STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155758	A. BUILDING -- B. WING	03/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/04/24 Facility Number: 001120 Provider Number: 155758 AIM Number: 200525120 At this Emergency Preparedness survey, Asbury Towers Health Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 48 certified beds. At the time of the survey, the census was 18. Quality Review completed on 03/11/24	E 0000		
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

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

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency	E 0004	1. The facility will review the Emergency Preparedness Plan.	04/20/2024

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	preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 03/04/2024 between 10:30 AM and 3:08 PM with the Maintenance Director present, documentation for an updated emergency program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available has not been reviewed within the past 12 months with no documentation of an update located anywhere within the plan. Based on interview at the time of record review, the Maintenance Director said that the plan was last reviewed in 2021. This finding was reviewed with the Maintenance Director at the exit conference.		2. Staff will be educated on the reviewed/revised emergency preparedness plan by 4/20/24. 3. Compliance will be discussed monthly by QAPI.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies			

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	and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update its emergency preparedness policies and procedures at least annually. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). Findings include: Based on record review of the facility's Emergency Preparedness Plan on 03/04/2024 between 10:30 AM and 3:08 PM with the Maintenance Director present, documentation for an updated emergency preparedness policies and procedures reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available has not been reviewed within the past 12 months with no documentation of an update located anywhere within the plan. Based on interview at the time of record review, the Maintenance Director said that the plan was last reviewed in 2021. This finding was reviewed with the Maintenance Director at the exit conference.	E 0013	1. The facility will review the policy and procedures for the emergency preparedness plan. 2. Staff will be educated on the reviewed/revised emergency preparedness policies and procedures by 4/20/24. 3. Compliance will be discussed monthly by QAPI.	04/20/2024

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E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update its emergency preparedness communication plan that complies with Federal, State, and local laws at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 03/04/2024 between 10:30 AM and 3:08 PM with the Maintenance Director present, documentation for an updated emergency preparedness communication plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available has not been reviewed within the past 12 months with no documentation of an update located anywhere within the plan. Based on interview at the time of record review, the Maintenance Director said that the plan was	E 0029	1. The facility will review the communication plan for the emergency preparedness plan. 2. Staff will be educated on the reviewed/revised communication plan for the emergency preparedness plan by 4/20/24. 3. Compliance will be discussed monthly by QAPI.	04/20/2024

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	last reviewed in 2021. This finding was reviewed with the Maintenance Director at the exit conference.			
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness			

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	training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency	E 0036	1. The facility will review the training and testing program for	04/20/2024

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	preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 03/04/2024 between 10:30 AM and 3:08 PM with the Maintenance Director present, documentation for an updated emergency preparedness training and testing program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available has not been reviewed within the past 12 months with no documentation of an update located anywhere within the plan. Based on interview at the time of record review, the Maintenance Director said that the plan was last reviewed in 2021. This finding was reviewed with the Maintenance Director at the exit conference.		the emergency preparedness plan. 2. Staff will be educated on the reviewed/revised emergency preparedness training and testing program by 4/20/24. 3. Compliance will be discussed monthly by QAPI.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:			

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	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):]			

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	(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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	facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires			

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	155758	A. BUILDING -- B. WING	03/04/2024

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	activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the			

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	LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the			

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	onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or			

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	functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as			

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	needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to ensure exercises testing the emergency plan at least twice during the past year were conducted in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 03/04/2024 between 10:30 AM and 3:08 PM with the Maintenance Director present, there was no after actions reports for the facility's emergency preparedness exercises. Based on interview at the time of record review, the Maintenance Director said he did not have any after action reports for the exercises. This finding was reviewed with the Maintenance Director at the time of the exit conference.	E 0039	1. The Maintenance Director or designee will ensure that after action reports are completed for every future emergency preparedness exercise. 2. During routine annual review/checks the Maintenance Director or designee will ensure that there are after action reports for all emergency preparedness exercises.	04/20/2024
E 0041 SS=F	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power			

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	155758	A. BUILDING -- B. WING	03/04/2024

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Bldg. --	§482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs			

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	155758	A. BUILDING -- B. WING	03/04/2024

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	and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1,			

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	2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on review of monthly generator inspection sheet with the Maintenance Director on 03/04/2024 between 10:30 AM and 3:08 PM, the monthly generator inspection sheet from the last twelve months were missing the transfer time, load percentage, and cool down time from the report. Additionally, the weekly visual generator inspection sheet for the weeks of 02/06/2024 and 01/17/2023 were not completed. Based on interview at the time of record review, the Maintenance Director stated the generators run automatically on the first Tuesday of the month and he was not aware of the additional	E 0041	1. On 3/4/24 it was found that the monthly generator inspection was not completed in its entirety. Staff will be educated on the need for the inspection forms to be completed in their entirety. 2. Monthly generator inspection sheets will be audited by the Maintenance Director or designee monthly to ensure that the inspection sheets are completed in their entirety. QAPI to also monitor compliance with completion of inspections.	04/20/2024

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	155758	A. BUILDING -- B. WING	03/04/2024

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	information required for the monthly load test. This finding was reviewed with the Maintenance Director at the exit conference.			
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/04/2024 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 483.90(a), Life Safety from Fire and the 2012 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 ground and first 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 Care Unit 1 and the first floor as Comprehensive Care Unit II. The facility also has a partial basement. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. All	K 0000		

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	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 48 certified beds. At the time of the survey, the census was 18. Quality Review completed on 03/11/24			
K 0100 SS=E Bldg. 02	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the 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 failed to ensure 1 of 1 shower room stall 3 combination ceiling light and heater unit on the ground floor shower room was properly maintained. NFPA 101 at 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect any residents and staff in the shower room. Findings include: Based on observations on 03/04/2024 between 3:08 PM and 5:20 PM on a tour of the facility with the Maintenance Director, the combination ceiling mounted light and heater unit in stall 3 of the ground level shower room was showing signs of heat damage due to the appearance of the hard	K 0100	1. On 3/4/24 during a walk through with the IDOH, it was found that a combination ceiling mounted light and heater unit in stall 3 of the shower room showed signs of heat damage. This was corrected on 3/5/24. 2. During routine walk-throughs the Maintenance Director or designee will check and replace any combination ceiling mounted light and heater units as needed.	03/05/2024

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	plastic vent being discolored. Based on interview at the time of observation, the Maintenance Director identified the discoloration as likely heat damage and would address the issue. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0211 SS=F Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on record review, observation and interview; the facility failed to ensure 1 of 6 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors if needing to exit the facility using the ground floor corridors. Findings include: Based on review of the facility's fire safety plan documentation with the Maintenance Director from 10:30 AM to 3:08 PM on 03/04/2024, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on interview at the time of review, the Maintenance Director acknowledged the aforementioned written fire	K 0211	1. The facility wishes that the tag be deleted because the wheeled equipment referred to in this tag was patient lift and transport equipment such as mechanical lifts, wheelchairs, and medication carts that were in use and not being stored. 2. On 3/4/24 during a walk through with the IDOH, it was found that wheeled equipment was observed in the hallways. 3. The fire safety plan will be updated to address the relocation of wheeled equipment during a fire or similar emergency. 4. Staff will be educated on the updated fire safety plan by 4/20/24.	04/20/2024

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	safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation with the Maintenance Director during a tour of the facility from 3:08 PM to 5:20 PM, wheeled equipment was located in the hallways on the ground floor and the South Ground Stairwell was marked as an exit. Based on interview at the time of observation, the Maintenance Director acknowledged wheeled equipment being stored in the hallways on the ground floor and was in the path of egress. This finding was reviewed with the Maintenance Director at the time of the exit conference. 3.1-19(b)			
K 0223 SS=D Bldg. 02	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a 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: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 boiler room doors were separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per	K 0223	1. On 3/4/24 during a walk through with the IDOH, it was found that the boiler room door was propped open with an object. This was corrected immediately by	03/06/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect maintenance staff. Findings include: Based on observation with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:20 PM, the door to the boiler room door in the basement was propped open with an object. Based on interview at the time of the observation , the Maintenance Director acknowledged the door being propped open and removed the object. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		removing the object and closing the door. 2. On 3/6/24 a sign was placed on the door stating, Do not prop open; door must remain closed. 3. During the routine weekly walk through the Maintenance Director or designee will ensure that the boiler room door is not propped open, and that the signage is place.	
K 0225 SS=F Bldg. 02	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure items stored in 1 of 2 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3.1 states open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This	K 0225	**1. The facility wishes that the tag be deleted because the wheelchair referred to in this tag does not interfere with egress. The wheelchair was 130 inches from doorway. See**	04/20/2024

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	03/04/2024

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	deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:20 PM, The south ground floor stairwell was being used for equipment storage for wheelchairs. Based on interview at the time of observation, the Maintenance Director agreed there was storage in the south ground floor stairwell. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		**Exhibit C and D for pictures of the location.** 2. On 3/4/24 during a walk through with the IDOH, it was found that wheeled equipment was observed in the stairwell. This was corrected on 3/4/24 by removing the equipment. 3. The fire safety plan will be updated to address the relocation of wheeled equipment during a fire or similar emergency. 4. Staff will be educated on the updated fire safety plan by 4/20/24. 5. During the routine weekly walk through the Maintenance Director or designee will ensure equipment is not being stored in the stairwells.	
K 0232 SS=E Bldg. 02	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 2 of 4 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the	K 0232	1. The facility wishes to have the tag deleted because the location of the benches referred to in this tag were not within 4 feet of an exit that is used for removal of nonambulatory residents. The exit located near the nurses station on the first floor leads into a	03/04/2024

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8 This deficient practice could affect all first floor residents when occupied, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 3:08 PM to 5:20 PM on 03/04/2024, near the first floor nurse's station, there were 2 benches which were not affixed to the wall or floor. Based on interview at the time of the observations, the Maintenance Director confirmed the benches were not affixed to the wall or floor.		stairwell. 2. On 3/4/24 during a walk through with the IDOH, it was found that 2 benches were not affixed to the wall or floor near the 1st floors nurse's station. This was corrected on 3/4/24 by moving the benches. 3. During the routine weekly walk through the Maintenance Director or designee will ensure that furniture located near exits are secured appropriately and do not reduce the clear unobstructed corridor.	

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	This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0311 SS=E Bldg. 02	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to ensure the protection of 1 of 3 stairwells in accordance of 19.3.1. LSC 19.3.1.1 states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall be in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or 8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing fire door assemblies having a minimum ¾-hour fire protection rating shall be permitted to continue to be used in vertical openings and exit enclosures in lieu of the minimum1-hour fire protection rating required in Table 8.3.4.2. This deficient practice could affect all residents on the first floor when occupied, staff, and visitors. Findings include:	K 0311	1. The facility wishes that the tag be deleted because the surveyors were inspecting outside of the SNF parameters. The door in which they refer to in this tag is located on the residential side of the building. During the walk through the Maintenance Director informed the surveyors of this fact. See the exhibits A and B for the pictures of location. 2. The door referred to in this tag will be replaced with a fire door with at least 1-hour fire resistance rating. 3. This will be completed by the Maintenance Director or designee by 4/20/24.	04/20/2024

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	155758	A. BUILDING 02 B. WING	03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Based on observations on a tour of the facility with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:20 PM, the ground floor center stairwell lacked a fire resistive rating tag on the door. This was verified by the Maintenance Director at the time of observation. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0321 SS=C Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops			

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 old copier rooms on the ground floor were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This room was over 50 square feet and was being used as a storage room for combustible supplies. This deficient practice could affect all residents, staff, and visitors while in the area of the nurse's station. Findings include: Based on observation on 03/04/2024 between 3:08 PM and 5:20 PM during a tour of the facility with the Maintenance Director, the old copier room was not equipped with a self-closing device and was being used to store paper goods and boxes. Based on interview at the time of observation, the Maintenance Director agreed the door was not equipped with a self-closing device and was being used to store combustible items. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0321	1. On 3/4/24 during a walk through with the IDOH, it was found that the old copier room that was being used to store paper goods and boxes did not have a self-closing device. This was corrected on 3/6/24 and was equipped with a self-closing device. 2. This door was added to the Skilled Doors and Fire Doors list and will be checked monthly by the Maintenance Director or designee.	03/06/2024
K 0331 SS=F Bldg. 02	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING			

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	Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish in all smoke compartments had a flame spread rating of Class A or Class B. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect up to 18 residents, staff, and visitors while in the same smoke compartments.	K 0331	**1. The facility wishes that the tag be deleted because the panels referred to in this tag are FRP panels. These panels meet the requirements. See Exhibit J for receipt and Exhibit K for details.** 2. On 4/9/24 the Executive Director and Maintenance Director created a binder for documentation related to flame spread ratings. The title of this binder is, "ISDH Flame Spread Ratings and Maintenance Documentation." The documentation for the FRP panels is included in this binder. 3. This binder will be in the front office so that it is readily available for review for surveys going forward.	04/20/2024

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	Findings include: Based on record review, no documentation regarding flame spread rating for wall finishes was available. Based on interview at the time of record review, the Maintenance Director stated flame spread documentation for the plastic paneling was not available. Based on observation on 03/04/2024 between 3:08 PM and 5:20 PM with the Maintenance Director, plastic paneling was observed on the bottom portion of all corridor walls of the first floor and ground floor. This finding was reviewed with Maintenance Director during the exit conference. 3.1-19(b)			
K 0341 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 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. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for	K 0341	1. On 3/4/24 during a walk through with the IDOH, it was found that the fire alarm control panel door was not locked. This was	03/05/2024

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	turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observation on 03/04/2024 between 3:08 PM and 5:20 PM during a tour of the facility with the Maintenance Director, the fire alarm control panel (FACP) door was not locked with the key hanging inside the panel. The FACP was located in the short hall to the Director of Nursing's office where all staff, residents, and visitors have access. Based on interview at the time of observation, the Maintenance Director agreed the FACP was unlocked and a key was in the lock. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		corrected on 3/4/24 by locking the control panel door and removing the key. 2. On 3/5/24 a sign was placed to keep the fire alarm control panel locked at all times. 3. During the routine weekly walk through the Maintenance Director or designee will ensure that the fire alarm control panel door is locked and replace sign as needed.	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the	K 0345	1. The facility wishes that the tag	04/20/2024

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: During record review with the Maintenance Director on 03/04/2024 between 10:30 AM and 3:08 PM, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, the Maintenance Director agreed that visual semi-annual inspections of the fire-alarm system were not completed. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected to 1 of 1 fire alarm system was complete. NFPA 72,		be deleted or revised because inspections referred to in this tag were completed. See Exhibit M for the annual fire alarm system inspection with itemized list of inspected/tested devices and the passing of all smoke alarms. The surveyors misread the report and thought the column marked as Sensitivity Alarm Point was the sensitivity observed during the inspection. 2. The Maintenance Director has confirmed that the semi-annual inspection will be completed on 4/15/24 by Koorsen Fire & Security. 3. On 4/17/24 Koorsen Fire & Safety will do a complete fire alarm inspection and smoke detector sensitivity test. 4. On 4/9/24 the Executive Director and Maintenance Director created a binder for documentation related to fire alarm and smoke detector inspections. The title of this binder is, “Koorsen Inspections.” The documentation related to the 5-year internal sprinkler pipe inspection is included in this binder. 5. This binder will be in the front office so that it is readily available for review for surveys going forward. 6. There will be a sheet in front of the binder with date of last inspections and due dates for the next inspections. 7. The Maintenance Director or	

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	National Fire Alarm Code, the 2010 Edition, at Section 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4. The record shall include a listing of all devices tested with device type, address, location and test results indicated: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test		designee will audit the binder biannually to ensure no inspections are missed.	

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	(e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 03/04/024 between 10:30 AM and 3:08 PM with the Maintenance Director, the annual fire alarm system from 07/2/2023 was not provided with an itemized list of fire alarm system devices inspected/tested indicating the device type, address, location and specific results of the testing. There was only the equivalent of a cover page with "Number Installed" and "Number Tested" for each device connected to the fire alarm system. This was acknowledged by the Maintenance Supervisor at the time of record review. This finding was reviewed with the Maintenance Director at the exit conference. 3. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.5 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. NFPA 72, 14.4.5.3.5 states smoke detectors or smoke alarms found to			

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	155758	A. BUILDING 02 B. WING	03/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 03/04/2024 between 10:30 AM and 3:08 PM the Alarm System Inspection from 07/20/2023 indicated all smoke detectors, duct detectors, ionization detectors, and heat detectors were outside the specified sensitivity range. Based on interview at the time of record review, the Maintenance Director agreed the devices were outside their listed sensitivity range and had no documentation of replacement or cleaning/recalibration. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0351 SS=F Bldg. 02	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in			

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	clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure that 1 of 1 mechanical rooms on the ground floor south wing was sprinklered. LSC 101 2012 edition Section 19.3.5.1 stated buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. This deficient practice could mostly affect staff. Findings include: Based on observation during a tour of the facility on 03/04/2024 between 3:08 PM and 5:20 PM with the Maintenance Director, the ground floor mechanical room was not equipped with a sprinkler or other means of fire protection. Based on interview at the time of observation, the Maintenance Director agreed there was no sprinkler in the ground floor mechanical room. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system or documentation of fire retardant material was provided for 1 of 1 ground floor canopies. NFPA 13-2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under	K 0351	1. The facility wishes that the tag be revised to delete the part that refers to the canopy. The canopy referred to in this tag is a MarChem CFI Holiday brand and has a Class A fire rating. See Exhibits L and O for the receipt and specifications. 2. On 3/4/24 during a walk through with the IDOH, it was found that there was no sprinkler in a mechanical room on the ground floor. 3. The Maintenance Director has called and scheduled Koorsen Fire & Security to install a sprinkler by 4/20/24. 4. On 4/9/24 the Executive Director and Maintenance Director created a binder for documentation related to flame spread ratings. The title of this binder is, “ISDH Flame Spread Ratings and Maintenance Documentation.” The documentation for the canopy is included in this binder. 5. This binder will be in the front office so that it is readily available for review for surveys going forward.	04/20/2024

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible or limited-combustible, or fire retardant. Textiles such as canvas used as an awning shall meet NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect at least 30 residents evacuating through main entrance. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:50 PM, there was a canvas canopy that exceeded 4 feet in length or width attached to the building and it was not sprinklered. Based in interview at the time of observation, the Maintenance Director agreed the canopy was attached to the building and not sprinklered. Based on record review with the Maintenance Director on 03/04/2024 between 10:30 AM and 3:08 PM, no documentation to show the canopy was inherently flame retardant was available for review. Based on interview at the time of record review, the Maintenance Director stated he did not have any documentation regarding the canopy's flame retardant rating. This finding was reviewed with the Maintenance Director at the time of the exit conference. 3.1-19(b)			
K 0352 SS=F	NFPA 101 Sprinkler System - Supervisory Signals			

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	155758	A. BUILDING 02 B. WING	03/04/2024

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Bldg. 02	Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director on 03/05/2024 between 10:30 AM and 3:08 PM, the sprinkler inspection inspection dated 01/04/2024 indicated the last date for the 5-year internal pipe inspection was 07/2017. Based on interview at the time of record review, the Maintenance Director stated they had an internal pipe inspection completed several years ago and thought it may have been around 2017.	K 0352	1. The facility wishes that the tag be deleted because the 5-year internal pipe inspection was completed on 11/3/22. See Exhibit Q. 2. On 4/9/24 the Executive Director and Maintenance Director created a binder for documentation related to sprinkler system inspections. The title of this binder is, “Koorsen Inspections.” The documentation related to the 5-year internal sprinkler pipe inspection is included in this binder. 3. This binder will be in the front office so that it is readily available for review for surveys going forward. 4. There will be a sheet in front of the binder with date of last inspections and due dates for the next inspections. 5. The Maintenance Director or designee will audit the binder biannually to ensure no inspections are missed.	04/20/2024

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ground floor dining rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all residents, staff, and visitors in the vicinity of the ground floor	K 0353	1. The facility wishes that the part of this tag that refers to the sprinkler gauge be deleted because all gauges were inspected on 7/20/23 and the report states that all gauges are within calibration or five year replacement. See Exhibit P for the report. The sprinkler gauge referred to in this tag is listed as location 1st Floor Riser B in stairwell in the Exhibit P report. See Exhibit S for picture of gauge and its tag showing location.	04/20/2024

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	dining room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 3:08 PM to 5:20 PM on 03/04/2024, 1 suspended ceiling tile was missing in the ground floor dining room. The room was equipped with pendant sprinklers installed on the suspended ceiling. Based on interview at the time of observation, the Maintenance Director acknowledged the missing ceiling tile in the ground floor dining room. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler system gauges at the center stairwell sprinkler riser were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states 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 could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 3:08 PM to 5:20 PM on 03/04/2024, the facility has a wet sprinkler system and had a sprinkler riser with 2		2. On 3/4/24 during a walk through with the IDOH, it was found that there was 1 missing suspended ceiling tile in the dining room. 3. The suspended ceiling tile was replaced on 3/5/24. 4. During the routine weekly walk through the Maintenance Director or designee will ensure that ceiling tiles are checked and replaced if missing. 5. The expired sprinkler system gauge will be replaced or updated and calibrated by 4/20/24. 6. During the routine annual walk through the Maintenance Director or designee will check the dates for the sprinkler system gauges and schedule required 5 year replacement or calibration before the end of the 4th year.	

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	155758	A. BUILDING 02 B. WING	03/04/2024

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ASBURY TOWERS HEALTH CARE CENTER	102 W POPLAR ST GREENCASTLE, IN 46135

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	gauges in the center stairwell. The manufacture date of 2017 was listed on the face of 1 of 2 of the sprinkler system gauges. No recalibration date information was affixed to the sprinkler system gauges. Based on interview at the time of the observations, the Maintenance Director stated was unsure why the sprinkler gauge was not updated or calibrated when the second gauge was in 2022. This finding was reviewed with the Maintenance Direction at the exit conference. 3.1-19(b)			
K 0355 SS=D Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the basement were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect all staff in the basement Findings include:	K 0355	1. On 3/4/24 during a walk through with the IDOH, it was found that a portable fire extinguisher was sitting on the floor and not mounted. This was corrected on 3/5/24 by mounting it in accordance with the requirements of NFPA 10, The Standard for Portable Fire Extinguishers. 2. During the routine monthly walk through the Maintenance Director or designee will ensure that all fire extinguishers are mounted in accordance with the requirements of NFPA 10.	03/04/2024

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	155758	A. BUILDING 02 B. WING	03/04/2024

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

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	Based on observations during a tour of the facility with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:20 PM, the ABC portable fire extinguisher located in the basement was sitting on the floor. Based on interview at the time of observation, the Maintenance Director acknowledged the extinguisher was sitting on the ground, not mounted. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0363 SS=F Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are			

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	155758	A. BUILDING 02 B. WING	03/04/2024

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

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	permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 14 of 14 Dutch doors to resident sleeping rooms on the ground floor fully latched into the door frame. This deficient practice could affect up to 18 residents, staff and visitors. Findings include: Based on observations on 03/04/2024 between 3:08 PM and 5:20 PM during a tour of the facility with the Maintenance Director, rooms 1, 3, 5, 7, 9, 11, 13, 15, 16, 17, 18, 19, 20, and 21 were equipped with Dutch doors which allowed the top half and bottom half of the doors to open independently. There was a sliding lock to connect the top and bottom halves of the doors which also had the capability to be unlocked. The bottom half of the doors were able to latch in the frame, however the top half of the doors do not have a latching mechanism. This was acknowledged by the Maintenance Director at the time of the observations.	K 0363	1. On 3/4/24 during a walk through with the IDOH, it was found that the rooms equipped with Dutch doors did not have latching mechanisms that latch into the frame for the top half of the doors. 2. All doors will be fastened together preventing the top half from being opened separately from the bottom half by 3/22/24. 3. On 3/4/24 during a walk through with the IDOH, it was also found that the weight room door was propped open with an object. This was corrected immediately by removing the object and closing the door. 4. On 3/6/24 a sign was placed on the door stating Do not prop open; door must remain closed. 5. During the routine weekly walk through the Maintenance Director or designee will ensure that the	03/22/2024

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	03/04/2024

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

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	This finding was reviewed reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 weight rooms were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 18 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:20 PM, the door to the weight room on the ground floor was propped open with an object. Based on interview at the time of the observations, the Maintenance Director acknowledged the door being propped open and removed the object. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		weight room door is not propped open, and that the signage is in place.	
K 0372 SS=F Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system			

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	155758	A. BUILDING 02 B. WING	03/04/2024

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

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	is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all staff and residents. Findings include: Based on observations with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:20 PM the following unsealed penetrations were discovered: a) an unsealed conduit in the North Skilled Ground Floor Door smoke barrier b) a 2 inch by 2 inch penetration in the South Wing smoke barrier c) a 4 inch by 8 inch penetration in the South Wing smoke barrier which was observable on both sides of the smoke barrier. Based on interview at the time of observation, the Maintenance Supervisor acknowledged each smoke barrier penetration and provided the measurements. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0372	1. On 3/4/24 during a walk through with the IDOH, it was found that there were unsealed penetrations to the north skilled ground floor door smoke barrier and the south wing smoke barrier. This was corrected on 3/18/24 and all areas were sealed. 2. The penetrations were sealed with 3M Fire Barrier Sealant CP 25WB+ 3. During the routine monthly walk through the Maintenance Director or designee will ensure that penetrations through smoke barriers are checked and sealed if found. See Exhibit I for ratings.	03/18/2024

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	155758	A. BUILDING 02 B. WING	03/04/2024

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ASBURY TOWERS HEALTH CARE CENTER	102 W POPLAR ST GREENCASTLE, IN 46135

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K 0511 SS=D Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas 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 1. Based on observation and interview, the facility failed to ensure 1 of over 1 wet locations in the ground floor dining room were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable.	K 0511	1. On 3/4/24 during a walk through with the IDOH, it was found that there was 1 electric receptacle within 3 feet of a sink that did not have a ground fault circuit interrupter, 2 breaker boxes that were not locked, and 1 electrical outlet was missing a face plate. 2. A ground fault circuit interrupter was installed in the electric receptacle on 3/5/24. 3. The breaker boxes were locked by the Maintenance Director on 3/4/24. 4. The missing face plate to the electrical outlet was replaced on 3/5/24. 5. During the routine monthly walk through the Maintenance Director or designee will ensure that electrical issues are checked and corrected if found.	03/05/2024

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	03/04/2024

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	Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff while at the sink in the ground floor dining room. Findings include:			

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	Based on observation on 03/04/2024 between 3:08 PM and 5:20 PM during a tour of the facility with the Maintenance Director, there was 1 electric receptacle within 3 feet of the sink in the drink area of the dining room on the ground floor. The electric receptacle was not provided with a ground fault circuit interrupter. This was confirmed by the Maintenance Director at the time of observation. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of at least 3 electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff in the east wing corridor of the ground floor. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:20 PM, 2 breaker boxes on			

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	the east wing corridor of the ground floor were not locked. Based on interview at the time of observation the Maintenance Director agreed the breaker boxes were not locked. This finding was reviewed with the Maintenance Director at the time of the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the Director of Nursing's office was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect staff members and up to 1 resident. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:20 PM the outlet switch cover in the Director of Nursing's office was missing. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that exposed wiring was visible. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			
K 0522 SS=F Bldg. 02	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central			

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	heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 boiler rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment. NFPA 101, Section 19.5.2.2(2) requires any fuel-fired heating device, other than a central heating plant, shall be designed and installed so they shall take air for combustion directly from the outside. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the boiler room. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 03/04/2024 between 3:03 PM and 5:20 PM, the boiler room had boilers with an automatic louver system that would open when the boilers are running to provide air from the outside. The louvers were closed at the time of observation and the Maintenance Director attempted to open them. The Maintenance Director indicated he was unable to open the louvers to allow outside air into the room. This finding was reviewed with the Maintenance Director at the exit conference.	K 0522	1. On 3/4/24 during a walk through with the IDOH, it was found that the automatic louver system for the boilers in the boiler room was closed and the Maintenance Director was unable to open them. 2. The Maintenance Director called AA Huber & Sons Plumbing and Heating to schedule an appointment for them to repair the louver system. 3. This repair was completed on 3/21/24. 4. During the routine monthly walk through the Maintenance Director or designee will check the automatic louver system to ensure it is functioning properly.	03/21/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3.1-19(b)			
K 0711 SS=F Bldg. 02	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. 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 fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the	K 0711	**1. The facility wishes that the tag be deleted because the wheeled equipment referred to in this tag was patient lift and transport equipment such as mechanical lifts, wheelchairs, and medication carts that were in use and not being stored.** **2. On 3/4/24 during a walk through with the IDOH, it was found that wheeled equipment was observed in the hallways.** **3. The fire safety plan will be updated to address the relocation of wheeled equipment during a fire or similar emergency.** **4. Staff will be educated on the updated fire safety plan by**	04/20/2024

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	clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on review of the facility's fire safety plan documentation with the Maintenance Director from 10:30 AM to 3:08 PM on 03/04/2024, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on interview at the time of review, the Maintenance Director acknowledged the aforementioned written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation with the Maintenance Director during a tour of the facility from 3:08 PM to 5:20 PM, wheeled equipment was located in the hallways on the ground floor. Based on interview at the time of observation, the Maintenance Director acknowledged wheeled equipment being stored in the hallways on the ground floor. This finding was reviewed with the Maintenance Director at the time of the exit conference. 3.1-19(b)		**4/20/24.** 5. The Fire safety plan will be reviewed annually as needed for any changes.	

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K 0761 SS=C Bldg. 02	Based on observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance of NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants in the first floor functional kitchen leading to an activity room Findings include: Based on record review on 03/04/2024 between 10:30 AM and 3:08 PM with the Maintenance Director, no documentation of an annual rolling fire door inspection was available for review. Based on interview at the time of record review, the Maintenance Director stated he did not have the inspection report. Based on observation during a tour of the facility from 3:08 to 5:20 PM, a rolling fire door was located in the first floor functional kitchen leading to an activity room. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0761	1. Due to the first floor closure the annual inspection of the rolling fire door located in the kitchen had not been completed for the year of 2023, because the area had not been in use. 2. The Maintenance Director or designee will complete the inspection by 4/20/24. 3. The Maintenance Director or designee will create an audit to ensure that the rolling fire door is inspected annually.	04/20/2024

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K 0916 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panel was in proper operating condition. This deficient practice could affect all the residents, as well as staff and visitors in the facility. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 03/04/2024 between 3:08 PM and 5:20 PM, the generator's low fuel light was illuminated. The Maintenance Director stated the light was on due to a load test being completed recently and the fuel container being approximately 3/4 full. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0916	**1. The low fuel light came on after a recent load test being completed. The light triggers when the fuel container is at 3/4 full.** 2. The Maintenance Director had a call out to have the fuel replaced at the time of survey. 3. The fuel will be replaced and the low fuel light will not be on by 4/20/24. **4.** During the routine weekly walk through the Maintenance Director or designee will check to see if any lights are illuminated on the emergency generator annunciator panel and address them accordingly.	04/20/2024
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing			

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall	K 0918	1. On 3/4/24 it was found that the weekly generator inspection was not completed in its entirety for the week of 2/6/24. Staff will be educated on the need for the inspection forms to be completed	04/20/2024

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	be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director on 03/04/2024 between 10:30 AM and 3:08 PM, no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Director stated the facility does have a diesel generator and thought a fuel quality test may have been completed but did not have the documentation. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1		in their entirety. 2. The Maintenance Director or designee to audit the weekly inspections weekly x4 weeks, then monthly in QAPI. 3. Monthly generator inspection sheets will be audited by the Maintenance Director or designee monthly to ensure that the inspection sheets are completed in their entirety. QAPI to also monitor compliance with completion of inspections.	

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	states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director on 03/04/2024 from 10:30 AM to 3:08 PM, thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Maintenance Director stated a four continuous hour load test had not been completed. Based on observation on a tour of the facility between 3:08 PM and 5:20 PM with the Maintenance Director, a diesel fired emergency generator on the outside of the building on the north east side of the property was located. This finding was reviewed with and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 2 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby			

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	155758	A. BUILDING 02 B. WING	03/04/2024

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ASBURY TOWERS HEALTH CARE CENTER	102 W POPLAR ST GREENCASTLE, IN 46135

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	Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director on 03/04/2024 between 10:30 AM and 3:08 PM, documentation for 01/17/2023 and 02/06/2024 were not completed. Based on interview at the time of record review, the Maintenance Director agreed the documentation was not completed for those 2 weeks. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 4. Based on record review and interview, the facility failed to document the transfer time to the alternate power source on the monthly load tests for 12 of the past 12 months to ensure the alternate power supply was capable of supplying service within 10 seconds. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 03/04/2024 between 10:30 AM and 3:08 PM with the Maintenance Director, the Monthly Generator Inspection sheets were reviewed over the past year and			

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	155758	A. BUILDING 02 B. WING	03/04/2024

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	lacked the transfer time from normal power to emergency power. Based on interview at the time of record review, the Maintenance Director indicated the transfer time is not written on the Generator Log Sheets Load Tests monthly when the load test is conducted. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 5. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants.			

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	Findings include: Based on review of generator load testing documentation with the Maintenance Director on 03/04/2024 from 10:30 AM to 3:08 PM, the load information to show the actual load percentage for the diesel powered generator was not documented. Based on interview at the time of record review, the Maintenance Director agreed there was no documentation of the load percentage on the documentation. This finding was reviewed with the Maintenance Director at the time of the exit conference. 3.1-19(b) 6. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 6.2.10 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review with the Maintenance Director on 03/04/2024 between 10:30 AM and 3:20 PM, the generator log form documented the			

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	generator was tested monthly, however there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			