

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2025
NAME OF PROVIDER OR SUPPLIER  Asbury Towers Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>38847</p> <p>Based on interview, record review, and observation, the facility failed to ensure food was served at a palatable temperature for 3 of 15 residents reviewed for food temperatures (Residents 7, 13, and 10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During an interview, on 3/24/25 at 11:26 a.m., Resident 7 indicated the food was cold when it was served.</li> </ol> <p>Resident 7's record was reviewed on 3/26/25 at 9:41 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 2/6/25, indicated the resident was cognitively intact.</p> <ol style="list-style-type: none"> <li>2. During a family interview, on 3/24/25 at 11:47 a.m., Resident 13's wife indicated the food was cold when it was served.</li> </ol> <p>Resident 13's record was reviewed on 3/26/25 at 1:28 p.m. A quarterly MDS assessment, dated 3/18/25, indicated the resident had a severe cognitive impairment.</p> <ol style="list-style-type: none"> <li>3. During an interview, on 3/24/25 at 1:34 p.m., Resident 10 indicated the food was often cold when it was served in her room, and the staff had to warm it up for her.</li> </ol> <p>During a continuous observation, on 3/27/25 from 11:16 a.m. to 12:02 p.m., the following was observed. At 11:16 a.m., the first floor dining room steam table was observed with three covered dishes in place. There were no residents or staff in the area. At 11:33 a.m., lunch service began in the first floor dining room. At 11:43 a.m., lunch service was completed in the first floor dining room, the food dishes were placed on a cart, and taken to the dining room downstairs. At 11:45 a.m., Dietary Aide 10 placed the covered dishes on a food warmer in the downstairs dining room and checked the temperatures of the food prior to the start of the lunch service. The meatloaf was 155 degrees Fahrenheit (F), mashed potatoes 155 degrees F, broccoli and cauliflower 132 degrees F, gravy 130 degrees F, and mechanical soft meatloaf 130 degrees F. From 11:50 a.m. to 12:02 p.m., trays were passed in the downstairs dining room and to the rooms on the unit. After the completion of the last tray, at 12:02 p.m., a test tray was plated from the food warmer. At 12:02 p.m., directly after the completion of the last tray on the unit, meatloaf was 142 degrees F, mashed potatoes were 120 degrees F, and broccoli cauliflower was 98 degrees F.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 3/27/25 at 12:02 p.m., Dietary Aide 10 indicated the food should have been 130 degrees F or above at the time it was served.</p> <p>Resident Council Minutes, dated 1/21/25, indicated the food was not so cold.</p> <p>On 3/27/25 at 1:40 p.m., the Administrator provided an undated document titled, Food Safety and Sanitation, and indicated it was the policy currently being used by the facility. The policy indicated, .Food Holding Temperatures/Service: Hot food should be served at 135 F or higher</p> <p>3.1-21(a)(2)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38847</p> <p>Based on observation, interview, and record review, the facility failed to ensure hair and beard nets were worn in the food service area during meal service during 1 of 4 dining observations.</p> <p>Findings include:</p> <p>During an observation, on 3/24/25 at 11:31 a.m., [NAME] 5 verified the food temperature and served lunch from the kitchen in first floor dining room. [NAME] 5 had facial hair and did not wear a beard net. A contracted service provider cleaned the fish tank in the dining room during the meal service. The contracted service provider entered the kitchen area, with no hairnet, and obtained water from the sink to fill the fish tank while [NAME] 5 served lunch. Registered Nurse (RN) 3 and Certified Nurse Aide (CNA) 4 entered the kitchen area and obtained drinks. RN 3 and CNA 4 did not wear hairnets in the kitchen area.</p> <p>During an interview, on 3/24/25 at 11:35 a.m., [NAME] 5 indicated no staff should have entered the kitchen area without hairnets in place.</p> <p>During an interview, on 3/24/25 at 11:38 a.m., RN 3 and CNA 4 indicated they had not been told they needed a hairnet to enter the kitchen area.</p> <p>On 3/27/25 at 1:40 p.m., the Administrator provided an undated document titled, Food Safety and Sanitation, and indicated it was the policy currently being used by the facility. The policy indicated, .Sanitation .Hair restraints must be worn at all times when in or around food production areas</p> <p>3.1-21(i)(3)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>38847</p> <p>Based on record review and interview, the facility failed to ensure a Physician's Order was obtained and documented for hospital transfers for 3 of 4 residents reviewed for hospitalization (Residents 6, 5, and 10).</p> <p>Findings include:</p> <p>1. Resident 6's record was reviewed on 3/25/25 at 10:13 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 3/11/25, indicated the resident was cognitively intact and had a diagnosis of medically complex conditions.</p> <p>A Progress Note, dated 6/2/24, indicated the resident's sister came to the facility and requested the resident be sent to the hospital for pain. The nurse called 911.</p> <p>The clinical record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer.</p> <p>A Progress Note, dated 6/3/24, indicated the resident returned to the facility from the hospital.</p> <p>A Progress Note, dated 6/4/24, indicated the nurse went into the resident's room and found his bedside table covered in water, resident was asleep and holding the cup that had spilled. The resident was difficult to wake up, and not touched his dinner, and was unable to say who he was. The resident stated he did not feel well. The resident's sister, Director of Nursing (DON), and physician were notified. The resident was sent to the hospital.</p> <p>The clinical record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer.</p> <p>A Progress Note, dated 6/13/24, indicated the resident returned to the facility from the hospital.</p> <p>A Progress Note, dated 6/23/24 at 6:20 p.m., indicated the resident's sister stated the resident called her and cried with pain from not having a bowel movement (BM). The nurse explained to the resident's sister that the resident had already received an enema and had large results. The resident's sister wanted the resident to be given another enema, and if the pain continued wanted him sent to the hospital. The physician stated to send the resident to the hospital as he just returned from the hospital the prior week for an illeus (intestinal blockage).</p> <p>A Progress Note, dated 6/23/24 at 6:46 p.m., indicated the resident's sister called back and was notified the physician wanted the resident transferred to the ER. 911 was called.</p> <p>The clinical record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Progress Note, dated 9/4/24 indicated the resident had tremors in his arms and hands, was lethargic, complained of severe back pain and his stomach cramping. The resident's sister visited and wanted the resident sent to the hospital. The physician and DON were notified, and 911 was called.</p> <p>The clinical record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer.</p> <p>A Progress Note, dated 9/6/24, indicated the resident returned to the facility from the hospital.</p> <p>A Progress Note, dated 1/14/25 at 1:09 p.m., indicated the resident complained he felt like his lungs were filling up and requested to go to the ER. The resident's family and the physician were notified.</p> <p>The clinical record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer.</p> <p>A Progress Note, dated 1/14/25 at 7:05 p.m., indicated the resident returned to the facility from the hospital.</p> <p>A Progress Note, dated 3/18/25, indicated the resident was transferred to the hospital for evaluation and treatment due to episodes of projectile vomiting. The resident's family and the physician were notified.</p> <p>The clinical record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer.</p> <p>A Progress Note, dated 3/19/25, indicated the resident returned to the facility from the hospital.</p> <p>During an interview, on 3/25/25 at 3:08 p.m., the DON indicated she was unable to find documentation a Physician's Order was obtained, written, or signed for the resident's hospital transfers.</p> <p>34525</p> <p>2. Resident 5's record was reviewed on 3/25/25 at 10:21 a.m. The profile indicated the resident's diagnoses included, but were not limited to, atypical atrial flutter (an abnormal heart rhythm where the electrical signals in the upper chambers beat too quickly and irregularly), and history of pulmonary embolism (a condition where a blood clot travels to the lungs and blocks one or more pulmonary arteries).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 3/19/25, indicated the resident received anticoagulant (AC) medication (drugs that help prevent blood clots from forming).</p> <p>The census indicated that the resident had been hospitalized from 3/7/25 to 3/12/25.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 3/7/25 at 3:21 p.m., indicated the resident presented a tissue with liquid and dark red saliva, and indicated it was from him coughing. He indicated he had coughed up a big glob of blood like a clot earlier when out on LOA (leave of absence) with his friend. The nurse advised the resident he should go to the emergency room (ER) for a workup. The resident agreed and his family, the Director of Nursing (DON), and physician were notified that the resident had been sent to the ER.</p> <p>The record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer.</p> <p>3. Resident 10's record was reviewed on 3/25/25 at 2:13 p.m. The profile indicated the resident's diagnoses included, but were not limited to, acute pyelonephritis (a sudden, severe bacterial infection of the kidney and renal pelvis), hydronephrosis with renal and urethral calculus obstruction (swelling of one or both kidneys due to a buildup of urine caused by blockages in the kidneys or the tubes carrying urine from the kidneys to the bladder), and unspecified psychosis (a diagnosis used when someone experiences psychotic symptoms [like hallucinations-seeing or hearing things that are not there] but doesn't meet the criteria for a specific psychotic disorder).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 12/30/24, indicated the resident had no cognitive deficit and received an antipsychotic medication (medication used to treat psychotic symptoms).</p> <p>During an interview, on 3/24/25 at 1:38 p.m., the resident indicated she had been out to the hospital last week related to a kidney stone.</p> <p>The census indicated the resident had been hospitalized from 3/7/25 to 3/13/25, and again on 3/14/25, and had returned on the same date.</p> <p>A progress note, dated 3/7/25 at 10:35 a.m., indicated the resident had been sent to the hospital overnight due to fever and hallucinations. The resident was found to be septic (a life-threatening condition that occurs when the body's immune system overreacts to an infection, causing widespread inflammation and damage to multiple organs) and had been transferred to a second hospital location for kidney stone surgery and treatment.</p> <p>The record lacked documentation a Physician's order was obtained, written, or signed by the physician for the hospital transfer.</p> <p>During an interview, on 3/25/25 at 3:08 p.m., the DON indicated she was unable to find documentation that a Physician's Order was obtained, written, or signed for the resident's hospital transfers.</p> <p>On 3/26/25 at 9:48 a.m., the DON provided a document, with a revised date of 10/17/24, titled, Transfer and Discharge (including AMA-against medical advice), and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Explanation and Compliance Guidelines .12. Emergency Transfers/Discharges .a. Obtain physician's order for emergency transfer or discharges .f. Document .the transfer in the medical record</p> <p>3.1-50 (a)(1)</p> <p>3.1-50(a)(2)</p>		