STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 - Few	Reasonably accommodate the needs and preferences of each resident. 38767 Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for 4 of 7 dependent residents reviewed for call light placement (Residents G, W, Y, and Z). Findings include: 1. On 10/18/21 at 10:28 a.m., Resident G was observed lying in bed, eyes closed, receiving oxygen per nasal cannula via a concentrator next to the bed. The call light was observed hanging below mattress level from the handrail on the right side of the bed. On 10/25/21 at 2:53 p.m., Resident G was observed to be out of her room. Certified Nursing Assistant (CNA) 43 indicated the resident was out to the hospital. CNA 43 indicated, the resident required extensive assistance for care and transfers. Resident G's record was reviewed on 10/25/21 at 11:52 a.m. Diagnoses on Resident G's profile included, but were not limited to, encephalopathy (brain disease that alters brain function), anoxic brain damage (brain injury when brain is deprived of oxygen), acute and chronic respiratory failure, and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment, completed on 8/11/21, assessed Resident G as having the ability to make herself understood and understood others. Brief Interview for Mental Status (BIMS) score of 15 indicated no cognitive deficit. The resident required extensive assistance of two or more persons physical assist for bed mobility, transfers, and toilet use. Did not walk in the room or corridor. Limited assistance of one person physical assist for locomotion on and off the unit. Extensive assistance of one person physical assist for dressing, and personal hygiene. A care plan for Resident G indicated the resident was at risk for falls related to disease process, history of falls, impaired cognition, psychotropic drug use, and incontinence. The goals were for the resident not to sustain major injury related to falls or have falls through the next review date. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan for Resident G indicated, the resident had an ADL (activities of daily living) self-care deficit in bed mobility, transfers, eating, toileting and required assistance with ADL's related to unsteadiness, limited mobility, left above the knee amputation, history of falls, and weakness. The resident had a recent fall. The goal was for the resident to demonstrate increased independence with ADL completion. Interventions included, but were not limited to, place call light within reach. Remind resident to call for assistance if cognitively intact. 2. On 10/18/21 at 11:29 a.m., Resident W was observed propped in bed, call light clipped to padding on the back and bottom of the bed out of reach of the resident. The resident indicated, if he needed the nurse, he was to use his call light for help. Resident W's record was reviewed on 10/25/21 at 12:05 p.m. Diagnoses on Resident W's profile included, but were not limited to, history of stroke, hemiplegia (paralysis on one side of the body), and seizure disorder. The quarterly MDS assessment, completed on 8/26/21, assessed Resident W was having the ability to make himself understood and to understand others. BIMS score of 8 indicated moderately impaired cognition. The resident required extensive assistance of two or more persons physical assist for bed mobility, transfers, toileting, and personal hygiene. Extensive assistance of one person physical assist for walking in the room and corridor, locomotion on and off the unit, and dressing. A care plan for Resident W indicated the resident was at risk for falls related to weakness, unsteadiness, limited mobility, psychotropic drug use, seizure disorder and left sided hemiplegia. The goal was for the resident to be without falls through the next review. Interventions included, but were not limited to, place call bell within reach, remind resident to call for assistance. 3. On 10/18/21 at 11:23 a.m., Resident Y was observed lying in bed, fall mat on floor on the right side of the bed, and his call light on a bedside dresser beside personal electronic pad near the door, out of reach of the resident. Resident Y's record was reviewed on 10/25/21 at 12:45 p.m. Diagnoses on Resident Y's profile included, but were not limited to, encephalopathy, psychotic disorders with hallucinations, dementia with behavioral disturbance, cognitive communication deficit, and generalized muscle weakness. A Significant Change in Status MDS assessment, completed on 8/10/21, assessed Resident Y as having the ability to make himself understood and to understand others. BIMS score of 8 indicated moderately impaired cognition. The resident required extensive assistance of two+ persons physical assist for bed mobility, and transfers. He did not walk in the room or corridor. Extensive assistance of one person physical assist for locomotion on and off the unit. Extensive assistance of one person physical assist dressing, eating, toilet use, and personal hygiene. A care plan for Resident Y indicated the resident was at risk for falls related to weakness, unsteadiness, limited mobility, psychotropic drug use, episodes of hallucinations, and diagnosis of dementia. The goal was for the resident to be free of falls through the next review. Interventions included, but were not limited to, be sure the call light is within reach and encourage to use it for assistance as needed. Prompt response to all requests for assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 10/18/21 at 11:26 a.m., Resident Z was observed lying in bed, the call light was on the floor under the bed out of reach of the resident. Registered Nurse (RN) 19 indicated, the resident needed his call light to call for assistance, he required 1 person assist to get out of bed. Resident Z's record was reviewed on 10/25/21 at 2:30 p.m. Diagnoses on Resident Z's profile included, but were not limited to, cerebral infarction (stroke), and hemiplegia following a stroke. A quarterly MDS assessment, completed on 9/28/21, assessed Resident Z as having the ability to make himself understood and to understand others. BIMS score of 5 indicated severe cognitive impairment. The resident required assistance of one person physical assist for bed mobility, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. Extensive assistance of two+ person physical assist for transfers, walking in the room and corridor. A care plan for Resident Z indicated the resident was at risk for falls related to weakness, unsteadiness, limited mobility, incontinence, and hemiplegia. The goal was for the resident to be without falls through the review date. Interventions included, but were not limited to, place call bell within reach, remind resident to call for assistance. A care plan for Resident Z indicated, ADL self-care performance deficit in bed mobility, transfers, eating, toileting, requires assistance with ADL's related to weakness, unsteadiness, and limited mobility. The goal was for the resident to demonstrate increased independence with ADL completion. Interventions included, but were not limited to, place call light within reach. Remind resident to call for assistance if cognitively intact. On 10/21/21 at 3:07 p.m., CNA 50 indicated, all staff were responsible to ensure residents had a call light within reach. That was why every shift change they checked every resident room. On 10/21/21 at 3:09 p.m., CNA 51 indicated, it was the responsibility of all staff to make sure residents had a call light and that the lights were answered. Any staff member who saw a resident without a call light was responsible for giving it back to the resident. On 10/21/21 at 3:20 p.m., Qualified Medication Aide (QMA) 45 indicated, it was everyone's responsibility to assure residents had an accessible call light. On 10/25/21 at 3:36 p.m., the Administrator In Training (AIT) provided a Resident Rights policy, dated 5/30/19, and indicate the policy was the one currently being used by the facility. The policy indicated, Residents will be treated with dignity and respect including but not limited to .c. To have a method to communicate need to staff i. Call light or bell access will be within reach of the resident as one method to communicate needs to staff. 1. Staff will answer call needs promptly. 2. Any staff within the vicinity will answer a call light . 3.1-3(v)(1)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38767 Based on interview and record review, the facility failed to monitor, assess and had a delay in providing Cardio-Pulmonary Resuscitation (CPR) according to the resident's code status preference, and failed to follow the CPR procedure for unresponsive residents for 1 of 3 residents reviewed for death (Resident J). The Immediate Jeopardy began [DATE], when the facility failed to initiate CPR on a resident found unresponsive. The Executive Director (ED), Administrator in Training (AIT) and Regional Director of Operations (RDCO) were notified of the Immediate Jeopardy on [DATE] at 4:25 p.m. The Immediate Jeopardy was removed on [DATE], but noncompliance remained at a lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that was not Immediate Jeopardy. Findings include: Resident J's record was reviewed on [DATE] at 9:13 a.m. Diagnoses on Resident J's profile included, but were not limited to, multiple pulmonary emboli (PE), deep vein thrombosis of the right lower extremity, atrial fibrillation, chronic viral hepatitis C, malignant neoplasm of left lung, gastrointestinal hemorrhage, history of transient ischemic attack (TIA), and hypertension. Physician's orders for Resident J included, a. On [DATE] CBC and CMP weekly x 4 b. On [DATE] Attempt Resuscitation/CPR c. On [DATE] CBC, and CMP d. On [DATE] STAT chest x-ray related to pain and bruises on the left chest wall. e. On [DATE] STAT (urgent, rush, immediately) laboratory orders for a complete blood count (CBC), comprehensive metabolic panel (CMP), prothrombin (PT), partial thromboplastin time (PTT) related to jaundice. An Indiana Physician Orders for Scope of Treatment (POST) form for Resident J, dated [DATE], indicated if resident has no pulse and is not breathing attempt resuscitation/CPR. Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as needed. Transfer to hospital and/or intensive care unit if indicated to meet medical needs. Physician Order: full code. An Admission Initial Evaluation assessment for Resident J, dated [DATE] at 5:52 p.m., indicated 48 Hour Baseline Care Plan, Code Status: full code . Vital Sign documentation for Resident J indicated, (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. On [DATE] at 5:53 a.m., temperature 96.9 Fahrenheit (F), (normal 97 F - 99 F), respirations 22 breaths per minute (normal 12 - 16, and oxygen saturations 96% on room air per LPN 19. b. On [DATE] at 9:40 a.m., blood pressure 105 / 66 (normal per American Heart Association,d+[DATE]) per LPN 19. c. On [DATE] at 11:16 a.m., temperature 97.2 F, respirations 18 breaths per minute, and oxygen saturations 94% on room air per LPN 19. A Progress Note for Resident J, dated [DATE] at 9:06 a.m., indicated the resident was observed to have yellow eyes, with bruises on the left side of his chest area extending a little to his back with associated pain when touched. The resident was seen by the physician with STAT labs ordered with a chest x-ray. The resident's Tylenol and Lipitor (used to treat high cholesterol) was discontinued. Staff to continue observing. A Late Physicians Progress Note for Resident J, dated [DATE] at 1:33 p.m., created by the physician's scribe on [DATE] at 1:34 p.m., indicated the patient was seen for admission history and physical. Per hospital records the patient presented to the hospital prior to admit to the facility with progressive weakness and shortness of breath. He was found to have segmental and subsegmental PE. New orders were given for stat labs and a chest x-ray related to new onset jaundice and chest wall bruising with pain. A late Progress Note for Resident J, dated [DATE] at 6:00 p.m., created by Licensed Practical Nurse (LPN) 10 on [DATE] at 5:24 p.m., indicated the writer was summoned to the resident's room by the unit staff. The resident was noted to be unresponsive. LPN 10 and other staff initiated CPR at that time. An automated external defibrillator (AED) was applied. 911, resident representative and the physician were called. Emergency medical technicians (EMT's) attempted resuscitation without success. Code Event Minutes for Resident J, dated [DATE], created by LPN 10, indicated first response CNA 20, time resident found approximately between 5:35 p.m. - 5:40 p.m. Resident found in bed non-responsive, no pulse, and not breathing. Time code called/initiated between 5:50 p.m. - 6:00 p.m., unable to obtain vital signs. Attempted CPR, AED utilized, no shock advised, CPR provided for 8 cycles. Oxygen was administered per mask. EMS called at 6:00 p.m. and arrived at 6:10 p.m. The resident record for Resident J, dated [DATE], lacked documentation Activity of Daily Living (ADL) services were provided after 1:15 p.m. when the entirety of the morning care was input into the system. A handwritten Witness Statement by CNA 20, dated [DATE], indicated, When I got here at 3:45 p.m. got upstairs and did a round check seen/thought he was sleep 3:48 p.m. is when I last seen him sleep then I went to check on my next resident didn't go back in his room till dinner then I realize he was gone and got the qualified medication aide [QMA] around 5:30ish then got [LPN 22] the nurse. A handwritten Witness Statement by QMA 21, dated [DATE], indicated, At 5:32 p.m the aide came and got me she said the resident was not waking up I looked at him he was unresponsive and I told her to get the nurse and she was notified at 5:30ish. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A handwritten Witness Statement by LPN 22, dated [DATE], indicated, CNA alerted nurse that resident had passed away in [room number] around 5:45 p.m. Nurse then alerted unit manager [LPN 10] at 5:46 p.m. When nurse entered room resident right arm in air very stiff nurse layed arm down. Then QMA and [LPN 10] to unit stating that resident was a full code so CPR initiated at 6:00 p.m. A Witness Statement typed by the Divisional Risk Coordinator, signed by LPN 22, undated, indicated, At 5:42 p.m. the CNA came I was giving insulin and she said we need you the patient in [room number] is dead. I gave the insulin and went right over to the room and his arm was in the air and I moved his arm down. Then I went out to the nurse's station and looked for the chart but could not locate it, so then I went to the computer and looked up his code status and it said [attempt resuscitation] and at the same time [QMA 23] found the chart and said he is a full code. [LPN 10] was coming with the crash cart and said call 911 and he immediately started CPR and I called 911. 911 put me on hold twice and I called back a third time and they finally answered. They arrived shortly after and they continued CPR. I was at the desk getting the paperwork and they came out and said he had passed. I called the son and let him know the situation. A handwritten Witness Statement by QMA 23, dated [DATE], indicated, Around 5:50 p.m. I was notified by [LPN 10] that resident in [room number] was found unconscious. I checked [the electronic documentation system] to verify his code status he was a full code. [LPN 10] and I started CPR on resident. A handwritten Witness Statement by LPN 10, dated [DATE], indicated, On [DATE] about 5:46 p.m. I received call from [LPN 22] the nurse on [NAME]. I returned call at this time she stated resident in [room number] had passed away and needed 2nd nurse for verification. I told her I was on my way. Unsure of time got to unit but QMA had informed me he was attempt CPR/Full Code. I grabbed crash cart and proceeded to unit. At that time nurse was at desk and stated he's a attempted resuscitation I educated nurse and all staff that means full code and proceeded to room and .started CPR. I instructed nurse to call 911. [QMA 23] and I continued several rounds of CPR with other floor staff present and [LPN 22] the nurse in room. [LPN 22] stated unable to get hold 911 at this time CNA called and was able and gave address as writer and [QMA 23] continued CPR. Then EMT arrived began CPR for ,d+[DATE] rounds and stated has gone and stopped. I then instructed [LPN 22] to get paperwork and inform NP/MD on call. I then left the unit. During an interview on [DATE] at 11:07 a.m., LPN 10 indicated, on [DATE] LPN 22 had called him and indicated someone had passed away and wanted him to verify. He went upstairs and brought the crash cart with him and stopped at the nurse's station as LPN 22 was sitting at the desk. LPN 10 went to Resident J's room and started CPR and instructed LPN 22 to call 911. LPN 10 indicated, he knew resident J was a full code as he had been told by QMA 23. LPN 22 told him Resident J was an attempt CPR and he told her that meant he was a full code. LPN 10 indicated, when he entered the room, Resident J was still warm, and was not blue or cold. As the nurse he would know if the resident was a code or no code as the code status automatically popped up on the banner in the electronic medical record every time the resident record was accessed. A resident code status could also be found in the hard chart in the physician's orders and on a POST form in the front of the chart. LPN 10 indicated Resident J had a physician's order, dated [DATE], attempt CPR. LPN 10 indicated, he could not answer as to why LPN 22 had not started CPR or called 911 prior to his arrival on the unit. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:06 p.m., the Divisional Risk Coordinator indicated, on the evening of [DATE], CNA 20 went to check on Resident J at 3:45 p.m. and thought he was sleeping. When she went to deliver his dinner somewhere between 5:30 p.m. - 5:40 p.m., she noticed he wasn't responding and went to get QMA 21. QMA 21 went to Resident J's room while the aide went and got LPN 22 from [NAME] 1. LPN 22 was administering insulin and when she finished, she went to [NAME] 2 and checked on the resident who wasn't responsive. LPN 22 indicated the resident was stiff and she went to the desk to validate his code status. LPN 22 indicated she could not find the resident's chart although it was at the desk. LPN 22 called LPN 10, then LPN 10 and QMA 23 came upstairs with the crash cart. LPN 10 and QMA 23 passed LPN 22 at the nurse's desk who said she was in the electronic medical record and his orders said, attempt CPR. LPN 10 and QMA 23 went to Resident J's room and started CPR while LPN 22 called 911. Resident J had an order for attempt CPR in the electronic medical record and a POST form in the hard chart, both indicated full code. During an interview on [DATE] at 3:08 p.m., LPN 22 indicated, on [DATE] at approximately 5:40 p.m., QMA 21 came to unit [NAME] 1 where she was giving insulin, and stated she was needed on the other side as Resident J was dead. QMA 21 told her Resident J was cold and hard. LPN 22 indicated she got a call from QMA 21 but did not answer because she was already in route to the unit. At 5:46 p.m. while in route to [NAME] 2 LPN 22 call the unit manager LPN 10 and reported Resident J was dead. LPN 22 entered Resident J's room and to her he looked clinically dead. His right arm was in the air, his feet were cold, and he had no pulses in either carotid artery. In her opinion the resident was already clinically dead, and CPR should not have been performed at that point. LPN 22 put the resident's arm down by his side and went to the nurse's station. At that time, she could not locate the resident's hard chart to find family information, so she logged into the electronic medical record. Once inside the chart she observed attempt CPR. LPN found the family contact information and called the son at approximately 5:52 p.m. to notify him the resident was deceased . At approximately 5:55 p.m. LPN 10 and QMA 23 were observed getting off the elevator and he yelled, Resident J was a full code, start CPR and call 911. LPN 10 and QMA 23 had the crash cart and went to Resident J's room and started CPR. The ambulance arrived at 6:05 p.m., and the EMT's did 1 round of CPR before calling the resident dead. It was her opinion that if [NAME] 2 staff to include QMA 21, CNA 20, and CNA 24 had checked on the resident he would have been found before he was cold. The resident was newer to the facility and his code status was not signed which made him an automatically a full code. LPN 22 indicated, she had never received education related to code status or when to initiate CPR during her employment at the facility. On [DATE] at 10:40 a.m., the AIT indicated there was no nursing documentation in Resident J's chart to indicate the resident was being monitored throughout the day for his decline in mental status, yellow eyes, bruises on his chest and back, or if STAT labs had been completed, beween 9:06 a.m. and when he was found unresponsive at 5:30 p.m. The AIT indicated, she could not answer as to why there was a delay more than 20 minutes for staff to initiate CPR after the resident was found, or why 911 was not called immediately after the resident was found unresponsive. On [DATE] at 10:50 a.m., the RDCO proved a basic life support (BLS) Provider CPR card for LPN 22 card issue date [DATE] and expiration date ,d+[DATE]. The RDCO indicated, as LPN 22 was no longer certified to perform CPR as her certification had expired, that was the reason she called LPN 10 to come perform CPR. Indicated, code status and CPR protocol education was presented to staff via electronic education, she did not provide a copy of the training per request. The facility lacked documentation to indicate LPN 22 had been CPR training or education regrading code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:00 a.m., LPN 10 indicated, Resident J's medical record lacked documentation on [DATE] to indicate the resident's vital signs or change in condition were monitored after the NP visit. LPN 10 indicated, he could not answer as to why there was a delay more than 20 minutes for staff to initiate CPR after the resident was found, why 911 was not called immediately after the resident was found unresponsive, or why there was no documentation to indicate the resident was being monitored after stat labs orders were obtained in the morning for a change in condition. On [DATE] at 3:10 p.m., the AIT indicated, there was no documentation in the electronic training to indicate nursing staff had received training regarding CPR and code status, or when to initiate CPR. It was the standard of the facility to have at least 1 CPR certified person in the facility every shift. On [DATE] at 4:10 p.m., the AIT provided a General Code Status policy, dated [DATE], and indicated the policy was the one currently being used by the facility. The policy indicated, The purpose of this policy is to guide clinical staff to quickly and accurately identify residents in the facility that do and do not request CPR as a treatment for respiratory and cardiac arrest .The use of an electronic health record [EHR] provides for fast retrieval to identify and how to appropriately respond to respiratory and cardiac arrest based upon the resident/representative wishes .Code Status is found in the electronic health record and will be used by the nurse to validate Code Status before initiating CPR .Two basic code status categories will be entered into the electronic medical record to guide staff for appropriate emergency treatment/actions should respirations cease and/or pulselessness occur are: i. CPR Code Status, ii. Do Not Resuscitate/DNR Status . On [DATE] at 4:10 p.m., the AIT provided an Initiate CPR policy, dated [DATE], and indicated the policy was the one currently being used by the facility. The policy indicated, It is the policy of this facility to promote resident centered care by respecting resident's right to formulate an advanced directive including to initiate CPR by training staff .1. Upon admission, discuss code status with the resident and/or family/guardian and document .2. The facility will maintain and train staff on a communication method that will quickly alert staff as to the code status of a resident in the event heart or respirations cease. 3. Residents found unresponsive, not breathing or without a pulse, will have staff immediately locate the Code Status and communicate this to the team. 4. If CPR is initiated, staff will begin CPR and call 911 with these expectations: a. There is a valid DNR order in place. b. There is obvious signs of clinical death [e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition] are present . The immediate jeopardy that began on [DATE] was removed on [DATE] when the facility conducted an audit on all residents that required CPR in the building for the prior 90 days, with no further findings. Charts were reviewed to ensure code status was correct on the charts, physicians' orders were in place, and care plans in the charts were accurate. All licensed nurses and QMA's were educated on the facilities policy identified as, General Code Status and Initiate CPR with emphasis on initiating CPR as soon as a code status is identified as Full Code, CPR, and Attempt Resuscitation. The DON/designee documented interviews with licensed nurses and QMA's on the facility policy regarding initiating CPR when a Full Code, CPR or Attempt Resuscitation. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. This Federal tag relates to Complaints IN00364436 and IN00365028.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38767 Based on interview and record review, the facility failed to have a system in place for ordering, obtaining, and tracking of STAT (urgent, rush, immediate) laboratory orders, and failed to ensure assessments and documentation were completed after a change in condition for 1 of 3 residents reviewed for death (Resident J). The Immediate Jeopardy began October 8, 2021, when the facility failed to ensure STAT laboratory orders were obtained and failed to document follow up assessments after the physician noted a change in condition to include a further decline in mental status, and new onset jaundice and bruising. The Executive Director (ED), Administrator in Training (AIT), Regional Director of Operations (RDCO), and Mobile Director of Nursing (Mobile DON) were notified of the Immediate Jeopardy on 10/21/21 at 5:15 p.m. The Immediate Jeopardy was removed on 10/22/21, but noncompliance remained at a lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that was not Immediate Jeopardy. Findings include: Resident J's record was reviewed on 10/19/21 at 9:13 a.m. Diagnoses on Resident J's profile included, but were not limited to, multiple pulmonary emboli (PE), deep vein thrombosis of the right lower extremity, atrial fibrillation, chronic viral hepatitis C, malignant neoplasm of left lung, gastrointestinal hemorrhage, history of transient ischemic attack (TIA), and hypertension. Physician's orders for Resident J included: a. On 10/1/21 complete blood count (CBC) and comprehensive metabolic panel (CMP) weekly times (x) 4 b On 10/7/21 CBC, and CMP c. On 10/8/21 STAT (urgent, rush, immediately) chest x-ray related to pain and bruises on the left chest wall. d. On 10/8/21 STAT laboratory orders for a CBC, CMP, prothrombin (PT), partial thromboplastin time (PTT) related to jaundice. Vital Sign documentation for Resident J indicated, a. On 10/8/21 at 5:53 a.m., temperature 96.9 Fahrenheit (F), (normal 97 F - 99 F), respirations 22 breaths per minute (normal 12 - 16), and oxygen saturations 96% on room air per Licensed Practical Nurse (LPN) 19. b. On 10/8/21 at 9:40 a.m., blood pressure 105/66 per LPN 19. c. On 10/8/21 at 11:16 a.m., temperature 97.2 F, respirations 18 breaths per minute, and oxygen saturations 94% on room air per LPN 19. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. The resident record lacked documentation vital signs were monitored after 11:16 a.m. on 10/8/21. American Health Associates Laboratory report, dated 10/7/21, indicated unable to obtain specimens. On the first attempt the phlebotomist was unable to obtain and adequate sample for testing. A second phlebotomist will be sent. The resident record lacked documentation on 10/7/21 that a 2nd attempt was made to obtain a sample related to the orders. The resident record lacked documentation on 10/8/21 that STAT lab orders were drawn. A late Skilled Documentation Assessment, dated 10/7/21 at 11:09 a.m. and created on 10/8/21 at 6:16 a.m. by Licensed Practical Nurse (LPN) 25, indicated no documentation of vital signs, resident denied pain, alert and within normal limits for mental status, mood and affect. Speech was clear. Lung sound was clear to auscultation bilateral. Abdomen was soft and non-tender with positive bowel sounds. Skin color and condition was within normal limits (WNL). The option for jaundice was not checked. Functional status was maintaining base line. No labs were obtained in the past or diagnostic tests in the past 24 hours. Resident wound, and Hepatitis C were not selected when given an option. No abnormal findings. Skilled services provided included education for discharge planning. A late entry Skilled Documentation Assessment, dated 10/8/21 at 10:30 a.m. and created on 10/14/21 at 10:41 a.m. by LPN 26, indicated no documentation of vital signs, resident denied pain, was alert and within normal limits for mental status, mood and affect. Speech was clear. Lung sound was clear to auscultation bilateral. Abdomen was soft and non-tender with positive bowel sounds. Skin color and condition WNL. The option for jaundice was not checked. Functional status was maintaining base line. No labs obtained in the past or diagnostic tests in the past 24 hours. Resident wound, and Hepatitis C were not selected when an option. There were no abnormal findings. Skilled services provided included management and evaluation of care plan. A Progress Note for Resident J, dated 10/8/2021 at 9:06 a.m., indicated the resident was observed to have yellow eyes, with bruises on the left side of his chest area extending a little to his back with associated pain when touched. The resident was seen by the physician with STAT labs ordered with a chest x-ray. The resident's Tylenol and Lipitor (used to treat high cholesterol) was discontinued. Staff were to continue observing. A Late Physicians Progress Note for Resident J, dated 10/8/21 at 1:33 p.m., created by the physician's scribe on 10/12/21 at 1:34 p.m., indicated the patient was seen for admission history and physical. Per hospital records the patient presented to the hospital prior to admission to the facility with progressive weakness and shortness of breath. He was found to have segmental and subsegmental pulmonary embolism. New orders were given for STAT labs and a chest x-ray. The physician indicated, new onset jaundice, added LFT's [liver function tests] and ammonia level. He has a history of Hepatitis C but previous liver enzymes unknown. The resident record for Resident J, dated 10/8/21, lacked documentation Activity of Daily Living (ADL) services were provided after 1:15 p.m. when the entirety of the morning care was input into the system. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/19/21 at 10:40 a.m., the AIT indicated there was no nursing documentation in Resident J's chart to indicate the resident was being monitored throughout the day for his decline in mental status, yellow eyes, bruises on his chest and back, or if STAT labs had been completed, between 9:06 a.m. and when he was found unresponsive at 5:30 p.m. On 10/21/21 at 11:05 a.m., the laboratory manager indicated, upon review of the laboratory services submitted through the electronic lab ordering system, Resident J had no orders submitted 10/1/21 to 10/7/21. The lab manager indicated: a. On 10/4/21 on a routine laboratory (lab) day the phlebotomist was in the facility and was given orders for the resident to have a CBC and CMP weekly x 4 weeks. The blood draw was attempted one time without success, and the phlebotomist indicated she would send out another phlebotomist to get the sample. The laboratory manager indicated, after a discussion between the nurse and phlebotomist, a decision was made to reschedule the blood draw for the next routine lab day. b. On 10/7/21 on a routine lab day the phlebotomist was in the facility and was given orders for the resident to have a CBC and CMP. The blood draw was attempted one time without success, and the nurse requested another phlebotomist come the same day and get the sample. The 2nd phlebotomist did not come to the facility. c. On 10/8/21 at 8:45 a.m., an order from the facility for STAT labs was put into the electronic lab ordering system. The dispatcher saw the STAT order, in addition to the routine orders on 10/1/21 and 10/7/21 and thought they were duplicate orders. The STAT orders were then canceled in error by the dispatcher, and the routine orders not completed as it was not a routine service day. The laboratory manager indicated, the dispatcher should have canceled the routine orders, not the STAT orders. During an interview on 10/19/21 at 11:00 a.m., LPN 10 indicated Resident J's medical record lacked documentation on 10/8/21 to indicate the resident's vital signs or change in condition were monitored after the Nurse Practitioner (NP) visit. LPN 10 indicated he could not answer as to why there was no documentation to indicate the resident was being monitored after STAT labs orders were obtained in the morning for a change in condition. On 10/20/21 at 2:16 p.m., the Mobile DON indicated lab personnel told the facility they were unable to get a specimen on 10/7/21. The Mobile DON indicated she was unsure why. There was a call out to see if staff could get reasoning why the blood was not drawn on 10/7/21. She had no comment regarding completion of STAT lab orders for 10/8/21. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/21 at 9:49 a.m., the NP indicated she had seen Resident J on 3 separate occasions the week he was admitted before his death. On 10/1/21 the NP saw the resident for an initial admission assessment as he was newly admitted from the hospital on 9/30/21. The resident was alert and oriented, sitting up in bed, and talkative. The visit addressed the resident having edema in the lower extremities, a sacral wound, and generalized pain. Labs ordered were given to do a CMP and CBC weekly x 4. The NP indicated she never received the results. On 10/5/21 the NP saw resident for continued follow up of his chronic pain and opioid medication management. On 10/6/21 the NP was asked by the Occupational Therapist (OT) to see the resident related to altered mental status (AMS). The resident was laying down in bed, alert, and verbalized he was aware he was confused, and did not feel like himself. The NP indicated she again gave lab orders for a CBC, and CMP. She documented in her note on the resident's chart she would get a urinary analysis with culture and sensitivity (US C&S) but did not specify that in her orders. The NP indicated she never received the results for those lab orders. On 10/8/21 the physician saw Resident J in the morning between 8:00 a.m. and 9 a.m. to complete a History and Physical (H&P). The physician ordered STAT labs to include a CBC, CMP, Ammonia level and chest x-ray related to a worsening AMS, new onset of jaundice and bruising, the resident had a history of Hepatitis C but there were no labs to compare with, so she also ordered liver function tests (LFT's), and due to multiple lab orders that week that had not been done. On 10/8/21 the NP arrived at the facility after 9:00 a.m., was told the resident had already been seen that morning by the MD between 8:00 and 9:00 a.m., and given STAT orders, so she did not go see him. On 10/21/21 at 10:00 a.m., the NP indicated Resident J was admitted to the facility post hospitalization after being on blood thinners for PE's but had not presented with the bruising on the initial visits per the NP. Hospital documentation prior to facility admission indicated Resident J had a procedure in the hospital and had been on intravenous (IV) blood thinners. The procedure was called inferior vena cava (IVC) filter placement (looks like a wire umbrella with netting meant to catch blood clots) where a catheter was run up the femoral artery from the groin to the top of the heart and a little rounded plug with mesh net meant to catch blood clot and prevent them from entering the heart was placed in the vessel. Concerns post procedure would be bleeding in the groin, monitoring of back and abdomen for rigidity, and bruising and tenderness that would indicate internal bleeding. The resident denied falling, and without further information she would assume the bruising on Resident J's side and back were internal bleeding. If the labs had been completed as ordered, the physician and NP could have determined if the resident was critical and could have sent him to the hospital as needed. AMS did not determine that a resident needed hospitalization . But abnormal critical lab values with AMS would have been a reason to hospitalize the resident for closer monitoring on a critical unit, where continued labs could have been drawn. In her medical opinion if she could have had those labs results, and if those labs were critical, she would have sent him to the hospital for critical care, and possibly prevented his death. On 10/21/21 at 10:15 a.m., the NP indicated after rounding and seeing residents, she would discuss her visit with the nurse if available and the nurse would write the orders and contact the labs. If the nurse was not at the desk, the NP would leave written orders on the nurse computer keyboard for her viewing. Physician or NP notes were dictated, and a scribe would input the notes into the residents in 1 to 2 weeks depending on when the scribe had time to process them. The scribe had documented in the NP notes that the resident had refused the labs, but that was a mistake. The lab phlebotomist came on 10/4 and 10/7 and had documented she was unable to get enough blood for a sample and would send another phlebotomist to obtain. When reviewing the laboratory electronic records, she could not see 10/8/21 STAT labs. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/21 at 11:05 a.m., the laboratory manager indicated the lab was scheduled to come into the facility routinely two days a week. When the phlebotomist shows up, he/she would draw any labs needed or requested by the facility staff. Staff in the facility could add labs to the electronic system at any time. If a lab was documented as a routine order, the lab personnel could not see the orders and would get a list when they arrive at the facility. If the nurse input the order as a STAT lab, then the order would show up at the lab on the electronic system. STAT draws were generally completed in a 4-5 hour turnaround time. It was preferred the phlebotomist get the blood within 2 hours to allow for processing. On routine labs i.e., PT/INR the facility could expect results before 3:00 p.m., basic chemistry and hematology results on the same day, and any other lab results could be expected within 24 hrs. The laboratory manager indicated when a blood draw was unsuccessful, a discussion was had with the nurse and a decision was made to either reschedule or plan to try on the next routine lab day. On 10/21/21 at 11:14 a.m., the RDCO indicated labs from 10/8/21 were put into the facility electronic documentation system. On 10/21/21 at 12:25 p.m., the RDCO indicated the facility had no policy for completion of STAT labs. On 10/21/21 at 2:57 p.m., Registered Nurse (RN) 8 indicated if she received an order for a lab, she would write the order in the resident's electronic record, then request a blood draw from the lab in the labs electronic medical system. It the lab was written as STAT the lab could see the order. The night shift nurse would print out a list for the phlebotomist on the routine lab days. RN 8 indicated if she had ordered a STAT lab, and the draw was not done on her shift, she would pass on the information to the next shift. She indicated she had no idea on the expected turn around time for a STAT lab. The contracted laboratory was ultimately responsible for assuring resident lab orders were completed. On 10/21/21 at 3:13 p.m., RN 19 indicated when getting a lab order from the physician, she would ask if the blood draw was a routine or STAT order. If routine the order was put into the electronic lab system for the next lab day. If a STAT order put into the system, the phlebotomist was expected to come that same day. STAT orders should be done within 2 hours, but in that facility, sometimes the lab did not come until the end of the shift. If STAT lab were done within a few hours or on her shift, she would call the lab to see why not. On 10/21/21 at 3:23 p.m., Licensed Practical Nurse (LPN) 25 indicated, if a resident received orders for new labs, she would put the orders into the resident's electronic medical record, the labs electronic medical system, and notify the family. When the phlebotomist came to the facility, he/she was given a lab requisition. After the blood draw was completed, the staff waited for the results then notified the physician, resident, and family. STAT lab orders were called to the lab, the nurse would be given a confirmation number, and the lab determines when they were coming. If the phlebotomist did not come within 2-4 hours she would call and ask where they were. If STAT labs were not drawn on her shift, she would pass along the information to the next shift. LPN 25 indicated nurses should document in the progress notes when the physician's ordered for STAT labs, and results came back. It was the responsibility of the nurse to assure labs orders were completed, but she could not control the lab or when they arrived to draw. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/21 at 3:32 p.m., LPN 32 indicated if she receives new lab order from the physician, she would enter the orders into the resident's electronic medical record, and the labs electronic system. The order was filed in the resident's hard chart, and she would notify the resident and family of the new orders. If the lab draw was a STAT order, it was supposed to be done within 4 hours, if not she would call the lab to see why it hadn't been done. If not completed on her shift, she would pass along the information to the next shift. If the phlebotomist was not coming for some reason, she would notify the physician and document the information in the resident's progress notes. On 10/22/21 at 3:50 p.m., the Mobile DON indicated there was no policy for monitoring of documentation related to a resident change in condition. Nurses were trained upon hire orientation on how to enter new laboratory orders into the laboratory provider electronic data base, then there was no further training related to processing or tracking of laboratory orders during the time of employment. A Quality Concern/Performance Improvement Report from the contracted laboratory, dated 10/22/21, indicated, orders for CMP and CBC were submitted to the laboratory on 10/4, 10/7, and 10/8 for Resident J. The phlebotomist was unsuccessful in her attempts to obtain blood from the resident on 10/4 and 10/7. On 10/8 the routine a.m. orders for Resident J, and the STAT orders specifying the same resident were interpreted by the phlebotomist team lead as duplicates. The STAT venipuncture was deferred to the phlebotomist in the faciilty performing the morning blood draws; that phlebotomist however did not attempt to obtain a blood specimen due to her unsuccessful attempts on 10/4 and 10/7. Lab tests for Resident J on 10/4, 10//7, and 10/8 were not completed as ordered. On 10/20/21 at 3:59 p.m., the AIT provided a Laboratory and Radiology Services and Results Reporting policy, dated 3/22/19, and indicated the policy was the one currently being used by the facility. The policy indicated, The facility is responsible for the quality and timeliness of services whether services are provided by the facility or an outside source. There are clinical and physiological risks when laboratory, radiology, or other diagnostic services are performed in a timely manner, or the results of these services are not reported or acted upon quickly. Delays may adversely affect a resident's diagnosis, treatment, assessment, and interventions . b. The facility assumes responsibility for the timeliness and quality of the laboratory and radiological services chosen and will make changes as needed to secure services On 10/21/21 at 4:35 p.m., the Mobile DON proved a Clinical Documentation Standards policy, dated 8/31/18, and indicated the policy was the one currently being used by the facility. The policy indicated, .A complete record contains an accurate and functional representation of actual experience of the resident and must contain enough information to show that the status of the individual is known, and a plan of care has been identified to meet the care needs identified in the medical record .The primary purpose of the medical record[s] is to provide continuity of care. i. Other reasons also include: 1. Clinical evidence of care and treatment records as evidence of care .iii. Document entries during the work shift and complete all entries before leaving the facility for that tour/shift. iv. Document the status of the resident including changes (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediate jeopardy that began on 10/8/21 was removed on 10/22/21 when the facility completed audits of laboratory orders for all resident with an order for STAT laboratory received in the prior 30 days. The laboratory provider electronic data base was reconciled with the facility electronic resident medical records, discrepancies identified, and the medical director notified. An audit was completed of all residents identified as having a change in condition in the prior 30 days to validate follow up assessments and documentation was completed. Staff education was provided to licensed nursing staff regarding ordering of resident laboratory orders, tracking of laboratory results, follow up when laboratory orders were not completed, and documentation required. Staff education provided to all direct care staff on how to identify resident change in condition, notification regarding change in condition, and documentation requirements. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. This Federal tag relates to Complaint IN00365028. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 38767 Based on interview and record review, the facility failed to have a system in place for ordering, obtaining, and tracking of routine and STAT (urgent, rush, immediate) laboratory orders for 1 of 3 residents reviewed for completion of laboratory orders (Resident J). The Immediate Jeopardy began October 1, 2021, when the facility failed to ensure routine laboratory orders were completed on 10/1/21 and 10/6/21, and STAT laboratory orders were completed on 10/8/21 after a physician noted a change in condition to include a further decline in mental status, and new onset jaundice and bruising. The Executive Director (ED), Administrator in Training (AIT), Regional Director of Operations (RDCO), and Mobile Director of Nursing (Mobile DON) were notified of the Immediate Jeopardy on 10/21/21 at 5:11 p.m. The Immediate Jeopardy was removed on 10/22/21, but noncompliance remained at a lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that was not Immediate Jeopardy. Findings include: Resident J's record was reviewed on 10/19/21 at 9:13 a.m. Diagnoses on Resident J's profile included, but were not limited to, multiple pulmonary emboli (PE), deep vein thrombosis of the right lower extremity, atrial fibrillation, chronic viral hepatitis C, malignant neoplasm of left lung, gastrointestinal hemorrhage, history of transient ischemic attack (TIA), and hypertension. Physician's orders for Resident J included: a. On 10/1/21 complete blood count (CBC) and comprehensive metabolic panel (CMP) weekly times (x) 4 b On 10/7/21 CBC, and CMP c. On 10/8/21 STAT (urgent, rush, immediately) chest x-ray related to pain and bruises on the left chest wall. d. On 10/8/21 STAT laboratory orders for a CBC, CMP, prothrombin (PT), partial thromboplastin time (PTT) related to jaundice. American Health Associates Laboratory report, dated 10/7/21, indicated unable to obtain specimens. On the first attempt the phlebotomist was unable to obtain and adequate sample for testing. A second phlebotomist will be sent. The resident record lacked documentation on 10/7/21 that a 2nd attempt was made to obtain a sample related to the orders. The resident record lacked documentation on 10/8/21 that STAT lab orders were drawn. A Progress Note for Resident J, dated 10/8/2021 at 9:06 a.m., indicated the resident was observed to have yellow eyes, with bruises on the left side of his chest area extending a little to his back with associated pain when touched. The resident was seen by the physician with STAT labs ordered with a chest x-ray. The resident's Tylenol and Lipitor (used to treat high cholesterol) was discontinued. Staff to continue observing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Late Physicians Progress Note for Resident J, dated 10/8/21 at 1:33 p.m., created by the physician's scribe on 10/12/21 at 1:34 p.m., indicated the patient was seen for admission history and physical. Per hospital records the patient presented to the hospital prior to admission to the facility with progressive weakness and shortness of breath. He was found to have segmental and subsegmental pulmonary embolism. New orders were given for STAT labs and a chest x-ray. The physician indicated, new onset jaundice, added LFT's [liver function tests] and ammonia level. He has a history of Hepatitis C but previous liver enzymes unknown. On 10/21/21 at 11:05 a.m., the laboratory manager indicated, upon review of the laboratory services submitted through the electronic lab ordering system, Resident J had no orders submitted 10/1/21 to 10/7/21. The lab manager indicated: a. On 10/4/21 on a routine laboratory (lab) day the phlebotomist was in the facility and was given orders for the resident to have a CBC and CMP weekly x 4 weeks. The blood draw was attempted one time without success, and the phlebotomist indicated she would send out another phlebotomist to get the sample. The laboratory manager indicated, after a discussion between the nurse and phlebotomist, a decision was made to reschedule the blood draw for the next routine lab day. b. On 10/7/21 on a routine lab day the phlebotomist was in the facility and was given orders for the resident to have a CBC and CMP. The blood draw was attempted one time without success, and the nurse requested another phlebotomist come the same day and get the sample. The 2nd phlebotomist did not come to the facility. c. On 10/8/21 at 8:45 a.m., an order from the facility for STAT labs was put into the electronic lab ordering system. The dispatcher saw the STAT order, in addition to the routine orders on 10/1/21 and 10/7/21 and thought they were duplicate orders. The STAT orders were then canceled in error by the dispatcher, and the routine orders not completed as it was not a routine service day. The laboratory manager indicated, the dispatcher should have canceled the routine orders, not the STAT orders. On 10/20/21 at 2:16 p.m., the Mobile DON indicated lab personnel told the facility they were unable to get a specimen on 10/7/21. The Mobile DON indicated she was unsure why. There was a call out to see if staff could get reasoning why the blood was not drawn on 10/7/21. She had no comment regarding completion of STAT lab orders for 10/8/21. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/21 at 9:49 a.m., the NP indicated she had seen Resident J on 3 separate occasions the week he was admitted before his death. On 10/1/21 the NP saw the resident for an initial admission assessment as he was newly admitted from the hospital on 9/30/21. The resident was alert and oriented, sitting up in bed, and talkative. The visit addressed the resident having edema in the lower extremities, a sacral wound, and generalized pain. Labs ordered were given to do a CMP and CBC weekly x 4. The NP indicated she never received the results. On 10/5/21 the NP saw resident for continued follow up of his chronic pain and opioid medication management. On 10/6/21 the NP was asked by the Occupational Therapist (OT) to see the resident related to altered mental status (AMS). The resident was laying down in bed, alert, and verbalized he was aware he was confused, and did not feel like himself. The NP indicated she again gave lab orders for a CBC, and CMP. She documented in her note on the resident's chart she would get a urinary analysis with culture and sensitivity (US C&S) but did not specify that in her orders. The NP indicated she never received the results for those lab orders. On 10/8/21 the physician saw Resident J in the morning between 8:00 a.m. and 9 a.m. to complete a History and Physical (H&P). The physician ordered STAT labs to include a CBC, CMP, Ammonia level and chest x-ray related to a worsening AMS, new onset of jaundice and bruising, the resident had a history of Hepatitis C but there were no labs to compare with, so she also ordered liver function tests (LFT's), and due to multiple lab orders that week that had not been done. On 10/8/21 the NP arrived at the facility after 9:00 a.m., was told the resident had already been seen that morning by the MD between 8:00 and 9:00 a.m., and given STAT orders, so she did not go see him. On 10/21/21 at 10:00 a.m., the NP indicated Resident J was admitted to the facility post hospitalization after being on blood thinners for PE's but had not presented with the bruising on the initial visits per the NP. Hospital documentation prior to facility admission indicated Resident J had a procedure in the hospital and had been on intravenous (IV) blood thinners. The procedure was called inferior vena cava (IVC) filter placement (looks like a wire umbrella with netting meant to catch blood clots) where a catheter was run up the femoral artery from the groin to the top of the heart and a little rounded plug with mesh net meant to catch blood clot and prevent them from entering the heart was placed in the vessel. Concerns post procedure would be bleeding in the groin, monitoring of back and abdomen for rigidity, and bruising and tenderness that would indicate internal bleeding. The resident denied falling, and without further information she would assume the bruising on Resident J's side and back were internal bleeding. If the labs had been completed as ordered, the physician and NP could have determined if the resident was critical and could have sent him to the hospital as needed. AMS did not determine that a resident needed hospitalization . But abnormal critical lab values with AMS would have been a reason to hospitalize the resident for closer monitoring on a critical unit, where continued labs could have been drawn. In her medical opinion if she could have had those labs results, and if those labs were critical, she would have sent him to the hospital for critical care, and possibly prevented his death. On 10/21/21 at 10:15 a.m., the NP indicated after rounding and seeing residents, she would discuss her visit with the nurse if available and the nurse would write the orders and contact the labs. If the nurse was not at the desk, the NP would leave written orders on the nurse computer keyboard for her viewing. Physician or NP notes were dictated, and a scribe would input the notes into the residents in 1 to 2 weeks depending on when the scribe had time to process them. The scribe had documented in the NP notes that the resident had refused the labs, but that was a mistake. The lab phlebotomist came on 10/4 and 10/7 and had documented she was unable to get enough blood for a sample and would send another phlebotomist to obtain. When reviewing the laboratory electronic records, she could not see 10/8/21 STAT labs. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/21 at 11:05 a.m., the laboratory manager indicated the lab was scheduled to come into the facility routinely two days a week. When the phlebotomist shows up, he/she would draw any labs needed or requested by the facility staff. Staff in the facility could add labs to the electronic system at any time. If a lab was documented as a routine order, the lab personnel could not see the orders and would get a list when they arrive at the facility. If the nurse input the order as a STAT lab, then the order would show up at the lab on the electronic system. STAT draws were generally completed in a 4-5 hour turnaround time. It was preferred the phlebotomist get the blood within 2 hours to allow for processing. On routine labs i.e., PT/INR the facility could expect results before 3:00 p.m., basic chemistry and hematology results on the same day, and any other lab results could be expected within 24 hrs. The laboratory manager indicated when a blood draw was unsuccessful, a discussion was had with the nurse and a decision was made to either reschedule or plan to try on the next routine lab day. On 10/21/21 at 11:14 a.m., the RDCO indicated labs from 10/8/21 were put into the facility electronic documentation system. On 10/21/21 at 12:25 p.m., the RDCO indicated the facility had no policy for completion of STAT labs. On 10/21/21 at 2:57 p.m., Registered Nurse (RN) 8 indicated if she received an order for a lab, she would write the order in the resident's electronic record, then request a blood draw from the lab in the labs electronic medical system. If the lab was written as STAT, the lab could see the order. The night shift nurse would print out a list for the phlebotomist on the routine lab days. RN 8 indicated if she had ordered a STAT lab, and the draw was not done on her shift, she would pass on the information to the next shift. She had no idea on the expected turnaround time for a STAT lab. The contracted laboratory was ultimately responsible for assuring resident lab orders were completed. On 10/21/21 at 3:13 p.m., RN 19 indicated when getting a lab order from the physician, she would ask if the blood draw was a routine or STAT order. If routine the order was put into the electronic lab system for the next lab day. If a STAT order put into the system, the phlebotomist was expected to come that same day. STAT orders should be done within 2 hours, but in that facility sometimes the lab did not come until the end of the shift. If STAT lab were done within a few hours or on her shift, she would call the lab to see why not. On 10/21/21 at 3:23 p.m., Licensed Practical Nurse (LPN) 25 indicated if a resident received orders for new labs, she would put the orders into the resident's electronic medical record, the labs electronic medical system, and notify the family. When the phlebotomist came to the facility, he/she was given a lab requisition. After the blood draw was completed, the staff waited for the results then notified the physician, resident, and family. STAT lab orders were called to the lab, the nurse would be given a confirmation number, and the lab determines when they were coming. If the phlebotomist did not come within 2-4 hours she would call and ask where they were. If STAT labs were not drawn on her shift, she would pass along the information to the next shift. LPN 25 indicated nurses should document in the progress notes when the physician's ordered for STAT labs, and results came back. It was the responsibility of the nurse to assure labs orders were completed, but she could not control the lab or when they arrived to draw. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/21 at 3:32 p.m., LPN 32 indicated if she receives new lab order from the physician, she would enter the orders into the resident's electronic medical record, and the labs electronic system. The order was filed in the resident's hard chart, and she would notify the resident and family of the new orders. If the lab draw was a STAT order, it was supposed to be done within 4 hours, if not she would call the lab to see why it hadn't been done. If not completed on her shift, she would pass along the information to the next shift. If the phlebotomist was not coming for some reason, she would notify the physician and document the information in the resident's progress notes. On 10/22/21 at 3:50 p.m., the Mobile DON indicated there was no policy for monitoring of documentation related to a resident change in condition. Nurses were trained upon hire orientation on how to enter new laboratory orders into the laboratory provider electronic data base, then there was no further training related to processing or tracking of laboratory orders during the time of employment. A Quality Concern/Performance Improvement Report from the contracted laboratory, dated 10/22/21, indicated orders for CMP and CBC were submitted to the laboratory on 10/4, 10/7, and 10/8 for Resident J. The phlebotomist was unsuccessful in her attempts to obtain blood from the resident on 10/4 and 10/7. On 10/8 the routine a.m. orders for Resident J, and the STAT orders specifying the same resident were interpreted by the phlebotomist team lead as duplicates. The STAT venipuncture was deferred to the phlebotomist in the facility performing the morning blood draws; that phlebotomist however did not attempt to obtain a blood specimen due to her unsuccessful attempts on 10/4 and 10/7. Lab tests for Resident J on 10/4, 10//7, and 10/8 were not completed as ordered. On 10/20/21 at 3:59 p.m., the AIT provided a Laboratory and Radiology Services and Results Reporting policy, dated 3/22/19, and indicated the policy was the one currently being used by the facility. The policy indicated, The facility is responsible for the quality and timeliness of services whether services are provided by the facility or an outside source. There are clinical and physiological risks when laboratory, radiology, or other diagnostic services are performed in a timely manner, or the results of these services are not reported or acted upon quickly. Delays may adversely affect a resident's diagnosis, treatment, assessment, and interventions . b. The facility assumes responsibility for the timeliness and quality of the laboratory and radiological services chosen and will make changes as needed to secure services The immediate jeopardy that began on 10/1/21 was removed on 10/22/21 when the facility completed audits of laboratory orders for all resident received in the prior 30 days. The laboratory provider electronic data base was reconciled with the facility electronic resident medical records, discrepancies identified, and the medical director notified. Staff education was provided to licensed nursing staff regarding ordering of resident laboratory orders, tracking of laboratory results, follow up when laboratory orders were not completed, and documentation required. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. This Federal tag relates to Complaint IN00365028. 3.1-37(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43491 Based on observation, interview, and record review, the facility failed to follow Centers for Disease Control (CDC) guidance during the COVID-19 pandemic and ensure infection control practices were followed when staff failed to ensure signs that indicated residents were on transmission-based precautions were placed on residents' doors to alert staff and visitors the residents were in isolation and what personal protective equipment (PPE) would be required to enter the residents' rooms (Residents P, Q, R, S, T, Ff); staff failed to wear proper PPE when they cared for residents in TBP, PPE was removed prior to exiting a TBP room, and staff washed their hands or used alcohol based hand sanitizer (performed hand hygiene) prior to providing care to a resident on TBP for 4 of 6 days of observation. The facility also failed to ensure suction equipment used in a resident's mouth was kept off the floor (Resident C) for 1 of 1 random observation. Findings include: 1. On 10/22/21 at 10:00 a.m., Resident R's room was observed. The resident's door was closed. A hanging storage organizer was hung on the door that contained disposable gowns, gloves, face shields, and N95 face masks. No sign was on the resident's door that indicated if the resident was in TBP or what PPE was required to enter the resident's room. On 10/22/21 at 10:12 a.m., Resident Q's room was observed. The resident's door was closed. A hanging storage organizer was hung on the door that contained disposable gowns, gloves, face shields, and N95 face masks. At this time, Physical Therapy Assistant (PTA) 37 was interviewed. She indicated she was going to work with Resident Q's roommate that day. She did not know if either resident was on isolation. She saw the PPE hung from the resident's door and assumed she should put it on before she entered the residents' room. No sign was on the residents' door that indicated if the residents were in TBP or what PPE was required to enter the residents' room. On 10/22/21 at 10:17 a.m., Resident P's room was observed. The resident's door was closed. A hanging storage organizer was hung on the door that contained disposable gowns, gloves, face shields, and N95 face masks. No sign was on the resident's door that indicated if the resident was in TBP or what PPE was required to enter the resident's room. During an uninterrupted observation that began on 10/22/21 at 10:31 a.m., Physical Therapist (PT) 38 was observed from the hallway, through an open door, as he worked with Resident P inside the resident's room. The PT wore a surgical mask, face shield, disposable gown, and gloves. The resident did not have on a face mask. PT 38's gown was observed to be untied, and his back and shoulders were uncovered. PT 38 was observed as he walked next to the resident and held onto a gait belt (an assistance device placed around a person's waist; used for lifting, transferring, and walking patients who have limited mobility issues) that was wrapped around the resident's waist. PT 38 was observed as he held on to the resident and the gait belt to assist the resident with sitting, standing, and walking in the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/21 at 10:46 a.m., PT 38 exited Resident P's room. During an interview at that time, PT 38 indicated, Resident P was on isolation because she was newly admitted to the facility. Resident P was not vaccinated for COVID-19. PTA 38 indicated he knew to put on an N95 face mask before he entered a resident's room who was on TBP. He just forgot that time. During an interview on 10/22/21 at 10:47 a.m., PTA 37 indicated Resident Q was on isolation because she was a new admission to the facility. She indicated she knew the resident was on isolation because she checked the resident's medical record. There was no sign on the door to tell her Resident Q's isolation status. On 10/22/21 at 10:58 a.m., Restorative Aide 40 was observed as she stood in a hallway, leaned against a wall, looking at a phone. Restorative Aide 40 had on a surgical face mask, pulled down to below her chin. Her face shield was tilted up and off of her face. She stood less than 6 feet from Resident Dd, who was seated in a wheelchair. During an interview on 10/22/21 at 11:00 a.m., Restorative Aide 40 indicated, she should have had her face mask over her mouth and nose. On 10/22/21 at 11:01 a.m., Resident Ff's call light was observed turned on. The resident's door was closed. A hanging storage organizer was hung on the door that contained disposable gowns, gloves, face shields, and N95 face masks. No sign was on the resident's door that indicated if the resident was in TBP or what PPE was required to enter the resident's room. Certified Nursing Assistant (CNA) 41 was observed as she exited another resident's room and walked to Resident Ff's door. CNA 41 did not perform hand hygiene as she left the previous resident's room. CNA 41 wore a surgical mask, pulled down below her nose, and a face shield. CNA 41 knocked on Resident Ff's door, opened it, and called in to the resident. CNA 41 put her arms through a disposable gown, but did not tie it in the back, leaving her back and shoulders exposed. CNA 41 put on gloves, entered the resident's room, and closed the door behind her. CNA 41 did not put on an N95 mask or perform hand hygiene before she put on gloves and entered Resident Ff's room. On 10/22/21 at 11:06 a.m., CNA 41 was observed as she exited Resident Ff's room. She stepped out into the hallway, removed the gown, and wadded it into a ball in her hand. She reached back into the resident's room, removed a trash bag from a trash can near the door, and carried the wadded gown in one hand and trash bag in the other hand down the hall. During an interview at that time, CNA 41 indicated, she usually wore an N95 mask into Resident Ff's room, she just forgot that time. She knew the resident was on TB but did not know why. She indicated she usually removed her PPE inside the resident's room, but just forgot that time. On 10/22/21 at 11:09 a.m., Culinary Aide 44 was observed with a surgical face mask pulled to below her chin. Culinary Aide 44 was observed talking with a coworker as she set wrapped silverware into napkins, stacked drink cups, and stood over open containers of food. During an interview at that time, Culinary Aide 44 indicated, she and her coworker were preparing for lunch for the residents. She knew she needed to wear a mask while she was in the facility, but she had asthma and it was hard to breathe while she worked with a face mask on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/21 at 11:17 a.m., Resident T's room was observed. The resident's door was opened. No resident was observed inside the room. A hanging storage organizer was hung on the door that contained disposable gowns, gloves, face shields, and N95 face masks. No sign was on the resident's door that indicated if the resident was in TBP or what PPE was required to enter the resident's room. During an interview on 10/22/21 at 11:25 a.m., the Administrator in Training (AIT) indicated, there should be signs on the isolation rooms that indicated if a resident was in TBP, what type of isolation the resident was in, and what PPE was required to enter the resident's room. On 10/22/21 at 1:45 p.m., the AIT provided a list of residents and confirmed Residents P, Q, R, S, Ff, and T were on TBP isolation. There should have been signs on the residents' doors that indicated the residents were in TBP isolation and what PPE staff should put on before they entered the residents' room. During an interview on 10/25/21 at 3:54 p.m., The Registered Nurse (RN) Regional Director of Clinical Operations (RDCO) indicated, staff are expected to perform hand hygiene before providing resident care and before putting on PPE. All staff should wear a surgical mask, over their mouth and nose, and a face shield, while in the facility. When staff go into a TBP room, they should put on an N95 mask, face shield, gown, and gloves. PPE should be put on at the doorway when they enter a resident's room and should be removed at the doorway prior to staff exiting the resident's room. The TBP rooms should have signs on the door that indicated the resident was in TBP, what type of isolation, and what PPE staff should put on before they entered the resident's room. The facility followed CDC and state department of health guidance. On 10/22/21 at 12:40 p.m., the AIT provided a policy titled, Use of PPE While in the Facility, dated 6/22/21. She indicated this was the current policy in use by the facility at that time. The policy indicated, .All staff must wear a surgical mask at all times, this include all departments (nursing, housekeeping, dietary, maintenance, business office, medical records, HR [human resources], and central supply .All direct care staff must wear a surgical mask and eye protection at all times .New admissions/ re-admissions who are not fully vaccinated against COVID-19, Residents who have been exposed (yellow quarantined/ observation area) .These are residents who may be contagious. N95 mask and eye protection required on the general area of the unit. Full PPE consisting of N95 mask, eye protection, gowns, and gloves donned when entering resident room .PPE is discarded before exiting the resident room and hand hygiene performed .All staff must wear a surgical mask, approved eyewear that protects the top and sides of the eyes 38767 2. On 10/18/21 at 10:03 a.m., Resident C was observed lying in bed, and the head of the bed slightly elevated. The resident was receiving oxygen per nasal cannula from a concentrator beside the bed. A suction machine with its tubing were observed on the floor on the left side of the resident's bed. On 10/18/21 at 10:40 a.m., CNA 14 was observed sitting at the Heritage Suites nurse's desk using her personal cell phone, she was not wearing a mask or face shield. At 10:45 a.m., LPN 33 was observed to prompt CNA 14 to put on her mask and handed her a face shield as she went down the hall passing out faceshields to staff working on the hallway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/18/21 at 10:52 a.m., the phlebotomist from the facility contracted lab was observed entering Resident Gg's room and drawing blood. The phlebotomist was wearing a surgical mask, but no protective eyewear. On 10/18/21 at 10:57 a.m., the phlebotomist was observed going in and out of resident rooms to draw blood samples, she was wearing a surgical mask, but no protective eyewear. The phlebotomist indicated, she had an extensive list of resident samples that morning, probably more than 20 before she finished. On 10/18/21 at 11:22 a.m., Culinary Aide 16 was observed leaning over the food counter in the Lofts dining room, looking at her personal cell phone. She indicated she was the server assigned for the lunch service. Culinary Aide 16 was observed to be wearing her surgical mask was under her chin and she was not wearing protective eyewear. There were trays of drinks, wrapped silverware and drink glasses in front of her on the counter. Culinary Aide 16 was then observed to prep drink pitchers, she did not wash or sanitize her hands. On 10/18/21 at 11:27 a.m., CNA 17 was observed on the Lofts 2 hallway going in and out of resident rooms to answer call lights, then walking down the hallway. CNA 17's protective face shield was pushed up on top of her head during the observation. On 10/18/21 at 11:35 a.m., Resident K was observed wheeling himself down the hallway, and indicated he was headed to the main dining room downstairs. Resident K's face mask was observed to under his chin as he passed RN 19 who did not prompt him to put his face mask on. Resident K was observed to stop and talk with Resident M, both without a mask. RN 19 did not prompt either resident to don their masks. On 10/18/21 at 11:51 a.m., Culinary Aide 18 was observed sitting at a table in the main dining room wrapping silverware into napkins from a large tray of silverware in front of her, as she talked with 2 residents who were sitting at nearby dining tables. Culinary Aide 18 was wearing a surgical under her chin and no protective eyewear. On 10/18/21 at 12:38 p.m., an unidentified dietary worker was observed walking from the main entrance desk to the kitchen, passing multiple residents who were observed self-propelling themselves outside in wheelchairs. The dietary worker had a surgical mask over her mouth, her nose was uncovered, and she had no protective eyewear. On 10/18/21 at 3:55 p.m., LPN 32 was observed sitting at the Health Suites nurse's station among peers wearing her surgical mask under her chin. On 10/20/21 at 4:42 p.m., LPN 49 and CNA 40 were observed sitting within 3 feet of each other having a conversation at a table in the Health Suites nurse's station, both with their surgical face masks down near their chins not covering the mouth or nose. On 10/20/21 at 4: 45 p.m., LPN 13 was observed at the Health Suites nurse's station conversing with the Mobile DON who was standing leaning over her shoulder. LPN 13 was wearing a face shield with her mask under her chin not covering her mouth or nose. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/21 at 2:43 p.m., CNA 42 was observed with 2 peers sitting in the Health Suites nurse's station, all viewing their personal cellphones. CNA 42's surgical mask was under her chin. State Department of Health Guidance, Long-term Care COVID-19 Clinical Guidance dated 9/7/21, indicated, Assure that red and yellow zone is clearly marked and each resident's door has TBP [transmission based precautions] signage for proper PPE. CDC Guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated 9/10/21, indicated, .the safest practice is for everyone in a healthcare setting to wear source control . Source control options for HCP [health care personnel] include: A NIOSH-approved N95 or equivalent or higher-level respirator OR A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note: these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR A well-fitting facemask . Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel) . Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel. CDC Guidance, Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages dated 12/29/20, indicated, In healthcare settings, facemasks are used by HCP as 1) PPE to protect their nose and mouth from exposure to splashes, sprays, splatter, and respiratory secretions (e.g., for patients on Droplet Precautions) and 2) source control to cover their mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. CDC Guidance, Hand Hygiene in Healthcare Settings, dated 1/8/21, indicated, When and How to Perform Hand Hygiene: Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient, after touching a patient or the patient's immediate environment, After contact with blood, body fluids or contaminated surfaces, immediately after glove removal. Wash with Soap and Water: When hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea. When and How to Wear Gloves: Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. 3.1-18(b)(1)(A) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-18(l)