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	03/28/2025

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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: March 24, 25, 26, 27, and 28, 2025 Facility number: 001120 Provider number: 155758 AIM number: 20052120 Census Bed Type: SNF/NF: 19 SNF: NA NF: NA Residential: 47 Total: 66 Census Payor Type: Medicare: 6 Medicaid: 13 Total: 19 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 10, 2025.	F 0000	It is the practice of this provider to provide care, programs and services for the highest well-being of our residents in accordance with State and Federal law.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on record review and interview, the facility failed to ensure they communicated with the receiving hospital, and documented their communication when residents were transferred to the emergency room (ER) for 3 of 4 residents reviewed for hospitalization (Residents 6, 5, and 10).	F 0622	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No negative outcomes occurred to residents #s 6, 10, and 5.	05/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric P Ahlbrand	Executive Director	04/25/2025

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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	Findings include: 1. Resident 6's record was reviewed on 3/25/25 at 10:13 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 3/11/25, indicated the resident was cognitively intact and had a diagnosis of medically complex conditions. A Progress Note, dated 6/23/24 at 6:20 p.m., indicated the resident's sister stated the resident called her and cried with pain from not having a bowel movement (BM). The nurse explained to the resident's sister that the resident had already received an enema and had large results. The resident's sister wanted the resident to be given another enema, and if the pain continued wanted him sent to the hospital. The physician stated to send the resident to the hospital as he just returned from the hospital the prior week for an illeus (intestinal blockage). A Progress Note, dated 6/23/24 at 6:46 p.m., indicated the resident's sister called back and was notified the physician wanted the resident transferred to the emergency room (ER). 911 was called. The note lacked documentation the facility communicated with the receiving hospital. A Progress Note, dated 6/24/24 at 12:38 a.m., indicated the nurse called the hospital for an update, and the resident was admitted for observation related to constipation. A Progress Note, dated 1/14/25 at 1:09 p.m., indicated the resident complained he felt like his lungs were filling up and requested to go to the ER. The resident's family and the physician were notified. The note lacked documentation the facility communicated with the receiving hospital.		**How other residents who have the potential to be affected by the same deficient practice will be identified, and what corrective action(s) will be taken**. All residents have the potential to be affected by the alleged deficient practice. Licensed staff educated on the Transfer and Discharge policy and documentation and communication to receiving hospital/ ER for transfers with emphasis on documentation of report being called and documented. Transfer log reviewed and any residents currently in ER/ Hospital reviewed and ER/ Hospital contacted to ensure all adequate information was received/ provided. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**? Licensed staff educated on The Transfer and Discharge policy and documentation and communication to receiving hospital/ ER for transfers with emphasis on documentation of report being called and documented. The IDT will review emergency transfers to acute care on the next business day to ensure communication with the receiving provider occurred and is	

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	A Progress Note, dated 1/14/25 at 7:05 p.m., indicated the resident returned to the facility from the hospital. A Progress Note, dated 3/18/25, indicated the resident was transferred to the hospital for evaluation and treatment due to episodes of projectile vomiting. The resident's family and the physician were notified. The note lacked documentation the facility communicated with the receiving hospital. A Progress Note, dated 3/19/25, indicated the resident returned to the facility from the hospital. During an interview, on 3/25/25 at 3:08 p.m., the Director of Nursing (DON) indicated she was unable to find documentation the facility communicated with the receiving hospital when the resident was transferred on 6/23/24, 1/14/25, or 3/18/25. 2. Resident 5's record was reviewed on 3/25/25 at 10:21 a.m. The profile indicated the resident's diagnoses included, but were not limited to, atypical atrial flutter (an abnormal heart rhythm where the electrical signals in the upper chambers beat too quickly and irregularly), and history of pulmonary embolism (a condition where a blood clot travels to the lungs and blocks one or more pulmonary arteries). A quarterly Minimum Data Set (MDS) assessment, dated 3/19/25, indicated the resident received anticoagulant (AC) medication (drugs that help prevent blood clots from forming). The census indicated that the resident had been hospitalized from 3/7/25 to 3/12/25.		documented in the EMR. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** DON/designee will complete "Discharge Transfer Audit" to include monitoring of ER transfer/discharge documentation including report being called. Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, and then monthly for a total of 6 months; reviewed quarterly thereafter to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. Additionally, the results of these audits will be reviewed by the QAPI Committee overseen by the ED. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	A progress note, dated 3/7/25 at 3:21 p.m., indicated the resident presented a tissue with liquid and dark red saliva, and indicated it was from him coughing. He indicated he had coughed up a "big glob of blood" like a clot earlier when out on LOA (leave of absence) with his friend. The nurse advised the resident he should go to the emergency room (ER) for a workup. The resident agreed and his family, the Director of Nursing (DON), and physician were notified that the resident had been sent to the ER. A progress note, dated 3/8/25 at 4:36 a.m., indicated that the resident was being held for observation. Resident had been diagnosed with lower lobe pneumonia (an infection that inflames the air sacs in the lower sections of the lungs) and influenza A (a highly contagious viral infection that primarily affects the respiratory system). The record lacked documentation of the facility communication to the receiving facility at the time of the transfer. 3. Resident 10's record was reviewed on 3/25/25 at 2:13 p.m. The profile indicated the resident's diagnoses included, but were not limited to, acute pyelonephritis (a sudden, severe bacterial infection of the kidney and renal pelvis), hydronephrosis with renal and urethral calculus obstruction (swelling of one or both kidneys due to a buildup of urine caused by blockages in the kidneys or the tubes carrying urine from the kidneys to the bladder), and unspecified psychosis (a diagnosis used when someone experiences psychotic symptoms [like hallucinations-seeing or hearing things that are not there] but doesn't meet the criteria for a specific psychotic disorder).			

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	A quarterly Minimum Data Set (MDS) assessment, dated 12/30/24, indicated the resident had no cognitive deficit and received an antipsychotic medication (medication used to treat psychotic symptoms). During an interview, on 3/24/25 at 1:38 p.m., the resident indicated she had been out to the hospital last week related to a kidney stone. The census indicated the resident had been hospitalized from 3/7/25 to 3/13/25, and again on 3/14/25 and had returned on the same date. A progress note, dated 3/7/25 at 10:35 a.m., indicated the resident had been sent to the hospital overnight due to fever and hallucinations. The resident was found to be septic (a life-threatening condition that occurs when the body's immune system overreacts to an infection, causing widespread inflammation and damage to multiple organs) and had been transferred to a second hospital location for kidney stone surgery and treatment. The record lacked documentation of the facility communication to the receiving facility at the time of the transfer. A progress note, dated 3/14/25 at 12:43 p.m., indicated the resident had been sent out to the ER due to complaints of shortness of breath (SOB) and hemoptysis (coughing up pf blood). The record lacked documentation of the facility communication to the receiving facility at the time of the transfer. During an interview, on 3/25/25 at 3:08 p.m., the DON indicated she had been unable to find any			

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	documentation of the nurses calling report to the hospital for the transfer. The expectation was that report should always be called to the hospital and documentation should be completed of who the nurse provided report to, at the time of the transfer. On 3/26/25 at 9:48 a.m., the DON provided a document, with a revised date of 10/17/24, titled, "Transfer and Discharge (including AMA-against medical advice)," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines...10. For a transfer to another provider...the following information must be provided to the receiving provider...d. All other information to meet the residents' needs, which includes, but may not be limited to, i. Resident status...; ii. Diagnoses and allergies; iii. Medications...; h. Additional information, if any, outlined in the transfer agreement with the acute care provider...." 3.1-12(a)(3)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded accurately for 1 of 16 residents' MDS Assessments reviewed (Resident 13). Findings include: Resident 13's record was reviewed on 3/26/25 at 2:39 p.m. A quarterly MDS assessment, dated 3/18/25, indicated the resident had an indwelling catheter and was always incontinent of bladder.	F 0641	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No negative outcomes occurred to resident # 13. The observed deficiency was corrected on 3/27/25 by the MDS Coordinator. The MDS was able to reopen the assessment and modify the response for section H.	05/02/2025

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	A Physician's Order, dated 9/27/24, indicated document suprapubic catheter (tube inserted into the bladder through the abdomen) output every shift. During an interview, on 3/27/25 at 9:56 a.m., the MDS Coordinator indicated the resident had a suprapubic catheter, and his continence should have been coded as not rated. The assessment should not have indicated the resident was always incontinent. On 3/27/25 at 10:16 a.m., the MDS Coordinator provided Section H of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, dated October 2024, and indicated it was the policy currently being used by the facility. The RAI manual indicated, "...H0300: Urinary Continence...Coding Instructions...Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days...."		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**. All residents with a urinary catheter have the potential to be affected by the alleged deficient practice. The MDS Coordinator completed an audit on the most recent assessments of all residents who have a catheter to determine if any other residents were affected. The audit was completed on 3/27/25. The audit found that no other residents were affected by the deficiency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Education/ Servicing completed for MDS with regards to accuracy of MDS. MDS will follow the “RAI Guidelines for completion of MDS.” **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the MDS/designee is responsible for the completion of the-QAPI tool MDS Accuracy-Section H weekly	

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			times 4 weeks, monthly times 6 months and then quarterly until continued compliance is maintained for 3 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on interview, record review, and observation, the facility failed to ensure food was served at a palatable temperature for 3 of 15 residents reviewed for food temperatures (Residents 7, 13, and 10). Findings include: 1. During an interview, on 3/24/25 at 11:26 a.m., Resident 7 indicated the food was cold when it was served. Resident 7's record was reviewed on 3/26/25 at 9:41 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 2/6/25, indicated the resident was cognitively intact. 2. During a family interview, on 3/24/25 at 11:47 a.m., Resident 13's wife indicated the food was cold when it was served. Resident 13's record was reviewed on 3/26/25 at 1:28 p.m. A quarterly MDS assessment, dated 3/18/25, indicated the resident had a severe cognitive impairment.	F 0804	**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. There were three (3) residents allegedly affected by the deficient practice, with evidence gathered during resident/family interviews. Beginning on 03/29/2025, the Dietary Manager began providing education to all dietary staff members responsible for the preparation of and the serving of food. All team members responsible for monitoring food temperatures received education verbally and in print regarding the	04/18/2025

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	3. During an interview, on 3/24/25 at 1:34 p.m., Resident 10 indicated the food was often cold when it was served in her room, and the staff had to warm it up for her. During a continuous observation, on 3/27/25 from 11:16 a.m. to 12:02 p.m., the following was observed. At 11:16 a.m., the first floor dining room steam table was observed with three covered dishes in place. There were no residents or staff in the area. At 11:33 a.m., lunch service began in the first floor dining room. At 11:43 a.m., lunch service was completed in the first floor dining room, the food dishes were placed on a cart, and taken to the dining room downstairs. At 11:45 a.m., Dietary Aide 10 placed the covered dishes on a food warmer in the downstairs dining room and checked the temperatures of the food prior to the start of the lunch service. The meatloaf was 155 degrees Fahrenheit (F), mashed potatoes 155 degrees F, broccoli and cauliflower 132 degrees F, gravy 130 degrees F, and mechanical soft meatloaf 130 degrees F. From 11:50 a.m. to 12:02 p.m., trays were passed in the downstairs dining room and to the rooms on the unit. After the completion of the last tray, at 12:02 p.m., a test tray was plated from the food warmer. At 12:02 p.m., directly after the completion of the last tray on the unit, meatloaf was 142 degrees F, mashed potatoes were 120 degrees F, and broccoli cauliflower was 98 degrees F. During an interview, on 3/27/25 at 12:02 p.m., Dietary Aide 10 indicated the food should have been 130 degrees F or above at the time it was served. Resident Council Minutes, dated 1/21/25, indicated the food was "not so cold."		correct food temperatures for both cold and hot foods. This education included: Food temperatures will be checked prior to it leaving the main kitchen and Server(s) will recheck the food temperatures after the food is plated and served: no food item will be served unless it is at a safe and palatable temperature. **How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?** Food Committee meeting will be held x1 to identify any resident concerns on or before 04/18/2025. Moreover, in order to ensure there are no residents affected by the alleged deficient practice, beginning on 03/29/2025, the Dietary Manager began providing education to all dietary staff members responsible for the preparation of and the serving of food. All team members responsible for monitoring food temperatures received education verbally and in print regarding the correct food temperatures for both cold and hot foods. This education included: food temperatures will be checked prior to it leaving the main kitchen and Server(s) will recheck the food temperatures after the food is plated and served: no food item will be served unless	

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	On 3/27/25 at 1:40 p.m., the Administrator provided an undated document titled, "Food Safety and Sanitation," and indicated it was the policy currently being used by the facility. The policy indicated, "...Food Holding Temperatures/Service: Hot food should be served at 135 F or higher...." 3.1-21(a)(2)		it is at a safe and palatable temperature. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?** All Dietary team members were educated on compliance relative to this alleged deficiency and per policy. The Dietary Manager, Registered Dietician or Dietary Supervisor will audit food temperature compliance in each serving area during meal service. Temperatures will be logged and the Executive Director will be notified immediately of any discrepancies. Copies of the food temperature logs will be placed in the Plan of Correction (POC) binder for the entire period covered by the POC. Additionally, Food Committee will be hosted 2x monthly to ensure resident satisfaction. **How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?** Progress toward the successful completion of this POC will be monitored using the Asbury F804-03282025 Food Temps Audit Tool with the following protocols: the Dietary Manager, Registered Dietician or Dietary Supervisor will	

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			audit food temperatures, including a test tray for six months with audits being completed daily for 2 weeks in each serving area during meal service, then 3 times weekly for 2 additional weeks, and weekly thereafter for 8 weeks; audits will then be completed monthly x3 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure hair and beard nets were worn in the food service area during meal service during 1 of 4 dining observations. Findings include: During an observation, on 3/24/25 at 11:31 a.m., Cook 5 verified the food temperature and served lunch from the kitchen in first floor dining room. Cook 5 had facial hair and did not wear a beard net. A contracted service provider cleaned the fish tank in the dining room during the meal service. The contracted service provider entered the kitchen area, with no hairnet, and obtained water from the sink to fill the fish tank while Cook 5 served lunch. Registered Nurse (RN) 3 and Certified Nurse Aide (CNA) 4 entered the kitchen area and obtained drinks. RN 3 and CNA 4 did not wear hairnets in the kitchen area.	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. There was one (1) food service area allegedly affected by the deficient practice, with evidence gathered through observation. Beginning on 03/29/2025, the Dietary Manager began providing education to those responsible for the preparation of and the serving	04/18/2025

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	During an interview, on 3/24/25 at 11:35 a.m., Cook 5 indicated no staff should have entered the kitchen area without hairnets in place. During an interview, on 3/24/25 at 11:38 a.m., RN 3 and CNA 4 indicated they had not been told they needed a hairnet to enter the kitchen area. On 3/27/25 at 1:40 p.m., the Administrator provided an undated document titled, "Food Safety and Sanitation," and indicated it was the policy currently being used by the facility. The policy indicated, "...Sanitation...Hair restraints must be worn at all times when in or around food production areas...." 3.1-21(i)(3)		of food relative to professional standards (sanitary, specifically regarding the requirement for hair and beard nets). Those responsible received education verbally and in print regarding the expectation. Additional signage was placed in the serving areas noting expectations to use hair and beard nets. **How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?** There was one (1) food service area allegedly affected by the deficient practice, with evidence gathered through observation. In order to ensure other food service areas are not negatively impacted by the alleged deficient practice, we will address them in the same manner as above: beginning on 03/29/2025, the Dietary Manager began providing education to those responsible for the preparation of and the serving of food relative to professional standards (sanitary, specifically regarding the requirement for hair and beard nets). Those responsible received education verbally and in print regarding the expectation. Additional signage was placed in the serving areas noting expectations to use hair and beard nets.	

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	155758	A. BUILDING 00 B. WING	03/28/2025

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			What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? All Dietary team members were educated on compliance relative to this alleged deficiency and per policy. The Dietary Manager, Registered Dietician or Dietary Supervisor will audit beard and hair net compliance daily in each serving area during meal service. Results of said audits will be logged and the Executive Director will be notified immediately of any noncompliance. Copies of said logs will be placed in the Plan of Correction (POC) binder for the entire period covered by the POC. **How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?**	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure a Physician's Order was obtained and documented for hospital transfers for 3 of 4 residents reviewed for hospitalization (Residents 6, 5, and 10). Findings include:	F 0842	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No negative outcomes occurred to resident #s 6, 10 and 5.	05/02/2025

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	1. Resident 6's record was reviewed on 3/25/25 at 10:13 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 3/11/25, indicated the resident was cognitively intact and had a diagnosis of medically complex conditions. A Progress Note, dated 6/2/24, indicated the resident's sister came to the facility and requested the resident be sent to the hospital for pain. The nurse called 911. The clinical record lacked documenation a Physician's order was obtained, written, or signed by the phsyician for the hospital transfer. A Progress Note, dated 6/3/24, indicated the resident returned to the facility from the hospital. A Progress Note, dated 6/4/24, indicated the nurse went into the resident's room and found his bedside table covered in water, resident was asleep and holding the cup that had spilled. The resident was difficult to wake up, and not touched his dinner, and was unable to say who he was. The resident stated he did not feel well. The resident's sister, Director of Nursing (DON), and physician were notified. The resident was sent to the hospital. The clinical record lacked documenation a Physician's order was obtained, written, or signed by the phsyician for the hospital transfer. A Progress Note, dated 6/13/24, indicated the resident returned to the facility from the hospital. A Progress Note, dated 6/23/24 at 6:20 p.m., indicated the resident's sister stated the resident called her and cried with pain from not having a		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by the alleged deficient practice. Licensed staff educated on The Transfer and Discharge policy and documentation and communication to receiving hospital/ ER for transfers with emphasis on documentation of calling the MD and obtaining an order to send to ER. Transfer log reviewed and any residents currently in ER/ Hospital reviewed and ER/ Hospital contacted to ensure that MD was notified, and an order was obtained to send to ER. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Licensed staff educated on The Transfer and Discharge policy and documentation and communication to receiving hospital/ ER for transfers with emphasis on documentation of of calling the MD and obtaining an order to send to ER**.** IDT will review emergency transfers to acute care on the next business day to ensure that MD was notified, and an order was	

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	bowel movement (BM). The nurse explained to the resident's sister that the resident had already received an enema and had large results. The resident's sister wanted the resident to be given another enema, and if the pain continued wanted him sent to the hospital. The physician stated to send the resident to the hospital as he just returned from the hospital the prior week for an illeus (intestinal blockage). A Progress Note, dated 6/23/24 at 6:46 p.m., indicated the resident's sister called back and was notified the physican wanted the resident transferred to the ER. 911 was called. The clinical record lacked documenation a Physician's order was obtained, written, or signed by the phsyician for the hospital transfer. A Progress Note, dated 9/4/24 indicated the resident had tremors in his arms and hands, was lethargic, complained of severe back pain and his stomach cramping. The resident's sister visited and wanted the resident sent to the hospital. The physician and DON were notified, and 911 was called. The clinical record lacked documenation a Physician's order was obtained, written, or signed by the phsyician for the hospital transfer. A Progress Note, dated 9/6/24, indicated the resident returned to the facility from the hospital. A Progress Note, dated 1/14/25 at 1:09 p.m., indicated the resident complained he felt like his lungs were filling up and requested to go to the ER. The resident's family and the physician were notified.		obtained and is documented in the EMR. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will complete "Discharge Transfer Audit" to include monitoring of ER transfer/discharge documentation including of calling the MD and obtaining an order to send to ER. Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, and then monthly for a total of 6 months; reviewed quarterly thereafter to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. Additionally, the results of these audits will be reviewed by the QAPI Committee overseen by the ED. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	The clinical record lacked documenation a Physician's order was obtained, written, or signed by the phsyician for the hospital transfer. A Progress Note, dated 1/14/25 at 7:05 p.m., indicated the resident returned to the facility from the hospital. A Progress Note, dated 3/18/25, indicated the resident was transferred to the hospital for evaluation and treatment due to episodes of projectile vomiting. The resident's family and the physician were notified. The clinical record lacked documenation a Physician's order was obtained, written, or signed by the phsyician for the hospital transfer. A Progress Note, dated 3/19/25, indicated the resident returned to the facility from the hospital. During an interview, on 3/25/25 at 3:08 p.m., the DON indicated she was unable to find documenation a Physician's Order was obtained, written, or signed for the resident's hospital transfers. 2. Resident 5's record was reviewed on 3/25/25 at 10:21 a.m. The profile indicated the resident's diagnoses included, but were not limited to, atypical atrial flutter (an abnormal heart rhythm where the electrical signals in the upper chambers beat too quickly and irregularly), and history of pulmonary embolism (a condition where a blood clot travels to the lungs and blocks one or more pulmonary arteries). A quarterly Minimum Data Set (MDS) assessment, dated 3/19/25, indicated the resident received anticoagulant (AC) medication (drugs that help prevent blood clots from forming).			

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	The census indicated that the resident had been hospitalized from 3/7/25 to 3/12/25. A progress note, dated 3/7/25 at 3:21 p.m., indicated the resident presented a tissue with liquid and dark red saliva, and indicated it was from him coughing. He indicated he had coughed up a "big glob of blood" like a clot earlier when out on LOA (leave of absence) with his friend. The nurse advised the resident he should go to the emergency room (ER) for a workup. The resident agreed and his family, the Director of Nursing (DON), and physician were notified that the resident had been sent to the ER. The record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer. 3. Resident 10's record was reviewed on 3/25/25 at 2:13 p.m. The profile indicated the resident's diagnoses included, but were not limited to, acute pyelonephritis (a sudden, severe bacterial infection of the kidney and renal pelvis), hydronephrosis with renal and urethral calculus obstruction (swelling of one or both kidneys due to a buildup of urine caused by blockages in the kidneys or the tubes carrying urine from the kidneys to the bladder), and unspecified psychosis (a diagnosis used when someone experiences psychotic symptoms [like hallucinations-seeing or hearing things that are not there] but doesn't meet the criteria for a specific psychotic disorder). A quarterly Minimum Data Set (MDS) assessment, dated 12/30/24, indicated the resident had no cognitive deficit and received an antipsychotic medication (medication used to			

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	treat psychotic symptoms). During an interview, on 3/24/25 at 1:38 p.m., the resident indicated she had been out to the hospital last week related to a kidney stone. The census indicated the resident had been hospitalized from 3/7/25 to 3/13/25, and again on 3/14/25, and had returned on the same date. A progress note, dated 3/7/25 at 10:35 a.m., indicated the resident had been sent to the hospital overnight due to fever and hallucinations. The resident was found to be septic (a life-threatening condition that occurs when the body's immune system overreacts to an infection, causing widespread inflammation and damage to multiple organs) and had been transferred to a second hospital location for kidney stone surgery and treatment. The record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer. During an interview, on 3/25/25 at 3:08 p.m., the DON indicated she was unable to find documentation that a Physician's Order was obtained, written, or signed for the resident's hospital transfers. On 3/26/25 at 9:48 a.m., the DON provided a document, with a revised date of 10/17/24, titled, "Transfer and Discharge (including AMA-against medical advice)," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines...12. Emergency Transfers/Discharges ...a. Obtain physician's order for emergency transfer or discharges...f. Document...the transfer			

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	in the medical record...." 3.1-50 (a)(1) 3.1-50(a)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 24, 25, 26, 27, and 28, 2025 Facility number: 001120 Residential Census: 47 Asbury Towers Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on April 10, 2025.	R 0000	It is the practice of this provider to provide care, programs and services for the highest well-being of our residents in accordance with State and Federal law.	