STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155758	A. BUILDING 00 B. WING	03/15/2023

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
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00402998 and IN00403082. This visit included the Investigation of Residential Complaints IN00397501 and IN00399574. Complaint IN00402998 - No deficiencies for this complaint are cited. Complaint IN00403082 - No deficiencies for this complaint are cited. Complaint IN00397501 - State Residential deficiencies related to the allegations are cited at R0052 Complaint IN00399574 - State Residential deficiencies related to the allegations are cited at R0052. Survey dates: March 13, 14, and 15, 2023 Facility number: 001120 Provider number: 155758 AIM number: 200525120 Census Bed Type: SNF/NF: 20 Residential: 46 Total: 66 Census Payor Type: Medicare: 03 Medicaid: 08 Other: 09 Total: 20 Asbury Towers Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Audra Rose	RN, DON	04/18/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	and 410 IAC 16.2-3.1 in regard to the Investigation of Nursing Home Complaints IN00402998 and IN00403082. Quality review completed on March 30, 2023.			
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaints IN00397501 and IN00399574. This visit included the Investigation of Nursing Home Complaints IN00402998 and IN00403082. Complaint IN00397501 - State Residential deficiencies related to the allegations are cited at 0052 Complaint IN00399574 - State Residential deficiencies related to the allegations are cited at 0052. Complaint IN00402998 - No deficiencies for this complaint are cited. Complaint IN00403082 - No deficiencies for this complaint are cited. Survey dates: March 13, 14, and 15, 2023 Facility number: 001120 Residential Census: 46 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on March 30, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from:			

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	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from neglect due to lack of supervision for cognitively impaired residents who exhibited behaviors for 6 of 7 residents reviewed for supervision to prevent accidents that resulted in a resident (Resident E) pushing down another resident (Resident F) who sustained a fractured neck of the right upper thigh bone, a resident (Resident E) having a physical altercation with 2 residents (Resident H and J), and for 1 resident (Resident K) who exhibited agitated behaviors nearby a vulnerable resident (Resident L). Using the reasonable person concept, it is likely that this would lead to chronic or recurrent fear and anxiety for residents residing on the dementia unit. Findings include: On March 13, 2023 at 11:45 a.m., Resident E's closed clinical records were reviewed. Resident E's diagnoses included, but were not limited to, dementia and anxiety disorder. Taber's Cyclopedic Medical Dictionary 22 Edition indicated dementia was a progressive, irreversible decline in mental function, marked by memory impairment and deficits in reasoning and judgement. The cognitive or thinking impairments diminish a person's social and intellectual abilities. The most current six month service plan, dated October 03, 2022, indicated Resident E was	R 0052	1. By 4/30/23 the DON or designee will reassess all residents who reside in the assisted living memory care Oasis to determine if they are still appropriate to per our guidelines to remain in the Oasis. 2. If a resident is no longer appropriate for our assisted living memory care Oasis, the facility will take actions to place them accordingly. Actions will include discussing assessment findings with the residents, their PCP, their families, and transitioning residents into new neighborhoods that can meet their needs such as our skilled care or other closest appropriate facility. 3. Comfort kits (person centered activities) were reviewed, updated, and made for residents who reside in assisted living memory care Oasis to assist with engaging residents in meaningful activities. 4. IDT will monitor and discuss residents who reside in our assisted living memory care Oasis daily during clinical meetings and monthly during behavior meetings until residents are placed appropriately. 5. DON or designee will	05/17/2023

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	disoriented to the point of no longer being able to function independently three or more days of a week. His decisions were poor, and he required cueing and supervision in planning, organizing, and correcting daily routines. He had difficulty remembering and using information and required at least daily cueing from others. He was able to independently self-transfer between surfaces (in and out chair/bed). He was able to get around/walk inside of the nursing home without the assistance of another person. The service plan and record documentation indicated Resident E met the requirements and resided within the facility's Oasis Unit (a secure unit for those who are living with cognitive challenges due to dementia or Alzheimer's). Progress notes indicated the following: -November 17, 2022 at 7:18 p.m.; "behavior ... agitated this afternoon. Believed he was fired. ... Trying to hit staff with his cane ... not easily redirected...." -December 13, 2022 at 12:06 a.m.; "... agitated. Shut door on staff's hand, verbally abusive towards staff ...." -December 14, 2022 at 8:00 p.m.; "Resident approached another resident [Resident F] who was walking in the hall and shoved her causing her to fall on the floor...." -December 14, 2022 at 8:06 p.m.; "QMA came out of a resident's room from giving scheduled medication when she saw a female resident [Resident J] in a w/c [wheelchair] asleep. The resident grabbed female resident by the wrist and pulled her out of the chair..."		complete service plans at least every quarter and as needed for all residents who reside on our assisted living memory care Oasis. In-services for Residents Rights (A), Resident Aggression (B), and Behavioral Health Services (C and D) was completed on 3/15/23. See Exhibit A, B, C, and D. A behavior binder with person-centered interventions for each resident was completed by SSD and placed in the Oasis on 4/18/23. Staff will utilize this binder if a resident exhibits any behavioral disturbances. If interventions/distractions listed in behavior binder are ineffective staff is to alert the nurse, and the nurse will contact family for 1-on-1. If the resident's behavior escalates and/or poses a risk to other residents the nurse will contact MD for orders which may include sending resident out to be evaluated. If staff working on the Oasis must provide care such as assistance with showering, they are to alert the nurse or other qualified staff member to supervise the floor during the duration they are assisting other residents. To ensure that an additional staff member is supervising the floor during showers a line will be added to the bottom of the shower sheets for the additional staff member to sign. The DON or	

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	-December 14, 2022 at 20:45 p.m.; "Resident was sitting in the dining room watching TV. Another male resident [Resident H] came in to sit and watch TV too. This resident yelled at this resident to 'Get out.' and hit other resident in the jaw... This resident separated from dining room. DON notified and instructed writer to transfer to ER [emergency room] for evaluation of AMS [altered mental status] with behaviors...." -December 15, 2022 at 2:15 a.m.; "Resident returned to facility from hospital ER ... has a UTI [urinary tract infection]...." -December 16, 2022 at 8:22 a.m.; "... resident was verbally agitated yesterday. Punched QMA in the face then slapped her in the face as well. ... Friend came in and sat with resident for a bit which calmed him down. After friend left, became agitated again. ..." The record lacked documentation of implemented supervision to prevent recurrence of behaviors directed towards other residents. On March 13, 2023 at 11:30 a.m., Resident F's closed clinical records were reviewed. Diagnoses included, but were not limited to, dementia. Records indicated Resident F met the requirements and resided within the facility's Oasis Unit. Progress notes, dated December 14, 2022 at 8:00 p.m., indicated, "This resident was walking in the hall when another resident [Resident E] walked up to her and shoved her causing her to fall on the floor landing on her right hip...." Record documentation indicated Resident F was transferred to a local hospital and diagnosed with a right femoral neck fracture and did not return to the nursing home.		designee will complete a weekly audit of shower sheets x 8 weeks to ensure compliance. To ensure residents are being supervised effectively the DON or designee will complete a daily audit of random visits to the Oasis x 4 weeks to ensure that there are observable staff at all times. Random visits will be done across all shifts and rotations to ensure compliance.	

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	On March 14, 2023 at 10:10 a.m., Resident J's clinical records were reviewed. Diagnoses included, but were not limited to, Alzheimer's disease. Records indicated Resident J met the requirements and resided within the facility's Oasis Unit. Progress notes, dated December 14, 2022 (no time indicated), indicated, "...QMA had taken medication to a resident ... when I came out I seen [sic] resident [Resident E] grab and pull her out of the chair...." On March 13, 2023 at 2:05 p.m., Resident H's clinical records were reviewed. Diagnoses included but were not limited to dementia. Records indicated Resident H met the requirements and resided within the facility's Oasis Unit. Progress notes: dated December 14, 2022 (no time indicated) indicated, "Resident was hit by another resident [Resident E]...." The Daily Schedule, dated December 14, 2023, indicated 1 staff had been assigned to provide care to residents on the Oasis Unit. The Daily Census, dated December 14, 2023, indicated 13 residents resided with the Oasis Unit. The annual Dementia Special Care Unit Disclosure Form, dated December 13, 2022, indicated Number of staff: 1 Qualified Medication Aide (QMA) with available Social Worker and Activity Staff for day/morning, 1QMA for afternoon/evening, and 1 QMA for night. On March 14, 2023 at 4:40 p.m., Employee 17 was interviewed. During the interview, Employee 17 verified she had worked on the Oasis Unit December 14, 2022. She had been the only staff assigned to the unit. This assignment was normal, as she always worked alone. When			

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	providing care to residents there would be "a little bit of time I would be off the floor." During this time no other staff were present. She described care as toileting, showers, medication administration and other assistance as needed. When Resident E pushed down Resident F, she had been "occupied with 2 other residents." She notified the facility charge nurse who came down to assist with transfer to the hospital care for Resident F. The charge nurse then left the unit. She went on to pass medications to another resident this was when Resident E grabbed Resident J. After Resident E hit Resident H in the jaw the Director of Nursing was called, and Resident E was sent to the hospital for evaluation. On March 13, 2023 at 4:00 p.m., Employee 23 was interviewed. During the interview, Employee 23 verified having worked on the evening of December 14, 2022. Employee 17 had called her to the unit, because Resident E pushed down Resident F and Resident F appeared injured and needed to be assessed. It was determined Resident F needed to be transferred to the hospital for evaluation. Upon completing assistance with the transfer, Employee 23 left the unit. During an observation of the Oasis Unit, on March 13, 2023 at 9:45 a.m., one staff was observed to be working and assigned to the unit. Census documentation (survey entrance), dated March 13, 2023, indicated 11 residents resided within the Oasis Unit. During an observation of the Oasis Unit, on March 14, 2023 at 9:45 a.m., upon entering the unit Resident K was at the door crying. Beside Resident K was Resident L who was positioned alongside of the wall and holding onto the walk			

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	rail. Resident K was holding an opened bag of Cheetos, crying, and saying "I can't find anyone, I can't find my mom." Resident K then followed with continued observation of the unit. The hallway, the dayroom, and back to the hallway. Once down the hall, a second time, a staff member (Employee 5) exited a resident's room. Employee 5 had been in the room to provide care to a resident. Employee 5 was interviewed at the time of the observation. Employee 5 indicated she was aware Resident K was upset. That was why she had the Cheetos, as the snack usually helped to calm her. Her mom she was looking for was her daughter, whom Resident K referred to as her mom. She would help Resident K call her daughter during her daughter's work break. Employee 5 further indicated she was the only staff assigned to the unit, "twelve hours a day every day." On March 14, 2023 at 10:30 a.m., Resident K's clinical records were reviewed. Diagnoses included but were not limited to dementia. Records indicated Resident K met the requirements and resided within the facility's Oasis Unit. Progress notes: dated February 15, 2023 at 5:30 p.m., indicated "...resident has been mean to all res [residents], yelling, making -2 or -3 word statements at res as walk by...." Progress notes; dated February 26, 2023 at 2:52 p.m.; indicated "...bad mood this morning..." On March 14, 2023 at 10:40 a.m.; Resident L's clinical records were reviewed. Diagnoses included but were not limited to dementia. Records indicated Resident L met the requirements and resided within the facility's Oasis Unit. Clinical record documentation dated January 01, 2023 to current indicated Resident E was pleasantly confused. Exhibited wandering behavior that was easily redirected, but for only a			

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	short term time frame, and then would continue wandering again. His wandering behavior had resulted in falls. During an observation of the Oasis Unit, on March 15, 2023 at 9:15 a.m., one staff was observed to be working and assigned to the unit. Once on the unit residents were observed to be up and about on the unit. No staff member could be seen. Soon after entering the unit, within five minutes, the staff was observed to exit out of a resident's room. The staff had been in the room providing care. On December 15, 2023 at 9:30 a.m.; the Director of Nursing provided documentation that an additional "Activities/C.N.A." had been assigned to the Oasis unit during the hours of 11:00 a.m. to 7:00 p.m. Interview, at that time, the Director of Nursing indicated that outside of those hours 1 employee was assigned to the Oasis Unit. Using the reasonable person concept, it is likely that this would lead to chronic or recurrent fear and anxiety for residents residing on the dementia unit. This State Residential Finding relates to Complaints IN00397501 and IN00399574.			