STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	102 W POPLAR ST GREENCASTLE, IN 46135

(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 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/24/14 Facility Number: 001120 Provider Number: 155758 AIM Number: 200525120 At this Life Safety Code survey, Asbury Towers Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility was located on the first and ground floors of a four story building and surveyed as one building since the construction dates of the original building and an addition were built prior to March 1, 2003. The facility was determined to be of Type II (222) construction and fully sprinklered. The facility identifies the ground floor as HCC Comprehensive	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	care Unit I and the first floor as Comprehensive care Unit II. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors connected to the fire alarm system. Battery powered smoke detectors were located in all resident rooms except rooms 9 through 22 on the south wing of the ground floor. Hard wired smoke detectors in resident rooms 117, 118, and rooms 9 through 22 alarm at the smoke detector only. The facility has the capacity for 48 and had a census of 44 at the time of this survey. All areas where residents have customary access were sprinklered except elevators cited at K56. All areas providing facility services were sprinklered.			
K 025 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 6 of 6 openings in a smoke partition, such as a wall or	K 025	K0025 SS=E An unsealed pipe penetration in three walls of the activities room closet were unsealed leaving one inch gaps	05/22/2015

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	ceiling, were sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and 10 or more residents on the ground floor. Findings include: a. Based on observation with the Director of Plant Operations on 05/06/15 at 11:40 a.m., unsealed pipe penetration in three walls of the activities room closet were unsealed leaving one inch gaps. The Director of Plant Operations said at the time of observation, he hadn't known these penetrations were unsealed. b. Based on observation with the Director of Plant Operations on 05/06/15 at 12:10 p.m., an unsealed pipe penetration in the ceiling in the kitchen service corridor was unsealed leaving a one inch gap. The Director of Plant Operations said at the time of observation, he hadn't known these penetrations were unsealed. 3.1-19(b)		and an unsealed pipe penetration in the ceiling in the kitchen service corridor was unsealed leaving a one inch gap. No residents or staff were harmed by the pipes being unsealed. A walk-through was completed looking for any more penetration to be sealed. All noted penetrations were properly fire caulked on May 22, 2015. All staff as well as outside contractors will be educated on penetrations being sealed when completing additions or modifications to the building. Monitoring will be ongoing by having the director of Plant Operations do an inspection to insure no penetrations were left exposed.	
K 029 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved			

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	automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
	Based on observation and interview, the facility failed to provide an automatic closer for a doors providing access to 1 of 10 hazardous areas such as a combustible materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents on the ground floor. Findings include: Based on observation with the Director of Plant Operations on 05/06/15 at 10:50 a.m., the door separating the seventy square foot housekeeping supply storage room on the ground floor was used for the storage of mattresses and miscellaneous cardboard and plastic wrapped items. The door had no self closing device. The Director of Plant Operations said at the time of	K 029	K 0029 SS=EThe door separating the seventy square foot housekeeping supply storage room on the ground floor was used for the storage of mattresses and miscellaneous cardboard and plastic wrapped items. The door had no self closing device. No Residents were harmed by the lack of a self closing device. All items that should not be stored in the housekeeping closet were removed May 21, 2015. All other housekeeping closets will be check for the same violation. New signs will be ordered to place on the doors of these closets stating they are not to have anything stored in them without the permission of the Director of Plant Operations. Checking the closets for impermissible items will be added to daily emergency light checks. If the closets are not empty Director of Plant Operations will be notified. Monitoring will be done by the maintenance staff and overseen by the Director of Plant Operations on a daily basis.	06/05/2015

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	observation, the room should not have been in use for the storage of these combustible materials. 3.1-19(b)			
K 048 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire plan dedicated to protect for the protection of 44 of 44 health care residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a review of multiple pages	K 048	K 0048 SS=FThe facility failed to provide a complete written fire plan dedicated to protect for the protection of 44 of 44 health care residents in the event of an emergency. No residents were harmed by the lack of a written fire plan. A new fire plan was drafted with the help of managers from other departments, advice from the Life Safety Inspector, the local fire chief, and the county hospital. The new fire plan will be much clearer and easier for the employees to understand. Changes will also be made to make it more efficient, including skilled care employees remaining on their unit to tend to their residents. The new plan will be developed with as many resources as possible and will be a team effort amongst the entire management team. A rough draft of the new fire plan is attached. See Exhibit A The fire plan will be monitored based on its effectiveness during fire drills by the management team. If staff appears to be struggling with it	06/05/2015

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	provided as documentation of the facility fire plan with the Director of Plant Operations on 05/06/15 at 1:30 p.m. included Procedures in the Health Center When Fire Alarm Sounds, Employees' Function In Fire Emergency, and a Charge Nurse Fire Emergency Checklist and Fire. The Procedures in the Health Center When The Fire Alarm Sounds notes: (1.) Alarm activation location information on the fire panel showing the device activating the alarm once an alarm has sounded should be written in the record book; (2) The Charge Nurse is to "send a staff member to that area to find out if this is a false alarm or not." Then provides direction for visually identifying "a small glowing light on a smoke detector." (3) After all previous steps have been taken reset the system." The Charge Nurse Fire Emergency Checklist directs the Charge Nurse to check the fire panel for the location of trouble, assign a staff member to find the smoke detector signaling trouble and report if whether the alarm is a drill or "true fire." "Fire" addresses what to do in the event "a fire is identified behind a door." Directing staff not to open the door, touch the door for a raised temperature, smell for smoke, and then implement RACE procedures. The Director of Plant Operations acknowledged at the time of		then it will be revisited and possibly altered. New fire plan will be in place by June 5, 2015	

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	record review, the required elements of a fire plan were not included or unclear and the fire plan directed a response by healthcare staff to areas other than healthcare during a fire alarm. 3.1-19(b)			
K 050 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on observation and interview, the facility failed to ensure all staff were familiar with fire drill response requirements for the protection of 44 of 44 residents. This deficient practice affects all occupants. Findings include: Based on observation of a fire drill conducted by the Director of Plant Operations on 05/06/15 at 11:45 a.m., the fire alarm was activated by the Director of Plant Operations. Charge Nurse #1 failed to respond to the alarm as did another unidentified staff person standing	K 050	K 0050 SS=FBased on observation and interview, the facility failed to ensure all staff were familiar with fire drill response requirements for the protection of 44 of 44 residents. This deficient practice affects all occupants. No residents were harmed by this deficient practice. All staff will be in-serviced on June 4, 2015 on the new fire plan. New staff will be trained over the new fire plan during orientation b the Director of Plant Operations. Our fire drill procedure will be reviewed by the entire management team and changes will be made to make the drills more effective and interactive. If a staff member transfers	06/05/2015

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	behind the nurses station desk. The Director of Plant Operations had to prompt the Charge nurse after she asked him, "Is this a drill?" She immediately handed a hand held radio to the the second staff at the desk and told her to go upstairs to the first floor of the healthcare center. Staff began arriving at the nurses station and the Charge Nurse Distributed checklists to each and they left to return to their assigned work areas. The Director of Plant Operations again prompted the Charge Nurse, reminding her to look at the fire panel and determine the location of the simulated fire. The fire drill was discontinued and the Charge Nurse interviewed to determine her understanding of staff responsibilities during a fire drill. She said at the time of interview, she had been employed five years at the facility as a CNA and three months as a charge nurse. She said she had not received training for fire alarm response specific to her new supervisory status. The Director of Plant Maintenance agreed at the conclusion of the fire drill, the drill was a failure and the procedure followed left residents unattended to allow staff to collect check lists. The Human Resources Director, charged with the task of orienting staff to the fire plan and their responsibilities was interviewed with the Director of Plant Operations in attendance on 05/06/15 at		departments or positions, the Director of Plant Operations will be notified of the employee's change and they will be retrained over their new responsibilities during a fire alarm. Staff will be trained annually on the fire plan and monthly during fire drills. New fire drill procedures and training will be completed by June 5, 2015.	

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	1:50 p.m., she acknowledged at the time of interview the Charge Nurse had not been reoriented to her responsibilities as the Charge Nurse when the fire alarm was activated. 3.1-19(b) 3.1-51(c)			
K 056 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 1 of 1 ground floor elevator equipment rooms was provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected	K 056	K 0056 SS = EThe ground floor south elevator equipment room was not provided with sprinkler coverage. No residents were harmed by the lack of a sprinkler system in the ground floor south elevator room. A suppression system will be installed in the ground floor south elevator room similar to the one that was installed last year in the other elevator control room.A quote was obtained and signed on May 22, 2015. See Exhibit	06/05/2015

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	elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect visitors, staff, and 10 or more residents on the ground floor. Findings include: Based on observation with the Director of Plant Operations on 05/06/15 at 11:00 a.m., the ground floor south elevator equipment room was not provided with sprinkler coverage. The Director of Plant Operations verified at the time of observation, the room had not been provided with sprinkler protection. 3.1-19(b)		BCompletion of required work anticipated by June 5, 2015.	
K 147 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure flexible cords including extension cords and powerstrips in 2 of 4 smoke compartments were not used as a substitute for fixed wiring. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed	K 147	K0147 SS=E Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure or where run through holes in walls. The overhead light fixture in the healthcare short hall mechanical room was powered by flexible conduit was run through the wall and connected to the electric outlet in the corridor on the opposite side of the wall.	06/05/2015

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	wiring of a structure or where run through holes in walls. This deficient practice could affect visitors, staff and 10 or more residents in the two ground floor smoke compartments. Findings include: a. Based on observation with the Director of Plant Operations on 05/06/15 at 12:00 p.m., the overhead light fixture in the healthcare short hall mechanical room was powered by flexible conduit was run through the wall and connected to the electric outlet in the corridor on the opposite side of the wall. The Director of Plant Operations acknowledged at the time of observation, the flexible power source was run through a wall. b. Based on observation with the Director of Plant Operations on 05/06/15 at 11:30 a.m., an extension cord behind the bed was used to supply power to equipment in room 10. The Director of Plant Operations said at the time of observation, this practice was not permitted. 3.1-19(b)		No residents were harmed by this deficient practice. K147(A.) The flexible conduit was replaced on May 22, 2015. The closets on other floors will be inspected for the same issue. Maintenance staff will be educated on the deficient practice. Completed work will be inspected and monitored by the Director of Plant Operations to ensure flexible conduit was not used. K147(B.) An extension cord behind the bed was used to supply power to equipment in room 10. No Residents were harmed by this deficient practice. The extension cord was removed on May 9, 2015. All staff will be educated that extension cords and power strips are not allowed and to notify the Director of Plant Operations if they are being used at an in-service held on June 4, 2015. Rooms will be inspected for the deficient practice during monthly maintenance rounds for bed rail measurements. Monitoring will be ongoing by the Director of Plant Operations when he reviews the bed rail measurement logs.	