PRINTED: 06/16/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155747		JILDING	nstruction <u>00</u>	(X3) DATE COMPI 05/30	LETED
NAME OF PROVIDER OR SUPPLIER ADAMS WOODCREST				1300 ME	DDRESS, CITY, STATE, ZIP COD ERCER AVE UR, IN 46733		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
F 0000 Bldg. 00	Home Complaint IN the Investigation of IN00460127. Complaint IN00458 to the allegations are Complaint IN00460	0127 - Deficiencies related to ited at R215 and R240. 0, 2025 0556 55747 90130	F 00	000			
R 0000	Adams Woodcrest v						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Dzejna McKenzie Director of Assisted Living 06/12/2025

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155747		ľ	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/30/2025		
		133747	B. WI			03/30/2023	
	PROVIDER OR SUPPLIE WOODCREST	R		1300 M	ADDRESS, CITY, STATE, ZIP COD IERCER AVE FUR, IN 46733		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	N
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
Bldg. 00	This visit was for the Complaint IN0046 Investigation of Not IN00458302. Complaint IN0045 the allegations are cited allegations are cited Survey date: May a Facility number: On Residential Census These State Reside accordance with 4 in Complaint IN0046 and Incomplaint IN0046 allegations are cited accordance with 4 in Complaint IN0046 and Incomplaint IN0046 allegations are cited Survey date: May a survey date and a su	he Investigation of Residential 0127. This visit included the ursing Home Complaint 8302- No deficiencies related to cited. 0127- Deficiencies related to the d at R215 and R240. 30, 2025 00556 s: 55	R 00		Preparation and execution of Plan of Correction does not constitute admission or agree by provider to the truth of the alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared executed solely because it is required by the provisions of federal and state law. Adams Woodcrest Assisted Living maintains that the alleged deficiencies do not individually collectively jeopardize the heat and/or the safety of the residents nor are they of such character as to limit the provider's capacity to rend adequate resident care. Furthermore, Adams Woodcrest Assisted Living asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and the Plan of Correction in its entire constitutes this provider's allegation of compliance. Further, we request desk revenue (paper compliance) for compliance, if acceptable. Completion dates provided for procedural proce purposes to comply with federand state regulations, and correlate with the most recent	this ment facts I and I or alth of der his ty riew are ssing ral	
					correlate with the most recent		

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155747		A. BUILDING 00 B. WING		COMPLETED 05/30/2025	
		100/4/	Б. W			03/30/	2020
NAME OF I	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD IERCER AVE		
ADAMS '	WOODCREST				UR, IN 46733		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
mo	REGULATORY	ESC IDENTIFICAÇÃO DE CAMATION		Mo	contemplated accomplished corrective action. These do not necessarily chronologically correspond to the date that Adams Woodcrest Assisted Li is under the opinion that it the requirements of participation of that corrective action was necessary.	ving	DATE
R 0215	410 IAC 16.2-5-2(b)					
D	Evaluation - Defici	iency					
Bldg. 00	failed to ensure asse of 6 residents review Findings include:		R 02	215	p paraid="989848798" paraeid="{3bbd9675-6b0e-4f9 f-e5ffd7a80f8c}{21}" >R215 4' IAC 16.2-5-2(b) Evaluation – Deficiency		06/13/2025
	Resident B's family bracelet was remove irritation and no bel seeking but after an	y, on 5/30/25 at 10:03 AM, indicated her code alert ed due to complaints of wrist naviors of wandering/exit elopement incident on 5/22/25 ed Resident B's code alert			Based on interview and record facility failed to ensure assessments were updated for of 6 residents reviewed (Resident).	r 1	
		was reviewed on 5/30/25 at is included Alzheimer's disease			What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice?	nts	
	checked Resident B night to right wrist a Nursing notes, dated reviewed. A note da B's code alert brace	ed 11/11/24 indicated staff 's code alert activation every at bedtime for safety. d 3/31/25 - 5/22/25, were ated 4/6/25, indicated Resident let was not on. There was no ate Resident B's code alert ed.			Immediate education was proto the nurse regarding Reside B's elopement assessment. Resident B had Code Alert removed on 3/31/2025 due to complaints of wrist irritation ar no wandering/exit-seeking behaviors. During this time.	nt	

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	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155747	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/30/2025		
	ROVIDER OR SUPPLIER	- R	STREET ADDRESS, CITY, STATE, ZIP COD 1300 MERCER AVE DECATUR, IN 46733				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION DATE		
me	An elopement asses indicated Resident B had a consafety. An elopement asses indicated Resident Resident B had a consafety. There was no other updated between 11 During an interview Director of Assisted indicated Resident removed on 3/31/2; and no observation behaviors. The Director of Conservation of the conservation of th	ssment dated 11/11/24, B was at risk for elopement and ode alert on her right wrist for ssment dated 5/23/25, B was at risk for elopement and ode alert on her right wrist for elopement assessments		Resident B was in room ison due to COVID-19. Code Al again placed on 5/23/2025 following the elopement into The elopement assessment completed at the time Code was initiated. How identify other resident the potential to be affected same deficient practice and corrective action will be taken to the completed on all residents residing in Assisted Living, other resident was identified risk for elopement, and she	colation fert was coldent. Int was e Alert Its having I by the I d what I ken? Vere One ed at		
	elopement assessment was not Assisted Living ind the order was not dupdated assessment A policy, titled Elo 3/2011, was provid 5/30/25 at 1:40 PM elopement risk asseresident quarterly a occurs.	changes required an updated ent and an updated elopement completed. The Director of licated she was unsure why iscontinued nor why an twas not completed. pement Risk Policy, last revised ed by the Executive Director on . The policy indicated an essment was completed on all and if a change in condition		already has Code Alert pla elopement assessment con per policy. Another resident identified as having the Con removed recently. Her recon were and both orders were discontinued, and elopement assessment was updated. Elopement assessments we any time a new Code Alert initiated or removed.	ced and mpleted at was de Alert ords e ent vill be is		
				place or what systemic cha make to ensure that the de practice does not recur?	<u> </u>		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155747	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMI	e survey Pleted 0/2025
	ROVIDER OR SUPPLIE	R	1300 M	ADDRESS, CITY, STATE, ZIP COD IERCER AVE FUR, IN 46733	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
				Risk Policy (Form 1) and Resident Policy (Form 2) updated and reviewed wi nursing staff. Education v provided to Nurses on freelopement assessment completion (Form 3 and Fer updated policy, elope assessment to be comple all residents in Assisted L upon admission, with ser and/or if any changes in occur. Elopement assess will be any time a new Co is initiated or removed. How be monitored to ensideficient practice will not	were th all was equency of Form 4). Ement eted on civing vice plan, condition ements ode Alert	
				i.e., what quality assurangering program will be put into	ce llace? ement	
				Plan (PIP) has been initial this deficient practice. The committee will provide owthis new process and	e QAPI versight of vide sure this of recur. ert is the e ensure ent has Unit	
				Nurse Manager will repor findings monthly during the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155747		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETEI B. WING 05/30/202			LETED	
	PROVIDER OR SUPPLIE	R		1300 M	ADDRESS, CITY, STATE, ZIP COD IERCER AVE TUR, IN 46733		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					meeting. The QAPI program was review this monitoring monthly at least 1 year, or longer necessary. The compliance expected goal is 100% from the first month and on (Form 5). By what date be completed?	y for	
					6/13/2025		
R 0240 Bldg. 00	410 IAC 16.2-5-4 Health Services -	• •					
	failed to ensure ph	and record review the facility ysician order documentation of 6 residents reviewed			p="" paraid="726122213" paraeid="{3bbd9675-6b0e-4f9 f-e5ffd7a80f8c}{205}"> p paraid="726122213" paraeid="{3bbd9675-6b0e-4f9		06/13/2025
	Resident B's family	Pindings include: During an interview, on 5/30/25 at 10:03 AM, Resident B's family indicated her code alert bracelet was removed due to complaints of wrist			f-e5ffd7a80f8c}{205}" >R 240 410 IAC 16.2-5-4(d) Health Services – Deficiency		
	irritation and no be seeking but after a	chaviors of wandering/exit n elopement incident on 5/22/25 ied Resident B's code alert			Based on interview and record facility failed to ensure physic order documentation was accorder 1 of 6 residents reviewed (Resident B).	ian	
	12:29 PM. Diagno with late onset. An active order, da checked Resident I	d was reviewed on 5/30/25 at sis included Alzheimer's disease ated 11/11/24, indicated staff B's code alert activation every at bedtime for safety.			What corrective action(s) will accomplished for those reside found to have been affected be deficient practice?	ents	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155747		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/30/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1300 MERCER AVE DECATUR, IN 46733				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	(MAR), dated 3/31/checked Resident B from 3/31/25 - 5/22 Nursing notes, date reviewed. A note da B's code alert brace other notes indicatin bracelet was remov An elopement assess indicated Resident I resident had a code safety. An elopement assess indicated Resident I and a code safety.	d 3/31/25 - 5/22/25, were ated 4/6/25, indicated Resident let was not on. There was no ng Resident B's code alert		Immediate was sent via em to all Woodcrest Assisted Livi staff for accurate documentati and activation checks. Reside had Code Alert removed on 3/31/2025 due to complaints of wrist irritation and no wandering/exit-seeking behave During this time, Resident B win room isolation due to COVID-19. Code Alert was acceptaced on 5/23/2025 following elopement incident. The order location checks was discontin on 3/31/25 when the code ale was removed. The activation checks order was not remove that time. The current orders were written to indicate accurate information.	ng on ent B of riors. vas gain the for ued rt d at		
	During an interview Director of Assisted indicated Resident removed on 3/31/25 and no observation behaviors. The Director indicated the code a discontinued. The I indicated she was undiscontinued nor where the code and a code alert bracked activation in had a code alert bracked was provided by the	y, on 5/30/25 at 12:53 PM, the I Living and Unit Manager B's code alert bracelet was 6 due to complaints of irritation of wandering or elopement actor of Assisted Living alert order should have been Director of Assisted Living ansure why the order was not any staff documented they when Resident B no longer		How identify other residents he the potential to be affected by same deficient practice and we corrective action will be taken. Immediate education was provided to the Nurses/QMAs regarding the document of code alert bracelet location activation (5/30/25). The AL Director also sent the about coalerts and documentation via on 6/2/25. The other resident, has a code alert bracelet, ordewere checked to ensure accurdocumentation.	the hat ? ation and ode email who ers		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155747		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/30/2025		
	NAME OF PROVIDER OR SUPPLIER ADAMS WOODCREST		1300 1	ADDRESS, CITY, STATE, ZIP COD MERCER AVE TUR, IN 46733	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	and function and d medical record. The documentation req no longer applied.	t bracelets daily for placement ocumented in the resident's he policy did not indicate uired when the code alert was		What measures will be put in place or what systemic chang make to ensure that the defic practice does not recur?	ges
	This citation relate	es to Complaint IN00460127.		Alert policy (Form 6) was updand reviewed with all staff. Education was provided to Noregarding the documentation Code Alert (Form 3 and Form All three policies were review with all nursing staff (Form 7) Code Alert orders were updat Once daily activation checks moved from night shift to day for better accuracy. In-person activation checks were compl with Nurses/QMAs to ensure competency (Form 8).	urses of 1 4). ed . ted. were shift
				p paraid="1460155136" paraeid="{24a64ec5-80d6-46 32-e2c222c4ce39}{106}" >	82-80
				How be monitored to ensure deficient practice will not recui.e., what quality assurance program will be put into place	ır,
				The Performance Improved Plan (PIP) has been initiated this deficient practice. The Question committee will provide oversignate this new process and provide ongoing monitoring to ensure	for API ght of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155747		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/30/2025	
	ROVIDER OR SUPPLII	ER	1300	ET ADDRESS, CITY, STATE, ZIP COD MERCER AVE ATUR, IN 46733	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				deficient practice does not reading time a new Code Alert is initiated or discontinued, the Assisted Living Unit Nurse Manager will ensure that both location and activation code a orders are initiated or discontinued. The AL Unit Number Manager will report the finding monthly during the QAPI meet The QAPI program will review monitoring monthly for at least year, or longer necessary. The compliance expected goal is 100% from the first month an (Form 5).	cur. nalert urse gs eting. v this et 1
				By what date be completed? 6/13/2025	
				p="" paraid="1460155136" paraeid="{24a64ec5-80d6-46 32-e2c222c4ce39}{106}">	82-80

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