STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155747	A. BUILDING -- B. WING	02/13/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/13/23 Facility Number: 000556 Provider Number: 155747 AIM Number: 100290130 At this Emergency Preparedness survey, Adams Woodcrest was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 143 and had a census of 97 at the time of this survey. Quality Review completed on 02/15/23	E 0000		
K 0000 Bldg. 03	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/13/23 Facility Number: 000556 Provider Number: 155747 AIM Number: 100290130 At this LSC survey, Adams Woodcrest was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alma Ahmetovic	Executive Director	03/01/2023

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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	Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), In 2022, the building was completely remodeled with additions causing the building to be surveyed with Chapter 18, New Health Care Occupancies and 410 IAC 16.2. 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 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 97 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services which were sprinklered. Quality Review completed on 02/15/23			
K 0222 SS=E Bldg. 03	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and Interview, the facility failed to ensure 2 of 9 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 35 residents in the C wing and activates area. Findings include: Based on observation with the Maintenance Director, Maintenance Tech, and Maintenance Manager, and Administrator on 02/13/23 at 11:00 a.m. and 11:15 a.m., the C wing and activates area exit doors were equipped with a 15 second delayed egress. When the exit doors were tested	K 0222	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Prior to the survey, there were problems with a couple of doors working when the facility IT dept. reattached wanderguard to the doors. The issue was fixed and wanderguard was functioning. However, during the survey, the configuration for two magnets locked the doors configured incorrectly so they didn't detect when the Maintenance Manager tried to open the door. The IT was contacted immediately and indicated that the door needed to be reset. The doors in the Cwing were reset and noted to be functioning properly right away (see Form 1). **2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be**	03/10/2023

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	the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Maintenance Director tried 3 times to activate the delay egress and stated the delayed egress are not working and will need to be repaired. This finding was reviewed with the Maintenance Director, Maintenance Tech, and Maintenance Manager, and Administrator during the exit conference. 3.1-19(b)		**taken;** -This deficiency could potentially affect 35 residents. All other doors on the 15 seconds egrass were checked and all are functioning properly. **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** -Anytime the IT department checks the exit doors, they will have to notify the Director of Facilities, so that the Facility staff can ensure all doors are functioning properly. All of the 15 seconds egrass doors will be checked monthly during the preventative maintenance checks. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** -The Director of Facilities will report on these checks monthly during the QAPI meetings. The QAPI committee will provide oversight of this new process and provide ongoing monitoring to ensure this deficient practice does not recur. The QAPI program will review this monitoring monthly for at least 1 year, or longer if deemed necessary. The	

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			compliance expected goal is 100% from the first month and on.	
K 0321 SS=E Bldg. 03	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 PPE storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous	K 0321	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	03/10/2023

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	area. This deficient practice could affect 20 residents in one Smoke compartment. Findings include: Based on observation with the Maintenance Director, Maintenance Tech, and Maintenance Manager, and Administrator on 02/13/23 at 11:10 a.m., the PPE storage room contained over 20 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room contained a set of double with one leaf latching into the other door leaf that did not automatically latch into the frame. The room was not protected as a hazardous area because a corridor door leaf was equipped with a manual slide latch. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and a corridor door leaf to the room was not automatic closing. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**practice;** The automatic latch was installed on the storage door on 2/24/2023 (see Form 2 and see Form 3). **2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** This deficiency could potentially affect 20 residents. All other storage doors were checked to ensure they have a self-closing device in place per requirement. **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The automatic latch will be installed on the corridor door. All other doors were checked to ensure they have a proper closure/latching system in place. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Director of Facilities will ensure that any new doors installed in boiler and fuel-fired heater rooms; laundries; repair, maintenance, and paint shops;	

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			soiled linens rooms; trash collection rooms/spaces; combustible storage rooms/spaces; and laboratories will be self-closing or automatic-closing. The QAPI committee will ensure that any new storage rooms have doors automatically latching.	
K 0354 SS=F Bldg. 03	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to conduct required testing for 1 of 1 dry sprinkler systems. NFPA 25 section 13.4.4.2.2.2 states every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service. 13.4.4.2.9 states dry pipe systems shall be tested once every 3 years for air leakage, using one of the following test methods: (1) A pressure test at 40 psi (3.2 bar) shall be performed for 2 hours.	K 0354	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The company was contacted immediately and the 3 year test of the dry sprinkler system for the trip test and air leakage was requested. The company was here on 2/22/2023 and the test was completed (see Form 4).	03/10/2023

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	(a) The system shall be permitted to lose up to 3 psi (0.2 bar) during the duration of the test. (b) Air leaks shall be addressed if the system loses more than 3 psi (0.2 bar) during this test. (2) With the system at normal system pressure, the air source (compressor or shop air) shall be shut off for 4 hours. If the low air pressure alarm goes off within this period, the air leaks shall be addressed. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review with the Maintenance Director, Maintenance Tech, and Maintenance Manager on 02/13/23 at 10:38 p.m., the dry system trip test and air leakage test was past due. The last documentation of completed tests were conducted on 12/04/19. Based on an interview at the time of record review, the Maintenance Director agreed the dry system trip test and air leakage test were past due. This finding was reviewed with the Maintenance Director, Maintenance Tech, and Maintenance Manager, and Administrator during the exit conference. 3.1-19(b)		**2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** This deficiency could potentially affect all residents, staff, and visitors in the facility. **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The calendar was made with all of the LSC items and their required checks – weekly, monthly, annually, and then every 2,3,4, and 5 years requirements. This will help the Director of Facilities keep track of what tests need to be done and when (see Form 5). **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Director of Facilities will report on these checks monthly during the QAPI meetings. The QAPI committee will provide oversight of this new process and provide ongoing monitoring to ensure this deficient practice does not recur.	

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K 0363 SS=D Bldg. 03	NFPA 101 Corridor - Doors Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 30 resident room corridor doors on A wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 930. Findings include: Based on observation with the Maintenance	K 0363	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The door to the resident room 930 was repaired immediately and latches properly (see Form 6). **2.How other residents having the potential to be affected by**	03/10/2023

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	Director, Maintenance Tech, and Maintenance Manager, and Administrator on 02/13/23 at 12:00 p.m., the corridor door to resident room 930 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame This finding was reviewed with the Maintenance Director, Maintenance Tech, and Maintenance Manager, and Administrator during the exit conference. 3.1-19(b)		**the same deficient practice will be identified and what corrective action(s) will be taken;** This deficient practice could affect 2 residents in room 930. All other rooms in the Health Center were checked and all latch properly. **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All resident rooms doors will be checked monthly to ensure all close and latch. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Director of Facilities will ensure that the resident room doors latch properly. The QAPI committee will provide oversight of this process and provide ongoing monitoring to ensure this deficient practice does not recur. The Director of Facilities will report to the QAPI committee monthly if any issues with door closures or latching. This check is on the monthly preventative maintenance check.	

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K 0918 SS=C Bldg. 03	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on records review and interview, the facility failed to ensure 1 of 1 emergency task generator	K 0918	**1.What corrective action(s) will be accomplished for those**	03/10/2023

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	battery backup lights were maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director, Maintenance Tech, and Maintenance Manager on 02/13/23 at 10:10 a.m., no documentation was available for review to show the emergency battery powered light at the generator was tested annually for a minimum of 90 minutes and monthly for 30 seconds. Based on an interview at the time of record review, the Maintenance Director stated there is a battery powered light within the generator housing and the annul test for the light was not conducted. This finding was reviewed with the Maintenance Director, Maintenance Tech, and Maintenance Manager Director, and Administrator during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice;** The emergency generator battery backup light was tested for 90 minutes to ensure working properly (see Form 7). **2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** This deficiency could potentially affect all residents in the facility. The battery operated emergency light at the generator was tested and functioning properly. **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education was provided to the maintenance staff regarding this requirement. The emergency battery backup light was added to the monthly preventative maintenance checks (see Form 8). **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** This emergency light will be checked monthly for 30 seconds	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155747	A. BUILDING 03 B. WING	02/13/2023

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

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			and annually for at least 90 minutes to ensure that it is functioning, and this monitoring will be report to the QAPI committee monthly. QAPI committee will provide oversight of this process and provide ongoing monitoring to ensure this deficient practice does not recur. This emergency light monitoring will be ongoing.	