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	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Towers Health Care Center	102 W Poplar St Greencastle, IN 46135

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interview, the facility failed to ensure the rights and dignity of a resident were maintained for 1 of 3 residents reviewed for resident rights (Resident B). The deficient practice was corrected on 3/19/26, prior to the start of the survey, and was therefore past noncompliance. Findings include:An intake document, dated 3/23/26 at 11:57 a.m., indicated the resident's rights had allegedly been violated when a facility Registered Nurse (RN) had taken a photograph of Resident B's anal area and had sent the photograph to an individual who was not involved with the resident's care and had no connection to the facility.Resident B's record was reviewed on 3/26/26 at 11:26 a.m. The profile indicated the resident's diagnoses included, but were not limited to, rectal prolapse (a condition where the lower end of the large intestine [rectum] loses its internal support, turns inside out, and protrudes through the anus).An admission Minimum Data Set (MDS) assessment, dated 1/4/25, indicated the resident had no cognitive deficits. A Photo Release Form, signed on 1/11/25, indicated the resident had given his permission for pictures to be taken. The form indicated the resident's photo could be used for any lawful purpose, including, but not limited to, magazine publication, publicity, advertising, web content, and social media. The form lacked documentation of permission for photographs to be provided to people outside the facility or for private body parts to be photographed.Review of the residents' progress notes, from admission to present, lacked any documentation of any pictures being taken.An Indiana State Reportable Incident form, dated 3/17/26, indicated the facility administration had been made aware of the allegation. The facility investigation had confirmed that RN 10 had taken the picture on her personal electronic device during resident care. She had sent the picture to a friend who was working with a resident with a similar diagnosis, via the electronic device. The RN had been suspended and removed from the nursing schedule, pending the facility investigation. The resident was assessed for physical and psychological concerns with no findings. Resident and staff interviews were conducted, with no further concerns identified. Based on the findings of the investigation RN had been terminated from her employment. Staff re-education related to resident rights, dignity, and prohibition of photos and recordings were completed. The resident was monitored by the Social services Director for any psychological concerns for 72 hours, with no concerns identified.During an interview, on 3/27/26 at 9:45 a.m., with the Regional Clinical Consultant and the Director of Nursing (DON), they indicated they had confirmed that the incident had happened. RN 10 had admitted to taking the picture. After the completion of the facility's investigation, RN 10's employment had been terminated. The DON indicated all staff had been immediately re-educated on resident rights, dignity, and the policy on prohibition of taking photographs and/or recordings. If the staff could not attend the group education opportunities, they were provided with the education prior to beginning there next shift.During an interview, on 3/27/26 at 11:07 a.m., Resident B indicated he did not remember ever giving permission to a nurse to a picture of his back side. If he had given permission for that he would think he would remember. The staff helped him change his depends, but he could not recall anyone taking a picture.ON 3/27/26 at 11:36 a.m., the DON provided a document, dated February 2021, titled Resident Rights, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Interpretation and (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implementation.1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; be treated with.dignity.3. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues.The deficient practice was corrected on 3/19/26, prior to the start of the survey, and was therefore past noncompliance. The deficient practice was corrected after the facility implemented a systemic plan that included the following actions. The facility reported the incident to the State and completed a thorough investigation of the incident. The resident was assessed both physically and psychologically and resident and staff interviews were conducted. The investigation resulted in the termination of the employee who committed the offense. The facility staff were re-educated on resident rights, dignity and prohibition of photos and /or recordings.This citation relates to intake 2961258.410 IAC (Indiana Administrative Code) 16.2-3.1-3(a)