, or in the bathroom. A reacher accessory tool was not observed in the room. During an observation on 4/23/26 at 12:08 p.m., Resident E sat in a wheelchair at the dining room table. The wheelchair seat appeared to be regular height of a standard wheelchair. The wheelchair did not have anti-tippers in place. The wheelchair brake handles were black and did not have bright tape applied to them.During an interview, on 4/23/26 at 1:55 p.m., LPN 18 indicated care plan interventions were to be followed as indicated. During an interview, on 4/23/26 at 2:25 p.m., the DON indicated fall care plan (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions were updated by either the MDS coordinator, the Assistant Director of Nursing, or herself. The IDT team determined what interventions were to be implemented and the intervention was added to the care plan. The management team ensured implemented care plan interventions were in place. Care Plan interventions were to be followed.During an interview, on 4/23/26 at 2:32 p.m., CNA 38 indicated Resident E was a fall risk. CNA 38 confirmed there was not a call for assistance sign in the general area of Resident E's room. Non-skid strips were not in place in Resident's E room or in his bathroom. Resident E did not fall out of bed, and a low bed was not utilized. CNA 38 had never observed a reacher-type assistive device in the resident's room and had not seen the resident have one. Resident E used to be on another unit, and it was possible he had omitted fall interventions in his old room, but not since he transferred to this unit. She was unsure when he transferred rooms, but it had been quite a while ago.During an interview, on 4/23/26 at 2:36 p.m., LPN 41 confirmed Resident E did not have anti-tippers on his wheelchair, and the wheelchair brake handles did not contain brightly colored tape. She was uncertain if the wheelchair seat was considered lowered or not.During an interview, on 4/24/26 at 11:40 a.m., the DON indicated care plan interventions were to be followed. Resident E last changed rooms in 2024, and previous fall interventions may have been for his previous room and were not transferred with his room change. She observed Resident E's wheelchair on 4/23/26 and his brakes did not have brightly colored tape on them. She was unsure if his wheelchair seat was lowered when she observed the wheelchair but noted the wheelchair did not contain anti-tippers.During an interview, on 4/24/26 at 2:28 p.m., LPN 22 indicated care plan interventions were to be followed. Unit managers followed up with implemented interventions to ensure they were in place. When a resident switched rooms, the interventions would follow the resident to the new room, such as non-skid strips and posted signs.A current facility policy, dated 10/20/25, titled Falls Management and Fall Risk, and provided by the Regional Director of Operations on 4/23/26 at 2:25 p.m., indicated the following: Policy/Procedure: 3. Each resident will have a resident centered fall care plan developed and implemented with updates as needed. 4 The care plan will be reviewed at a minimum of quarterly, post fall, annually, and with significant change in condition.8. The falls related care plan will address both prevention of falls as well as when applicable specific interventions in response to an occurrence of a fall.11. If falling occurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.14.staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.A current facility policy, dated 2/22/25, titled Comprehensive Care Plans, provided by the DON, on 4/24/26 at 1:19 p.m., indicated the following: Policy: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Procedure: 4 .including the right to: e. Receive the services, interventions, and items included in the plan of care .12. The interdiciplinary team reviews and updates the care plan and ensures interventions in place are implemented per plan of care: .This citation relates to Intake 2984573. 410 Indiana Administrative Code (IAC) 16.2-3.1-35(g)(1)410 IAC 16.2-3.1-45(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to complete physician ordered pre-dialysis assessments for 1 of 2 residents (Resident E) and physician ordered post-dialysis assessments for 2 of 2 residents reviewed for dialysis. (Residents D & E) Findings include:1.Resident E's clinical record was reviewed on 4/22/26 at 10:18 a.m. Diagnosis included end stage renal disease with dependence on renal dialysis, acquired absence of a kidney, and type 2 diabetes mellitus with diabetic chronic kidney disease.Current physician orders included monitor left chest dialysis access site for infection daily, obtain vital signs, blood pressure and pulse, and monitor pre and post dialysis for: altered mental status, lethargy, edema, chest pain, shortness of breath, abdominal pain, nausea, vomiting, unusual itching, bleeding at site, bruises, abnormal muscle cramps, redness, swelling, tenderness, or signs of infection at dialysis site every shift on Mondays, Wednesdays, and Fridays, apixaban 5 milligram tablet (blood thinner) to be administered orally twice a day, and check site of dialysis catheter every shift for drainage and condition of dressing.Review of the clinical record indicated a pre-dialysis assessment was not completed for Resident E on March 6, 24, and 30, 2026.Review of the clinical record indicated a post-dialysis assessment was not completed for Resident E on March 4, 6, 9, 13, 20, 23, 24, 30, and April 3, 8, 10, 22, 2026.Resident E's dialysis binder indicated dialysis had been completed on these dates.2.Resident D's clinical record was reviewed 4/22/26 at 11:00 a.m. Diagnosis included end stage renal disease with dependence on renal dialysis and chronic kidney disease stage 5 (end stage kidney failure that needs dialysis or a kidney transplant).Current physician orders included monitor right chest port for infection daily, apixaban 5 milligram tablet (blood thinner) to be administered orally twice a day, check arteriovenous (AV) access site to right chest port every shift for active thrill and bruit, do not perform blood pressures or venipuncture on access arm, and leave dressing in place (If present) for 12 hours post-treatment, check AV fistula site for bruit and thrill every shift, check site of dialysis catheter every shift for drainage and condition of dressing.Review of the clinical record indicated a post-dialysis assessment was not completed for Resident D on March 4, 6, 13, 20, 23, 25 and April 3, 8, 13, 15, 2026.Resident D's dialysis binder indicated dialysis had been completed on these dates.During an interview, on 4/23/26 at 1:55 p.m., LPN 18 indicated nurses were to perform pre and post dialysis assessments each day a resident had a dialysis treatment. The assessments were to be completed in the resident's electronic health record and there was a communication form in the resident's dialysis binder.During an interview, on 4/23/26 at 2:25 p.m., the DON indicated nurses were to complete a pre-dialysis assessment before the resident left the facility for dialysis and complete a post-dialysis assessment upon the resident's return to the facility. The assessments were to be documented in the resident's electronic health record.During an interview, on 4/24/26 at 2:28 p.m., LPN 22 indicated nurses were to complete pre and post dialysis assessments. The post assessment was important as the nurse was to assess access points for infusion and any dressings that were in place.During an interview, on 4/24/26 at 2:00 p.m., the DON indicated nursing did not complete pre and post Dialysis assessments for Residents D & E.A current facility policy, dated 2/22/21, titled Dialysis provided by the Regional Director of Operations, on 4/23/24 at 2:25 p.m., indicated the following: Policy: To ensure residents receiving hemodialysis are monitored for complications.A current facility policy, undated, titled Hemodialysis Access Care, provided by the Administrator, on 4/24/26 at 12:04 p.m., indicated the following: . Documentation: The general medical nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (interventions if needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis.This citation relates to Intake 2970449.410 Indiana Administrative Code (IAC) 16.2-3.1-37(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the sanitary storage of food for resident use in refrigerators on the nursing units for 2 of 3 nursing unit refrigerators observed. (Intermediate and Arcadia)Findings include:During an observation of the nursing unit's refrigerators, accompanied by the Dietary Manager, on 4/22/26 at 12:53 p.m., the following was observed: 1.On the Intermediate unit, a small refrigerator was located in the nurses' station. The refrigerator contained a packaged deli sandwich, dated 4/14/26, a frozen entree, an unopened bottle of strawberry soda, an unopened strawberry/banana Greek yogurt, four open partial bottles of waters, an open partial bottle of mandarin orange water, and an undated foam container with cabbage, sausage, corn bread, and an unidentiˆable yellow substance. The freezer section of the refrigerator contained a sticky, soft, ice cream sandwich, two frozen nutritional supplements, and an uncovered Dairy Queen cup that was stuck to the shelf of the freezer. LPN 33 indicated that the refrigerator was for the residents and the staff had a break room for storing their items. They normally stored fortiˆed pudding and applesauce for the residents in the refrigerator.2. On the Arcadia unit, a refrigerator was located in the dining/kitchen area. The refrigerator contained a staff member's lunch tote. The freezer contained an unopened candy bar, a clear storage bag of ˆour, and a plastic grocery bag with two ice packs. The Memory Care Director indicated the ice packs were used on a resident's breast who had a new diagnosis of breast cancer.During an interview, on 4/23/26 at 4:10 p.m. the Regional Director of Operation indicated that staff should not have stored there personal food in the refrigerators and that there was a breakroom available for staff to store their food. A current facility policy, titled Food Storage, provided by the Administrator on 4/24/26 at 9:48 a.m. indicated the following: .Procedure.12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before refrigerated. Leftover food must be used within 7 days or discarded as per the 2022 Federal Food Code. 13. All refrigerator units should be always kept clean and in good working condition. all foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded.410 IAC 16.2-3.1-21(i)(3)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, observation and record review, the facility failed to ensure accurate documentation was reflected in a resident's clinical records for 2 of 2 records reviewed for dialysis. (Resident D and E) Findings include:1.Resident E's clinical record was reviewed on 4/22/26 at 10:18 a.m. Diagnosis included end stage renal disease with dependence on renal dialysis, acquired absence of a kidney, and type 2 diabetes mellitus with diabetic chronic kidney disease.A dialysis pre/post evaluation, dated 1/28/26 at 3:15 p.m., indicated Resident E had a dialysis access location in his left upper extremity.A dialysis pre/post evaluation dated 2/2/26 at 5:52 a.m., indicated Resident E had a dialysis access location in his left arm.A dialysis pre/post evaluation dated 3/25/26 at 5:14 a.m., indicated Resident E had a dialysis access location in his left chest and the access site had a bruit and thrill.During an interview, on 4/23/26 at 9:45 a.m., Resident E indicated his dialysis access site was in his left upper chest During an interview, on 4/23/26 at 4:50 p.m., Resident E indicated he did not have an arteriovenous (AV) fistula dialysis access site in his left arm. LPN 18 was present in his room at this time. LPN 18 confirmed Resident E's only dialysis access site was in his left upper chest and an assessment for a bruit and thrill was not needed due to type of access site he had.2.Resident D's clinical record was reviewed 4/22/26 at 11:00 a.m. Diagnosis included end stage renal disease with dependence on renal dialysis and chronic kidney disease stage 5 (end stage kidney failure that needs dialysis or a kidney transplant).A hospital nephrology note, dated 11/9/25 at 10:44 a.m., indicated Resident D's right AV fistula failed, was nonfunctional, and no thrill was noted. He had a right tunneled dialysis catheter (a long-term vascular access device placed under the skin).A dialysis pre/post evaluation, dated 2/4/26 at 5:42 a.m., indicated Resident D had a dialysis access location in his left upper extremity and the access site had a bruit and thrill.A dialysis pre/post evaluation, dated 2/13/26 at 5:49 a.m., indicated Resident D had a dialysis access location in his right arm and the access site had a bruit and thrill.A dialysis pre/post evaluation, dated 2/18/26 at 4:47 a.m., indicated Resident D had a dialysis access location in his right arm and the access site had a bruit and thrill.A dialysis pre/post evaluation, dated 3/18/26 at 12:50 p.m., indicated Resident D had a dialysis access location in his right arm and the access site had a bruit and thrill.A dialysis pre/post evaluation, dated 3/25/26 at 5:13 a.m., indicated Resident D had a dialysis access location in his right chest and the access site had a bruit and thrill.A dialysis pre/post evaluation, dated 4/6/26 at 12:44 p.m., indicated Resident D had a dialysis access location in his right chest and the access site had a bruit and thrill.A dialysis pre/post evaluation, dated 4/8/26 at 4:58 a.m., indicated Resident D's dialysis access location was in his right chest and the access site had a bruit and thrill.A February 2026 electronic treatment administration record (ETAR) indicated Resident D's AV fistula site was to be checked for a bruit and thrill every shift. The administration record was marked as administered twice a day except on 2/14-night shift and 2/27-day shift. The identified dates lacked documentation and it was blank.A February 2026 electronic medication administration record (EMAR) indicated Resident D's AV access site to his right chest port was to be assessed every shift for a bruit and thrill and if not present to contact the physician and document finding. The administration record was marked as administered twice a day except on 2/27-day shift, which lacked documentation and was blank.A March 2026 ETAR indicated Resident D's arteriovenous (AV) fistula site was to be checked for a bruit and thrill every shift. The administration record was marked as administered twice a day except on 3/7-day shift, 3/13-night shift, and 3/14-night shift in which the record lacked documentation, and it was blank. On 3/23-day shift the documentation indicated the resident was away from the facility.A March 2026 EMAR indicated Resident D's AV access site to his right chest port was to be assessed every shift for a bruit and thrill and if not present to contact the physician and document finding. The administration record was marked as administered twice a day, except on 3/9-night shift and 3/23-day shift, which indicated the resident was away from the facility.An April 2026 ETAR indicated (continued on next page)

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	04/24/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident D's arteriovenous (AV) fistula site was to be checked for a bruit and thrill every shift. The administration record was marked as administered twice a day except on 4/10-day shift, 4/11-night shift, 4/13-day shift, 4/15-day shift, and 4/19-day shift. The identified dates lacked documentation and were blank. On 4/14, 4/16, and 4/21-day shift, the record indicated the resident was away from the facility.An April 2026 EMAR indicated Resident D's AV access site to his right chest port was to be assessed every shift for a bruit and thrill and if not present to contact the physician and document finding. The administration record was marked as administered every day except on 4/11-night shift, which lacked documentation and was blank. On 4/14 and 4/16-day shift which indicated the resident was away from the facility.During an interview, on 4/23/26 at 9:43 a.m., Resident D indicated he had a dialysis port in right upper chest. He had a fistula in his right upper arm previously but was no longer used and was deactivated. A dressing to his right upper chest was intact and his right upper arm was scarred.During an interview, on 4/23/26 at 4:48 PM, Resident D confirmed his only dialysis access site was in his right upper chest. The access site to his right arm had not been used for more than six months.During an interview, on 4/23/26 at 4:50 p.m., LPN 18 indicated Resident D's only access site was in his right upper chest and assessment for a bruit and thrill was not needed.During an interview, on 4/24/26 at 11:40 a.m., the DON indicated if a resident's EMAR or ETAR was blank it meant it was either not done or not documented. A check mark on the EMAR and ETAR indicated the task was administered or completed.During an interview, on 4/24/26 at 12:57 p.m., the DON indicated Resident D had an old fistula but was uncertain if it had a bruit and thrill. Resident E did not have an AV fistula access site and recently received vein mapping for an AV fistula placement. Resident D and E used chest ports for their dialysis treatments. She confirmed the EMAR, ETAR, and several nursing assessments indicated Resident D had a fistula with a bruit and thrill.During an observation, on 4/24/26 at 1:50 p.m., the DON indicated Resident D did not have an AV fistula in either upper extremity. The right upper arm was scarred and the fistula had been removed. His only dialysis access point was his right upper chest port. Bruits and thrills could not be assessed in a chest port. She confirmed the nursing assessments, EMAR, and ETAR were documented inaccurately. During an interview, on 4/24/26 at 2:28 p.m., LPN 22 indicated an AV fistula site in an extremity was to be assessed for a bruit and thrill, but not in a chest port. A chest port for dialysis would not have a bruit and thrill. An assessment of a chest port consisted of ensuring the dressing was intact and if there was bleeding. Resident E did not have an AV fistula. LPN 22 confirmed Resident D's dialysis and access site orders on his EMAR and ETAR were written incorrectly and contained errors. Resident D's right chest port should not be assessed for a bruit and thrill, and he did not have an AV fistula.During an interview, on 4/24/26 at 3:00 p.m., the DON indicated when physician orders were entered, they were audited the next business day by the management team. Resident D's dialysis orders had a lot of things wrong within the orders, and she discontinued the orders during the interview. She confirmed nurses had documented AV fistula assessments and neither Resident D nor E had an AV fistula. A current facility policy, undated, titled Documentation in Medical Record provided by the Administrator, on 4/24/26 at 2:42 p.m., indicated the following: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: 3. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information should not be documented. ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided.b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.This citation relates to Intake 2970449.410 Indiana Administrative Code (IAC) 16.2-3.1-50(a)(2)