STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155758	A. BUILDING 02 B. WING	05/23/2016

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 0000 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: 05/23/16 Facility Number: 001120 Provider Number: 155758 AIM Number: 200525120 At this Life Safety Code survey, Asbury Towers 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. This 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 was fully sprinklered. The facility identifies the ground floor as HCC Comprehensive	K 0000		

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

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	Care Unit 1 and the first floor as Comprehensive Care Unit II. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. All resident rooms have battery powered smoke detection 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 46 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered except for the Electrical room on North wing hall, Ground floor. Quality Review completed on 06/01/16 - DA			
K 0021 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening			

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	or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 2 of 5 doors leading into hazardous areas such as the Laundry and Supply rooms with combustible items were not held open to prevent the door from closing. This deficient practice could affect 9 residents on East wing as well as visitors and staff. Findings include: Based on observations on 05/23/16 at 1:27 p.m. with the Maintenance Supervisor, the following hazardous area room doors located on East wing, Ground floor were held open with the following impediments which prevented the doors from closing: a. Central Supply room door was held open using a stick of wood wedged between the self closing device and the door jam. The Central Supply room stored over twenty cardboard boxes and was greater than fifty square feet. b. Laundry room door was held open by	K 0021	·All current and potential impediments preventing anyself-closing door within the facility will be removed by June 22, 2016. ·All current and potential impediments preventing anyself-closing door within the facility will be removed by June 22, 2016. ·Staff will be re-educated via a hand out and postingthroughout the building that no self-closing door can propped open or impededfrom closing (Exhibit D). · During weeklyfire door inspections, the maintenance designee will observe all self-closingdoors for impediments. ·All impediments will be removed by June 22, 2016.Maintenance designee will begin observing self-closing doors for impediments byJune 22, 2016. Staff re-education will be done by June 22, 2016.	06/22/2016

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	placing a chair between the door and its frame. Based on interview on 05/23/16 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned corridor doors were provided with impediments preventing closure of the doors. 3.1-19(b)			
K 0046 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on record review and interview, the facility failed to provide documentation of a 30 second monthly functional test or a 90 minute annual functional test for 54 of 54 battery operated lights. LSC Section 7.9.3 requires a functional test be conducted monthly for 30 seconds on every required emergency lighting system and annually for not less than 1 1/2 hours. This deficient practice could affect all occupants in the facility including staff, visitors and residents if emergency battery powered lights were not available.	K 0046	·A 90-minute functional test was performed on everyemergency light on May 26, 2016. ·A 90-minute functional test was performed on everyemergency light on May 26, 2016 to ensure all emergency lights were functioningproperly. ·A maintenance designee will perform a 30 secondfunctional test on every emergency light weekly and a 90-minute functional testmonthly. These tests will be recorded on Exhibits A and B. Maintenancedepartment was re-educated on this process at department meeting on June 7,2016 (Exhibit C)	06/22/2016

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	Findings include: Based on Fire Safety Record review on 05/23/16 during the tour between 1:38 p.m. to 3:30 p.m. with the Maintenance Supervisor the facility could not provide documentation for the testing of interior and exterior battery powered emergency lights located throughout the facility. Based on interview concurrent with record review with the Maintenance Supervisor it was acknowledged the battery back up emergency lights were checked monthly and annually, but the documentation was not available for review. 3.1-19(b)		·A maintenance designee will perform a 30 secondfunctional test on every emergency light weekly and a 90-minute functional testmonthly. These tests will be recorded on Exhibits A and B. ·Maintenance department was re-educated at departmentmeeting on June 7, 2016 (Exhibit C). Weekly and monthly functional tests willbe in place by June 22, 2016.	
K 0051 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual			

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	alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6			
	1. Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff. Findings include: Based on observation on 05/23/16 at 1:54 with the Maintenance Supervisor the breaker for the fire alarm panel located in the corridor next to the MDS office was identified by "Fire" in black and the electric panel was not locked and fully accessible to unauthorized personnel. Based on interview concurrent with the observation with the Maintenance	K 0051	1. ·The fire alarm breaker box will have a lock installedon it by maintenance personnel. The fire alarm breaker will be marked with redand a red label will be applied next to the breaker stating "FIRE ALARM CIRUITCONTROL". ·Only maintenance personnel will be provided with keysto the breaker box containing the fire alarm breaker. ·Only maintenance personnel will be provided with keysto the break box containing the fire alarm breaker. ·Maintenance designee will begin checking to ensure thebreaker box is locked during weekly fire door inspections. ·All work and procedures will be completed by June 22,2016. 1. ·The rooms observed to not be in compliance will havetheir smoke detectors moved so that they are at least 18'' away from the edgeof the ceiling fan blades. ·All other rooms equipped with	06/22/2016

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	Supervisor it was acknowledged the fire alarm circuit breaker was not properly identified and accessible to anyone. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 6 of 12 smoke detectors were installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 14 residents on South wing hall, First floor as well as visitors and staff. Findings include: Based on observations on 05/23/16 during the tour between 2:00 p.m. to 2:30 p.m. with the Maintenance Supervisor, the smoke detectors in resident rooms 117, 118, 122, 124, 132 and 135 are located directly above ceiling fans. Based on interview concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detectors were installed above ceiling fans which would interfere with the smoke detector's ability to detect smoke to its fullest capability.		ceiling fans will havetheir smoke detector placement inspected by the Director of Plant Operations ordesignee. If the smoke detector is not located at least 18'' from the edge ofthe ceiling fan blade, then it will be moved accordingly. ·Prior to any ceiling fans being installed the Directorof Plant Operations or designee will inspect the placement of the smokedetector located in the room. If the smoke detector is found to be too close tothe location of the installed ceiling fan, then the ceiling fan will either notbe installed or the smoke detector's location will be moved. ·Prior to any ceiling fans being installed the Directorof Plant Operations or designee will inspect the placement of the smokedetector located in the room. If the smoke detector is found to be too close tothe location of the installed ceiling fan, then the ceiling fan will either notbe installed or the smoke detector's location will be moved. The maintenancedepartment was re-educated on June 7, 2016 (Exhibit C) that if they are addinga ceiling fan to a room they first need to have it inspected by the Director ofPlant Operations or designee. ·All smoke detectors will be moved and inspections ofother rooms will be performed by June 22, 2016.	

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	3.1-19(b)			
K 0062 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation, record review and interview, the facility failed to ensure 3 of 3 gauges for the sprinkler system were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on observation on 05/23/16 at 2:18	K 0062	·The 3 gauges that were not in compliance were replacedon May 24, 2016. The date they were replaced was written on them with apermanent marker. ·The 3 gauges that were not in compliance were replacedon May 24, 2016. The date they were replaced was written on them with apermanent marker. ·The 3 gauges on the sprinkler riser system werereplaced and dated with the date of installation. The designated maintenance personnelperforming the weekly fire pump test will observe the date on the gauges duringeach test. ·The 3 gauges on the sprinkler riser system werereplaced and dated with the date of installation. The designated maintenancepersonnel	06/22/2016

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	p.m. with the Maintenance Supervisor three pressure gauges on the sprinkler riser system located in the Mechanical riser room on North wing, Ground floor had a manufacturer's dates of 2010. Based on Sprinkler Inspection Records review on 05/23/16 at 03:45 p.m., documentation did not reveal the sprinkler system gauges had been calibrated or replaced. Based on interview on concurrent with record review with the Maintenance Supervisor it was acknowledged the pressure gauges had exceeded the five year calibration or replacement limit. 3.1-19(b)		performing the weekly fire pump test will observe the date on thegauges during each test. The maintenance department was re-educated on June 7,2016 (Exhibit C) that these 3 gauges must be replaced or recalibrated every 5years. ·The 3 gauges were replaced on May 24, 2016. Observationof the gauges during weekly fire pump tests will begin by June 22, 2016.Maintenance department was re-educated at department meeting on June 7, 2016(Exhibit C).	
K 0143 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and			

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	Compressed Gas Association. 8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs had an electrical light switch and two outlets less than five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect 10 residents as well as visitors and staff on South wing hall, First floor. . Findings include: Based on observation on 05/23/16 at 2:40 p.m. with the Maintenance Supervisor, the oxygen room located on South wing hall had one electrical light switch and two outlets just inside the room located four feet or less above the floor. Based on interview concurrent with the observation with the Maintenance Supervisor, it was acknowledged the electrical light switch and outlets in the	K 0143	·The electrical light switch and two outlets will berelocated at least 5 feet above the floor in the oxygen supply room. ·The room will be inspected by the Director of PlantOperations or designee for any other electrical switches or outlets locatedless than 5 feet from the floor. If any are found they will be relocated atleast 5 feet above the floor. ·If any electrical outlets or switches are to be addedto the oxygen supply room, or the room is to be relocated in the future, itwill first be inspected by the Director of Plant Operations or designee toensure any additional outlets or switches are above 5 feet from the floor orthat the new location has no electrical outlets or switches below 5 feet fromthe floor. ·The maintenance department was re-educated on June 7,2016 (Exhibit C) that the oxygen supply room cannot have any electricalswitches or outlets located below 5 feet from the floor. If an electricaloutlet or switch is to be added or the supply room is to be moved in thefuture, it will have to be first inspected by the Director of Plant Operationsor designee. ·The maintenance department was re-educated on June 7,2016 (Exhibit C). All switches and outlets will be relocated above 5	06/22/2016

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	oxygen storage room used for oxygen transfer was located less than five feet above the floor. 3.1-19(b)		feet fromthe floor in the oxygen supply room by June 22, 2016.	