STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING COMPLE					
		155747		B. WING 12/13/2024			
NAME OF PROVIDER OR SUPPLIER ADAMS WOODCREST				1300 ME	ADDRESS, CITY, STATE, ZIP COD ERCER AVE UR, IN 46733		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg			E 00	E 0000			
K 0000							
Bldg. 03	Licensure Survey w Department of Heal 483.90(a). Survey Date: 12/13 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this LSC survey, not in compliance w	mber: 000556 mber: 155747					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI		TITLE		(X6) DATE

(X6) DATE

Alma Ahmetovic **Executive Director** 12/30/2024

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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f ´		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155747		A. BUILDING <u>03</u> COMPLETER B. WING 12/13/202			
		100141	D. W			12/13/	12024
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD ERCER AVE		
ADAMS \	WOODCREST				UR, IN 46733		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
mo		Life Safety from Fire and the		mo			DATE
	1 //	National Fire Protection					
	Association (NFPA) 101, Life Safety Code (LSC),					
	1 2022 1 1 11						
		g was fully remodeled and g A, B, and C wings along					
	-	a activities area, therapy gym,					
		and the B-wing 1000-hall					
	addition. Therefore	, the building was surveyed					
	-	ew Health Care Occupancies					
	and 410 IAC 16.2.						
	This one-story facil	lity with a stairway to the					
		s separated with a two-hour					
		ottom of the stairs was					
		ype V (111) construction and					
		ed. The facility has a fire alarm detection in corridors, areas					
	-	rs and hard-wired smoke					
	-	dent rooms. The facility has a					
		had a census of 114 at the					
	time of this survey.						
	All areas where the	residents have customary					
		ered. Areas providing facility					
	services which were	e sprinklered.					
	Quality Review cor	mpleted on 12/17/24					
K 0226	NFPA 101						
SS=E	Horizontal Exits						
Bldg. 03							
		on and interview, the facility	K 0	226	K226 Horizontal Exits SS = E		01/03/2025
		f 1 doors in a two hour fire t in B-wing were self-closing			Based on observation and interview, the facility failed to	0	
		7.2.4.3.10 states all fire door			ensure 1 of 1 doors in a two	•	
	_	ontal exits shall be self-closing			hour fire rated horizontal exi	t	
	· ` `	g in accordance with 7.2.1.8.			in B-wing were self-closing a		
	This deficient pract	ice could affect 40 residents in			latching. LSC 7.2.4.3.10 state	es	
	i B-Wing		1		all fire door assemblies in		ì

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>03</u>			COMPLETED	
155747		B. WING 12/13/2024			/2024			
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	IR.			IERCER AVE			
ADAMS	WOODCREST				TUR, IN 46733			
ADAIVIO	·			DLOAI				
(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	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					horizontal exits shall be			
	Findings include:				self-closing or automatic			
					closing in accordance with			
		ion during a tour of the facility			7.2.1.8. This deficient practic	ce		
		rator, the LSC Coordinator, and			could affect 40 residents in			
		ead on 12/13/24 at 1:02 p.m., the			B-wing.			
		on B-wing between the 900-hall			1.What corrective action(s)	vill		
		used as a horizontal exit with			be accomplished for those			
		oors. When tested, one of the			residents found to have bee	n		
		t latch in the door frame. Based			affected by the deficient			
		time of observation, the			practice;			
		agreed the doors were in a fire			The Maintenance Lead worke			
	barrier wall and di	d not latch when tested.			the doors right away. The doo			
	TTI : C' 1:				were closing better but the fire			
	_	eviewed with the Administrator,	door company was called to come					
		tor, and the Maintenance Lead			in and check the door for bette			
	during the exit con	iterence.			latching. Central Indiana Hard			
	2.1.10(1)				company was notified immedi	-		
	3.1-19(b)				of the issue with the door in B	wing		
					between the 900-hall and			
					1000-hall. The company came			
					on 12/17/2024 and repaired the			
					door by increasing the power			
					adjusting the door closures (S Form 1).	ee		
					2.How other residents havin	a		
					the potential to be affected by	-		
					the same deficient practice v	-		
					be identified and what			
					corrective action(s) will be			
					taken;			
					The other fire doors were che	cked		
					and it was noticed that the fire			
					door by the treatment room or			
					Bwing was also slow latching.			
					Central Indiana Hardware			
					company adjusted the hinges	to		
					stop from rubbing, increased			
					power, and adjusted the door			
					closures (See Form 1). The o			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 03			COMPLETED		
155747		B. WI	/2024				
	PROVIDER OR SUPPLIE	R		1300 N	ADDRESS, CITY, STATE, ZIP COD MERCER AVE FUR, IN 46733		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	fire doors on Bwing between Health Center and Bwing entrance, Awing, Cwing, and Health Center were all checke and all were self-closing and latching 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; The fire doors are currently checked monthly with the fire alarms and annually on PM fo self-closing and latching. Goin forward, all fire doors will be checked for self-closing and latching by maintenance week x4, monthly x6 months and the quarterly thereafter until 12/31 and then will be reevaluated fo frequency of checks (See Forn 2, 3, and 4). The Preventative Maintenance form was update reflect this change. Education provided to all facility staff regarding proper self-closing a latching of the fire doors (see Form 10). 4. How the corrective action(will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place; and The LSC Coordinator will repor fire door checks/latching mont during the QAPI meetings. Th QAPI committee will provide	r ng kly en /25 or ms ed to was and (s) the ut	DATE
1					oversight of this process and		1

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155747		A. BU	ILDING	03	COMPI	LETED			
		B. WI	NG		12/13	/2024			
NAME OF S				STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	PROVIDER OR SUPPLIE	К		1300 M	IERCER AVE				
ADAMS	WOODCREST			DECAT	UR, IN 46733				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE		
					provide ongoing monitoring to				
					ensure this deficient practice of	does			
					not recur.				
					5. By what date the systemic				
					changes for each deficiency				
					will be completed. January 3	,			
					2025				
K 0293	NFPA 101								
SS=E	Exit Signage								
Bldg. 03	- Zxii Oigilago								
J	Based on observati	on and interview the facility	K 0	293	K293 Exit Signage SS = E 01/		01/03/2025		
	failed to ensure 1 of 1 exits by the Director of Nursing (DON) office contained the correct			273	Based on observation and		01/03/2023		
					interview the facility failed to)			
		nce with LSC 7.10.8.3.1 which			ensure 1 of 1 exits by the				
	states any door, pas	ssage, or stairway that is			Director of Nursing (DON) of	fice			
	neither an exit nor	a way of exit access and that is			contained the correct signage				
	located or arranged	so that it is likely to be			in accordance with LSC				
	mistaken for an exi	it shall be identified by a sign			7.10.8.3.1 which states any				
	that reads as follow	vs: NO EXIT. The NO EXIT			door, passage, or stairway th	nat			
	sign shall have the	word NO in letters 2 inches			is neither an exit nor a way o	of			
	high, with a stroke	width of 3/8ths inch, and the			exit access and that is locate	ed			
	word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 40 residents in one smoke				or arranged so that it is likely	y			
					to be mistaken for an exit sh	all			
					be identified by a sign that				
	compartment.				reads as follows: NO EXIT. T	he			
					NO EXIT sign shall have the				
	Findings include:				word NO in letters 2 inches				
	D 1 1	1			high, with a stroke width of	·			
		on during a tour of the facility			3/8ths inch, and the word EX	A F			
		ator, the LSC Coordinator, and			below the word NO, unless				
		ead on 12/13/24 at 12:02 p.m.,			such sign is an approved				
		oors by the DON office were			existing sign. This deficient				
		with an "EXIT" sign, but the closed courtyard with no			practice could affect 40 residents in one smoke				
		non way. Based on an							
		ne of observation, the			compartment. 1.What corrective action(s) v	vill			
		LSC Coordinator, and the			be accomplished for those	VIII			
	1 rammonator, the	Loc coordinator, and the			I NO GOODHIPHIBLIEU IOI HIUSE		i .		

Maintenance Lead agreed the sliding glass door

did not lead to the common way and stated it was

residents found to have been

affected by the deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	03	COMPLETED	
155747		B. WING 12/13/2024			
		<u> </u>	CTREE	T ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	R		MERCER AVE	
VDVMS /	WOODCREST			ATUR, IN 46733	
ADAINS	WOODCREST		DECA		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		and needs the current sign		practice;	
	replaced with a "No	O EXIT" sign.		The big Exit sign above the sl	iding
				door was removed immediate	· I
		eviewed with the Administrator,		(See Form 5). Not an exit sign	
		or, and the Maintenance Lead		was placed immediately on th	
	during the exit conf	ference.		door across from the Director	of
				Nursing office (See Form 6).	
	3.1-19(b)			Proper NO EXIT signage (The	
				EXIT sign will have the word I	
				letters 2 inches high, with a st	
				width of 3/8ths inch, and the v	
				EXIT below the word NO) has	
				ordered and should be comin	~ '
				day now. This sign will replac	e the
				current Not an Exit sign.	
				2.How other residents havin	_
				the potential to be affected by	-
				the same deficient practice	will
				be identified and what	
				corrective action(s) will be	
				taken;	11
				This deficiency could potentia	·
				affect 40 residents in one smo	
				department. All other doors in	
				facility were checked to ensur that they have a proper exit/n	
				signage in place.	O GVII
				3.What measures will be put	
				into place and what systemi	
				changes will be made to	
				ensure that the deficient	
				practice does not recur;	
				Proper signage will be placed	on
				the door across from the Dire	
				of Nursing office. All other do	
				that are not considered exit de	
				will also have "no exit" signag	
				Education was provided to the	
				maintenance staff as well as	
				facility staff about the "no exit	

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CENTERS FOR MEDICARE & MEDICAID SERVICES	š

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155747		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 03 COMPLETED B. WING 12/13/2024			ETED		
	ROVIDER OR SUPPLIER			1300 MI	ADDRESS, 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 BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0920 SS=E Bldg. 03	NFPA 101 Electrical Equipme Extens	ent - Power Cords and			signage requirement (See For 10). 4. How the corrective action(will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place; and The facility will ensure that any new doors or replacement docare reviewed for proper signages. By what date the systemic changes for each deficiency will be completed. January 3 2025.	s) he ut / ors ge.	
	failed to ensure 3 of as a substitute for fi 400.8 state unless si flexible cords and c as a substitute for fi practice could affect smoke compartment. Based on observation with the Administrative Maintenance Lep.m. and 1:00 p.m., or multi-plug adapter a. In resident room powering a radio. b. In resident room powering chargers	on and interview, the facility (3) flexible cords were not used exed wiring. NFPA-70/2011, pecifically permitted in 400.7 ables shall not be used for (1) exed wiring. This deficient is tup to 50 residents in two its. On during a tour of the facility etor, the LSC Coordinator, and ad on 12/13/24 between 12:02 the following extension cords for swere used as fixed wiring: 1942 an extension cord was 1979 a multi-plug adaptor was 1985 station an extension cord	K 0	920	K920 Electrical Equipment - Power Cords and Extension Cords SS = E Based on observation and interview, th facility failed to ensure 3 of 3 flexible cords were not used a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted 400.7 flexible cords and cable shall not be used for (1) as a substitute for fixed wiring. The deficient practice could affect up to 50 residents in two smoothing compartments. 1. What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice; All three flexible (extension) con-	as in es nis et oke	01/03/2025

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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 03	(X3) DATE SURVEY COMPLETED 12/13/2024	
	PROVIDER OR SUPPLIER		1300 N	ADDRESS, CITY, STATE, ZIP COD MERCER AVE FUR, 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 APPROPRI, DEFICIENCY)	
TAG	was powering a lap Based on an intervi- the Administrator, t Maintenance Lead a or multi-plug adapte This finding was re	we at the time of observations, the LSC Coordinator, and the acknowledged extension cords for were in use. wiewed with the Administrator, for, and the Maintenance Lead	TAG	- In resident room 942 an extension cord powering a radin resident room 979 a multipadaptor powering charger, and the B-wing nurses' station and extension cord powering a lap were removed immediately. 2. How other residents having the potential to be affected by the same deficient practice by the identified and what corrective action(s) will be taken; This deficiency had potential affect up to 50 residents in two smoke compartments. All otheresident rooms and common areas were checked for extension cords and multiplug adapters. Christmas time and families, though they are reminded vianewsletter upon admission and annually that extension cords not allowed in the facility, may have brought them in. 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 resident rooms and commareas will be checked for extension cords, multiplug adapters, proper power strips weekly x 4, then monthly x6 months and quarterly thereaff until 12/31/25 and then will be reevaluated for frequency of checks (See Forms 7, 8, and The Preventative Maintenance).	dio, olug din otop, g Dy will to o er asion . It is even are of the common . Th

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	03	COMPL	ETED	
		155747	B. WII	NG		12/13/	2024
			Ц,				
NAME OF F	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD		
					ERCER AVE		
ADAMS \	WOODCREST			DECAT	UR, 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	TE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					form was updated to reflect th	is	
					change. Education was provid	ed	
					to all facility staff regarding no		
					extension cords are allowed ir	the	
					facility (See Form 10). The em	nail	
					including use of extension cor		
					and power strips in resident ro		
					was also sent to all families or		
					12/19/2024 at 10am (See Fori		
					11).		
					4. How the corrective action((s)	
					will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place; and		
					The LSC Coordinator will repo	ort on	
					extension cords monthly durin		
					the QAPI meetings. The QAPI	•	
					committee will provide oversig		
					this process and provide ongo	-	
					monitoring to ensure this defic	ient	
					practice does not recur.		
					5. By what date the systemic	:	
					changes for each deficiency		
					will be completed. January 3	,	
					2025		

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