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	02/06/2025

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. This visit included the Investigation of Complaint IN00443635. Complaint IN00443635- No deficiencies related to the allegations are cited. Survey dates: January 30, 31, February 4, 5, and 6, 2025 Facility number: 000461 Provider number: 155401 AIM number: 100275290 Census Bed Type: SNF/NF: 95 Total:n95 Census Payor Type: Medicare: 9 Medicaid: 65 Other: 21 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 14, 2025.	F 0000	**Ben Hur Annual Survey POC 2025** 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. **F0641- MDS inaccuracy** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected by alleged deficient practice.** 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 **Any resident who experiences death in facility has the potential to be affected.** **RAI specialist audited discharges from previous 6**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Makenzie Miles	Executive Director	02/19/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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			months to ensure accuracy of discharge MDS. All discharge MDS' were found to be accurate. 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 MDS coordinator.** 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 **MDS Accuracy** 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. **2/19/25**	

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F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded correctly for 1 of 19 resident assessments reviewed (Resident 58). Findings include: Resident 58's closed record was reviewed on 2/6/25 at 11:42 a.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease with late onset (a degenerative brain disease that causes dementia) and Parkinson's disease (a progressive neurological disorder that affects movement, balance, and coordination). The record indicated the resident passed away in the facility on 12/7/24. An entry MDS, dated 12/7/24, was observed and indicated the resident had re-entered the facility. The record lacked documentation that a death in facility MDS assessment had been completed and uploaded. During an interview, on 2/6/25 at 11:44 a.m., the MDS Coordinator indicated the resident's entry MDS assessment had been coded incorrectly. The assessment should have been completed as a death in facility rather than an entry MDS assessment. The "CMS (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2024,	F 0641	**Ben Hur Annual Survey POC 2025** 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. **F0641- MDS inaccuracy - Facility failed to ensure an MDS was coded correctly for 1 of 19 residents. Resident 58.** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected by alleged deficient practice.** 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 **Any resident who experiences death in facility has the potential to be affected.**	02/19/2025

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	indicated, "...A0310: Type of Assessment (continued): Coding Instructions for A0310F...Enter the number corresponding to the reason for completing this assessment or tracking record...01. Entry tracking record...12. Death in facility tracking record...." 3.1-31(a)		**RAI specialist audited discharges from previous 6 months to ensure accuracy of discharge MDS. All discharge MDS' were found to be accurate.** 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 MDS coordinator.** 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 **MDS Accuracy** 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.	

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			2/19/25	