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	01/19/2024

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: 01/19/24 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 107 at the time of this survey. Quality Review completed on 01/24/24	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: 01/19/24 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	02/05/2024

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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, therefore the building was 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 107 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 01/24/24			
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.			

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	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 hazardous area was protected in accordance with 18.3.2.1. Hazardous 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). This deficient practice could affect 50 residents in front smoke compartment. Findings include: Based on observations with the Maintenance Technician, the Life Safety Coordinator, and Administrator on 1/19/24 at 11:17 a.m., the ISO storeroom containing large amounts of medical supplies had a set of double doors to the room. The doors to the room were not labled with tags indicating the fire rating so the fire rating of the doors could not be determined. Based on interview at the time of observation, the Maintenance Technician stated there was no fire-rating on the doors and was unsure if the doors were at least 3/4-hour fire-rated doors.	K 0321	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The double doors to the room were immediately checked for the fire rating and the tag was unable to be located. The fire rating of the doors could not be determined. New double doors have been ordered. **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;** All of the storage doors were checked, and the fire rating tag was present on all storage doors. **3.What measures will be put into place and what systemic**	04/18/2024

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	The finding was reviewed with the Maintenance Technician, the Life Safety Coordinator, and the Administrator during the exit conference. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur;** Any time the room is changed into the storage room, the doors will be checked to ensure an appropriate fire rating tag is 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 have an appropriate fire rating tag in place. The QAPI committee will ensure that any new storage room doors have an appropriate fire rating.	
K 0363 SS=E 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			

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	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 25 resident room corridor doors was provided with a means suitable for keeping the door closed, had no impediment to closing, and would resist the passage of smoke. This deficient practice could affect 25 residents on B-wing. Findings include: Based on observations with the Maintenance Technician, the Life Safety Coordinator, and Administrator on 1/19/24 at 11:55 a.m., the corridor door to room 905 would not close when tested, because the door was tied open with a rope from the room door handle to the restroom door handle. Based on interview at the time of observation, the Maintenance Technician acknowledged the condition, removed the rope, and shut the door. The finding was reviewed with the Maintenance Technician, the Life Safety Coordinator, and the Administrator during the exit conference. 3.1-19(b)	K 0363	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The rope that was tied to the door handle to keep the door open was removed immediately by the Maintenance Technician on 1/19/24 during the LSC surveyor visit. The resident in room 905 was educated regarding not tying the door handles. The resident was instructed to report any door issues to the staff nurses. **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;** All of the other doors were checked by the Maintenance Technician to ensure they stay open all the way and no “objects” are used to keep the doors open. Doors to Rooms **3.What measures will be put into place and what systemic changes will be made to**	02/16/2024

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			ensure that the deficient practice does not recur; Education was provided to all staff on completing a work order for any doors that are unable to stay open (See Form 3). Education will be provided to the residents during their next Resident Council meeting in February. The Maintenance Technician continues to check all doors for proper latching monthly. **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 door checks/latching 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.	
K 0911 SS=E Bldg. 03	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was	K 0911	**1.What corrective action(s) will be accomplished for those**	02/16/2024

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	maintained for 2 of 2 electrical panels. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A) (1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90-degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be clear and extend from the grade, floor, or platform to a height of 61?2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could 35 residents in A-wing. Findings include: Based on observations with the Maintenance Technician, the Life Safety Coordinator, and Administrator on 1/19/24 at 11:31 a.m., the electrical panels in A-wing storeroom were blocked from access with medical equipment stored in front of the panels. Based on interview at the time of the observations, the Life Safety Coordinator agreed items were stored within the		**residents found to have been affected by the deficient practice;** Two vital signs machines that were parked in front of electrical panels in the storage room on A wing were immediately removed from the area on 1/19/24 during the LSC surveyor visit. Immediate education was provided to two nurses on Awing to ensure nothing is stored within the 3 feet of the panels. **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;** All other electrical panels were checked, and nothing was stored within the working space in front of the other electrical panels. **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 all staff regarding storing medical equipment in front of electrical panels (See Form 3). New signs were posted by all electrical panels stating, “Please do not place anything in front of electrical panels. This is a Fire Code Violation.” **4. How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	working space in front of the electrical panels. The finding was reviewed with the Maintenance Technician, the Life Safety Coordinator, and Administrator during the exit conference. 3.1-19(b)		**recur, i.e., what quality assurance program will be put into place;** The Director of Facilities will report on any concerns with electrical panels 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.	
K 0920 SS=E Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			

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	Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice can affect 5 residents in the therapy gym. Findings include: Based on observations during a tour of the facility with the Maintenance Technician, the Life Safety Coordinator, and Administrator on 1/19/24 at 11:17 a.m., a power strip was mounted to a entertainment stand in the therapy gym where resident care was provided did not meet 1363A or 60601-1. Based on interview at the time of observation, the Life safety Coordinator agreed a power strip was in use in a resident care area and did not meet 1363A or 60601-1. The finding was reviewed with the Maintenance Technician, the Life Safety Coordinator, and Administrator during the exit conference. 3.1-19(b)	K 0920	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The flexible cord power strip on the portable TV cart in the therapy gym was replaced immediately by the Maintenance Technician with a power strip that met the required UL rating of 1363A or 606601-1 on 1/19/24 during the LSC surveyor visit. (See Form 4) **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;** All other rooms were checked to ensure only power strips that met the required UL rating were being used. All power strips in use were appropriate. **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 all staff regarding the appropriate power strips (See Form 3). Information about power strips will be included in the Resident/Family Annual Letter. Education will be provided to the residents during their next Resident Council meeting in February. Power strips were added to the Life Safety Check Monthly PM and will be completed	02/16/2024

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			monthly for all resident care areas (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 power strips 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.	