STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155401		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING COMPLETE B. WING 09/20/202			LETED		
	ROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COD 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933				
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE	(X5) COMPLETION DATE	
Bldg	conducted by the Ir accordance with 42 Survey Date: 09/20 Facility Number: 0 Provider Number: 100 At this Emergency Health and Rehabil compliance with En Requirements for N Participating Provid 483.73 The facility has 110 the survey, the cens	0/22 000461 155401 275290 Preparedness survey Ben Hur itation was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR	E 00	000	Ben Hur Life Safety Surve POC 2022 The creation and submission this plan of correction does constitute an admission by provider of any conclusion in the statement of deficien of any violation of regulation.  This provider respectfully restrated the Plan of Correction considered the letter of creallegation and requests a dereview in lieu of a Post Consurvey Revisit on or after.  K211: Means of Egress  - what corrective action(be accomplished for those residents found to have been affected by the deficient proceeding chair in front of roce 205 and the dining room of in front of room 401 were immediately removed from hallway.  - how other residents has the potential to be affected same deficient practice will identified and what correcting action(s) will be taken	on of not this set forth cies, or n. equests be dible esk applaint  s) will en actice:		

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

TITLE

(X6) DATE

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.

### DE CE

PRINTED: 10/21/2022 M APPROVED NO. 0938-039

PARTMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SU			

	OF CORRECTION	IDENTIFICATION NUMBER  155401	A. BUILDING B. WING	onstruction 	COMPLETED 09/20/2022		
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  1375 S GRANT AVE  CRAWFORDSVILLE, IN 47933				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				visitors have the potential to effected.	be		
				All staff will be educated on means of egress. All medical necessary items will be store on one side of the hallway not o reduce the clear unobstructed corridor width less than 60 in.	ed ot		
				- what measures will be into place or what systemic changes will be made to ensu that the deficient practice does recur;	re		
				IDT will round daily to ensure means of egress are clear an unnecessary items are not being stored in the hallway.			
				- how the corrective action( 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 <b>Environmental</b> CQI tool week times 4 weeks, monthly times and then quarterly to encomparall shifts until continued compliance is maintained for 2 consecutive quarters. The rest of these audits will be reviewed the CQI committee overseen in	ole kly 6 ass 2 ults d by		

FORM CMS-2567(02-99) Previous Versions Obsolete

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155401	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/20/2022
	ROVIDER OR SUPPLIE		1375 S	ADDRESS, CITY, STATE, ZIP COD G GRANT AVE FORDSVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE
			the ED. If threshold of 95% achieved an action plan will developed to ensure compli - by what date the syster changes will be completed.	be ance.	
				10/07/2022  K tag: 300 – Protection – C Facility failed to replaced battery operated smoke al installed in resident sleepi rooms in accordance with NFPA 72.	arms
				- what corrective action(s be accomplished for those residents found to have bee affected by the deficient pra	en
				New smoke alarms were ordered and replaced. (Pic attached of new smoke ala	
				- how other residents ha the potential to be affected same deficient practice will identified and what correctiv action(s) will be taken;	by the be
				15 residents, staff, and vis in vicinity of rooms 608 an had the potential to be affected.	
				- what measures will be into place or what systemic changes will be made to en that the deficient practice do recur;  Education provided to	sure

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  I OF CORRECTION IDENTIFICATION NUMBER A. BUILDING  B. WING				(X3) DATE SURVEY COMPLETED 09/20/2022		
NAME OF P	ROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD GRANT AVE		
BEN HUF	R HEALTH AND RE	EHABILITATION			FORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
					Maintenance Director regarding smoke alarms and need to be replaced every 10 years.		
					Maintenance Director/Design will check every smoke alarm in the building to ensure all a in compliance and maintain a log with expiration dates.	n are	
					- how the corrective actions 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 completion of the <b>Smoke Alar</b> Rounding Tool CQI tool week times 4 weeks, monthly times and then quarterly to encompare all shifts until continued compliance is maintained for 2 consecutive quarters. The resure of these audits will be reviewed the CQI committee overseen the ED. If threshold of 95% is achieved an action plan will be developed to ensure compliant by what date the systemic changes will be completed.	or the rm ly 6 ass 2 ults ad by by not e lace.	
					K511: Utilities – Gas and Electric		

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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 09/20/2022	
NAME OF P	ROVIDER OR SUPPLIER			TADDRESS, CITY, STATE, ZIP COD S GRANT AVE	
BEN HUF	R HEALTH AND RE	HABILITATION		VFORDSVILLE, IN 47933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				<ul> <li>what corrective action(s) be accomplished for those residents found to have been affected by the deficient pract</li> </ul>	
				Outlet in Beauty Shop was immediately corrected and i GFCI protected against elec shock.	
				- how other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken Residents or staff utilizing beauty shop have the potento be affected.	the
				Maintenance director will be educated on importance of GFCI protection.	
				- what measures will be into place or what systemic changes will be made to ensuthat the deficient practice doe recur;	ıre
				Maintenance will identify all areas where GFCI protected outlets should be installed a ensure all are working appropriately.	
				how the corrective action will be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place.	e r,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED  B. WING 09/20/2022				
		155401	B. W			09/20/	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD GRANT AVE		
BEN HU	R HEALTH AND RE	HABILITATION			FORDSVILLE, IN 47933		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		ALSC IDENTIFYING INFORMATION		TAG	To ensure compliance the ED/Designee is responsible for the completion of the Environmental CQI tool week times 4 weeks, monthly times and then quarterly to encompare all shifts until continued compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed the CQI committee overseen by the ED. If threshold of 95% is achieved an action plan will be developed to ensure compliant by what date the systemic changes will be completed.  10/07/2022  K761: Maintenance, Inspection & Testing - Doors  - what corrective action(s) be accomplished for those residents found to have been affected by the deficient practic fire Door was immediately inspected and paint over the rating label was removed. (prattached of paint removed from the label)	on,  on,  will  fice:	DATE

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	F OF HEALTH AND HUI R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155401	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE	
					<ul> <li>how other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken</li> <li>25 residents have the potent to be affected.</li> </ul>	the		
					- what measures will be into place or what systemic changes will be made to ensu that the deficient practice does recur;	re		
					Oxygen Transfilling Room w added to the annual fire door inspection list.			
					Education was provided to the maintenance director.	he		
					<ul> <li>how the corrective action will be monitored to ensure the deficient practice will not recui i.e., what quality assurance program will be put into place;</li> </ul>	e ſ,		
					To ensure compliance the ED/Designee is responsible for the completion of the <b>Fire Door</b> CQI tool weekly times 4 weeks, monthly times 6 and the quarterly to encompass all shi	nen		

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until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155401	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/20/2022	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BEN HU	R HEALTH AND RE	HABILITATION			FORDSVILLE, IN 47933		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL				.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG			DATE
					committee overseen by the EI threshold of 95% is not achieved an action plan will be developed ensure compliance.  - by what date the systemic changes will be completed.	ed to	
K 0000							
Bldg. 01							
Bidg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 09/20 Facility Number: 0 Provider Number: 100 At this Life Safety 0 and Rehabilitation w with Requirements Medicare/Medicaid Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa This facility, which building additions w two-story facility, w (111) construction a facility also has a se building that is not	00461 155401 275290 Code survey, Ben Hur Health was found not in compliance	K 0	000	Ben Hur Life Safety Survey POC 2022  The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation of regulation.  This provider respectfully requitant the Plan of Correction be considered the letter of credibinallegation and requests a desireview in lieu of a Post Complibure Survey Revisit on or after.  K211: Means of Egress  - what corrective action(s) be accomplished for those residents found to have been affected by the deficient practice.  Path of Egress was immediately cleared. The rocking chair in front of room 205 and the dining room chair in front of room 401 were	ot s s i forth s, or uests le k aint will ice:	

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corridors, in all areas open to the corridor, and in

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immediately removed from

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155401	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER		1375 S	ADDRESS, CITY, STATE, ZIP COD G GRANT AVE FORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
IAU	resident Room 612 has battery operated resident sleeping ro capacity of 110 and of this survey.  All areas where res were sprinklered. A services were sprinklered equipment storage and the storage of t	and 613 in Wing 9. The facility dismoke detectors in all other forms. The facility has a lihad a census of 78 at the time didents have customary access all areas providing facility klered except for a detached and maintenance building.  Impleted on 09/22/22	IAG	hallway.  - how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken 26 residents and 4 staff and visitors have the potential to effected.  All staff will be educated on means of egress. All medicanecessary items will be storn on one side of the hallway reto reduce the clear unobstructed corridor width less than 60 in.  - what measures will be into place or what systemic changes will be made to ensure that the deficient practice docrecur;  IDT will round daily to ensure that the deficient practice docrecur;  IDT will round daily to ensure the deficient practice will not rective in the hallway.  - how the corrective action will be monitored to ensure the deficient practice will not rective., what quality assurance program will be put into place.  To ensure compliance the ED/Designee is responsi	y the e e ally red not n to e put ure es not  re nd  n(s) ne ur, e;	

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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 01 COMPLETED			LETED	
		155401	B. WING 09/20/2022				/2022
		<u>I</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			GRANT AVE		
BEN HU	R HEALTH AND RI	EHABILITATION		CRAW	FORDSVILLE, IN 47933		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					for the completion of the	Lala a	
					Environmental CQI tool wee	-	
					times 4 weeks, monthly times and then quarterly to encompa		
					all shifts until continued	a55	
					compliance is maintained for 2		
					consecutive quarters. The res		
					of these audits will be reviewe		
					the CQI committee overseen I	•	
					the ED. If threshold of 95% is	-	
					achieved an action plan will be	Э	
					developed to ensure complian	ice.	
					- by what date the systemic	3	
					changes will be completed.		
					10/07/2022		
					K tag: 300 - Protection - Oth	er,	
					Facility failed to replaced		
					battery operated smoke alar		
					installed in resident sleeping rooms in accordance with	1	
					NFPA 72.		
					- what corrective action(s)	will	
					be accomplished for those		
			1		residents found to have been		
					affected by the deficient practi	ce	
					New smoke alarms were		
			1		ordered and replaced. (Pic		
					attached of new smoke alarn	n)	
					- how other residents havir	ng	
					the potential to be affected by	the	
					same deficient practice will be	!	
					identified and what corrective		
					action(s) will be taken;		
					15 residents, staff, and visito		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/21/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 0938-				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING					(X3) DATE SURVEY COMPLETED 09/20/2022		
	PROVIDER OR SUPPLIER		1375 S	ADDRESS, CITY, STATE, ZIP COD GRANT AVE FORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			
	` `			had the potential to be affected.  - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does recur;  Education provided to Maintenance Director regarding smoke alarms and need to be replaced every 10 years.  Maintenance Director/Designe will check every smoke alarm in the building to ensure all all in compliance and maintain a log with expiration dates.  - 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 completion of the Smoke Alarr Rounding Tool CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encomparall shifts until continued	e not  ee re fthe m / So	DATE	
				compliance is maintained for 2 consecutive quarters. The resu of these audits will be reviewed the CQI committee overseen by	ılts d by		

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the ED. If threshold of 95% is not achieved an action plan will be

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	F OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155401	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  09/20/2022
	ROVIDER OR SUPPLIE		1375 S	ADDRESS, CITY, STATE, ZIP COD GRANT AVE FORDSVILLE, IN 47933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIA DEFICIENCY)  developed to ensure complian - by what date the systemic	DATE Ce.
				changes will be completed.  10/07/2022  K511: Utilities – Gas and Electric	
				- what corrective action(s) be accomplished for those residents found to have been affected by the deficient practi	
				Outlet in Beauty Shop was immediately corrected and is GFCI protected against elect shock.	
				- how other residents havin the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken Residents or staff utilizing beauty shop have the potent to be affected.	the
				Maintenance director will be educated on importance of GFCI protection.	
				<ul> <li>what measures will be into place or what systemic changes will be made to ensure that the deficient practice does recur;</li> </ul>	re
				Maintenance will identify all areas where GFCI protected	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155401	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/20/2022
	PROVIDER OR SUPPLIE		1375 S	ADDRESS, CITY, STATE, ZIP COD GRANT AVE FORDSVILLE, IN 47933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIA DEFICIENCY)	DATE
				outlets should be installed a ensure all are working appropriately.  - how the corrective action will be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put into place.  To ensure compliance the ED/Designee is responsite for the completion of the Environmental CQI tool week times 4 weeks, monthly times and then quarterly to encompall shifts until continued compliance is maintained for consecutive quarters. The rest of these audits will be reviewed the CQI committee overseen the ED. If threshold of 95% is achieved an action plan will be developed to ensure complianting by what date the systemic changes will be completed.  10/07/2022  K761: Maintenance, Inspective Testing – Doors	(s) e r, ; shole kly 6 asss 2 cults ed by by s not e noce. c

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what corrective action(s) will

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		X1) PROVIDER/SUPPLIER/CLIA	î í		ONSTRUCTION	(X3) DATE SURV	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED		
		155401	B. WI	NG		09/20/2022	2
	PROVIDER OR SUPPLIER			1375 S	ADDRESS, CITY, STATE, ZIP COD GRANT AVE FORDSVILLE, IN 47933		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CON	MPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					be accomplished for those residents found to have been		
					affected by the deficient practi	ce:	
					Fire Door was immediately inspected and paint over the rating label was removed. (pi attached of paint removed fro label)	С	
					- how other residents havin the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken	the	
					25 residents have the potent to be affected.	al	
					- what measures will be into place or what systemic changes will be made to ensur that the deficient practice does recur;	re e	
					Oxygen Transfilling Room was added to the annual fire door inspection list.		
					Education was provided to the maintenance director.	ne	
					- how the corrective action( 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		

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	OF CORRECTION	IDENTIFICATION NUMBER  155401	A. BUILDING B. WING	01	COMPLETED 09/20/2022
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION		1375 S	ADDRESS, CITY, STATE, ZIP COD GRANT AVE FORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0211	NFPA 101			the ED/Designee is responsible for the completion of the <b>Fire Door</b> CQI tool weekly times 4 weeks, monthly times 6 and the quarterly to encompass all shift until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the committee overseen by the ED threshold of 95% is not achieve an action plan will be developed ensure compliance.  - by what date the systemic changes will be completed.  10/07/2022	CQI D. If eed eed to
SS=E Bldg. 01	in accordance with of egress is contin all obstructions to	General  ays, corridors, exit cations, and accesses are a Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2			
	Based on observation facility failed to main from obstructions in facility. LSC 19.2.3 required width shall equipment, provided conditions are met:  (a) The wheeled equipment clear unobstructed coin. (1525 mm.)	on and staff interview, the intain the means of egress free 1.2 of 8 corridors within the 1.4(4) states, projections into the 1.4(4) states, projections into the 1.4(4) be permitted for wheeled 1.4 that all of the following 1.4 the projection of	K 0211	Ben Hur Life Safety Survey POC 2022  The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation.  This provider respectfully requirements the Plan of Correction be	t s forth s, or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
155401		B. WING 09/20/2022			09/20/2022		
		<u> </u>		CTREET	ADDRESS CITY STATE TIL COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DEN HIII	R HEALTH AND RE	THADILITATION			GRANT AVE FORDSVILLE, IN 47933		
DEN HUI	K NEALTH AND KE	ENABILITATION		CRAWI	FORDSVILLE, IN 47933		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	training program ac	ldress the relocation of the			considered the letter of credib	le	
	wheeled equipment	during a fire or similar			allegation and requests a desl	k	
	emergency.				review in lieu of a Post Compl	aint	
	(c) The wheeled eq	uipment is limited to the			Survey Revisit on or after.		
	following:				K211: Means of Egress		
	i. Equipment in use						
	_	ncy equipment not in use			- what corrective action(s)	will	
		ransport equipment			be accomplished for those		
	_	ice could affect approximately			residents found to have been		
	26 residents, 4 staff	f and visitors.			affected by the deficient practi	ice:	
	Findings include:				Path of Egress was		
					immediately cleared. The		
		ons made on 09/20/22 during a			rocking chair in front of room		
		from 11:07 a.m. to 12:40 p.m.			205 and the dining room cha	ir	
		ce Director, the following was			in front of room 401 were		
	noted:				immediately removed from		
		g chair being stored in the			hallway.		
	_	resident room 205.					
		nair was stored in the corridor					
	outside resident roo				- how other residents havir	_	
		with the Maintenance Director			the potential to be affected by		
		vations, he agreed the means			same deficient practice will be	;	
	_	continuously maintained free			identified and what corrective		
		or impediments to full instant			action(s) will be taken		
	use in the case of it	re or other emergency.			26 residents and 4 staff and	ha	
	This finding was no	viewed with the Executive			visitors have the potential to	De	
	_	enance Director at the time of			effected.		
	exit.	enance Director at the time of			All staff will be educated on		
	CAIL.				means of egress. All medica	llv.	
	3.1-19(b)				necessary items will be store	-	
	3.1-17(0)				on one side of the hallway no		
					to reduce the clear		
					unobstructed corridor width	to	
					less than 60 in.		
					loss than ou iii.		
					- what measures will be	nut	
					into place or what systemic	P	
					changes will be made to ensu	re	
	I		- 1		1		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155401	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  09/20/2022
	PROVIDER OR SUPPLIE R HEALTH AND R		1375 S	ADDRESS, CITY, STATE, ZIP COD GRANT AVE FORDSVILLE, 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 APPROPRIAT DEFICIENCY)  that the deficient practice does	DATE
				recur;  IDT will round daily to ensure means of egress are clear and unnecessary items are not being stored in the hallway.	
				- 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 Environmental CQI tool week times 4 weeks, monthly times 6 and then quarterly to encompal all shifts until continued compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed the CQI committee overseen by the ED. If threshold of 95% is achieved an action plan will be developed to ensure compliance by what date the systemic	ally 5 ss  allts d by y not
				changes will be completed.	
K 0300 SS=E Bldg. 01	Section 18.3 and	r RKS section any LSC			

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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 COMPLETED 01 B. WING 09/20/2022 155401 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1375 S GRANT AVE BEN HUR HEALTH AND REHABILITATION CRAWFORDSVILLE, IN 47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility K 0300 K tag: 300 - Protection - Other, 10/07/2022 failed to replace 2 of 63 battery operated smoke Facility failed to replaced alarms installed in resident sleeping rooms in battery operated smoke alarms accordance with NFPA 72. NFPA 72, 2010 installed in resident sleeping rooms in accordance with Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published **NFPA 72.** instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond what corrective action(s) will to operability tests but shall not remain in service be accomplished for those longer than 10 years from the date of manufacture. residents found to have been This deficient practice could affect over 15 affected by the deficient practice residents, staff, and visitors in the vicinity of Rooms 608, and 502. New smoke alarms were ordered and replaced. (Pic Findings include: attached of new smoke alarm) Based on observations with the Maintenance how other residents having Director on 09/20/22 during a tour of the facility the potential to be affected by the from 11:07 a.m. to 12:40 p.m., manufacturer's same deficient practice will be documentation affixed to the battery operated identified and what corrective smoke alarms installed on the ceiling in resident action(s) will be taken; sleeping rooms 608 and 502 indicated each device was manufactured 03/14/2012. Based on interview 15 residents, staff, and visitors at the time of the observations, the Maintenance in vicinity of rooms 608 and 502 Director agreed the aforementioned smoke alarms had the potential to be were more than ten years old and would check the affected. rest of the battery operated smoke detectors as they were all installed at the same time. what measures will be put into place or what systemic This finding was reviewed with the Executive changes will be made to ensure Director and Maintenance Director during the exit that the deficient practice does not conference. Education provided to 3.1-19(b) **Maintenance Director** regarding smoke alarms and need to be replaced every 10

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	OF CORRECTION ID	) PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER 55401	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/20/2022
	ROVIDER OR SUPPLIER	ABILITATION	1375 S	ADDRESS, CITY, STATE, ZIP COD GRANT AVE FORDSVILLE, IN 47933	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Maintenance Director/Design will check every smoke alarn in the building to ensure all a in compliance and maintain a log with expiration dates.	n ere
				- how the corrective action( 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 fo completion of the <b>Smoke Alar</b> Rounding Tool CQI tool weekl	r the <b>m</b>
				times 4 weeks, monthly times and then quarterly to encomparall shifts until continued compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewe the CQI committee overseen by the ED. If threshold of 95% is achieved an action plan will be developed to ensure complian by what date the systemic changes will be completed.	6 ass  ults d by not ecc.
				10/07/2022	
K 0511 SS=D Bldg. 01					

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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 COMPLETED 01 B. WING 09/20/2022 155401 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1375 S GRANT AVE BEN HUR HEALTH AND REHABILITATION CRAWFORDSVILLE, IN 47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility K 0511 K511: Utilities – Gas and 10/07/2022 failed to ensure 1 of 2 wet locations in the beauty **Electric** shop was provided with ground fault circuit interrupter (GFCI) protection against electric what corrective action(s) will shock. NFPA 70, NEC 2011 Edition at 210.8 be accomplished for those Ground-Fault Circuit-Interrupter Protection for residents found to have been Personnel, states, ground-fault circuit-interruption affected by the deficient practice: for personnel shall be provided as required in 210.8(A) through (C). The ground-fault **Outlet in Beauty Shop was** circuit-interrupter shall be installed in a readily immediately corrected and is accessible location. GFCI protected against electric Informational Note: See 215.9 for ground-fault shock. circuit interrupter protection for personnel on feeders. how other residents having (B) Other Than Dwelling Units. All 125-volt, the potential to be affected by the single-phase, 15- and 20-ampere receptacles same deficient practice will be installed in the locations specified in 210.8(B)(1) identified and what corrective through (8) shall have ground-fault action(s) will be taken circuit-interrupter protection for personnel. Residents or staff utilizing (1) Bathrooms beauty shop have the potential (2) Kitchens to be affected. (3) Rooftops (4) Outdoors Maintenance director will be Exception No. 1 to (3) and (4): Receptacles that are educated on importance of not readily accessible and are supplied by a GFCI protection. branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment what measures will be put shall be permitted to be installed in accordance into place or what systemic with 426.28 or 427.22, as applicable. changes will be made to ensure Exception No. 2 to (4): In industrial establishments that the deficient practice does not only, where the conditions of maintenance and recur; supervision ensure that only qualified personnel are involved, an assured equipment grounding Maintenance will identify all conductor program as specified in 590.6(B)(2) areas where GFCI protected shall be permitted for only those receptacle outlets should be installed and

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
155401		B. WING 09/20/2022				
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R		GRANT AVE		
BEN HUI	R HEALTH AND RE	HABILITATION		FORDSVILLE, IN 47933		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ly equipment that would		ensure all are working		
	_	ard if power is interrupted or		appropriately.		
	having a design that	t is not compatible with GFCI				
	protection.			- how the corrective action	(s)	
		eceptacles are installed within		will be monitored to ensure the		
		outside edge of the sink.		deficient practice will not recu	r,	
		(5): In industrial laboratories,		i.e., what quality assurance		
	-	supply equipment where		program will be put into place:	;	
	_	vould introduce a greater				
	-	nitted to be installed without		To ensure compliance		
	GFCI protection.			the ED/Designee is responsible	ole	
	-	(5): For receptacles located in		for the completion of the		
		s of general care or critical		Environmental CQI tool week	-	
		care facilities other than those		times 4 weeks, monthly times		
	covered under			and then quarterly to encompa	ass	
		protection shall not be required.		all shifts until continued		
	(6) Indoor wet locat			compliance is maintained for 2		
	1 1	vith associated showering		consecutive quarters. The res		
	facilities			of these audits will be reviewe	-	
		e bays, and similar areas where		the CQI committee overseen	· I	
	electrical			the ED. If threshold of 95% is		
		nt, electrical hand tools.		achieved an action plan will be		
	· ·	Vet Locations, requires all		developed to ensure compliar		
	-	ed equipment within the area of		- by what date the systemic	C	
		have ground-fault circuit		changes will be completed.		
		protection. Note: Moisture can		40/07/0000		
		resistance of the body, and		10/07/2022		
		is more subject to failure. This				
	_	ould affect at least 2 residents				
	and staff in the beau	ity shop.				
	Findings include:					
	Based on observation	on on 09/20/22 between 11:07				
		during a tour of the facility				
		ce Director, the electric				
		ne sink closest to the door in				
	_	s provided with a GFCI				
		r, when tested with a GFCI				

testing device, it did not break the circuit. Based

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155401		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 09/20/2022			
	ROVIDER OR SUPPLIER		1375	ET ADDRESS, CITY, STATE, ZIP COD 5 S GRANT AVE .WFORDSVILLE, IN 47933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
	Maintenance Direct not GFCI protected. This finding was re-	viewed with the Executive enance Director during the exit			
K 0761 SS=E Bldg. 01					
	interview, the facilitinspection and testin assembly was comp 19.1.1.4.1.1 commutative barriers required permitted only in comparities and self-cle (See also Section 8. required to have a fix 8.3.4.2 shall be protabled fire door assemblies and their including all frames and sills in accordant NFPA 80, Standard Opening Protectives specified in this Coddoor assemblies shall be sides to assess the o	on, records review, and ty failed to ensure annual ng of at least 1 fire door eleted in accordance of LSC micating openings in dividing d by 19.1.1.4.1 shall be peridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings are protection rating by Table eleted by approved, listed, semblies and fire window accompanying hardware, accompanying h	K 0761	K761: Maintenance, Inspect & Testing – Doors  - what corrective action(s be accomplished for those residents found to have been affected by the deficient practice and paint over the rating label was removed. (attached of paint removed label)  - how other residents have the potential to be affected be same deficient practice will be identified and what corrective action(s) will be taken  25 residents have the potential to be affected.	) will n ctice: ne dpic from dring by the de e
	the following items			into place or what systemic	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	COMPLETED		
		155401	B. W	ING		09/20/2022
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹			GRANT AVE	
REN HI II	R HEALTH AND RE	HARII ITATION			FORDSVILLE, IN 47933	
DENTIO	· · · · · · · · · · · · · · · · · · ·	HABILITATION		CIVAVII		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	either the door or fr				that the deficient practice does	s not
		light frames, and glazing beads			recur;	
		ely fastened in place, if so				
	equipped.				Oxygen Transfilling Room w	
		e, hinges, hardware, and			added to the annual fire door	•
		eshold are secured, aligned,			inspection list.	
		er with no visible signs of				
	damage.				Education was provided to the	ne
	(4) No parts are mis	•			maintenance director.	
	· ·	s do not exceed clearances				
	listed in 4.8.4 and 6				- how the corrective action(	
		device is operational; that is,			will be monitored to ensure the	
		npletely closes when operated			deficient practice will not recur	,
	from the full open p				i.e., what quality assurance	
	closes before the ac	is installed, the inactive leaf			program will be put into place;	
					T	
		are operates and secures the			To ensure compliance	
	door when it is in the	vare items that interfere or			the ED/Designee is responsible	oie
		are not installed on the door or			for the completion of the Fire	
	frame.	are not histaired on the door of			Door CQI tool weekly times 4	.on
		fications to the door assembly			weeks, monthly times 6 and the quarterly to encompass all shi	
		ed that void the label.			until continued compliance is	its
	_	edge seals, where required, are			maintained for 2 consecutive	
		their presence and integrity.			quarters. The results of these	
	-	ice could affect at least 25			audits will be reviewed by the	coı
	residents and staff.				committee overseen by the EI	
					threshold of 95% is not achiev	
	Findings include:				an action plan will be develope	
	8				ensure compliance.	
	Based on record rev	view and interview with the			- by what date the systemic	;
	Maintenance Direct	tor on 09/20/22 between 9:38			changes will be completed.	
		., no documentation of an			]	
		or the fire door assembly at the			10/07/2022	
	_	g room was available for review.				
		on during the tour of the				
		intenance Director, the Oxygen				
		located in 600 Hall, has one				
	_	vever the rating label was				
		nterview at the time of records				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155401	ĺ	ILDING NG	onstruction 01	(X3) DATE COMPL 09/20	ETED
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	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	stated the annual fir include the Oxygen would add it to the a tasks and remove the	tion, the Maintenance Director e door inspection did not Transfilling room and he annual fire door inspection e paint from the label. riewed with the Executive enance Director at the exit					

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