STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 27, 28, 29, 30, and December 1 and 4, 2023 Facility number: 000461 Provider number: 155401 AIM number: 100275290 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 3 Medicaid: 68 Other: 19 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 12, 2023.	F 0000	**Ben Hur Annual Survey POC 2023** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **F550: Resident Rights – Facility failed to ensure the dignity of a resident when a lab tech attempted to perform a blood draw in the main dining room.** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Resident did not have blood drawn in dining area. LPN redirected resident and lab tech to resident's room for blood draw.** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective	

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
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			action(s) will be taken **All residents who require blood to be drawn in facility have the potential to be affected.** **Education provided to lab tech immediately. Resident was taken to room for blood draw. DNS notified lab tech supervisor immediately.** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Education provided to Lab tech and lab tech supervisor.** **Education provided to staff regarding proper procedure for blood draws.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; To ensure compliance, the ED/Designee is responsible for the completion of the **Resident Rights** QAPI tool weekly times 4 weeks, monthly times 3 months and then quarterly to encompass all shifts until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. by what date the systemic changes will be completed. **12/8/23** **F695**: **Respiratory/Tracheostomy Care and Suctioning – Facility failed to obtain an order for oxygen delivery to a resident upon the resident's admission to the facility until 6 days later and failed to ensure the correct oxygen flow for 1 of 1 residents reviewed for respiratory care.** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident 245 immediately assessed to ensure appropriate orders and oxygen delivery were in place.** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Resident's who require the use of oxygen have the potential to be affected. **All residents requiring oxygen were reviewed and orders were verified.** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Education provided to nurses regarding timely entering of orders related to oxygen delivery.** **The IDT admission review tool will be completed within 72 hours of new or re-admission to facility.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; To ensure compliance, the DNS/Designee is responsible for the completion of the **Oxygen Therapy QAPI tool weekly** times 4 weeks, monthly times 3 months and then quarterly to encompass all shifts until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. what date the systemic changes will be completed. **12/8/23** **F812: Food Procurement, Store/Prepare/Serve-Sanitary – Facility failed to ensure food thermometers were cleaned according to policy.** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected. Food was immediately discarded, education provided to cook, and appropriate wipes were given to cook.** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **9 total residents who require a soft and bite sized diet had the potential to be affected.** **Ensured probe wipes were**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			available at all times to kitchen staff. **Culinary manager and kitchen staff educated on proper food storage and preparation.** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Culinary Manager/Designee to observe meal service daily for 30 days, weekly times 4 weeks, monthly times 3 months, and then quarterly for 2 consecutive quarters.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place To ensure compliance, the ED/Designee is responsible for the completion of the **Trayline Observation QAPI tool and Kitchen Sanitation/Environmental Review tool** weekly times 4 weeks, monthly times 3 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			achieved an action plan will be developed to ensure compliance. by what date the systemic changes will be completed. **12/8/23**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to obtain an order for oxygen delivery to a resident upon the resident's admission to the facility until 6 days later and failed to ensure a resident received the correct oxygen flow for 1 of 1 resident reviewed for respiratory care (Resident 245). Findings include: On 11/27/23 at 2:15 p.m., during observation of Resident 245, oxygen delivered by a concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen), at 3 liters (L) continually by nasal cannula (NC) (a medical device to provide	F 0695	**F695**: **Respiratory/Tracheostomy Care and Suctioning – Facility failed to obtain an order for oxygen delivery to a resident upon the resident's admission to the facility until 6 days later and failed to ensure the correct oxygen flow for 1 of 1 residents reviewed for respiratory care.** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	12/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	supplemental oxygen therapy to people who have lower oxygen levels). The Resident indicated he had been on 4 to 5 liters and was to have 6 liters when he was up walking. He indicated it should be at least 5 L. Resident had some shortness of breath during the observation and interview. On 11/30/23 at 8:54 a.m., Resident tested positive for COVID-19 and was placed in droplet precautions (isolation requiring personal protective equipment). The resident was pale and shaky. Oxygen was being administered by a concentrator at 6 L per NC continually. During interview on 11/30/23 at 10:01 a.m., Licensed Practical Nurse (LPN) 4 indicated the liter flow should be set at 3 to 5 L, and the resident was receiving 5 L. She indicated she checked on the resident and verified it was set at 5 liters. LPN 4 indicated Certified Nurse Aides (CNA) were to tell the nurse to adjust liter flow since the CNA did not adjust the liter flow. During an interview on 12/1/23 at 12:57 p.m., Licensed Practical Nurse (LPN) 7 indicated she would call the physician at the time of admission and obtain an order for oxygen if a resident needed it and was aware the resident was on oxygen after being admitted. LPN 7 indicated Resident 245 did not have an order for oxygen at the time of admission. LPN 7 indicated the resident currently had an order for 3 to 5 liters to keep oxygen SATs (saturation level) (a percentage of how much oxygen your blood is carrying compared to the maximum it is capable of carrying), above 90%. On 12/1/23 at 1:15 p.m., a medical record review indicated Resident 245 had diagnoses of Atherosclerotic heart disease of native coronary		**Resident 245 immediately assessed to ensure appropriate orders and oxygen delivery were in place.** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken **Resident's who require the use of oxygen have the potential to be affected.** **All residents requiring oxygen were reviewed and orders were verified.** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Education provided to nurses regarding timely entering of orders related to oxygen delivery.** **The IDT admission review tool will be completed within 72 hours of new or re-admission to facility.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	artery (refers to heart weakening caused by reduced blood flow to your heart) without angina pectoris (chest pain), essential (primary) hypertension (high blood pressure), COPD (chronic obstructive pulmonary disease) (a group of diseases that cause airflow blockage and breathing-related problems), pneumonia (respiratory infection which affects the lungs), and respiratory failure with hypoxia (low levels of oxygen in your body tissues). Hospital discharge, dated 11/21/23, indicated an order of O2 (oxygen): at rest: 5L with activity: 6L with Oxymizer (an oxygen-conserving device that is designed to function optimally at lower flow rates, typically up to about 6 liters per minute). It was advised to continue use at ECF (extended care facility). Resident 245 had acute hypoxic respiratory failure secondary to left upper lobe pneumonia and sepsis and the treatment plan was to continue antibiotics, steroids, and the O2 order above. Oxygen order, dated 11/27/23 at 6:59 p.m., indicated Oxygen at 3 to 5 L per nasal cannula to keep O2 sats above 90%, every shift for diagnosis of chronic obstructive pulmonary disease. Staff were to monitor Oxygen sats every shift, dated 11/27/2023. A care plan, dated 11/28/23, indicated resident has a potential for impaired gas exchange related to COPD. Intervention dated, 11/28/23, administer oxygen as ordered, 3 to 5 Liters per nasal cannula. The medication administration record indicated an order for Oxygen at 3 to 5 L per nasal cannula to keep O2 sats above 90%. The record indicated the order was administered beginning 11/28/23.		i.e., what quality assurance program will be put into place; To ensure compliance, the DNS/Designee is responsible for the completion of the **Oxygen Therapy QAPI tool weekly** times 4 weeks, monthly times 3 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. what date the systemic changes will be completed. **12/8/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Nurse progress note dated, 11/21/23 at 5:02 pm indicated, "Resident receives O2 at 5L at rest." Nurse progress note dated, 11/22/23 at 4:32 p.m., indicated "Respiratory Assessment: Uses oxygen (device/LPM) 5L/NC, Bi-pap/C-pap, SOB on exertion." On 11/30/23the Executive Director (ED) provided an undated document, titled, "Oxygen Therapy and Devices" and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose, Oxygen is a basic human need. Without it, we would not survive. The air that we breathe contains approximately 21% oxygen. For most people with healthy lungs, this is sufficient, but for some people with certain health conditions whose lung function is impaired, the amount of oxygen that is obtained through normal breathing is not enough. Therefore, they require supplemental amounts to maintain normal body function ...Indications for oxygen use 1. Obstructive pulmonary disease, 2. Shortness of breath ...Definition of Oxygen ...1. Oxygen is a drug which must be ordered by the physician ...Initiation of Oxygen ...1. Verify physician order ...7. Apply device to patient with appropriate liter flow ...," 3.1-47(a)(6)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food thermometers were cleaned according to policy which had the potential to effect 9 of 9 residents who received a modified meal from the kitchen. Findings included: During a random kitchen observation on 11/30/23 at 11:40 a.m., food temperatures were checked by Dietary Cook 9. Cook 9 removed a packet from the box, removed the wipe from the packet, cleaned the thermometer, and plunged it into a full container of the soft and bite pizza (modified meal for residents requiring soft and bite size food). The box she retrieved the packet from was observed to be Sureprep Skin Protectant Wipes (a liquid film-forming dressing applied to skin to form a protective barrier to reduce friction). When asked what she cleaned the thermometer with, she indicated she had just cleaned the thermometer and showed the opened wipe package that she had placed in a bowl. The packet indicated it was a Sureprep skin protectant wipe. Cook 9 indicated	F 0812	**F812: Food Procurement, Store/Prepare/Serve-Sanitary – Facility failed to ensure food thermometers were cleaned according to policy.** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected. Food was immediately discarded, education provided to cook, and appropriate wipes were given to cook.** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **9 total residents who require a**	12/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	probe wipes (thermometer sanitizing wipes). When asked to read the packaging, she picked up the box of Sureprep skin protectant wipes and indicated it said probe wipes. When asked to re-read it, she again indicated it to be probe wipe cleaner while she pointed at the words. When informed that the wipes she used to clean the thermometer were not probe cleaning wipes, the box did not indicate they were probe cleaning wipes, and the wipes used were a medical skin treatment, Cook 9 called for the Dietary Manager (DM) and asked him if the wipes she just used were the correct wipes. The DM indicated they were probe wipe cleaners and pulled packets out of his shirt pocket to compare. The packets he pulled from his pocket were observed to be Wipes Plus probe wipes. The DM was notified that the wipes Cook 9 had were not probe wipes but were a medical skin treatment. Cook 9 indicated she could not serve the soft and bite pizza after putting the thermometer in it without being cleaned with probe wipe cleaners. She notified the DM that the container of food needed to be thrown away. In an interview on 11/30/23 at 11:47 a.m., the DM indicated that the box of skin protectant wipes had been in the kitchen since the last dietary manager was there before him, and since he started. The wipes were stored in a drawer located at the cook's station. The DM checked the drawer and only Wipes Plus probe wipe cleaners were found to be in the drawer. The DM indicated that he gave the skin protectant wipes to the Executive Director (ED) to get rid of. On 11/30/23 at 2:45 p.m., the ED provided and identified a document as a current facility policy, titled, "American Senior Communities Food Temperatures" with a revised date of 6/23. The		**soft and bite sized diet had the potential to be affected.** **Ensured probe wipes were available at all times to kitchen staff.** **Culinary manager and kitchen staff educated on proper food storage and preparation.** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Culinary Manager/Designee to observe meal service daily for 30 days, weekly times 4 weeks, monthly times 3 months, and then quarterly for 2 consecutive quarters.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place To ensure compliance, the ED/Designee is responsible for the completion of the **Trayline Observation QAPI tool and Kitchen Sanitation/Environmental Review tool** weekly times 4 weeks, monthly times 3 months and then quarterly to encompass all shifts until continued compliance is maintained for 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	12/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	policy indicated, " ...5. Temperatures should be taken with a sanitized and calibrated thermometer ...." On 11/30/23 at 2:57 p.m., the ED provided and identified a document as the current product description for the skin protectant wipes that had been used to clean the thermometer in the kitchen. The description included a picture of the box that indicated, "Medline; skin protectant ... Sureprep protective wipe ... effective protection between adhesive and skin ... helps tape and film adhesion; non-irritating ...." On 11/30/23 at 3:00 p.m., the ED provided and identified a document as current facility material safety data sheet (SDS), titled, "Safety Data Sheet Sureprep Skin Protectant Wipe" with a revised date of 8/10/23. The SDS indicated, " ...Section 4. First-Aid Measures ...ingestion: if swallowed, call a physician immediately. Rinse mouth and throat thoroughly with water ...." 3.1-21(i)(3)		consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. by what date the systemic changes will be completed. **12/8/23**	