PRINTED: 02/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155401		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/06/2025				
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE		
F 0000 Bldg. 00	Licensure Survey. Investigation of Co Complaint IN0044 the allegations are Survey dates: Janu 2025 Facility number: 0 Provider number: AIM number: 1000 Census Bed Type: SNF/NF: 95 Total:n95 Census Payor Typ Medicare: 9 Medicaid: 65 Other: 21 Total: 95 These deficiencies accordance with 4	ary 30, 31, February 4, 5, and 6, 00461 155401 275290 e: reflect State Findings cited in	F 00	000	Ben Hur Annual Survey POC 2025 The creation and submission this plan of correction does not constitute an admission by the provider of any conclusion see in the statement of deficiencies of any violation of regulation. This provider respectfully requite that the 2567 Plan of Corrective be considered the letter of creatilegation and requests a desireview in lieu of a Post Comp Survey Revisit on or after. F0641- MDS inaccuracy what corrective action(s) where the deficient practice is a desired by the deficient practice. No residents were affected alleged deficient practice. No residents were affected alleged deficient practice will be identified and what corrective action(s) will be taken Any resident who experience death in facility has the potential to be affected. RAI specialist audited discharges from previous 6	of ot is is t forth es, or uests on edible sk olaint will tice by			

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

TITLE

(X6) DATE

Makenzie Miles Executive Director 02/19/2025

Any defiency statement 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155401		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/06/2025		
NAME OF P	ROVIDER OR SUPPLIEF	 \			ADDRESS, CITY, STATE, ZIP COD		
BEN HUF	R HEALTH AND RE	HABILITATION			GRANT AVE FORDSVILLE, IN 47933		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	months to ensure accuracy of discharge MDS. All discharge MDS' were found to be accurate. what measures will be pure into place or what systemic changes will be made to ensure that the deficient practice does recur; Education provided to MDS coordinator. how the corrective action (will be monitored to ensure the deficient practice will not recure i.e., what quality assurance program will be put into place. To ensure compliance, the DNS/Designee is responsible	of ie ut re s not	DATE
					the completion of the MDS Accuracy times 4 weeks, more times 3 months and then quare	-	
					to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the		
					committee overseen by the El threshold of 95% is not achiev an action plan will be developensure compliance.	D. If /ed	
					what date the systemic changes will be completed.		
					2/19/25		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		COMPLETED				
155401		B. W	02/06/	2025				
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DDOVIDED'S DLAN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0641	483.20(g)							
	Accuracy of Asses	ssments						
SS=A Bldg. 00	Based on record reversal failed to ensure a Massessment was code resident assessment. Findings include: Resident 58's closed 2/6/25 at 11:42 a.m. resident's diagnoses limited to, Alzheimed degenerative brain of and Parkinson's disconcurological disorded balance, and coordinate the facility on 12/7/2. An entry MDS, date indicated the resident The record lacked of facility MDS assess uploaded. During an interview MDS Coordinator in MDS assessment has assessment should be assessment assessment should be assessment.	riew and interview, the facility finimum Data Set (MDS) ed correctly for 1 of 19 s reviewed (Resident 58). If record was reviewed on a The profile indicated the included, but were not er's disease with late onset (a disease that causes dementia) ease (a progressive er that affects movement, nation). If the profile indicated the included, but were not er's disease with late onset (a disease that causes dementia) ease (a progressive er that affects movement, nation).	F 00	541	Ben Hur Annual Survey POC 2025 The creation and submission this plan of correction does not constitute an admission by thi provider of any conclusion set in the statement of deficiencie of any violation of regulation. This provider respectfully requitate the 2567 Plan of Correction be considered the letter of creallegation and requests a desceview in lieu of a Post Comp Survey Revisit on or after. F0641- MDS inaccuracy - Facility failed to ensure an MDS was coded correctly for of 19 residents. Resident 58. what corrective action(s) who be accomplished for those residents found to have been affected by the deficient practice. No residents were affected alleged deficient practice. how other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken	of ot s s forth es, or lests on dible k laint r 1 - vill ice by	02/19/2025	
	The "CMS (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2024,				Any resident who experience death in facility has the potential to be affected.	es		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155401		í í	· /		ONSTRUCTION	(3) DATE SURVEY	
		B. WI	ILDING NG	00	COMPLETED 02/06/2025		
		100101	2	_	ADDRESS STEW STATE TIP COD	02/00/2020	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
BEN HUI	R HEALTH AND RE	EHABILITATION			FORDSVILLE, IN 47933		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION 0: Type of Assessment		TAG	BEIGHNOTT	DATE	
	(continued): Codin				RAI specialist audited		
	A0310FEnter the number corresponding to the			discharges from p			
reason for completing this assessment or tracking record01. Entry tracking record12. Death in				months to ensure accuracy	of		
				discharge MDS. All discharg	е		
	facility tracking red	cord"	MDS' were found to be				
	2.1.21(2)				accurate.		
	3.1-31(a)				what measures will be pu	ıt	
					into place or what systemic	it	
					changes will be made to ensu	re	
					that the deficient practice does		
					recur;		
					Education muovided to MDC		
					Education provided to MDS coordinator.		
					coordinator.		
					how the corrective action(s	2)	
					will be monitored to ensure the	•	
					deficient practice will not recui		
					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, mor		
					times 3 months and then quar	teriy	
					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 EI		
					threshold of 95% is not achiev		
					an action plan will be develope	ed to	
					ensure compliance.		
					what date the systemic changes will be completed		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155401	B. WING		02/06/2025		
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933				
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE			ID	,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
				-	2/19/25		

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