

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/04/2017
NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASLTE, 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
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00216816 and IN00218399.</p> <p>Complaint IN00216816 - Substantiated. No deficiencies related to the allegation were cited.</p> <p>Complaint IN00218399 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: January 3 and 4, 2017</p> <p>Facility number: 001120 Provider number: 155756 AIM number: 200525120</p> <p>Census bed type: SNF/NF: 37 Residential: 55 Total: 92</p> <p>Census payor type: Medicare: 4 Medicaid: 19 Other: 14 Total: 37</p> <p>Sample: 5</p> <p>Quality Review completed by 34438 on January 9, 2017.</p>	F 000		

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.