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	12/13/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/13/24 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 114 at the time of this survey. Quality Review completed on 12/17/24	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: 12/13/24 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	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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	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 fully remodeled and redesigned including A, B, and C wings along with additions of an activities area, therapy gym, three kitchenettes, and the B-wing 1000-hall addition. Therefore, the building was surveyed with Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one-story facility with a stairway to the basement which was separated with a two-hour fire barrier at the bottom of the stairs was determined to be 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 114 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 12/17/24			
K 0226 SS=E Bldg. 03	NFPA 101 Horizontal Exits Based on observation and interview, the facility failed to ensure 1 of 1 doors in a two hour fire rated horizontal exit in B-wing were self-closing and latching. LSC 7.2.4.3.10 states all fire door assemblies in horizontal exits shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 40 residents in B-wing	K 0226	**K226 Horizontal Exits SS = E** **Based on observation and interview, the facility failed to ensure 1 of 1 doors in a two hour fire rated horizontal exit in B-wing were self-closing and latching. LSC 7.2.4.3.10 states all fire door assemblies in**	01/03/2025

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	Findings include: Based on observation during a tour of the facility with the Administrator, the LSC Coordinator, and the Maintenance Lead on 12/13/24 at 1:02 p.m., the two-hour fire wall on B-wing between the 900-hall and 1000-hall was used as a horizontal exit with 90-minute rated doors. When tested, one of the door leaves did not latch in the door frame. Based on interview at the time of observation, the Maintenance Lead agreed the doors were in a fire barrier wall and did not latch when tested. This finding was reviewed with the Administrator, the LSC Coordinator, and the Maintenance Lead during the exit conference. 3.1-19(b)		**horizontal exits shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 40 residents in B-wing.** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; The Maintenance Lead worked on the doors right away. The doors were closing better but the fire door company was called to come in and check the door for better latching. Central Indiana Hardware company was notified immediately of the issue with the door in Bwing between the 900-hall and 1000-hall. The company came in on 12/17/2024 and repaired the door by increasing the power and adjusting the door closures (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 taken**; The other fire doors were checked and it was noticed that the fire door by the treatment room on Bwing was also slow latching. Central Indiana Hardware company adjusted the hinges to stop from rubbing, increased the power, and adjusted the door closures (See Form 1). The other	

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			fire doors on Bwing between Health Center and Bwing entrance, Awing, Cwing, and Health Center were all checked 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 for self-closing and latching. Going forward, all fire doors will be checked for self-closing and latching by maintenance weekly x4, monthly x6 months and then quarterly thereafter until 12/31/25 and then will be reevaluated for frequency of checks (See Forms 2, 3, and 4). The Preventative Maintenance form was updated to reflect this change. Education was provided to all facility staff regarding proper self-closing and latching of the fire doors (see Form 10). **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 LSC Coordinator will report on fire door checks/latching monthly during the QAPI meetings. The QAPI committee will provide oversight of this process and	

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			provide ongoing monitoring to ensure this deficient practice does not recur. **5. By what date the systemic changes for each deficiency will be completed. January 3, 2025**	
K 0293 SS=E Bldg. 03	NFPA 101 Exit Signage Based on observation and interview the facility failed to ensure 1 of 1 exits by the Director of Nursing (DON) office contained the correct signage in accordance with LSC 7.10.8.3.1 which states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 40 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Administrator, the LSC Coordinator, and the Maintenance Lead on 12/13/24 at 12:02 p.m., the sliding glass doors by the DON office were marked as an exit with an "EXIT" sign, but the doors lead to an enclosed courtyard with no access to the common way. Based on an interview at the time of observation, the Administrator, the LSC Coordinator, and the Maintenance Lead agreed the sliding glass door did not lead to the common way and stated it was	K 0293	**K293 Exit Signage SS = E** **Based on observation and interview the facility failed to ensure 1 of 1 exits by the Director of Nursing (DON) office contained the correct signage in accordance with LSC 7.10.8.3.1 which states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 40 residents in one smoke compartment.** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	01/03/2025

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	an exit at one time and needs the current sign replaced with a "NO EXIT" sign. This finding was reviewed with the Administrator, the LSC Coordinator, and the Maintenance Lead during the exit conference. 3.1-19(b)		**practice;** The big Exit sign above the sliding door was removed immediately (See Form 5). Not an exit sign was placed immediately on the door across from the Director of Nursing office (See Form 6). Proper NO EXIT signage (The NO EXIT sign will have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO) has been ordered and should be coming any day now. This sign will replace the current Not an Exit sign. **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 40 residents in one smoke department. All other doors in the facility were checked to ensure that they have a proper exit/no exit signage in place. **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Proper signage will be placed on the door across from the Director of Nursing office. All other doors that are not considered exit doors will also have “no exit” signage on. Education was provided to the maintenance staff as well as all facility staff about the “no exit”	

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			signage requirement (See Form 10). **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 facility will ensure that any new doors or replacement doors are reviewed for proper signage. **5. By what date the systemic changes for each deficiency will be completed. January 3, 2025.**	
K 0920 SS=E Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 50 residents in two smoke compartments. Findings include: Based on observation during a tour of the facility with the Administrator, the LSC Coordinator, and the Maintenance Lead on 12/13/24 between 12:02 p.m. and 1:00 p.m., the following extension cords or multi-plug adaptors were used as fixed wiring: a. In resident room 942 an extension cord was powering a radio. b. In resident room 979 a multi-plug adaptor was powering chargers c. In the B-wing nurses' station an extension cord	K 0920	**K920 Electrical Equipment - Power Cords and Extension Cords SS = E Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 50 residents in two smoke compartments.** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All three flexible (extension) cords	01/03/2025

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	was powering a laptop. Based on an interview at the time of observations, the Administrator, the LSC Coordinator, and the Maintenance Lead acknowledged extension cords or multi-plug adaptors were in use. This finding was reviewed with the Administrator, the LSC Coordinator, and the Maintenance Lead during the exit conference. 3.1-19(b)		- In resident room 942 an extension cord powering a radio, in resident room 979 a multi-plug adaptor powering charger, and in the B-wing nurses' station an extension cord powering a laptop, were removed immediately. **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 had potential to affect up to 50 residents in two smoke compartments. All other resident rooms and common areas were checked for extension cords and multiplug adapters. It is Christmas time and families, even though they are reminded via newsletter upon admission and annually that extension cords are 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 common areas will be checked for extension cords, multiplug adapters, proper power strips, etc. weekly x 4, then monthly x6 months and quarterly thereafter until 12/31/25 and then will be reevaluated for frequency of checks (See Forms 7, 8, and 9). The Preventative Maintenance	

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			form was updated to reflect this change. Education was provided to all facility staff regarding no extension cords are allowed in the facility (See Form 10). The email including use of extension cord and power strips in resident rooms was also sent to all families on 12/19/2024 at 10am (See Form 11). **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 LSC Coordinator will report on extension cords monthly during the QAPI meetings. The QAPI committee will provide oversight of this process and provide ongoing monitoring to ensure this deficient practice does not recur. **5. By what date the systemic changes for each deficiency will be completed. January 3, 2025**	