

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  04/24/2014
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NAME OF PROVIDER OR SUPPLIER  ASBURY TOWERS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135
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K020000	<p>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).</p> <p>Survey Date: 04/24/14</p> <p>Facility Number: 001120 Provider Number: 155758 AIM Number: 200525120</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>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.</p> <p>The facility located on the first and ground floors of a four story building was 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</p>	K020000		
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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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	<p>sprinklered. The facility identifies the ground floor as HCC Comprehensive 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 in 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 a capacity of 48 and had a census of 44 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered except elevators cited at K56. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/01/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K020011 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 openings in fire barrier walls separating health care from the assisted living occupancy provided the protection needed for a two hour fire barrier. NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect visitors, staff and 15 or more first floor residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 04/24/14 at 12:55 p.m., the door in the fire wall between the kitchen and the assisted living dining room did not latch after self closing. The Director of Plant Ops acknowledged at the time of observation, the door failed to maintain the fire barrier between the two occupancies.</p>	K020011	K 0011No Residents were harmed by this deficiency. Maintenance has repaired the locks on the doors separating the kitchen and the assisted living dining room. The doors are latching properly. This will be monitored by the maintenance and dietary departments monthly during the fire drills. Date of completion 05/09/2014.	05/09/2014

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K020021 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure doors in 1 of 2 first floor smoke barrier door sets were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 15 or more residents on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 04/24/14 at 12:55 p.m., one</p>	K020021	K 0021 No residents or staff were harmed by the doors not latching properly. Maintenance has readjusted the settings on the door to ensure they are latching properly. The fire doors will be checked weekly to ensure the proper settings are maintained. See Exhibit C. Monitored ongoing by the Maintenance Department with reports given to the Director of Plant Operation. Completed 05/08/2014.	05/08/2014			

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K020029 SS=D	<p>door in the first floor double smoke barrier door set near the elevator failed to close when tested twice with the Director of Plant Ops. The Director of Plant Ops said at the time of observation, one door caught on the door frame and had to be adjusted repeatedly.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved 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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 12 doors to hazardous areas, such as the maintenance repair room, latched when closing automatically. Doors to hazardous areas</p>	K020029	K 0029 No residents were harmed by the maintenance door not latching properly. Maintenance has rebuilt the latches to the maintenance rooms doors. The doors now latch properly and no longer stick. The	05/06/2014

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K020046 SS=E	<p>are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors and 4 or more staff in an area inaccessible to residents.</p> <p>Findings include:</p> <p>Based on observations with the Director of Plant Ops on 04/24/14 at 12:45 p.m., two self closing corridor doors to the maintenance repair room each failed to latch after self closing. Upon closer inspection by the Director of Plant Ops at the time of observations, the latching mechanisms in the doors were "sticking."</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 battery powered emergency lighting fixtures on the south wing of the first floor would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 15 or more residents on the first</p>		<p>Director of Plant Operations has re-educated his staff to report and repair any latches that are not working properly. Completed 05/06/2014.</p>				
		K020046	<p>K 0046No residents were harmed by the failure of the battery operated emergency lights to illuminate. The emergency lights are on the daily check list for testing. The person responsible for checking this was aware it was not working and had failed to change the battery. Staff was re-educated to the importance of immediately repairing or replacing any emergency lights that fail to</p>	05/02/2014			

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K020056 SS=E	<p>floor.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 04/24/14 at 12:05 p.m., the battery powered emergency lighting near resident room 129 failed to illuminate when tested twice. The Director of Plant Ops acknowledged at the time of observation, the light was not working.</p> <p>3.1-19 (b)</p> <p>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</p>		pass the daily checks. Light has been repaired. Monitoring will be ongoing by the Director of Plant Operations.				

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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 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 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 15 or more residents.</p> <p>Findings include:</p> <p>Based on observation on 04/24/14 at 12:25 p.m. with the Director of Plant Ops, the elevator equipment room was not provided with sprinkler coverage. The Director of Plant Ops said at the time of observation, there was confusion about the sprinkling of the room because the elevator contractor said not to sprinkle the room.</p> <p>3.1-19(b)</p>	K020056	<p>K 0056 No residents or staff were harmed by the lack of a sprinkler head in the elevator room. Director of Plant Operations has contacted Koorsen and they have been on site and measured the elevator room. A signed/approved quote for sprinkling this room is attached. See Exhibit D. Anticipated completion date 05/24/2014</p>	05/24/2014			

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K020130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program in accordance with the manufacturer's recommendations for cleaning and replacement of battery operated smoke detectors in 34 of 34 resident sleeping rooms. LSC 4.6.12.2 requires any like safety code features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice could affect visitors, staff and 34 or more residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 04/24/14 between 11:25 a.m. and 1:40 p.m., battery operated smoke detectors were installed in ground floor resident rooms. During a review of preventive maintenance records with the Director of Plant Ops on 04/24/14 at 2:25 p.m., no record of a monthly function test, battery change or cleaning schedule was found. The Director of Plant Ops</p>	K020130	<p>K 0130 (1.) No residents were harmed by the lack of a preventative maintenance check on the battery operated smoke detectors. The Director of Plant Operations has instituted a preventative maintenance check list (See Exhibit A) to be completed by staff on a monthly basis. The smoke detectors have been numbered and will be cleaned, checked and the batteries changed according to the schedule. Batteries will be changed every six months and as needed. Preventative procedures will be monitored by the Director of Plant Operations Completed 05/12/14. (2.) No residents were harmed by this deficiency. The water heaters were inspected on April 17, 2014, but did not leave a inspection report. Following the Life Safety Survey, we requested a copy of the inspection report, a copy of which is attached. See Exhibit E. The Certificates of Inspection are forthcoming and will be in place by 05/24/14. The Director of Plant Operations will put a Outlook reminder on the calendar to contact the State Boiler Inspector to come before</p>	05/24/2014
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	<p>said at the time of record review, the smoke detectors were not tested monthly, so no record was prepared.</p> <p>3.1-19(a)</p> <p>2. Based on observation, record review, and interview, the facility failed to ensure 2 of 3 service water heaters had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect visitors, staff, and 20 or more residents on the first and ground floors.</p> <p>Findings include:</p> <p>a. Based on observation on 04/24/14 at 11:25 a.m. with the Director of Plant Ops, one service water heater in the ground floor mechanical room identified as IN302417 had a certificate of inspection which expired 04/02/14. The Director of Plant Ops said at the time of observation, the vessel had been inspected but he had nothing to verify the date of inspection.</p> <p>b. Based on observation on 04/24/14 at 1:40 p.m. with the Director of Plant Ops, the posted certificate of inspection for the first floor service water heater in the</p>		the expiration date of the previous inspection. Completion Date 05/24/14				

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K020147 SS=D	<p>mechanical room identified as IN319003 had a certificate of inspection which identified another vessel. The Director of Plant Ops said at the time of observation, he was unaware of the posting and later, during record review, reported he had no other inspection record for the first floor service water heater.</p> <p>3.1-19(b)</p> <p>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 1 of 1 flexible cords was 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 wiring of a structure. This deficient practice could affect 2 or more staff and visitors in the environmental services</p>	K020147	<p>On 04/24/14 Life Safety Code Inspector observed a power strip cord piggybacked to another power strip cord. These were immediately separated. On May 2, 2014 maintenance moved the outlet to a more accessible locations for the Environmental Services Manager eliminating the need for multiple power strips. On 05/05/2014 Director of Plant Operations sent an e-mail to all Asbury users reminding/informing them that two power strips could</p>	05/06/2014

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	<p>office and supply room where no residents have access.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 04/24/14 at 12:30 p.m., a power strip extension cord was piggy backed to a second power strip to supply power to equipment in the room. The Director of Plant Ops said at the time of observation, this practice was not permitted.</p> <p>3.1-19(b)</p>		<p>not be connected and extension cords could not be connected to a power strip. See Exhibit B. Housekeeping will be instructed to check for violations when they are cleaning rooms and offices. Any violations will be reported to the Director of Plant Operations. Completed 05/06/2014</p>	