STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN CROSSING AND THE LOFTS	**5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for 4 of 5 residents observed for call light use (Residents V, W, X, and Y). Findings include: 1. On 8/14/2020 at 7:45 a.m., Resident V was observed lying in bed propped towards the door on his right side with a pillow. The resident was alert and talkative, and indicated he would like to eat but needed to be straightened up in the bed first. A breakfast tray with bacon, eggs, and oatmeal were observed to be uncovered on an over the bed table on the left side of the bed, out of reach of the resident. The silverware was wrapped in a paper napkin. Resident V requested his call light with a red button to be found. The call light was observed on the floor beside the bed. Resident V indicated he had not had the call light since the night before. Registered Nurse (RN) 19 was observed going into the resident room to provide care. On 8/14/2020 at 8:01 a.m., a second observation of Resident V lying reclined in bed, attempting to reach his breakfast tray on an over the bed table, positioned on the left side of the resident's bed, with his right hand. Resident requested his call light. The call light was observed underneath the pillow on the right side of the resident, and tucked underneath his back. CNA 20 was asked to come get the call light for Resident V, she indicated the resident's call light should have been clipped to his chest as he could not reach that far. Resident V's record was reviewed on 8/14/2020 at 9:00 a.m. [DIAGNOSES REDACTED]. The admission MDS (Minimum Data Set) assessment, completed on 6/25/2020, assessed Resident Vas having the ability to make himself understood and to understand others. A brief interview for mental status (BIMS) score of 12 indicated moderately impaired cognition. The resident had no rejection of care, and he was frequently incontinent of bowel and bladder. Extensive assistance of two persons for bed mobility, transfers, locomotion off the unit, dressing, toilet use, and personal hygiene. Extensive assistance of one for locomotion on the unit. Limited assistance of one person for walking in room and corridor, and eating. Mobility devices included a wheelchair. No functional limitation in range of motion in upper or lower extremities. A Care Plan for Resident V, dated 8/1/2020, indicated the resident was at risk for falls related to weakness, unsteadiness, limited mobility, and [MEDICAL CONDITION] drug use. The goal was for the resident to be free of falls through the review date. Interventions included, but were not limited to, be sure the call light was within reach, encourage the resident to use it for assistance as needed, and prompt response to all requests for assistance. 2. On 8/14/20 at 7:49 a.m., Resident W was observed lying reclined in the bed, with a breakfast tray on an over the bed table positioned over his knees. Resident W indicated, the staff would help him to eat if he needed assistance, but most days he fed himself. The resident indicated, he could reach items on his tray, however while being observed, the resident was unable to straighten himself up in bed or pull the blanket down to cover his feet. Observation of the call light attached to the upper left side of residents bed, out of reach of the resident. Resident W's record was reviewed on 8/14/2020 at 9:30 a.m. [DIAGNOSES REDACTED]. A Care Plan for Resident W, dated 8/7/2020, indicated the resident had an ADL (Activity of Daily Living) deficit related to partial amputation of the left foot. The goal was for the resident to improve his current level of function in the bed by the target date of 11/5/2020. Interventions included, but were not limited to, physical therapy and occupational therapy treatment per physician's orders [REDACTED]. 3. On 8/14/2020 at 7:55 a.m., Resident X was observed lying reclined in the bed, her arms drawn up onto her chest in front of her, and her bandaged feet propped on a pillow. An over the bed table was placed over her lap, the food was uncovered, and the silverware wrapped in a paper napkin. The resident was observed to have eaten a partial piece of bacon, she did not eat the rest of the meal. Resident X indicated, if she needed help from staff she would use the call button. A call button was observed hanging down the left side of the bed by the bed frame, out of reach of the resident. Resident X's record was reviewed on 8/14/2020 at 9:10 a.m. [DIAGNOSES REDACTED]. The admission MDS assessment, completed on 8/5/2020, assessed Resident X as having the ability to make herself understood and to understand others. A BIMS score of 15 indicated no cognitive impairment. She required extensive assistance by two people for transfers, dressing, toileting, and hygiene. She required total dependence by one person for walking in her room, and did not walk in the corridor. She required limited assistance by one person for eating, and she was always incontinent of bladder and frequently incontinent of bowel. A Care Plan for Resident X, dated 8/11/2020, indicated the resident was at risk for falls related to weakness, unsteadiness, limited mobility, incontinence, [MEDICAL CONDITION] drug use, and an episode of [MEDICAL CONDITION]. Her interventions included, but were not limited to, be sure the call light was within reach, encourage the resident to use it for assistance as needed, and prompt response to all requests for assistance. 4. On 8/14/2020 at 8:10 a.m., Resident Y, a morbidly obese female, was observed lying on her back, slightly sideways in her bed, with a nasal cannula on her face but out of her nostrils. The alert and talkative resident indicated, she had slipped and spilled her water and was all wet, and had called for the nurse but no one had come. The resident indicated, she usually used a call light to call for assistance but could not find it. Observation of a light gray call button tucked into the bottom of the side rail on the side of the bed, out of reach and sight of the resident. LPN 6 was asked to come get the call light for the resident, and she indicated Resident Y's call light should have been clipped to the resident's sheet where she could have reached it. Resident Y's record was reviewed on 8/14/2020 at 9:35 a.m. [DIAGNOSES REDACTED]. The quarterly MDS assessment, completed on 6/14/2020, assessed Resident Y as having the ability to make herself understood and to understand others. A BIMS score of 10 indicated moderate cognitive impairment. She required extensive assistance by two people for bed mobility and hygiene. Total dependence by two people for transfers and toilet use. Total dependence by one person for locomotion and dressing. She did not walk in her room or the corridor. She required supervision by one person for eating, and she was frequently incontinent of bladder and bowel. A Care Plan for Resident Y, dated 6/26/2020, indicated the resident was at risk for falls related to weakness, unsteadiness, limited mobility, incontinence, and [MEDICAL CONDITION] medications. Interventions included, but were not limited to, be sure the call light was within reach, and encourage the resident to use it for assistance as needed. On 8/14/2020 at 11:41 a.m., the Regional Nurse provided a Resident Rights Policy, reviewed 5/30/2019, and indicated the policy was the one currently being used by the facility. The policy indicated, It is the policy of this facility to provide resident centered care that meets psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care .Residents will be treated with dignity and respect including by not limited to .c. To have a method to communicate needs to staff. i. Call light or bell access will be within reach of the resident as one method to communicate with staff. 1. Staff will answer promptly. 2. Any staff within the vicinity will answer a call light This Federal tag relates to Complaint IN 845. . 3.1-3(v)(1)
F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate supervision to prevent a newly admitted ,

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN CROSSING AND THE LOFTS	**5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254**

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) deaf, cognitively impaired resident, who was assessed with [REDACTED]. After being found by a bystander on a curb next to the road and transported to an emergency room by emergency medical services, the resident was found to have a fractured left knee and high blood pressure. (Resident B) The immediate jeopardy began on 8/03/2020 when the resident exited through a fire exit door at 5:30 a.m. Registered Nurse (RN) 11 turned off the alarm to the fire exit door, failed to investigate the cause of the alarm sounding, failed to report the alarm sounding, and failed to initiate the elopement protocol. The facility failed to identify Resident B as missing from the facility for 4 hours until notified by a local hospital emergency department at 9:30 a.m. The Executive Director (ED), Director of Nursing (DON), and Regional Director of Clinical Services were notified of the immediate jeopardy at 1:40 p.m. on 8/14/2020. The Immediate Jeopardy was removed, and the deficient practice corrected, on 8/7/2020, prior to the start of the survey and was therefore Past Noncompliance. Findings include: An Indiana State Reportable Incident form, dated 8/3/2020 at 4:53 p.m., indicated Resident B eloped from the facility without notifying staff at approximately 5:30 a.m. The resident was located and taken to the hospital for evaluation. An emergency room (ER) Medical Doctor Exam and Disposition report, dated 8/3/2020, indicated it was discovered Resident B had walked out of his nursing facility where he was an inpatient. The patient presented with left knee pain and scrapes on his palms. Patient was deaf and had dementia which made communicating with the interpreter difficult. Resident B indicated he started walking and felt very dizzy. His troponin level (measured heart injury) was slightly elevated, a troponin was to be repeated and a magnetic resonance imaging (MRI) scheduled. Emergency [DIAGNOSES REDACTED]. An emergency room report, dated 8/3/2020, titled, DC Summary, indicated, Patient had MRI of left lower extremity performed due to complaints of knee pain and abrasions. He had acute/subacute stress fracture . Patient was hypertensive on admission with blood pressure 190s/80s Patient's EKG showed left bundle branch block that was reportedly new but I have no prior EKGs to compare to A left knee MRI result for Resident B, dated 8/3/2020, indicated an acute or subacute stress fracture involving the anterior lateral tibial plateau (a break of the larger lower leg bone below the knee that breaks into the knee joint itself), and complex tear of the body and posterior horn of the medial meniscus (back of the knee). A Discharge Planning Assessment from a local hospital, dated 8/3/2020, indicated Resident B required assistance with decision making, and had a primary [DIAGNOSES REDACTED]. The hospital Social Worker indicated Resident B was found down in the community by emergency medical services (EMS). The ER nurse reported he had on clothing labeled with his name and was wearing a nursing home style brief. Resident B was hearing and speech impaired but did answer basic questions for the nurse and interpreter. The resident had a wallet with a name and phone number of his family member. Case management called facilities in the area in attempts to identify the resident. The Social Worker found the family member who reported the resident had just recently transferred to the long term care facility. Case Management placed a call to the facility and spoke with the Executive Director (ED), who was not aware the client was not in the facility. A call was placed back to the facility to speak with the bedside nurse. The nurse was surprised to learn the resident was in the ER, and argued he was at the facility since she had not sent him out. The nurse was informed the resident had gone into the community, was found by the local EMS, and brought to the ER. Lab results indicated the client was in [MEDICAL CONDITION] and the emergency department was trying to determine if that was new for the resident. A Social Work Assessment from a local hospital, dated 8/3/2020, indicated Resident B arrived to the ER after wandering outside. The resident was found with cash in excess of $500. Family was contacted after a name and phone number were found in Resident B's wallet. Family indicated Resident B had dementia, frequently wandered away, and the facility was supposed to have put an ankle location monitor on him. A Discharge Summary for Resident B from a local hospital, dated 8/4/2020, indicated the resident was brought to the ER by EMS after he was found wandering by a bystander and appeared to have fallen. The patient was deaf, and used American Sign Language (ASL). Using a sign language interpreter via iPad, the history was still hard to obtain. The ASL interpreter repeatedly mentioned that the patient appeared confused. Resident B's record was reviewed on 8/13/2020 at 9:20 a.m. [DIAGNOSES REDACTED]. An Admission Observation Tool for Resident B, dated 7/30/2020, indicated the resident's chief complaint was dementia without behavioral problems, and the resident was deaf. Behaviors to include exit seeking behaviors were not exhibited. The assessment indicated it was unknown if the resident had a history of [REDACTED]. physician's orders [REDACTED]. Assessments for Resident B, dated 7/30/2020 - 8/13/2020, indicated there was no elopement assessment. Review of Resident B's electronic medical record, dated 7/30/2020 - 8/2/2020, indicated there was no documentation or assessments observed by the social services department. A 48 hour Baseline Care Plan for Resident B, dated 7/30/2020, indicated the resident required extensive assistance of one for bed mobility, transfers, walking in the room, locomotion on the unit and toileting. Equipment needed included a wheelchair; alarms and restraints were not required. There was no documentation regarding risk for elopement. A Fall Risk Observation Tool for Resident B, dated 7/31/2020, indicated the resident had diminished safety awareness, was ambulatory without assistance, and had normal walking/striding without hesitation. No assistance was required for transfers. The resident was able to stand/walk, and maintain body alignment, and there was no fall history. The tool indicated, based on this assessment, the resident had been identified as a potential risk for falls. A Nurse's Note, dated 8/3/2020 at 9:42 a.m., indicated Resident B was discovered to be outside of the facility and was transported to a local hospital for evaluation and workup. An investigation revealed the resident had defeated the egress door on the terminal end of the unit. The resident had proceeded down the stairwell and exited the facility and was down at the curb. An employee statement by Certified Nursing Assistant (CNA) 9, dated 8/3/2020, indicated, I came in this morning around 8:00 a.m. I was called in was told no aide was upstairs .on either side .walked up and down halls collected trays. Passed ice water still haven't seen (Resident B). I did not see him the entire time being on (name of unit) .checked his room a few times still no sign of him I assumed he was (at an) appointment, at [MEDICAL TREATMENT], with therapy, etc. An employee statement by Registered Nurse (RN) 11, dated 8/3/2020, indicated, Early morning on August 3rd around 5:15 a.m. - 5:30 a.m. . I finished bed check with LPN (Licensed Practical Nurse) 10 .I went to find CNA 22 to see if she was ok that I left early since my bed check was finished. I went to the other side of the (upstairs unit name) and CNA 22's bags and supplies were in the middle of the hall. I looked in a couple of rooms for her, but noticed the stair alarm going off and assumed that she had gone down the stairs for some reason. I turned off the alarm, and peeked in another room before going back to the other side of the building to tell LPN 10 that CNA 22 must be on a break or something because I couldn't find her. And asked that if she was ok I was going to go ahead and leave .she said that was fine so I left. An employee statement by RN 12, dated 8/3/2020, indicated, I (RN 12's name) came on the unit and was notified I had no CNA, but someone would be here to help soon. I got report from the nurse about critical patient and everyone else was fine. I began to pass trays, after I passed every tray I began to feed (Resident BB) until a CNA relieved me. I began my morning med pass, and was almost done when my DON asked me about (Resident B). I said he's in his room. I knew for sure because I had passed every single tray on this unit. I got a phone call that the emergency room had my patient, he was already gone before I got here, he had left building at 5:25 a.m. before my shift. Having never worked this particular unit I didn't know what resident looked like or anything. DON, family, facility was notified An employee statement by Licensed Practical Nurse (LPN) 10, dated 8/3/2020, indicated, I (LPN 10's name), was the nurse working on the (second floor unit name) on Sunday 8/2/2020. Alongside RN 11 and CNA 22. I had no knowledge of an elopement that took place during my shift. I am aware of the (company name) Elopement Protocol. During an interview on 8/13/2020 at 1:51 p.m., RN 12 indicated she was usually the night nurse on the upstairs unit, but on 8/3/2020 she picked up the day shift and had come in to work at 7:00 a.m. RN 12 had received report from LPN 10 and CNA 22, both who had indicated everyone was fine. CNA 22 reported she had worked alone and had personally checked and changed all residents by herself. LPN 10 indicated there were no dayshift CNAs, so RN 12 locked her medication cart, and along with the nurse on the other side of the upstairs units, both started to pass trays. RN 12 indicated she passed every single tray, did blood sugar checks, and was looking at the Medication Administration Record [REDACTED]. The ED indicated the resident had exited the facility. A nurse from the emergency room called and indicated Resident B had exited the facility, he was hot, and a passerby on the street attempted to talk with him, and since he was deaf and could not communicate, they called 911. The emergency room nurse indicated Resident B was hot and had signs of kidney failure. Resident B's family member called to check on the resident, and RN 12 had to tell her that the resident had eloped. Upon head count Resident B's bed was observed to be perfectly made and his room spotless. RN 12 had been told in report that Resident B was independent, and there was no mention of him being an elopement risk. Management had observed cameras and saw RN 11 disarming the alarm. RN 11 had not told LPN 10 or CNA 22 or anyone else about the alarm sounding. To her knowledge RN 11 had not looked at the camera video, in resident rooms, or attempted to find out if any resident was missing. RN 12 indicated the alarms were loud, and if she had heard them she would have told the DON or called maintenance as she did not have access to disarm the alarm. RN 12 indicated the alarm was on the stairwell, and if it went off, that possibly meant someone went down the fire escape. The stairwell did not come out in the building; it went directly to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN CROSSING AND THE LOFTS	**5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254**

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) outside. RN 11 had not done a head count or called anyone. RN 11 should have automatically done a head count, and notified the other aide. When a head count was done, every room was checked, if a resident was seen in the room, the door was closed and the check mark was put in front of the door to alert others the resident was inside and safe. If a resident could not be found, the nurse should have called over the speaker system that there was an elopement, look at all the doors, look for the patient high and low. On 8/13/2020 at 2:22 p.m., the DON indicated, on 8/3/2020 upon review of the camera footage, Resident B was observed walking down the hallway. The resident made it to the end of the hallway on the back right end, and he pressed on the fire escape door for 15 seconds and defeated the lock. The resident had no wanderguard alarm as he had no history of elopement. Resident B walked down the stairwell holding onto the rail, and he exited out of the exterior door. A passerby found him on the side of the street and called 911. The resident was estimated to have been outside for approximately 30 minutes. He was assessed in the emergency room and found to have no injuries, and his labs were fine. The DON indicated there was no harm from the event. The resident went to a sister facility with a secured memory care unit when discharged from the hospital. The DON indicated he was not sure how the emergency room staff or EMS knew the resident was from their particular facility, but it could have been due to the location where he was found. There was an alarm on the fire door, it alarmed when the resident opened the door, and per staff the door had alarmed. Staff had responded after Resident B had already exited. The resident pushed on the door, the alarm sounded, RN 11 turned the alarm off, opened up the stairwell door, and per her statement she had called out in the stairwell, and when she saw no one there, returned to her duties. RN had not initiated looking for a resident, and she did not initiate a code silver to indicate there was a resident missing. DON was not sure why the night or day shifts had not identified the resident missing. The expectation for staff would be for the aides to do rounds every 2 hours, and the day nurses to do rounds upon arrival no later than 7:30 a.m. On 8/13/2020 at 2:25 p.m., the ED indicated on 8/3/2020 Resident B had been dressed in regular clothing when he eloped. The resident had not previously been on a secured unit at his previous facility as he had no history of wandering. The ED indicated they could identify when fire doors were disengaged as there was a system that monitored the time when the doors were opened. Resident B was estimated to have been outside approximately 30 minutes by the time the locks disengaged and the 911 call. There was an alarm on all fire doors with a sign indicating to push for 15 seconds to open the door. There was an expectation, if staff could not determine the cause of a fire alarm sounding, they would initiate a head count of residents in the facility. There was restricted access to who could reset alarms to the fire doors and access to the stairwells, and as a unit manager RN 11 had access to reset the alarms. On 8/14/2020 at 11:41 a.m., the Regional Nurse provided an Elopement Prevention Policy, reviewed 4/20/17, and indicated the policy was the one currently being used by the facility. The policy indicated, elopement is defined as when a resident/patient leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident/patient at harm or injury .Procedure: 1. Identify resident/patients who are at risk for elopement. a. All new admissions that are at risk for elopement will have interventions in place immediately until further assessment is complete. Interventions may include but are not limited to: Environmental modifications to prevent undetected exit such as wandering alerts, door alarms. Increased frequency of resident observation rounds. b. Any resident/patient admitted who is cognitively impaired and can self-ambulate is considered an elopement risk until determined otherwise. c. Any resident/patient that has a change in condition that places them at risk for elopement. 2. Obtain current photograph of resident/patient identified for risk of elopement. 3. Complete the Risk Alert: Elopement. 4. Place the Risk Alert: Elopement form in the elopement risk identification book. Maintain in an easily accessible area. 5. Develop the care plan with input for the interdisciplinary team and the resident patient and family/responsible party . On 8/14/2020 at 11:41 a.m., the Regional Nurse provided an Elopement Prevention and Management Overview Policy, reviewed date 5/30/2020, and indicated the policy was the one currently being used by the facility. The policy indicated, . Procedure: 1. Identify resident/patients who are at risk for elopement. 2. Determine elopement risk factors which may include, but not limited to: a. Acute or chronic confusion/disorientation, b. anxiety, c. dementia, or dementia related disease, d. History of purposeful wandering and/or elopement, e. new admission with adjustment difficulties, or a desire to return to previous living situation, f. restless, irritable. 3. Document factors. 4. Develop and document individualized interventions to manage risk factors. 5. Discuss interventions and goals with resident/patient and/or family responsible party. 6. Communicate risk factors and interventions to the caregiver staff. 7. Monitor and document resident/patient response to elopement risk reduction interventions. 8. Evaluate effectiveness of interventions during clinical meetings. 9. Modify goals and interventions as indicated and communicate changes to the caregiving team, resident/patient and/or family responsible party On 8/14/2020 at 11:41 a.m., the Regional Nurse provided the Missing Resident Policy, reviewed date 4/20/17, and indicated the policy was the one currently being used by the facility. The policy indicated, .definition of missing resident: not immediately available but not requiring immediate supervision - for example, a cognitively intact resident may be able to take a leave of absence (LOA), leaves the facility but forgets to sign out of the facility. This resident is missing, not an elopement. Elopement: cognitively impaired resident that requires supervision but wanders to an unsafe area unsupervised. Policy: 1. It is the policy of this facility to provide a safe environment for residents and staff will be aware of and responsible for the resident's location. 2. In the event a resident cannot be accounted for on the unit, the following procedure will be implemented to locate the missing resident as quickly as possible. Procedure: 1. Identify that the resident is not on the unit noting that time is a critical factor for discovery. 2. Determine if the resident has been taken off the unit by family or a staff member of another department .3. If the resident cannot be immediately located, the nurse will organize a search of the center and surrounding grounds including but not limited to .4. If search fails to locate resident within 15 minutes .5. Provide police the following information . The Past Noncompliance Immediate Jeopardy began on 8/3/2020. The Immediate Jeopardy was removed and the deficient practice corrected on 8/7/2020 when the facility implemented a systemic plan that included transfer of the affected resident to another facility, interviewed all residents to assess for potential elopement risk, wander/elopement assessments were completed on residents identified at risk, care plans were updated with interventions to prevent elopement, and each identified residents' information was added to the elopement binder. Staff were in-serviced on elopement prevention and management to include the wandering/elopement/missing person drill policy and procedure. This Federal tag relates to Complaint IN 184. 3.1-45(a)(1) 3.1-45(a)(2)
F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide nutritional care and services including the failure to obtain weekly weights, failure to provide assistance with meals and alternative food/supplement choices and failure to notify the physician and address the resident's refusal of nutritional supplements and poor intakes, for 1 of 3 residents reviewed for nutrition (Resident V). This resulted in a severe weight loss of 23 percent in less than 2 months and a change in body mass index (BMI) from normal to underweight. Findings include: During a random observation, on 8/11/20 at 11:30 a.m., Resident V was observed lying on a low air loss mattress covered with a blanket. During a wound dressing change observation, on 8/13/20 at 11:52 a.m., Licensed Practical Nurse (LPN) 29 provided wound care to Resident V. The resident's overall body appearance was thin, ashy in color, and gaunt in appearance that included protruding bony prominences (areas where bones are close to the surface) to the hips, knees, elbows, and wrists. During a Hoyer lift observation, on 8/13/20 at 3:15 p.m., Resident V was observed to be weighed. At this time, the Hoyer lift scale indicated 99.9 pounds (lbs.). During an observation, on 8/14/20 at 7:45 a.m., Resident V was observed lying in bed propped on his right side with a pillow. An uncovered breakfast tray was observed with bacon, eggs, and oatmeal on an over the bed table on the left side of the resident's bed, regular silverware still wrapped in a paper napkin. The resident was alert and talkative, and at this time indicated he would like to eat but needed to be straightened up in the bed first. Resident requested assistance finding his red button (call light) to be found. The call light was observed on the floor beside the bed. Resident V indicated, he had not had the call light since the night before. Resident V's record was reviewed on 8/11/20 at 1:54 p.m. An admission Minimum Data Set (MDS) assessment, dated 6/25/20, indicated the resident required limited assist of one for eating. The resident's height was 67 inches, and weight was 130 lbs. [DIAGNOSES REDACTED]. A hospital facility to facility report, dated 6/18/20, indicated the resident weighed 135.5 lbs. and nutritional intake had been marginal and patient needed encouragement. A physician's orders [REDACTED]. The order was discontinued on 6/26/20. A nutritional assessment, dated 6/25/20, indicated the resident was on a regular diet, regular texture with thin liquids. Resident received medical food supplement of ensure three times daily and intake of 50-100%. Limited assist for dining and no adaptive equipment used for eating. Anthropometrical measurements indicated 67 inches height, 128 lbs weight (58.2 kg), BMI 20 (low normal). No nutrition [DIAGNOSES REDACTED]. Nutrition monitoring and evaluation: weights, labs, and intakes. A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN CROSSING AND THE LOFTS	**5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254**

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 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) physician's orders [REDACTED]. The resident's clinical record lacked documentation of weekly weights between 6/29/20 and 7/27/20. A physician progress notes [REDACTED]. The objective indicated the resident had severe hand contractures and decreased range of motion to bilateral lower extremities. A weight flow sheet, indicated the following weights: On 6/18/20, 128 lbs via wheelchair scale. On 6/25/20, 130 lbs via mechanical lift. On 8/13/20, 99.9 lbs via mechanical lift. Reweight was 104.6 lbs via wheelchair scale. A care plan, initiated on 6/25/20, indicated the resident was at risk for nutritional decline related to a [DIAGNOSES REDACTED]. The goals included, but were not limited to, resident will consume an average of >50 % of food and beverages at meals, will consume >50% of medical food supplements. Interventions included, but were not limited to, give appetite stimulant as ordered, administer vitamin/mineral supplement per physician order, provide feeding/dining assistance as needed, and monitor and evaluate weight /weight changes. A care plan, initiated on 6/19/20 and revised on 8/11/20, indicated the resident admitted with 9 pressure ulcers with slough and or eschar on right outer ankle, sacrum, hips, iliac crest right side. Ulcers related to thin fragile skin, limited mobility, incontinence, skin desensitized to pain or pressure. Interventions included, but were not limited to, prevalon boots, monitor nutritional status. Serve diet as ordered, monitor intake and record. A food consumption report, dated June 2020, indicated 0) 0-25% consumed and no substitute accepted, on 6/19/20 at 9:00 a.m. and 1:00 p.m., 6/20/20 at 1:00 p.m., 6/21/20 at 1:00 p.m., 6/24/20 at 6:00 p.m., 6/25/20 at 1:00 p.m., 6/27/20 at 6:00 p.m., 6/28/20 at 9:00 a.m. and 1:00 p.m. The report lacked documentation for eating self-performance and support provided. A dietician note, dated 7/2/20, indicated the resident had refused weights, and weekly weights were not appropriate. Resident does appear to be losing weight. Resident had indicated no artificial nutrition, and to continue regular diet and ensure three times daily and Juven every day. The resident's medical record lacked documentation the physician had been notified of the dietician's note that weekly weights were not appropriate, and lacked documentation the order for weekly weights had been discontinued. A Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. The medical record lacked documentation the physician had been notified the resident's weight had not been obtained on 7/6 and 7/13, and the resident had refused on 7/20/20. A MAR, dated July 2020, indicated Ensure with meals for supplement was unavailable on the following dates: at 9:30 a.m. on 7/13 and 7/18, at 12:00 p.m. on 7/13, 7/15, and 7/18, and at 5:00 p.m. on 7/14. The MAR indicated [REDACTED]. A MAR, dated July 2020, indicated Juven every day shift. The MAR indicated [REDACTED]. The resident's medical record lacked documentation the physician had been notified of the refusals. A food consumption report, dated July 2020, indicated 0) 0-25% consumed and no substitute accepted, on 7/1 at 1:00 p.m. and 6:00 p.m., 7/2/20 at 9:00 a.m. and 1:00 p.m. the 6:00 p.m. meal lacked any documentation, 7/3/20 at 9:00 a.m. and 1:00 p.m., 7/4/20 at 9:00 a.m. and 1:00 p.m., 7/5/20 at 9:00 a.m. and 1:00 p.m., 7/6/20 at 6:00 p.m., 7/8/20 at 9:00 a.m. and 1:00 p.m. meals lacked any documentation, 7/9/20 at 9:00 a.m., 7/11/20 at 9:00 a.m. and 1:00 p.m., 7/12/20 at 9:00 a.m. and 1:00 p.m., 7/14/20 at 9:00 a.m. and 1:00 p.m., 7/15/20 at 9:00 a.m., 1:00 p.m., and 6:00 p.m., 7/17/20 at 9:00 a.m. and 1:00 p.m., 7/20/20 at 9:00 a.m. and 1:00 p.m., 7/22/20 at 9:00 a.m., 7/24/20 at 9:00 a.m., and 1:00 p.m., 7/25/20 at 9:00 a.m., 7/27/20 at 9:00 a.m., and 1:00 p.m., 7/29/20 at 9:00 a.m., and 7/30/20 at 9:00 a.m., and 1:00 p.m. A food consumption report, dated August 2020, lacked documentation of percentage eaten and eating self-performance and support provided, on 8/1/20, for breakfast and lunch. The document indicated 0) 0-25% consumed and no substitute accepted with limited assistance of 1, on 8/3/20 at 1:00 p.m., 8/4/20 at 9:00 (supervision, set up only) and 1:00 p.m. (supervision, setup only), 8/5/20 at 9:00 (supervision, setup only, 1:00 p.m. (supervision, setup only), and 6:00 p.m. (limited assist of 1), 8/6/20 at 6:00 p.m. (limited assist of 1), 8/9/20 at 9:00 (supervision, setup only) and 1:00 p.m. (supervision, setup only), 8/11/20 at 900 a.m., and 8/12/20 at 9:00 a.m. (supervision, setup only) and 6:00 p.m. (supervision, setup only). A MAR, dated August 2020, indicated the resident refused Juven on 8/2, 8/3, 8/5, 8/6, 8/7, 8/10-8/12. The record lacked documentation the physician had been notified. A notification form for physician or nurse practitioners, undated, indicated the Assistant Director of Nursing (ADON) had been notified the resident refused juven at least 3-4 times per week and could they look into changing the order. The documentation lacked any response from the physician or a date. A progress note, dated 8/13/20 at 4:53 p.m., indicated the resident's weight was obtained and weight loss was noted. The Hoyer lift weight was 99.9 lbs and a reweight obtained was 104.6 lbs. A progress note, dated 8/14/20 at 10:37 a.m., indicated the physician was notified of weight loss. A progress note, dated 8/14/20 at 10:44 a.m., indicated the resident's BMI was 16.4 (underweight). During an interview, on 8/13/20 at 2:05 p.m., the Director of Nursing (DON) indicated he was unable to find where the physician had been notified of the registered dietician's recommendation for weekly weights not to be obtained and the order was never discontinued. He could not find where the physician had been notified the resident at times refused nutritional supplements, and the physician should have been notified of the weekly weights not being obtained and of the refusals. He was also unaware the supplements had been unavailable and when that happened an alternative supplement should have been offered. During an interview, on 8/13/20 at 2:23 p.m., the ADON indicated she could not find documentation where the physician had been notified of the resident's refusals to be weighed. If the order for weekly weights had been stopped, the order should have been discontinued and was not. During an interview, on 8/14/20 at 12:56 p.m., the DON indicated the resident's BMI was 16.4 and considered underweight. On 8/13/20 at 1:54 p.m., the Assistant Director of Nursing (ADON) provided a policy, revised 4/1/17, and titled, Standard Precautions, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure for Hand Hygiene .B. Using liquid soap and water . 5. Rinse hands with water from wrists to finger .6. Dry hands thoroughly with a clean paper towel. 7. Turn off faucet with paper towel and discard On 8/13/20 at 2:07 p.m., the ADON provided a policy, dated 2/18/19, and titled, Refusal of Care and Treatment, and indicated it was the policy currently being used by the facility. The policy indicated, .Low Risk (non-emergency) refusal of care. A. Education the resident/family/representative for non-emergency refusals to assist with potential reasons and assistance with refusals. i. For on-going refusals, a care conference will be used to address on-going concerns for care and treatments, and possible solutions. C. Notify the ordering physician after three refusals of care for treatment or medications. D. Document refusal and reasons if known, in progress notes. IV. Document: a. Education provided to the resident/family/representative regarding risks and benefits of the care or treatment. B. attempts made to resolve the refusal including but not limited to other routes, other times, other methods that the resident is in agreement with. C. Contact attempts to the provider/ordering physician for all high-risk refusals of care. D. Contact attempts to Medical Director if applicable On 8/13/20 at 2:07 p.m., the ADON provided a policy, dated 5/19/16, and titled, Resident Weight, and indicated it was the policy currently being used by the facility. The policy indicated, It is the policy of this facility that a resident's weight will be accurately obtained . as ordered by the physician or practitioner .3. On Admission .b) obtain weekly weights times 4 weeks for baseline. C) stable residents will be weighed monthly thereafter, unless physician or [DIAGNOSES REDACTED]. 3.1-46(a)(1)
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure proper procedures were followed to ensure residents' medications were accounted for when delivered from the pharmacy for 1 of 6 residents reviewed for pharmaceutical services (Resident Q). Findings include: Resident Q's record was reviewed on 8/13/20 at 12:03 p.m. A physician's orders [REDACTED]. A nurse's note, dated 6/26/20, indicated the facility was unable to locate the resident's [MEDICATION NAME]. Replacement medication was ordered from the pharmacy, the resident had not missed any doses of medication, and an investigation was initiated. A Drug Diversion Tool, dated 6/26/20, indicated [MEDICATION NAME] 150 mg, 14 capsules, were missing from the facility. The facility investigation revealed the pharmacy delivered medications and a nurse signed for the delivery on 6/24/20. The nurse the delivered the medications to the nurse's station where two other nurses were present. Facility systemic changes included two nurses would be required to collect and sign for medications at the door to ensure accuracy of delivery. During an interview, on 8/13/20 at 11:37 a.m., the Director of Nursing (DON) indicated when they discovered the [MEDICATION NAME] was missing, there was no medication or narcotic count log. During an interview, on 8/13/20 at 11:53 a.m., the DON indicated the facility policy was the pharmacy delivery driver and the facility nurse should have verified the count of narcotic medications and sign. Two facility nurses should have then verified the count when the medication was placed in the medication cart. They were unsure if the [MEDICATION NAME] was ever actually delivered from the pharmacy. The pharmacy had changed some of the protocols related to COVID-19, and he was unsure if the nurses had verified the delivery of the medication with the pharmacy delivery driver. The staff realized the medication was missing on 6/26/20, and pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN CROSSING AND THE LOFTS	**5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254**

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) records indicated it had been delivered to the facility on [DATE]. During an interview, on 8/13/20 at 1:52 p.m. the Pharmacy Account Manager indicated they had changed some of their delivery protocols related to COVID-19. They now only delivered to one single point at the facility, instead of going to each nurse's station. They also transitioned to having the delivery driver type in the receiving nurse's name, instead of the nurse physically signing. However, they have started attempting to go back to actually getting signatures from the receiving nurses. Any narcotic medications that were required to be counted, including [MEDICATION NAME], should always have been verified and counted with the delivery driver and the nurse accepting the delivery. On 6/18/20, the pharmacy sent an updated memo out which stated they would continue to deliver to one point at the facility, and would require the signature of the nurse, instead of the driver typing in the nurse's name. On 8/13/20 at 11:38 a.m., the DON provided a document titled, Chain of Custody for Controlled Substances, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: .The purpose of this policy is to provide a consistent and traceable method to maintain the chain of custody of controlled substances from delivery from the pharmacy to administering to the resident or to disposal .Procedure: 1. Receiving a Pharmacy Delivery .c. If no discrepancies are noted, the nurse will accept delivery of controlled drugs from the pharmacy delivery driver. i. The driver and nurse will validate a correct quantity and contents against the invoice provided. ii. The driver and nurse will sign the invoice. d. Two nurses will provide a count of controlled substances before placing in medication cart(s). i. Nurses will adjust the shift-to-shift count sheet to reflect addition of new medications. ii. In the event a second nurse is unavailable, the nurse will secure the controlled substances in the double-locked drawer This Federal tag relates to Complaint IN 230. 3.1-25(g)(1)
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a medication was held as ordered by the physician during 1 of 1 random medication administration observations (Resident N). Findings include: During a medication administration observation on 8/12/20 at 9:45 a.m., Licensed Practical Nurse (LPN) 8 administered Xarelto (a blood thinner) 20 milligrams (mg) by mouth to Resident N. Resident N's record was reviewed on 8/12/20 at 10:55 a.m. A physician's orders [REDACTED]. A nurse's note, dated 8/11/20, indicated the Nurse Practitioner (NP) visited the resident and gave new orders related a hematoma (bruise) on the resident's left breast. Orders included, but were not limited to, hold Xarelto on 8/12/20. A physician's orders [REDACTED]. During an interview, on 8/12/20 at 11:05 a.m., LPN 8 indicated the Xarelto for Resident N showed up to administer on the electronic Medication Administration Record [REDACTED]. During an interview, on 8/12/20 at 11:38 a.m., the Director of Nursing (DON) indicated Resident N's Xarelto should have been held. The nurse who took the order from the NP had not put the order in the electronic MAR indicated [REDACTED]. On 8/12/20 at 1:55 p.m., the DON provided a document titled, Medication Administration, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: .The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer. Procedure: I. General Procedures: a. Administer medication only as prescribed by the provider This Federal tag relates to Complaint IN 230. 3.1-48(c)(2)