STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 10/07/2014
NAME OF PROVIDER OR SUPPLIER ADAMS WOODCREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733	

(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
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/07/14 Facility Number: 000556 Provider Number: 155747 AIM Number: 100290130 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Adams Woodcrest was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original section of the building consisting of A Wing, C Wing, the Extended Care Wing and the main dining room was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was with only a basement stairway was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire	K010000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	alarm system with smoke detection in corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 143 and had a census of 119 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 10/10/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 1 of 1 stairways was enclosed with one hour construction. This deficient practice could affect any residents near the stairway in the event of an emergency.	K010020	*K020* - - -	10/24/2014

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	Findings include: Based on observation with the Maintenance Supervisor and the Housekeeping Supervisor on 10/07/14 at 12:25 p.m., the door at the top of the stairway leading to the basement was a nonrated solid wood core door. The door at the bottom of the stairway was a nonrated metal door that lacked latching hardware and failed to latch into the door frame. At the time of observation, the Maintenance Supervisor was unable to find a fire rating label on the doors and was unable to provide documentation to confirm the doors had a one hour fire rating. 3.1-19(b)		*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No Residents were identified. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* No residents were identified. - *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* The door penetrating the fire resistive wall will have a passage set installed to assure positive latching in a closed position. The door at the top of the stairs will be replaced with a 1 hr. fire resistive door. - *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*Once the replacement is made the Environmental Services Supervisor will file the associated documentation electronically for retrieval as needed. A report will be made to the QAPI committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/07/2014
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			on progress and upon completion. Expected date of completion – 10/24/2014	
K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 7 exit doors was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(c) requires an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. This deficient practice could affect any residents evacuated through the service hall from the main dining room in the event of an emergency. This deficient practice could affect 1 of 4 smoke compartments. Findings include: Based on observation with the Maintenance Supervisor and the Housekeeping Supervisor on 10/07/14 at 2:43 p.m. the exit door on A wing near resident room 932 was equipped with a electromagnetic lock. The device failed	K010038	*K038* *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were identified. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* No residents were identified. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* The magnetic door latch which was discovered to be defective later in day of the survey was replaced with a new magnetic latch the next day. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Once the replacement is made the Environmental Services Supervisor will file the associated documentation electronically for	10/08/2014

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	to sound an alarm and release after the Maintenance Supervisor applied force for 25 seconds. The Maintenance Supervisor acknowledged the door did not release and stated he thought the problem was with the electronics on the releasing device. A sign on the door stated the electromagnetic lock would release within 15 second once force was applied to the door. The door did release upon activation of the fire alarm system. 3.1-19(b)		retrieval as needed. A report will be made to the QAPI committee on progress and upon completion. Expected date of completion – 10/08/2014	
K010048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment	K010048	*K048* - - - *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were identified. *2. How will the facility identify other residents having the*	10/08/2014

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	(7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review with the Maintenance Supervisor and Housekeeping Supervisor on 10/07/14 at 12:05 p.m., the "Fire Plan" did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was confirmed by the Maintenance Supervisor at the time of record review. 3.1-19(b)		*potential to be affected by the same alleged deficient practice and what corrective action will be taken?* No residents were identified. - *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* After the survey exited the facility, it was discovered that the documentation supplied to the surveyors was outdated and not reflective of current practice. Indeed the current plan DOES identify the extinguisher type as required. Copy of relevant page attached. - *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*Once the replacement is made the Environmental Services Supervisor will file the associated documentation electronically for retrieval as needed. A report will be made to the QAPI committee on progress and upon completion. Expected date of completion – 10/08/2014	

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K010050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on record review of the "Fire Drill/Incident Report" with the Maintenance Supervisor and the Housekeeping Supervisor on 10/07/14 at 11:15 a.m., there was no record of a second shift fire drill for the first quarter of 2014. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1-19(b) 3.1-51(c)	K010050	*K050* - - - *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were identified. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* No residents were identified. - *3. What measures will be put into place or what systemic changes*	11/07/2014

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			will be made to ensure that the alleged deficient practice does not recur? Fire drills will be conducted at least monthly on each shift for 3 months. Each will be conducted under the supervision of the facility administrator, who will then assess the response and documentation and any attendant training required by facility staff. Such training will be conducted by the Staff Development Coordinator and documented. Then, under the same conditions, the drills will return to one per shift per quarter with the monitoring unchanged. - *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*A report will be made to the QAPI committee on the performance and follow up actions for each fire drill at the committee's regularly scheduled meetings. The committee will make further recommendations as it sees fit. Expected date of completion – 11/07/2014	
K010130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786			

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	Based on observation and interview, the facility failed to ensure the penetration in 4 of 4 fire barrier walls were maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific	K010130	*K130* - - - *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were identified. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* No residents were identified. - *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* 1.) Upon discovery of the unsealed smoke barrier penetrations resulting from a recent upgrade to the nurse call system, the facility maintenance staff filled the offending penetrations with fire caulk as required. A documented one -time tour of all the smoke	10/10/2014

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	purpose. This deficient practice could affect all occupants. Findings include: Based on an observations with the Maintenance Supervisor on 10/07/14 from 12:40 p.m., to 1:20 p.m., the following deficiencies were noted: a) above the ceiling tile at the fire doors separating health care and independent living there were three unsealed penetrations measuring one fourth inch around wires and in the attic at the same fire barrier wall there was a three inch by three inch square cut out of the drywall around two wires. b) the access panels cut into the attic fire barrier wall drywall to allow access from one smoke compartment to the adjacent smoke compartment had been removed at the fire barrier wall entering A wing and entering C wing. c) above the ceiling tile at the fire barrier wall entering A wing there was an unsealed penetration measuring three inches. d) above the ceiling tile at the fire barrier wall entering C wing there were two penetrations where the fire caulk had been pulled away from the wall leaving a one fourth inch gap. e) above the ceiling tile at the fire barrier		barriers was then made to assure that all penetrations had been filled. 2.) All inspection certificates were located and installed on each of the offending water heaters. All were inspected as prescribed. - *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*A report of that documentation will be made to the QAPI committee on the completeness of the sealing of the smoke barrier penetrations and the posting of the inspection certificates at its regularly scheduled meeting. The committee will make further recommendations as it sees fit. Expected date of completion – 10/10/2014 -	

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	wall near the extended care unit nurses' station there was a penetration where the fire caulk had been pulled away from the wall leaving a one fourth inch gap. The Maintenance Supervisor acknowledged the fire wall penetrations and provided the measurements at the time of observations. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 3 of 5 water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice could affect 2 of 4 smoke compartments. Findings include: Based on record review with the Maintenance Supervisor on 10/08/14 from 2:10 p.m. to 2:30 p.m., the two water heaters in the mechanical room at the A wing nurses' station and one water heater in the mechanical room at the C wing nurses' station lacked a Certificate of Inspection. Based on interview with the Maintenance Supervisor at the time of			

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	observations, he was unable to locate the Certificate of Inspection for the water heaters. 3.1-19(b)			
K010147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power for medical equipment or high current draw equipment. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 1 resident in resident room 322 and facility staff. Findings include: Based on observation with the Maintenance Supervisor and the Housekeeping Supervisor on 10/08/14 at 1:40 p.m., a refrigerator was plugged in and supplied with electricity by an extension cord power strip in the	K010147	- - *K-147* - *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were identified. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* No residents were identified. - *3. What measures will be put into*	10/21/2014

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	extended care unit employee break room. At 2:40 p.m., a concentrator was plugged in and supplied with electricity by an extension cord power strip in resident room 322. This was acknowledged by the Maintenance Supervisor at the time of observations. 3.1-19(b)		*place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* All resident rooms were searched for the use of power strips supplying electricity to medical equipment/high current draw equipment. None were noted. Staff education that the medical devices must be plugged into the wall outlet is ongoing. Housekeepers have tasked with checking daily to assure that medical equipment/high current draw equipment are not plugged into power strips. Reports of violations will be made to the Environmental Supervisor, who will report to the relevant department for action up to and including discharge from employment. - *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*A report of that documentation will be made monthly to the QAPI committee on the use of power strips used for medical equipment/high current draw equipment at its regularly scheduled meeting. The committee will make further recommendations as it sees fit.	

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			Expected date of completion – 10/21/2014	
K020000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/07/14 Facility Number: 000556 Provider Number: 155747 AIM Number: 100290130 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Adams Woodcrest was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The Rehabilitation Administration addition including a rehabilitation pool, apartment, nurses' station and offices which was surveyed with Chapter 18, New Health Care Occupancies. This one story facility with only a	K020000		

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	basement stairway was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 143 and had a census of 119 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 10/10/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K020048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans.	K020048	*K048* - -	10/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED 10/07/2014
NAME OF PROVIDER OR SUPPLIER ADAMS WOODCREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733	

(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
	LSC 18.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review with the Maintenance Supervisor and Housekeeping Supervisor on 10/07/14 at 12:05 p.m., the "Fire Plan" did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was confirmed by the Maintenance Supervisor at the time of record review. 3.1-19(b)		- *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were identified. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* No residents were identified. - *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* After the survey exited the facility, it was discovered that the documentation supplied to the surveyors was outdated and not reflective of current practice. Indeed the current plan DOES identify the extinguisher type as required. Copy of relevant page attached. - *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*Once the replacement is made the Environmental Services	

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			Supervisor will file the associated documentation electronically for retrieval as needed. A report will be made to the QAPI committee on progress and upon completion. Expected date of completion – 10/08/2014	
K020050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on record review of the "Fire Drill/Incident Report" with the Maintenance Supervisor and the Housekeeping Supervisor on 10/07/14 at	K020050	*K050* - - - *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were identified.	11/07/2014

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	11:15 a.m., there was no record of a second shift fire drill for the first quarter of 2014. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1-19(b) 3.1-51(c)		*2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* No residents were identified. - *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Fire drills will be conducted at least monthly on each shift for 3 months. Each will be conducted under the supervision of the facility administrator, who will then assess the response and documentation and any attendant training required by facility staff. Such training will be conducted by the Staff Development Coordinator and documented. Then, under the same conditions, the drills will return to one per shift per quarter with the monitoring unchanged. - *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*A report will be made to the QAPI committee on the performance and follow up actions for each fire drill at the committee's regularly scheduled	

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			meetings. The committee will make further recommendations as it sees fit. Expected date of completion – 11/07/2014	