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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Nursing Home Complaint IN00231023. This visit was in conjunction with the Investigation of Nursing Home and Residential Complaint IN 00233388. Complaint IN00231023 - Substantiated. No deficiencies related to allegations are cited. Complaint IN00233388 - Substantiated. No deficiencies related to allegations are cited. Survey dates: June 15, 16, 19, 20, 21 and 22, 2017. Facility number: 001120 Provider number: 155758 AIM number: 200525120 Census Bed Type: SNF/NF: 37 Residential: 50 Total: 87	F 0000		

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

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	Census Payor Type: Medicare: 7 Medicaid: 15 Other: 15 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 30, 2017.			
F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-			

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to ensure the accuracy of an antidepressant medication received for the coding of the MDS (Minimum Data Set Assessment) MDS and failed to ensure the accuracy of coding for urinary incontinence for 2 of 25 residents reviewed for MDS assessments (Resident 61 and Resident 34). Findings include: 1. Resident 61's record was reviewed on 6/19/17 at 11:17 a.m. The physians orders indicated, but was not limited to, diagnosis of insomnia. The MAR (Medication Administration Record) dated May 2017 indicated, but was not limited to, trazodone (antidepressant) 100 mg (milligrams) PO (by mouth) at HS (bedtime) for insominia with date intitiated 5/5/17 was given on	F 0278	**Tag Cited: F278** **§483.20(g) – Accuracy of Assessment** **Issue Cited:** **"Inaccurate Assessment of Resident"** Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1.Immediate action(s) taken for the resident(s) found to have been affected include: Resident #61 will be	07/22/2017

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	5/6, 5/7, 5/8, 5/9, 5/10, 5/11, and 5/12/17. Also indicated the antidepressant medication was given on 5/27, 5/28, 5/29 and 5/30/17. An Admission MDS assessment, dated 5/12/17, indicated no antidepressant was received during the last 7 days. A 30 day MDS assessment, dated 6/2/17, indicated no antidepressant was received during the last 7 days.2. Resident 34's record was reviewed on 6/21/17 at 10:56 a.m. An admission record dated 4/24/17 indicated diagnoses of dementia without behavioral disturbance, heart failure unspecified, and chronic pulmonary edema. A quarterly Minimum Data Set (MDS) assessment, dated 4/26/17, indicated resident was occasionally incontinent of bladder. Occasionally incontinent was defined as less than 7 episodes of incontinence during the 7 day assessment period. A Certified Nursing Assistant (CNA) Activities of Daily Living (ADL) tracking form for 6 a.m. to 6 p.m. indicated 3 episodes of urinary incontinence on 6/20/17, 3 episodes of urinary incontinence on 6/21/17, and 2 episodes of urinary incontinence on 6/23/17 for a		reassessed no later than 7/22/17 to include the use of antidepressant medications. Resident #34 will be reassessed no later than 7/22/17 to include accurate coding of urinary incontinence. 1.Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **1.Actions taken/systems put into place to reduce the risk of future occurrence include: Exhibit A** An in-service education program will be conducted by the Education Coordinator or designee with all licensed staff including MDS Coordinator(s) addressing the importance of accurate assessments of residents in regard to proper coding of anti-depressants on the MDS and accuracy of incontinence coding. **1.How the corrective action(s) will be monitored to ensure the practice will not recur:**	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	total of 8 urinary incontinence episodes. During an interview on 6/20/17 at 9:31 a.m., CNA 5 indicated resident was incontinent of bladder. During an interview on 6/21/17 at 12:01 p.m., the Director of Nursing (DON) indicated resident was having some bladder incontinence. During an interview on 6/21/17 at 12:13 p.m., Registered Nurse (RN) Consultant indicated the MDS coordinator would get the information from the CNA ADL tracking form to code the urinary incontinence on the MDS assessment. Resident should have been coded as frequently incontinent for the quarterly MDS assessment on 4/26/17. On 6/21/17 at 2:18 p.m., the DON provided a document titled, "Resident Assessment-RAI," and indicated the policy was the one currently being used by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines: 1. The current version of the RAI (MDS3.0) will be utilized when conducting a comprehensive assessment of each resident, in accordance with the instructions found in the RAI Manual. 2. The assessment will include at least the following...i. Continence...n. Special		The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents per week receiving anti-depressant medications for four (4) consecutive weeks, monthly times two (2), and than quarterly times three (3). The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents per week with urinary incontinence for four (4) consecutive weeks, monthly times two (2), and than quarterly times three (3). Information gathered will be submitted to the QAPI meeting for review and revisions will be made if 95% substantial compliance is not met. This audit will begin on or before 7/22/17. These residents and their medical records will be assessed to ensure the accuracy of assessments. Exhibit B(1) Findings of this audit will be discussed with QAPI. This plan of correction will be monitored at the QAPI meetings as noted above. Corrective action completion date:	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	treatments and procedures...." 3.1-31(g)		_____.	
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under			

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	§483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to develop and implement an individualized, comprehensive care plan for 2 of 25 residents reviewed for care plan development (Resident 27 and Resident 61). Findings include: 1. Resident 27's record was reviewed on 6/19/17 at 10:06 a.m. A physicians order	F 0279	F279 It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. **What corrective action(s) will**	07/22/2017

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	with an order date of 11/7/16 indicated, but was not limited to, trazodone (antidepressant) 50 mg (milligrams) tablet give 1/2 tablet (25mg) by mouth at bedtime for insomnia. And a physicians order with an order date of 6/11/16 that indicated, but was not limited to, buspirone hcl (antidepressant) 10 mg give 1 tablet by mouth 2 times a day for depression/anxiety. During a review of care plans, no care plan for insomnia or depression were observed. During an interview on 6/19/17 at 2:10 p.m., the RN (Registered Nurse) Consultant indicated she did not find a care plan that addressed the residents use of a medication for insomnia or the medication used for depression and that care plans would be updated at least quarterly and with significant changes. 2. Resident 61's record was reviewed on on 6/19/17 at 11;17 a.m. The physicians orders indicated, but was not limited to, diagnosis of insomnia. The MAR (Medication Administration Record) dated May 2017 indicated, but was not limited to, trazodone (antidepressant) 100 mg (milligrams) PO (by mouth) at HS (bedtime) for insomnia		**be accomplished for those residents found to have been affected by the deficient practice** Resident #27 care plan has been reviewed/revised as needed to reflect current resident status Resident #34 care plan has been reviewed/revised as needed to reflect current resident status Resident #61 care plan has been reviewed/revised as needed to reflect current resident status Resident #42 care plan has been reviewed/revised as needed to reflect current resident status Resident #53 care plan has been reviewed/revised as needed to reflect current resident status Resident # 56 care plan has been reviewed/revised as needed to reflect current resident status	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	with date initiated 5/5/17. During a review of care plans, no care plan for insomnia was observed. During an interview on 6/19/17 at 3:11 p.m., the RN Consultant indicated she did not find a care plan that addressed the residents diagnosis and use of a medication for insomnia. On 6/21/17 at 2:18 p.m., the DON (Director of Nursing) provided a policy titled, "Resident Care Plan Policy," and indicated was the one currently being used by the facility. The policy included, but was not limited to: "Purpose: To provide an individualized plan of care for each resident... 7. The plan of care shall be based on a composite of current assessments and include the identification of the resident's problems or needs. The assessment system will be used by facility staff in conjunction with other focus assessment tools and professional standards toward assisting the resident to attain or maintain her highest practicable physical, mental and psychosocial well-being...." 3.1-35(a)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Residents currently residing in the facility have the potential to be affected by the alleged deficient practice. Residents currently residing in the facility care plans have been reviewed/revised as needed to reflect current resident status. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The IDT team has been re-inserviced on MDS/care plan completion (including basic care plan, comprehensive care plan and acute care plan updates). The Director of Education/designee will audit the care plan completion at least	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
			monthly to ensure care plans are completed accurately. The IDT meets weekly to discuss specific residents care plan. Documentation of the discussion will be completed in the medical record. Residents care plan is reviewed/updated by the IDT within 7 days of the completion of the MDS, with changes in condition and at least quarterly. Resident/family is invited to attend the care plan conference at least quarterly. The MDS Coordinator is responsible to ensure staff compliance with the Care plan process. **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** ·A Care Plan QA audit tool will be completed weekly for four weeks monthly x 2, then quarterly thereafter by the Director of Nursing Services or designee.	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
			See EXHIBIT C ·The results of the A Care plan QA audit tool will be reviewed by the QA Committee and an action plan will be developed, as needed, to improve compliance. ·Noncompliance with facility MDS Process may result in re-education and/or disciplinary action. **By what date the systemic changes will be completed** ·Changes will be made on or before 7/22/17	
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.			

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	(v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.			

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review, and interview, the facility failed to ensure care plans were revised for 3 of 25 resident care plans reviewed. (Residents 56, 53, and 42). Findings include: 1. A review of Resident 56's record was completed on 6/20/17 at 1:49 p.m. The Physician's Order document, dated 6/2017, indicated the resident diagnoses included, but were not limited to, CVA (cerebral vascular accident) with left sided neglect and paresis (a condition of muscular weakness caused by nerve damage or disease, partial paralysis), dementia, hypertension, and prostate cancer.	F 0280	**Tag Cited: F280** **§483.21(b)(2) – Comprehensive Care Plans** **Issue Cited:** **"Failure to review and revise the care plan after a significant status change"** Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	07/22/2017

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	The resident's admission MDS (minimum data set) assessment, dated 2/3/17, indicated the resident had no cognitive deficit and was an extensive assist with 1-person physical assist for toilet use. A quarterly MDS assessment, dated 4/26/17, indicated the resident was an extensive assist with 1-person physical assist for toilet use. A care plan, dated 1/30/17, and revised on 4/19/17, indicated the resident required assistance from staff to perform his ADL's (activities of daily living). Interventions included, but were not limited to, the resident required the assistance of 1 staff person with toilet use. During an interview, on 6/21/17 at 9:17 a.m., the resident indicated he takes himself to the bathroom. During an interview, on 6/21/17 at 9:20 a.m., the DON (director of nursing) indicated the resident takes himself to the bathroom. During an interview, on 6/21/17 at 10:10 a.m., CNA (certified nursing assistant) 9 indicated the resident toilets himself during the day and wears a brief at night.		1.Immediate action(s) taken for the resident(s) found to have been affected include: On ___7/14/17___ the MDS coordinator updated the care plan for Resident #42. On ___7/14/17___ the MDS coordinator updated the care plan for Resident #53. On ___7/14/17___ the MDS coordinator updated the care plan for Resident #56. 1.Identification of other residents having the potential to be affected was accomplished by: All residents of the facility havethe potential to be affected by this practice. **1.Actions taken/systems put into place to reduce the risk of future occurrence include: EXHIBIT D** The facility's MDS team and Interdisciplinary Team attended an in-service presented by the MDS nurse consultant on _____ 6/30/17 _____. **1.How the corrective action(s) will be monitored to ensure the practice will not**	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	During an interview, on 6/21/17 at 10:32 a.m., COTA (certified occupational therapy assistant) 10 indicated the resident had been discharged from therapy services. He was able to toilet himself independently. 2. Resident 53'3 record was reviewed on 6/20/17 at 9:16 a.m. The residents care plan indicated, but was no limited to, diagnosis of osteoporosis. A care plan initiated on 4/11/17 indicated, but was not limited to, "Focus: at risk for falls... Goal: revision on 4/18/17, resident will not have any falls through the review date... Interventions: date initiated 4/11/17, fall risk assessment will be done on admission, quarterly, and after a fall...." The fall that occurred on 5/7/17 was not updated on the risk for falls careplan. A review of the daily skilled nurses notes dated 5/7/17 at 5:05 a.m. included, but was not limited to, resident was found lying supine on back net to recliner, resident indicated she was transferring self from wheelchair to recliner and fell. During an interview on 6/20/17 at 11:24 a.m.,the Education Coordinator indicated, the care plan would be updated with interventions after a fall, and the		**recur:** MDS Coordinator will review care plans daily for (2) weeks for those residents experiencing a change in status to ensure new or modified interventions have been addressed and documentedregarding the resident's care. The Director of Nursing Services or designee will review a random sample of care plans one (1) time per week for one (1) month and monthly times two (2), than quarterly times three (3) to assure the review and revision of care plans. See EXHIBIT E(1) Results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance of 95% has been achieved. Findings of this audit will be discussed with the QAPI team. Corrective action completion date: on or before 7/22/17.	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	residents care plan was not updated after the fall on 5/7/17.3. Resident 42's record was reviewed on 6/19/17 at 10:09 a.m. An admission record, dated 4/24/17, included, but was not limited to, diagnoses of muscle weakness generalized, unspecified abnormalities of gait and mobility, repeated falls, and age related osteoporosis without current pathological fracture. A nurse's note, dated 5/31/17, at 5:15 a.m., included, but was not limited to, resident was found sitting on the floor beside the bed. Resident had indicated she slid out of the bed. Resident was transferred to the wheelchair. There was no indication of a new intervention or a care plan update related to the fall. A care plan, last revised on 2/24/17, included, but was not limited to, a focus of resident was at risk for falls related to gait/balance problems. Interventions included, but were not limited to, be sure call light was within reach, encouraged resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, ensured resident wore appropriate footwear, resident had a pressure alarm, resident needed a safe environment, used a chair/bed alarm, and physical therapy evaluated and treated as ordered and as			

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	needed. During an interview on 6/20/17, at 3:31 p.m, the Education Coordinator indicated she was not able to find any update of the care plan for the resident's fall on 5/31/17. Care plans should be updated with each fall. The fall care plan should have been updated. On 6/21/17, at 2:18 p.m., the Director of Nursing (DON) provided a document titled, "Resident Care Plan Policy," and indicated the policy was the one currently being used by the facility. The policy indicated, "...Purpose: To provide an individualized plan of care for each resident...10. Additions and modifications will be made by each disciplinary team member to assist facility personnel in meeting the needs of the resident. Plans will be reviewed at least quarterly and revised at any time the condition of the resident changes or the resident exercises rights including the right to refuse treatment or after each assessment or assessment review where change has occurred which would alter the plan of care...." On 6/21/17, at 2:18 p.m., the Director of Nursing (DON) provided a policy titled, "Licensed Nurse Procedure Fall Prevention Personal Alarm			

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	Device/Systems," and indicated the policy was the one currently being used by the facility. The policy indicated, "...Purpose: To establish procedures for ensuring the safety of residents and to prevent/reduce resident falls...10. Potential fall risks will be identified on the resident's care plan. Interventions will be re-evaluated each quarter and after each fall for continued appropriateness of the fall prevention plan...." 3.1-35(d)(2)(B)			
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview the facility failed to adequately implement the plan of care for a resident at risk for falls for 1 of 4 residents reviewed for accidents (Resident 42). Findings include:	F 0282	**Tag Cited: F282** **§483.21(b)(3)(ii) – Qualifications of Facility Staff/Comprehensive Care Plans** **Issue Cited:**	07/22/2017

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	During a random observation of incontinence care on 6/20/17, at 1:19 p.m., a regular mattress was observed on Resident 42's bed. No mats were observed next to the bed. On 6/20/17, at 2:21 p.m., Resident 42 was observed lying in bed. No scoop mattress or floor mats were observed. On 6/20/17, at 3:30 p.m., Resident 42 was observed lying in bed. No scoop mattress or floor mats were observed. During an interview on 6/20/17, at 1:21 p.m., Certified Nursing Assistant (CNA) 5 indicated Resident 42 did not have a scoop mattress or mats next to the bed. During an interview on 6/20/17, at 2:21 p.m., Registered Nurse (RN) 8 indicated she was not sure if Resident 42 had a scoop mattress or mats next to the bed. At the same time, RN checked the Treatment Administration Record (TAR) for June 2017. Indicated Resident 42 did not have mats next to the bed but should have a scoop mattress. Information for fall interventions would be found on the CNA assignment sheet. Indicated the CNA assignment sheet only had a pressure alarm. Floor mats should have been indicated on the CNA assignment sheet.		**"Failure to Provide Assistive Devices"** Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1.Immediate action(s) taken for the resident(s) found to have been affected include: On 6/20/27 the assistive device(s) recommended for Resident #42 was obtained and it's use was initiated. 1.Identification of other residents having the potential to be affected was accomplished by: All residents of the facility requiring assistive devices have the potential to be affected by this practice. **1.Actions taken/systems put into place to reduce the risk of future occurrence include: See EXHIBIT F** On or before 7/22/17,	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	During an interview on 6/20/17, at 2:41 p.m., the Education Coordinator indicated resident should have a scoop mattress and floor mats next to the bed. Resident 42's record was reviewed on 6/19/17 at 10:09 a.m. An admission record, dated 4/24/17, included, but was not limited to, diagnoses of muscle weakness generalized, unspecified abnormalities of gait and mobility, repeated falls, and age related osteoporosis without current pathological fracture. A physician's order, dated 1/8/17, indicated scoop mattress in place. A care plan, last revised 2/24/17, indicated a focus of resident was at risk for falls related to gait/balance problems. Goals included but were not limited to resident would be free from falls, scoop mattress related to climbing out of bed, and mat at bedside for safety. A CNA assignment sheet for health center included, but was not limited to, pressure alarm in bed and chair. There was no indication of floor mats or scoop mattress. On 6/21/17, at 2:18 p.m., the Director of		Education Coordinator will provide in-service education programs for direct care staff regarding the use of assistive devices for residents requiring same. **1.How the corrective action(s) will be monitored to ensure the practice will not recur:** Director of Nursing or designee will observe for weekly times four (4), monthly times two (2), than quarterly times three (3) for those residents requiring the use of assistive devices for falls to ensure proper and consistent use of the equipment for residents requiring same. Information gathered will be submitted to the QAPI meeting for review and revised if substantial compliance of less than 95% is not met. See EXHIBIT G (1) Results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved. Findings of this audit will be	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	Nursing (DON) provided a policy titled, "Licensed Nurse Procedure Fall Prevention Personal Alarm Device/Systems," and indicated the policy was the one currently being used by the facility. The policy indicated, "...Purpose: To establish procedures for ensuring the safety of residents and to prevent/reduce resident falls...11. All devices will be visually monitored and function verified by testing, as per manufacturer's recommendations, every shift and documented on a facility approved form...." 3.1-35(g)(2)		discussed with the QAPI team. Corrective action completion date: on or before 7/22/17.	
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents			

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview the facility failed to ensure a resident was treated appropriately for a Urinary Tract Infection (UTI) for 1 of 5 resident's reviewed for unnecessary medications (Resident 25). Findings include: Resident 25's record was reviewed on 6/19/17, at 10:09 a.m. A diagnosis list on the care plan included, but was not limited to, diagnoses of dementia in other disease classified elsewhere with behavioral disturbance. A physician's order, dated 5/8/17, indicated Bactrim DS (an antibiotic), one by mouth twice daily for UTI. Repeat culture and sensitivity (C & S) of urine (a lab test to check for urine infection) in 14 days. A C & S report, approval date 5/8/17, included,	F 0309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** ·Resident order for U/A culture. Resident was displaying no symptoms of a urinary tract infection. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** ·Residents requiring Physicians orders have the potential to be	07/22/2017

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	but was not limited to, a result of escherichia coli (a bacteria) which was resistant to trimethoprim/Sulfamethoxaz (an antibiotic equivalent to Bactrim DS). A C & S report, approval date 5/25/17, included, but was not limited to, a result of Proteus mirabilis (a bacteria) and Escherichia coli (a bacteria). A physician's order, dated 5/25/17, indicated Cephalexin (an antibiotic) 500 milligrams (mg) twice a day by mouth for 10 days. Trimethoprim 100mg once a day by mouth for 30 days for UTI. During an interview on 6/19/17, at 11:46 a.m., Registered Nurse (RN) 8 indicated she was not able to find documentation of any further communication with the physician regarding the bacteria's resistance to the antibiotic prescribed. She had faxed the C & S to the physician, but there was no response. On 6/21/17, at 2:18 p.m., the Director of Nursing (DON) provided a document titled, "Licensed Nurse Procedure Guidelines for Physician Notification for Change in Condition Overview," and indicated the policy was the one currently being used by the facility. The policy indicated, "...These guidelines were developed to ensure that...2. Medical care problems are communicated to the attending physician in a timely, concise, and thorough manner...C. Laboratory results...2. The pathogen is not sensitive to antibiotic which has been prescribed...." 3.1-37(a)		affected by the alleged deficient practice. ·Licensed nurses were re in-serviced on Physician orders (including labs) by the DON/designee by 7/22/17 ·The Physician will be notified of a resident's change in condition. ·Physician telephone order will be completed per licensed nurse. ·The Physician order will be transcribed to the resident's Medication Administration Record and /or Treatment Administration Record. ·Licensed nurses / QMA's will sign the appropriate record when task is complete. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** ·Licensed nurses were re in-serviced on Physician orders by the DON/designee by 7/22/17 ·The Physician will be notified of a resident's change in condition. ·Physician telephone order will be completed per licensed nurse. ·The Physician order will be transcribed to the resident's Medication Administration Record and / or Treatment Administration Record. ·Licensed nurses / QMA's will sign the appropriate record when task is complete.	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
			·The IDT will review MD orders / 24-hour reports for follow up. interventions at the morning clinical meeting ·Charge nurse is responsible to monitor for lab follow up. ·A lab tracking form has been initiated for follow up on physician orders for labs. SEE EXHIBIT H ·The lab tracking form will be reviewed in the morning meeting Monday through Friday excluding holidays. **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** ·A lab services QA tool will be utilized weekly times 4, monthly times 2, then quarterly thereafter. ·Data will be submitted to the CQI committee for review and follow up. ·The Executive Director and / or designee will be responsible for program compliance. **Compliance date: 7/22/17**	
F 0465 SS=D Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional,			

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation and interview, the facility failed to ensure living environments were functional and comfortable for 2 of 2 units reviewed for comfortable living environments. (Health Facility and First Floor). Findings include: On 6/22/17 at 1:16 p.m., during the environmental tour with the Maintenance Director, the following issues were observed: Health Center: Room 5: Marred areas under the hand sanitizer on the north wall and to the door frames of the room entry door and the bathroom door. Room 8: Marred areas on the bathroom door and doorframe. Room 9: Marred areas on the bathroom door and doorframe. The vent cover on the heating/air conditioning unit was rusted. Room 11-B: A marred/gouged area, measured by the Maintenance Director as 10 inches in length by 8 inches wide, on the wall behind the resident's recliner. Room 13: An area of torn/missing wall covering, in the bathroom, to the right of the mirror above the sink, and to the right of the paper towel	F 0465	**Tag Cited: F465** **§483.90(h) – Other Environmental Conditions** **Issue Cited:** **"Safe/Functional/Sanitary/Comfortable Environment"** Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1.Immediate action(s) taken for the resident(s) found to have been affected include: Room numbers 5,8,9,11B,13,15,20,21,22,126 A,128B,129 will be repaired on or before 7/22/17	07/22/2017

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	holder, measured by the Maintenance Director, as 8 inches in length by 5 inches wide, and 6 inches in length by 10 inches wide, respectively. Room 15: An area of torn/missing wall covering , in the bathroom, on the upper right of the paper towel holder, measured by the Maintenance Director, as 16 inches in length by 13 inches wide, and 2 small areas of missing wall covering to right of the head of bed B. Room 20: Marred areas to the door frames of the room entry door and to the bathroom door. Room 21: An unfinished area to the wall under the soap dispenser in the bathroom. The right window blind was bent. Marred area to the lower portion of the room entry door, and several small marred areas to the wall behind the resident's recliner. Room 22: The bottom third bathroom door was marred, with small marred areas on the wall next to the dresser and behind the resident's recliner. First Floor: Room 126-A: Several marred areas on the wall behind the head of the resident's bed. Room 128-B: Several marred areas on the wall behind the head of the resident's bed. Room 129: Several marred areas on the wall behind the head of the resident's bed, and a gouged area on the east wall, measured by the Maintenance Director, as 3 inches in length by 2 inches wide. During an interview on 6/22/17 at 10:52 a.m., the Maintenance Director indicated he was not aware		1.Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **1.Actions taken/systems put into place to reduce the risk of future occurrence include:** Maintenance Director in-serviced Maintenance staff and Environmental Services regarding reporting procedures for observation of room conditions and reporting functional and/or aesthetic problems via the work order system. See EXHIBIT I **1.How the corrective action(s) will be monitored to ensure the practice will not recur:** The Maintenance Director, or designee, will conduct a random audit of rooms, assessing the functional and aesthetic conditions for five (5) residents' rooms, per week for four (4) consecutive weeks and monthly thereafter. See EXHIBIT J Findings of this audit will be discussed with the QAPI	

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	of any of the issues observed during the environmental rounds. The facility had a work request procedure in place to make him aware of maintenance needs observed by staff. When staff observed maintenance or repair needs, a work order request form would be completed. The form would be emailed, placed in his mailbox, or given the receptionist. He checked for work requests several times daily and each morning after he arrived at work. Work requests were prioritized for completion based on urgency, severity, and resident need. He indicated it was obvious the staff had not utilized the work request procedure as required. On 6/22/17 at 1:50 p.m., the Maintenance Director provided an undated document, titled, "Repair Services," and indicated the policy was the one currently being used by the facility. The policy indicated, "The Maintenance staff is responsible for the repair of...facilities. They operate on a work order system that requires a written request for service...." 3.1-19(f)		team. This plan of correction will be monitored at the quarterly QAPI meeting until such time consistent substantial compliance of no less than 4 out of 5 room has been met. Corrective action completion date: On or before 7/22/17 .	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaint IN00231023. This visit was in conjunction with the Investigation of Nursing Home and Residential Complaint IN00233388.	R 0000		

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	Complaint IN00231023 - Substantiated. No deficiencies related to allegations are cited. Complaint IN00233388 - Substantiated. No deficiencies related to allegations are cited. Survey dates: June 15, 16, 19, 20, 21 and 22, 2017. Facility number: 001120 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 30, 2017.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing			

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a minimum of one awake person, with first aid certificates were on site at all times. This deficient practice had the potential to affect 50 out of 50 residents. Findings include: Employee records were reviewed on 6/21/17 at 12:00 p.m. The records lacked indication facility staff had first aid certification. The employee daily schedule, dated 6/15/17 to 6/22/17, was reviewed. The records lacked indication a staff member with first aid certification was in the building for day, evening, or night shift for those days. During an interview on 6/21/17 at 3:35 p.m., the Human Resources Director indicated, she was unsure if staff had first aid certification and would have to check	R 0117	**R 0117** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On or before 7/22/17 at least one staff member per shift will be provided first aid training **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 resident of the facility has the potential to be affected by this practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** 1. new employees will be trained in first aid as part of their new employee orientation. 2. current nursing staff will be	07/22/2017

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	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	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) COMPLETION DATE
	employee files. During an interview on 6/22/17 at 11:25 a.m., the Administrator indicated, the Human Resource Director was out of the office for the day and that she had provided all the documentation she had found. The documentation provided did not included indication that any staff had first aid certification. The administrator also indicated there was no documentation for first aid certification.		provided first aid training **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;** Human Resource Director will monitor employee license and certification log monthly. See EXHIBIT K Results will be reviewed by QAPI team quarterly until such time consistent substantial compliance has been achieved as determined by the committee. **By what date the systemic changes will be completed;** Corrective action completion date: on or before 7/22/17	