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	11/27/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Healthcare Complaints IN00447309, IN00447325, and Assisted Living Complaint IN00447049. This visit also included a State Residential Licensure Survey. Complaint IN00447309 - No deficiencies related to the allegations are cited. Complaint IN00447325 - No deficiencies related to the allegations are cited. Survey dates: November 21, 22, 25, 26, and 27 2024. Facility number: 000556 Provider number: 155747 AIM number: 100290130 Census Bed Type: SNF/NF: 107 Total: 107 Census Payor Type: Medicare: 7 Medicaid: 60 Other: 40 Total: 107 These deficienies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 3, 2024	F 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 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 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 contemplated accomplished corrective action.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alma Ahmetovic	Executive Director	12/18/2024

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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			These do not necessarily chronologically correspond to the date that Adams Woodcrest is under the opinion that it the requirements of participation or that corrective action was necessary.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review the facility failed to enusre non pharmacologic interventions were utilized prior to giving anti-anxiety medication to 1 of 6 residents reviewed. (Resident 4) Findings include: In an interview, on 11/21/24 at 10:02AM, the Registered Nurse (RN 3) indicated Resident 4 frequently had behaviors related to anxiety. RN 3 indicated Resident 4 was difficult to redirect but if caught early or at the right time you could attempt playing music or walk with her. RN 3 indicated giving her the prn (as needed) Ativan (anti anxiety medication) was the easiest and best way to deal with the behaviors. Resident 4's record review began on 11/22/24 at 12:22PM. Resident 4's diagnoses included Alzheimer's disease, chronic pain, and anxiety. Resident 4's physician orders included Buspar 20mg three times a day. Ativan tablet 0.5mg give 1 tablet by mouth every 4 hours as needed for distress start date 10/29/24 end date 11/12/24. Ativan 1mg tablet give 1 tablet by mouth every 4 hours as needed for anxiety for 14 days start date 11/13/24 and end date 11/21/24. Ativan tablet 1mg,	F 0758	**F758 SS=D Free from Unnec Psychotropic Meds/PRN Use. Psychotropic Drugs. Based on interview and record review the facility failed to ensure non pharmacologic interventions were utilized prior to giving anti-anxiety medication to 1 of 6 residents reviewed. (Resident 4):** **1.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 staff who take care of Resident 4 to ensure they attempt and document non-pharmacological behavior interventions and try to deescalate behaviors before they administer PRN antianxiety medication. Behavior monitoring sheets were reviewed and recent behaviors were added. The care plan was reviewed and updated with recent behavior of “attempting to get peers to elope” which was added	12/27/2024

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	give 1 tablet by mouth every 4 hours as needed for anxiety for 3 Months dated 11/21/24. Resident 4's current comprehensive Minimum Data Set (MDS), dated 9/4/24, Section D, for mood indicated no issues. Section E for Behaviors indicated no issues. Resident 4's Medication Administration Record (MAR), dated November 2024 was reviewed. On 11/1/24, Ativan 0.5 mg was administered at 3:02 PM. On 11/7/24, Ativan 0.5mg was administered at 12:34PM On 11/8/24, Ativan 0.5mg was administered at 8:57PM. On 11/9/24, Ativan 0.5mg was administered at 9:00AM. On 11/9/24, Ativan 0.5mg was administered at 4:40PM. On 11/12/24, Ativan 0.5mg was administered at 2:05PM. On 11/13/24, Ativan 0.5mg was administered at 2:00PM. On 11/15/24, Ativan 0.5mg was administered at 7:04PM. On 11/21/24, Ativan 0.5mg was administered at 7:20PM A progress note, dated 11/1/24 at 3:16 PM, indicated the resident refused medications all day. She had a garbage bag packed of random things, and said she was going home. She had been paranoid, hallucinating, and interfereing with other residents. RN3 was finally able to convince the resident to take prn Ativan at around 3PM. The note indicated the staff would continue to monitor behaviors.		to the care plan. All other behaviors were already noted in the care plan. The care plan also indicated that the resident daughter requested that PRN antianxiety medication be administered for behavior management anytime Resident 4 is anxious as the medication helps manage resident behaviors. Resident 4 was seen by the psych NP on 11/20/24 and the NP indicated that “Staff report Ativan very effective when utilized, much improved moods and less distressing anxiety, intermittent continued episodes.” Resident 4 will be seen by the psych NP on her next round (December) and the NP will reassess use of PRN antianxiety medication. **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;** Immediate education was provided to all Nurses/QMAs via email on 11/25/2024. The medication records were reviewed and it was noted that 4 other residents have orders for PRN psychotropic medication. Four residents progress notes were reviewed and all PRN psychotropic medications had prior nonpharmacological interventions documented in attempts to deescalate behaviors. **3.What measures will be put**	

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	No deescalating techniques were documented in the note. A progress note, dated 11/7/24 at 6:14PM, indicated Resident 4 was" VERY" anxious throughout the shift. Very argumentative with staff and refused to come back from hair salon". Resident 4 refused to take her medications after several attempts, until RN 3 indicated they were from her daughter. PRN Ativan was given at this time. Resident 4 was tearing apart an entire box of tissues and pulling apart the layers and trying to sew them back together. Resident 4 refused to use her walker. Resident 4 attempted to enter the restroom with other residents. PRN Ativan was given. The note did not indicate any deescalating techniques were attempted. A progress note, dated 11/8/24 at 10:39PM, indicated Resident 4 was anxious, was getting dressed for the day after bedtime shower. The resident stated she had to go pick up her kids several times asking where her car was and when the family was coming. PRN Ativan given and effective. No deescalating techniques were documented as attempted. There were no progress notes, dated 11/9/24, regarding Resident 4's behaviors, anxiety, or any interventions attempted prior to antianxiety medication administration . A progress note, on 11/12/24 at 3:55PM, indicated Resident 4 very anxious. PRN Ativan given. Resident 4 asked the same questions repeatedly, the residents packed the entire closet onto her		**into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Social Service Director will run a monthly list of all residents who receive PRN Psychotropic medications (currently 5 residents). The Social Service Director will then run a medication administration record for each PRN psychotropic medication and will review the documentation for each administration to ensure nonpharmacological interventions were attempted before PRN psychotropic medication was administered. The new Nonpharmacological Interventions Evaluation has been created. This evaluation will be used by Nurses/QMAs to document the nonpharmacological interventions used prior to PRN psychotropic medication administration and whether these interventions were effective or not (See Form 1). The Social Service Director will discuss their findings in the QAPI meeting monthly using the PRN Psychotropic medication documentation tracking sheet (See Form 2). The Social Service Director will also review PRN psychotropic medication documentation tracking sheet during the monthly Behavior meeting with the consultant pharmacist, the psych NP, and the IDT team present. All	

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	walker and took them to nursing station to inform them she was moving out. Resident 4 was attempting to rouse other residents into leaving with her. PRN Ativan was given but was ineffective. The staff would continue to monitor. No deescalating techniques were documented. A progress note, dated 11/13/24 at 5:52PM, indicated Resident 4 was very anxious after lunch and packing clothes again. Received new orders from the physician to increase Ativan from 0.5mg to 1mg every 4 hours as needed (PRN). It was given. Resident 4 calmed down and was able to enjoy visiting with daughter and friend. There was no documentation deescalating techniques had been attempted. No progress notes were available, dated 11/15/24, to address the use of PRN Ativan. A progress note, dated 11/21/24 at 6:07 PM, indicated Resident 4 refused medications, refused to get dressed and stayed in a house coat throughout the day. Resident 4 was hitting the utility room door. Resident 4 was very difficult to redirect and became very argumentative with staff. Resident 4 was packing belongings. Resident 4's daughter was at supper and indicated she could not convince her mother to get dressed either. There was no documentation of PRN Ativan administration or the medications effectiveness. Behavior monitoring, dated November 2024, indicated the facility was monitoring frequent crying, repeated movements, yelling, kicking/hitting, pushing, grabbing, pinching, biting, wandering, abusive language, threatening behavior, sexually inappropriate, rejection of care,		residents receiving PRN Psychotropic medications will be reviewed monthly during the behavior meeting. The policy "Behavior Health Services Policy" (See Form 3 entry number 12) and "Psychotropic Medication Policy" (See Form 4 entry numbers 11 and 12 and 13) were reviewed and updated to include this new process. Education will be provided during daily huddles and via PowerPoint presentation to Nurses/QMA with the Post test. Education will be added to the new hires (Nurses and QMAs) job specific orientation. **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 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. The Social Service Director will monitor the use of psychotropic medications and nonpharmacological interventions documentation and will report the findings monthly during the QAPI meeting. The QAPI program will review this monitoring monthly for at least 1 year, or longer if deemed necessary. The	

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	none of the above, and not applicable. The only behavior symptom marked was on 11/1/24 at 11:23 PM for refusal of care. There was no other documentation regarding Resident 4's behaviors. Resident 4 was care planned for resistive to care related to dementia, behavioral problems increased anxiety and repetitive questioning, the resident has anxiety, and resident used psychotropic medications. The increased anxiety, refusing medications, attempting to get peers to elope, and repetitive questioning were not on CNA behavior monitoring tasks. Resident 4's Behavior Summary, dated November 2024, indicated Resident 4 had an increase in anxiety 11/20, 11/17, 11/16, and 11/13. The interventions were listed as one-on-one and calls to family. Behavior committee recommendations were; Resident 4 had an increase in anxiety, Ativan 1mg was effective, continue to observe. In an interview, on 11/26/24 at 9:32 AM, the Administrator indicated all staff should be using deescalating techniques and documented behaviors. The Administrator indicated they recently switched their computerized charting, yet the staff were required to document deescalating techniques used and their effectiveness. A policy titled, "Behavioral Health Services Adams Heritage/Adams Woodcrest" dated 2/2017, provided by the Administrator on 11/26/24 at 9:24AM indicated ...11.Facility will implement person-centered care approached designed to meet the goals and needs of each resident, which includes non-pharmacological interventions. Examples of individualized non pharmacological interventions to help meet behavioral health needs of all ages may include but are not limited		compliance expected goal is 100% from the first month and on. **5.By what date the systemic changes for each deficiency will be completed.** 12/27/2024	

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	to ...focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities, offering verbal reassurance, n. utilizing techniques such as music, art, massage, reminiscing, Providing support with skills related to verbal reescalation, coping skills, and stress management. A policy titled, "Psychotropic Medication Policy and Procedure" dated 2/1/1994 provided by the Administrator on 11/26/24 at 9:24AM, focused on the duration of the order and each member of the team responsibility to ensure monitoring was in place. There were no noted specified nonpharmacological interventions noted throughout the policy. 3.1-48(b)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review the facility failed to ensure sanitation of an ice machine; labeling, dating and removal of expired food items in the kitchen and unit pantries. 110 of 110 residents received food prepared in the facility kitchen. Findings include: During a kitchen observation beginning 11/21/24 at 9:11 AM, a bottle of lemon juice was observed in a reach in cooler with an open date of 9/14/24. No printed manufacturers expiration date was found on the bottle. Ziploc baggies filled with light brown material were observed in a container directly beneath the evaporator and fan unit in the walk-in freezer. The bags were frozen together and	F 0812	**F 812 SS=E Food Procurement, Store/Prepare/Serve-Sanitary. Food safety requirements. Based on observation, interview, and record review the facility failed to ensure sanitation of an ice machine; labeling, dating and removal of expired food items in the kitchen and unit pantries. 110 of 110 residents received food prepared in the facility kitchen. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All expired/undated items were	12/27/2024

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	covered in an irregular pyramid shaped clump of ice about 4 inches above the container and spread across the width of the container, covering about 2/3 of the contents of the container. An additional container of Ziploc bagged bananas contained bananas dated 3/19/24 and 1/5/24 with visible white frosty debris on top of the bananas. A bag of tater tots tied closed with a twist-tie was observed on a shelf. No open date was recorded on the bag of tater tots. During an interview, on 11/21/24 at 9:14 AM, the Nutrition Services Manager (NSM) indicated lemon juice was fine for a long time and did not need discarded. The NSM did not provide a date on which the juice should be discarded. During an interview, on 11/21/24 at 9:15 AM, the Dietary Manager (DM) indicated the lemon juice should be discarded within 7 days. The DM indicated the bags covered in ice contained bananas and should be discarded. She indicated frozen bananas were good for one year. The DM indicated the tater tots should have been dated upon opening. During an observation, on 11/21/24 at 10:13 AM, two cups of yogurt were observed in the refrigerator in the A-wing pantry. The expiration date on each container was 10/21/24. Two containers of lime sherbet were observed in the freezer with no expiration date. During an interview, on 11/21/24 at 10:14 AM, Qualified Medicine Aide (QMA) 5 indicated the yogurt cups should have been discarded upon expiration and should not have been in the refrigerator. QMA 5 indicated she was not able to determine when the lime sherbet should be discarded because the container did not have an		removed upon identification (lime juice, frozen bananas, tater tots) and discarded from the main kitchen. All expired items were removed upon identification and discarded from the Awing resident pantry (yogurt), Bwing resident pantry (round and rectangular containers of ice cream) and Cwing resident pantry (chocolate ice cream). Main kitchen is managed by the nutritional service staff while resident pantry refrigerators on the wings are managed by the nursing staff. It was noted that sherbet containers do not have manufacturing date on the cups. The Gordon Foods representative was notified and suggested adding the received by date and the expiration date on the box (6 months). The maintenance staff were made aware of the dirty interior lid on the ice machine. The ice machine was taken out of service and the entire machine including the upper interior lid were cleaned the same day 11/21/24. **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;** Immediate education was provided to all of the nutritional service and nursing staff on 11/21/24. All of the food items in the main kitchen	

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	expiration date. During an observation, on 11/21/24 at 10:38 AM, a round container of ice cream with a loosely applied lid was observed in the freezer in the dementia unit. No open date or manufacturer's expiration date was observed on the container. A rectangular container of black raspberry ice cream was observed in the same compartment of the freezer with no open date on the container. The expiration date on the container contained an ink smear, obscuring the date. Certified Nurse Aide (CNA) 7 opened each lid, revealing a ½ inch coating of frost covering the top of each product. During an interview, on 11/21/24 at 10:39 AM, CNA 7 indicated the ice cream containers should have been dated when opened and should be discarded. During an observation, on 11/21/24 at 11:20 AM, black debris was observed in the upper interior portion of the ice machine in the A- wing pantry. In the refrigerator, a foil wrapped container was observed with no date visible. Containers of lime sherbet with no expiration date, and a container of chocolate ice cream with an expiration date on 8/24 were observed in the freezer. During an interview, on 11/21/24 at 11:21 AM, Licensed Practical Nurse 6 indicated the black debris should not be present in the ice machine and the machine should be taken out of service and cleaned prior to any further use. She indicated items in the refrigerator and freezer should be dated when opened and discarded upon the expiration date. She indicated any undated items should be discarded. A current policy, titled Resident Pantry, dated		cooler and in the resident pantries were checked to ensure appropriate labeling, dating, and expired foods were removed. The maintenance staff was educated to ensure the interior lid is cleaned anytime the ice machine is cleaned. **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 Nutritional Service Manager will provide in person education about labeling, dating, and removal of expired foods to all of the nutritional service staff on (12/23/2024). Going forward, this education will be provided to all of the nutritional service staff annually during the skills-checkoff and upon new hires (See Form 5). The Nutritional Services Manager will use the Main Kitchen and Wing Kitchens Checklist (See Form 6) to ensure compliance with the foods stored in the main kitchen and wing kitchens coolers. The Executive Director and Director of Nursing provided education to the nursing staff regarding the resident pantry refrigerators. The Resident Pantry Refrigerator Checklist (See Form 7) will be used by the Unit Managers to ensure compliance with the foods stored in the resident pantry fridges. The consultant dietitian will spot check	

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	7/2023, provided by the Administrator on 11/21/24 at 5:12 PM indicated the nursing staff was responsible for cleaning and maintaining the residents' pantries. The policy indicated all food and drink items should be marked with the date opened at the time of opening and discarded 7 days after opening. The policy indicated the nursing department was responsible for checking for and discarding expired items daily. A current policy, titled Labeling, Dating, and Discarding Foods, provided by the Administrator on 11/21/24 at 5:12 PM indicated all foods, once opened or manufactured, should be labeled, dated, and discarded to food code regulations. The policy indicated frozen items should be discarded within 180 days. A current policy, titled Ice Machines and Portable Ice Carts, provided by the Administrator on 11/21/24 at 5:12 PM indicated ice machines should be cleaned quarterly and as needed when contaminated or visibly soiled. 3.1-21(i)(3)		the main kitchen and resident pantries monthly to ensure all food items are labeled, dated, and removed when expired. The consultant dietitian will report her findings to the IDT team via dietary report. The ice machine preventative maintenance (PM) form was updated and the interior lid cleaning added to ensure the lid is cleaned each time ice machine is cleaned. (See Form 8). The policies “Resident Pantry” (See Form 9), “Labeling, dating, and discarding foods policy” (See Form 10), and “Ice machine and Portable Ice Carts Policy” (see Form 11) were reviewed and updated with the new process. **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 Performance Improvement Plan (PIP) has been initiated for this deficient practice. The QAPI committee will provide oversight of labeling, dating, and removal of expired food items and provide ongoing monitoring to ensure this deficient practice does not recur. The Nutritional Services Manager will complete checks of the main kitchen and wing kitchens weekly x 4 weeks, Biweekly x 8 weeks and monthly thereafter to ensure all food items are labeled, dated,	

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			and expired items removed. The Nutritional Services Manager will report the findings monthly during the QAPI meeting. The Unit Managers on each wing will complete Resident Pantry Refrigerator Checklists monthly and report the findings during the QAPI meeting. The Consultant Dietitian will complete spot checks periodically. The QAPI program will review this monitoring monthly for at least 1 year, or longer if deemed necessary. The compliance expected goal is 90% in the first 3 months, 95% the following 3 months, and 100% after that and on. **5.By what date the systemic changes for each deficiency will be completed.** 12/27/24	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Healthcare Complaints IN00447309, IN00447325, and Residential Complaint IN00447049. Complaint IN00447049 - No deficiencies related to the allegations are cited. Survey dates: November 21, 23, 25, 26, and 27, 2024. Facility number: 000556	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 maintains that the alleged deficiencies do not individually or collectively	

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	11/27/2024

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
	Residential Census: 53 Adams Woodcrest was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00447049. Quality review completed December 3, 2024.		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 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 contemplated accomplished corrective action. These do not necessarily chronologically correspond to the date that Adams Woodcrest is under the opinion that it the requirements of participation or that corrective action was necessary.	