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	04/23/2025

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/23/25 Facility Number: 001120 Provider Number: 155758 AIM Number: 200525120 At this Emergency Preparedness survey, Asbury Towers Health Care Center was found 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 20. Quality Review completed on 04/25/25	E 0000	The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this *CMS-2567 Plan of Correction* be considered the *Letter of Credible Allegation of Compliance* and requests a desk review in lieu of a post-survey review on, or after **05/12/2025**.	
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: 04/23/25 Facility Number: 001120 Provider Number: 155758 AIM Number: 200525120 At this Life Safety Code survey, Asbury Towers	K 0000	The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this *CMS-2567 Plan of Correction* be considered the *Letter of Credible Allegation of Compliance* and requests a desk	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric P Ahlbrand	Executive Director	05/13/2025

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	Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 resident rooms have battery powered smoke detection except rooms 9 through 22 on the south wing of the ground floor. Hard wired smoke detectors in resident rooms 117, 118, and rooms 9 through 22 alarm at the smoke detector only. The facility has a capacity of 48 and had a census of 20 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered except for the Electrical room on North wing hall on the ground floor. Quality Review completed on 04/25/25		review in lieu of a post-survey review on, or after **05/12/2025**.	
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Based on observation and staff interview, the	K 0211	*What corrective action(s) will be*	05/09/2025

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	facility failed to maintain the means of egress free from obstructions in 1 of 4 corridors within the facility. LSC 19.2.3.4(4) states, 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 clear unobstructed corridor width to less than 60 in. (1525 mm.) (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 approximately 6 residents, 2 staff, and 2 visitors. Findings include: Based on observations made with the Maintenance Director on 04/23/25 at 12:16 p.m. during a tour of the facility, there was a small plastic three drawer chest being stored in the corridor immediately outside resident room #11. This chest contained personal protective equipment and was not on wheels. Based on interview with the Maintenance Director on 04/23/25 at 12:18 p.m. he acknowledged the chest was not on wheels and spoke to a nurse that stated she would change out the chest to one with wheels immediately. This item was discussed with the Executive Director, the Plant Operations Support Director and the Maintenance Director on 04/23/25.		*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. No residents were affected by the alleged deficient practice. *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?* No residents were affected by the alleged deficient practice. 6 residents, 2 staff and 2 visitors were identified as having the potential to be affected. We will ensure the corridors within the facility meet compliance and will be audited through observation per the protocol listed below. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Maintenance and Licensed staff will be educated on the expectation regarding general egress protocols pursuant to the alleged deficient practice. In	

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	3.1-19(b)		addition, the Executive Director, Maintenance Director or designee will monitor the related corridors in the facility for compliance. *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 K211-04232025 Egress Audit Tool* and by using the following protocols: the Executive Director, Maintenance Director or designee will audit the corridors daily for two (2) weeks beginning 04/24/2025, three (3) times weekly for two (2) additional weeks, one (1) time weekly for (8) weeks and monthly for three (3) months (24 weeks in total), OR until substantial compliance has been achieved. The Executive Director will be notified immediately of any noncompliance. In addition, progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Asbury Towers QAPI Committee meeting (chaired by the Executive Director) each month for six (6) months total. The Executive Director, and/or designee will be responsible for monitoring this POC to ensure its successful	

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			completion.	
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing 1) Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system	K 0353	*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. No residents were found to have been affected by the alleged deficient practice. *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?* All residents, staff and visitors in the facility had the potential to be affected by the alleged deficient practice. On May 9, 2025, our support vendor (Koorsen) installed a new Backflow Preventer valve and tested. Testing related to the alleged deficient practice was successful both for the quarterly and backflow inspections.	05/12/2025

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	inspection records on 04/23/25 at 9:52 a.m. with the Maintenance Director present, there was no quarterly sprinkler system inspection report available for the first quarter (January, February, and March) of 2025 with the last documented inspection being conducted on 12/27/24. Based on an interview with the Maintenance Director on 04/23/25 at 9:54 a.m., he agreed that there was no documentation available to show the sprinkler system had been inspected during the first quarter of 2025 adding that his vendor was awaiting parts to fix the backflow device, and they have pushed back the inspection date until the parts were received. This item was discussed with the Executive Director, the Plant Operations Support Director and the Maintenance Director on 04/23/25. 3.1-19(b) 2) Based on record review and interview, the facility failed ensure 1 of 1 backflow prevention device in the sprinkler system piping was tested annually in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.6.2.1 states all backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system		*What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* On May 9, 2025, our support vendor (Koorsen) installed a new Backflow Preventer valve and tested. Testing related to the alleged deficient practice was successful both for the quarterly and backflow inspections. *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 through the *Asbury K353-04232025 Sprinkler System Audit Tool* and by using the following protocols: the Executive Director, Maintenance Director or designee will audit compliance-related Sprinkler System – Maintenance and Testing protocols for two (2) weeks beginning 05/12/2025, three (3) times weekly for two (2) additional weeks, one (1) time weekly for (8) weeks and monthly for three (3) months (24 weeks in total), OR until substantial compliance has been achieved (when testing passes or is successful). The Executive Director will be notified	

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	inspection records on 04/23/25 at 9:46 a.m. with the Maintenance Director present, the most recent documentation that could be provided in reference to an inspection of the backflow preventer was dated 04/12/24. The inspection documentation provided also indicated that the backflow preventer test failed. Based on an interview with the Maintenance Director on 04/23/25 at 9:48 a.m., a letter from the vendor stated that as of 03/27/25, the backflow preventer had still not been repaired. This letter contained a quote for the repairs, but no date as to when the repairs could be conducted. When asked why the repairs have been delayed for almost a year, the Maintenance Director stated that the facility considered this repair to be a financial hardship. The Maintenance Director was then asked if a waiver had been applied for because of the financial hardship and he replied not to his knowledge and agreed that as of the time of this survey, the backflow preventer had still not been repaired. This item was discussed with the Executive Director, the Plant Operations Support Director and the Maintenance Director on 04/23/25. 3.1-19(b)		immediately of any noncompliance. In addition, progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Asbury Towers QAPI Committee meeting (chaired by the Executive Director) each month for six (6) months total. The Executive Director, and/or designee will be responsible for monitoring this POC to ensure its successful completion.	
K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 12 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This	K 0355	*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	05/09/2025

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	deficient practice could affect 6 residents, 2 staff, and 2 visitors in the facility. Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 04/23/25 at 11:48 a.m., the portable fire extinguisher located in the Main floor I.T. room was mounted on the wall with the top of the extinguisher 5 feet 2 inches above the floor. Based on interview on 04/23/25 at 11:49 a.m., the Maintenance Director stated the fire extinguisher was indeed mounted too high and gave the aforementioned measurement listed adding that he would have it lowered as soon as possible. This item was discussed with the Executive Director, the Plant Operations Support Director and the Maintenance Director on 04/23/25. 3.1-19(b)		Medicaid programs are met in accordance with federal and state law. No residents were found to have been affected by the alleged deficient practice. *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?* No residents were found to have been affected by the alleged deficient practice. The alleged deficient practice could have affected 6 residents, 2 staff and 2 visitors in the affected unit at the time of survey. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* We relocated the one (1) fire extinguisher in question to the correct height from the floor (60”). *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 through the following	

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			protocol: the Executive Director and Maintenance Director will verify the fire extinguisher identified is at the correct height (sixty inches above the floor). Future fire extinguisher installations or replacements will be at the correct height. The Executive Director will be notified immediately of any future potential noncompliance. In addition, progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Asbury Towers QAPI Committee meeting (chaired by the Executive Director) each month for six (6) months total. The Executive Director, and/or designee will be responsible for monitoring this POC to ensure its successful completion.	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 3 of 33 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately 6 residents, 2 staff, and 2 visitors. Findings include: Based on observations made with the Maintenance Director during a tour of the facility	K 0363	*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.	05/09/2025

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	on 04/23/25 the following was noted: 1) On 04/23/25 at 11:51 a.m., resident room #1 failed to latch into the doorframe when tested on three separate occasions. Based on an interview with the Maintenance Director at 11:52 a.m., he agreed that the corridor door to resident room #1 failed to latch into the doorframe. 2) On 04/23/25 at 11:55 a.m., resident room #5 failed to latch into the doorframe when tested on three separate occasions. Based on an interview with the Maintenance Director at 11:55 a.m., he agreed that the corridor door to resident room #5 failed to latch into the doorframe. 3) On 04/23/25 at 12:40 p.m., resident room #20 failed to latch into the doorframe when tested on three separate occasions. Based on an interview with the Maintenance Director at 12:41 a.m., he agreed that the corridor door to resident room #20 failed to latch into the doorframe. Based on a final interview on 04/23/25 at 12:43 p.m. with the Maintenance Director, he agreed that all the above aforementioned resident room doors failed to latch into the doorframe after each was tested on three separate occasions adding that he would have his staff address the issues as soon as possible. This item was discussed with the Executive Director, the Plant Operations Support Director and the Maintenance Director on 04/23/25. 3.1-19(b)		There were 3 doors affected by the alleged deficient practice (Rooms 1, 5 and 20) – the 3 door latches were replaced. Afterward, all 33 of the corridor doors related to the alleged deficient practice were tested and found to be in compliance. *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 were 3 doors affected by the alleged deficient practice (Rooms 1, 5 and 20) – the 3 door latches were replaced. Afterward, all 33 of the corridor doors related to the alleged deficient practice were tested and found to be in compliance. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* The three (3) door latches were replaced (Rooms 1, 5 and 20). All 33 of the corridor doors related to the alleged deficient practice were tested and found to be in compliance. *How will the corrective action(s) be monitored to ensure the alleged*	

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			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 through the following protocol: the Executive Director and Maintenance Director will verify the corridor doors identified (Rooms 1, 5 & 20) latch per code. In addition, compliance will be monitored through the *Asbury K363-04232025 Corridor Door Audit Tool* and by using the following protocols: the Executive Director, Maintenance Director or designee will audit all Corridor Doors in the affected area for two (2) weeks beginning 04/24/2025, three (3) times weekly for two (2) additional weeks, one (1) time weekly for (8) weeks and monthly for three (3) months (24 weeks in total), OR until substantial compliance has been achieved (100% compliance). The Executive Director will be notified immediately of any noncompliance. In addition, progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Asbury Towers QAPI Committee meeting (chaired by the Executive Director) each month for six (6) months total. The Executive Director, and/or designee will be responsible for monitoring this POC to ensure its successful	

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			completion.	
K 0914 SS=F Bldg. 02	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review, observation, and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 04/23/25 at 10:10 a.m. with the Maintenance Director, the annual receptacle retention inspection documentation provided was dated 01/24/24. When asked if a more recent document was available for review, the Maintenance Director provided a record entitled "2024 - 1st Floor Receptacle Testing" and " 2024 - Ground Floor Receptacle Testing" at 10:21 a.m. When it was noted that this testing was also dated in 2024, the Maintenance Director	K 0914	*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. No residents were found to have been affected by the alleged deficient practice. *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?* No residents were found to have been affected by the alleged deficient practice. The alleged deficient practice could have affected all residents. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Systemic measures are in place to ensure the alleged deficient	05/09/2025

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	04/23/2025

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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	stated that he thought the date may have been incorrect. Based on an interview on 04/23/25 at 10:25 a.m. when asked if a more recent inspection of the electrical receptacles was available, the Maintenance Director stated that this document was all he could provide. Based on further interview the Maintenance Director also indicated all of the electrical receptacles in the resident rooms were not hospital-grade and also indicated there was no further documentation of annual testing per NFPA 99, Receptacle Testing requirements. Based on observations made during a tour of the facility, it was noted that all resident rooms did not have hospital grade receptacles within them. This item was discussed with the Executive Director, the Plant Operations Support Director and the Maintenance Director on 04/23/25. 3.1-19(b)		practice does not occur. It is a part of the Asbury Towers Preventive Maintenance Plan and the facility uses an electronic building management application (TELS from Direct Supply) to further ensure compliance. Additionally, the annual receptacle retention inspection documentation dated '2024' was in fact completed on December 19, 2024 and should have been dated as such. An annual receptacle retention inspection was completed post-survey (April 30, 2025) with 100% compliance noted. *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 through an audit completed on April 30, 2025 in the affected area(s) pursuant to this alleged deficiency. It is a part of the Asbury Towers Preventive Maintenance Plan and the facility uses an electronic building management application (TELS from Direct Supply) to further ensure compliance. Additionally, the annual receptacle retention inspection documentation dated '2024' was in fact completed on December 19, 2024 and should	

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			have been dated as such. An annual receptacle retention inspection was completed post-survey (April 30, 2025) with 100% compliance noted on the report. In addition, progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Asbury Towers QAPI Committee meeting (chaired by the Executive Director) each month for six (6) months total. The Executive Director, and/or designee will be responsible for monitoring this POC to ensure its successful completion.	