STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING _____ B. WING _____	C 05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEN HUR HEALTH AND REHABILITATION	**1375 S GRANT AVE CRAWFORDSVILLE, IN 47933**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00401429 and IN00404497. This visit included a COVID-19 Focused Infection Control Survey.

Complaint IN00401429 - No deficiencies to the allegations were cited.

Complaint IN00404497 - No deficiencies to the allegations were cited.

Survey dates: May 4 and 5, 2023

Facility number: 000461
Provider number: 155401
AIM number: 100275290

Census Bed Type:
SNF/NF: 79
Total: 79

Census Payor Type:
Medicare: 5
Medicaid: 50
Other: 24
Total: 79

Ben Hur Health and Rehab was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00401429 and IN00404497, and the COVID-19 Focused Infection Control Survey.

Quality review completed on May 12, 2023.

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