STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155747	A. BUILDING 00 B. WING	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAMS WOODCREST	1300 MERCER AVE DECATUR, IN 46733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 the Investigation of Nursing Home Complaint IN00458302. This visit included the Investigation of Residential Complaint IN00460127. Complaint IN00458302. - No deficiencies related to the allegations are cited. Complaint IN00460127 - Deficiencies related to the allegations are cited at R215 and R240. Survey date: May 30, 2025 Facility number: 000556 Provider number: 155747 AIM number: 100290130 Census Bed Type: SNF/NF: 108 Residential: 55 Total: 163 Census Payor Type: Medicare: 13 Medicaid: 58 Other: 92 Total: 163 Adams Woodcrest was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Nursing Home Complaint IN00458302. Quality review completed June 2, 2025	F 0000		
R 0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dzejna McKenzie	Director of Assisted Living	06/12/2025

Any defiencystatement 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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Bldg. 00	This visit was for the Investigation of Residential Complaint IN00460127. This visit included the Investigation of Nursing Home Complaint IN00458302. Complaint IN00458302- No deficiencies related to the allegations are cited. Complaint IN00460127- Deficiencies related to the allegations are cited at R215 and R240. Survey date: May 30, 2025 Facility number: 000556 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 2, 2025	R 0000	Preparation and execution of this Plan of Correction does not constitute admission or agreement by provider to the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and 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 or collectively jeopardize the health and/or the safety of the residents nor are they of such character as to limit the provider's capacity to render 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 this Plan of Correction in its entirety constitutes this provider's allegation of compliance. Further, we request desk review (paper compliance) for compliance, if acceptable. Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent	

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			contemplated accomplished corrective action. These do not necessarily chronologically correspond to the date that Adams Woodcrest Assisted Living is under the opinion that it the requirements of participation or that corrective action was necessary.	
R 0215 Bldg. 00	410 IAC 16.2-5-2(b) Evaluation - Deficiency Based on interview and record review the facility failed to ensure assessments were updated for 1 of 6 residents reviewed (Resident B). Findings 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 irritation and no behaviors of wandering/exit seeking but after an elopement incident on 5/22/25 the facility re-applied Resident B's code alert bracelet. Resident B's record was reviewed on 5/30/25 at 12:29 PM. Diagnosis included Alzheimer's disease with late onset. An active order dated 11/11/24 indicated staff checked Resident B's code alert activation every night to right wrist at bedtime for safety. Nursing notes, dated 3/31/25 - 5/22/25, were reviewed. A note dated 4/6/25, indicated Resident B's code alert bracelet was not on. There was no other notes to indicate Resident B's code alert bracelet was removed.	R 0215	p paraid="989848798" paraeid="{3bbd9675-6b0e-4f90-a10 f-e5ffd7a80f8c}{21}" >R215 410 IAC 16.2-5-2(b) Evaluation – Deficiency Based on interview and record the facility failed to ensure assessments were updated for 1 of 6 residents reviewed (Resident B). What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Immediate education was provided to the nurse regarding Resident B's elopement assessment. Resident B had Code Alert removed on 3/31/2025 due to complaints of wrist irritation and no wandering/exit-seeking behaviors. During this time,	06/13/2025

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	An elopement assessment dated 11/11/24, indicated Resident B was at risk for elopement and Resident B had a code alert on her right wrist for safety. An elopement assessment dated 5/23/25, indicated Resident B was at risk for elopement and Resident B had a code alert on her right wrist for safety. There was no other elopement assessments updated between 11/11/24 - 5/23/25. During an interview on 5/30/25 at 12:53 PM, the Director of Assisted Living and Unit Manager indicated Resident B's code alert bracelet was removed on 3/31/25 due to complaints of irritation and no observation of wandering or elopement behaviors. The Director of Assisted Living indicated the code alert order should have been discontinued. Any changes required an updated elopement assessment and an updated elopement assessment was not completed. The Director of Assisted Living indicated she was unsure why the order was not discontinued nor why an updated assessment was not completed. A policy, titled Elopement Risk Policy, last revised 3/2011, was provided by the Executive Director on 5/30/25 at 1:40 PM. The policy indicated an elopement risk assessment was completed on all resident quarterly and if a change in condition occurs. This citation relates to complaint IN00460127.		Resident B was in room isolation due to COVID-19. Code Alert was again placed on 5/23/2025 following the elopement incident. The elopement assessment was completed at the time Code Alert was initiated. How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Elopement assessments were completed on all residents residing in Assisted Living. One other resident was identified at risk for elopement, and she already has Code Alert placed and elopement assessment completed per policy. Another resident was identified as having the Code Alert removed recently. Her records were and both orders were discontinued, and elopement assessment was updated. Elopement assessments will be any time a new Code Alert is initiated or removed. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?	

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			Risk Policy (Form 1) and Missing Resident Policy (Form 2) were updated and reviewed with all nursing staff. Education was provided to Nurses on frequency of elopement assessment completion (Form 3 and Form 4). Per updated policy, elopement assessment to be completed on all residents in Assisted Living upon admission, with service plan, and/or if any changes in condition occur. Elopement assessments will be any time a new Code Alert is initiated or removed. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Performance Improvement Plan (PIP) has been initiated for this deficient practice. The QAPI committee will provide oversight of this new process and provide ongoing monitoring to ensure this deficient practice does not recur. Any time a new Code Alert is initiated or discontinued, the Assisted Living Unit Nurse Manager will follow up to ensure the elopement assessment has been completed. The AL Unit Nurse Manager will report the findings monthly during the QAPI	

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			meeting. The QAPI program will review this monitoring monthly for 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? 6/13/2025	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency Based on interview and record review the facility failed to ensure physician order documentation was accurate for 1 of 6 residents reviewed (Resident B). Findings 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 irritation and no behaviors of wandering/exit seeking but after an elopement incident on 5/22/25 the facility re-applied Resident B's code alert bracelet. Resident B's record was reviewed on 5/30/25 at 12:29 PM. Diagnosis included Alzheimer's disease with late onset. An active order, dated 11/11/24, indicated staff checked Resident B's code alert activation every night to right wrist at bedtime for safety.	R 0240	p="" paraid="726122213" paraeid="{3bbd9675-6b0e-4f90-a10f-e5ffd7a80f8c}{205}"> p paraid="726122213" paraeid="{3bbd9675-6b0e-4f90-a10f-e5ffd7a80f8c}{205}" >R 240 410 IAC 16.2-5-4(d) Health Services – Deficiency Based on interview and record the facility failed to ensure physician order documentation was accurate for 1 of 6 residents reviewed (Resident B). What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	06/13/2025

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	Resident B's Medical Administration Record (MAR), dated 3/31/25 - 5/22/25, indicated staff checked Resident B's code alert activation daily from 3/31/25 - 5/22/25. Nursing notes, dated 3/31/25 - 5/22/25, were reviewed. A note dated 4/6/25, indicated Resident B's code alert bracelet was not on. There was no other notes indicating Resident B's code alert bracelet was removed. An elopement assessment, dated 11/11/24, indicated Resident B was at risk for elopement and resident had a code alert on her right wrist for safety. An elopement assessment, dated 5/23/25, indicated Resident B was at risk for elopement and resident had a code alert on her right wrist for safety. There was no other elopement assessments updated between 11/11/24 - 5/23/25. During an interview, on 5/30/25 at 12:53 PM, the Director of Assisted Living and Unit Manager indicated Resident B's code alert bracelet was removed on 3/31/25 due to complaints of irritation and no observation of wandering or elopement behaviors. The Director of Assisted Living indicated the code alert order should have been discontinued. The Director of Assisted Living indicated she was unsure why the order was not discontinued nor why staff documented they checked activation when Resident B no longer had a code alert bracelet on. A policy, titled Code Alert System, dated 5/2025, was provided by the Executive Director on 5/30/25 at 1:40 PM. The policy indicated staff checked all		·Immediate was sent via email to all Woodcrest Assisted Living staff for accurate documentation and activation checks. Resident B had Code Alert removed on 3/31/2025 due to complaints of wrist irritation and no wandering/exit-seeking behaviors. During this time, Resident B was in room isolation due to COVID-19. Code Alert was again placed on 5/23/2025 following the elopement incident. The order for location checks was discontinued on 3/31/25 when the code alert was removed. The activation checks order was not removed at that time. The current orders were rewritten to indicate accurate information. How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·Immediate education was provided to the Nurses/QMAs regarding the documentation of code alert bracelet location and activation (5/30/25). The AL Director also sent the about code alerts and documentation via email on 6/2/25. The other resident, who has a code alert bracelet, orders were checked to ensure accurate documentation.	

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	operable code alert bracelets daily for placement and function and documented in the resident's medical record. The policy did not indicate documentation required when the code alert was no longer applied. This citation relates to Complaint IN00460127.		What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? Alert policy (Form 6) was updated and reviewed with all staff. Education was provided to Nurses regarding the documentation of Code Alert (Form 3 and Form 4). All three policies were reviewed with all nursing staff (Form 7). Code Alert orders were updated. Once daily activation checks were moved from night shift to day shift for better accuracy. In-person activation checks were completed with Nurses/QMAs to ensure competency (Form 8). p paraid="1460155136" paraeid="{24a64ec5-80d6-4682-8032-e2c222c4ce39}{106}" > How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Performance Improvement Plan (PIP) has been initiated for this deficient practice. The QAPI committee will provide oversight of this new process and provide ongoing monitoring to ensure this	

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			deficient practice does not recur. Any time a new Code Alert is initiated or discontinued, the Assisted Living Unit Nurse Manager will ensure that both location and activation code alert orders are initiated or discontinued. The AL Unit Nurse Manager will report the findings monthly during the QAPI meeting. The QAPI program will review this monitoring monthly for 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? 6/13/2025 p="" paraid="1460155136" paraeid="{24a64ec5-80d6-4682-8032-e2c222c4ce39}{106}">	