

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155401</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/18/2024</b>	
NAME OF PROVIDER OR SUPPLIER  <b>BEN HUR HEALTH AND REHABILITATION</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>1375 S GRANT AVE</b> <b>CRAWFORDSVILLE, IN 47933</b>			
(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
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/19/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 01/18/24</p> <p>Facility Number: 000461 Provider Number: 155401 AIM Number: 100275290</p> <p>At this PSR survey, Ben Hur Health and Rehabilitation was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility, which consisted of one-story building additions with a partial basement to a two-story facility, was determined to be of Type V (111) construction and fully sprinklered. The facility also has a separate detached laundry building that is not sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor, and in resident Room 612 and 613 in Wing 9. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 110 and had a census of 91 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility</p>			{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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{K 000}	Continued From page 1 services were sprinklered except for a detached equipment storage and maintenance building.  Quality Review completed on 01/19/24	{K 000}			