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	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adams Woodcrest	1300 Mercer Ave Decatur, IN 46733

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45243 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, 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 [DATE], 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, 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 [NAME] Heritage/[NAME] 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 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)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 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 [DATE] at 9:11 AM, a bottle of lemon juice was observed in a reach in cooler with an open date of [DATE]. 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 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 ,d+[DATE] of the contents of the container. An additional container of Ziploc bagged bananas contained bananas dated [DATE] and [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE]. Two containers of lime sherbet were observed in the freezer with no expiration date. During an interview, on [DATE] 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 expiration date. During an observation, on [DATE] 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 , d+[DATE] inch coating of frost covering the top of each product. During an interview, on [DATE] at 10:39 AM, CNA 7 indicated the ice cream containers should have been dated when opened and should be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on [DATE] 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 ,d+[DATE] were observed in the freezer. During an interview, on [DATE] 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 ,d+[DATE], provided by the Administrator on [DATE] 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 [DATE] 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 [DATE] at 5:12 PM indicated ice machines should be cleaned quarterly and as needed when contaminated or visibly soiled. 3XXX,d+[DATE](i)(3)