

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/18/2023
NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit to the Investigation of Residential Complaints IN00397501 and IN00399574 completed on March 15, 2023.</p> <p>Complaint IN00397501 - Corrected. Complaint IN00399574 - Corrected.</p> <p>Survey date: May 18, 2023</p> <p>Facility number: 001120</p> <p>Residential Census: 54</p> <p>Asbury Towers Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the Post Survey Revisit to the Investigation of Residential Complaints IN00397501 and IN00399574.</p> <p>Quality review completed on May 30, 2023.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE