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	07/14/2022

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 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. 38768 Based on observation, interview and record review, the facility failed to ensure thorough assessments of residents to identify change in conditions, send residents with change of conditions out the hospital upon residents' request and failed to identify necrotic toes on a resident's foot prior to admission to the hospital emergency room for 2 of 3 residents reviewed for hospitalization (Resident B and C). The immediate jeopardy began on 6/14/22, when Resident B called 911 and requested to be sent to the hospital due to nausea, vomiting, and not feeling right. Resident B arrived at the hospital emergency room (ER) covered in stool and urine, had gangrenous toes, and had open wounds to his heel. On 6/20/22, Resident C was seen by the psychiatrist and was confused. Laboratory tests were obtained and indicated the resident had a high ammonia level of 194 (normal range 11-74). On 6/21/22, Resident C requested to go to the ER multiple times starting at 10 a.m., the Nurse Practitioner ordered for the resident to go to the ER at 5:04 p.m., and the resident was sent to the ER by EMS at 7:07 p.m., after falling on the floor. Upon arrival at the ER, the resident's ammonia level was 137 and his creatinine was 2.03 (normal range 0.7 to 1.3) and was admitted to the hospital with a diagnosis of acute kidney injury. The Administrator, Director of Nursing (DON), Regional Clinical Risk Manager (RCRM), and the Regional Director of Clinical Operations (RDCO) were notified of the immediate jeopardy on 7/8/22 at 5:20 p.m. The immediate jeopardy was removed on 7/9/22, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. On 7/7/22 at 8:45 a.m., Resident B's medical record was reviewed after his emergent discharge on 6/14/22. He had diagnoses which included, but were not limited to, respiratory failure, type II diabetes mellitus, chronic kidney disease, and congestive heart failure. Resident B's annual Minimum Data Set (MDS) assessment, dated 3/9/22, indicated he was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. No behaviors were coded for the 7-day look back and he was at risk for the development of pressure ulcers with 3 open areas at the time of the assessment. Resident B was followed by the wound care team and copies of his wound notes were provided on 7/8/22 at 10:00 a.m., by the Director of Risk Management (DRM). The wound notes were reviewed at that time and revealed: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	a. An arterial wound on his right lateral ankle which was still being treated. b. A stage III (Full thickness tissue loss where subcutaneous fat may be visible, but bone, tendon or muscle are not exposed and slough may be present but does not obscure the depth of tissue loss) pressure ulcer on his right heel, which was healed out on 3/22/22. c. A stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed and often includes undermining and tunneling) pressure ulcer on his right lateral foot, which was healed out on 4/19/22. Resident B had comprehensive care plan which included, but were not limited to: a. A care plan, most recently revised on 1/1/22, which indicated he required assistance with his activities of daily living (ADLs). Interventions for this plan of care included but were not limited to staff assistance for bed mobility, toileting, bathing, and eating. b. A care plan, most recently revised on 4/13/22, which indicated he was at risk for skin break down and had an arterial ulcer on his right ankle and right lateral foot. Interventions for the plan of care included, but were not limited to, evaluation of the existing wound daily to monitor for signs/symptoms of the wounds worsening and to provide peri-care as needed to avoid skin breakdown due to incontinence. c. A care plan, most recently revised on 3/16/22, which indicated he required the use of a gastrostomy tube (g-tube, a surgically placed device used to give direct access to the stomach for supplemental feeding) and that he sometimes refused his g-tube feedings. Interventions for this plan of care included, but were not limited to, administer flushes per medical provider's order, administer medications via tube per orders and Nutritional consults. There was no care plan for Resident B's refusal of care or treatments. The record lacked documentation of Resident B's refusal of care or treatments. The record lacked documentation of any concerns related to Resident B's toes at the time of his discharge on 6/14/22. The record lacked documentation of any additional open wounds at the time of his discharge on 6/14/22. The record lacked documentation of a change in Resident B's condition due to nausea and vomiting. Resident B had the following physician orders: a. Treatment to the right lateral ankle: Cleanse with normal saline, and pat dry. Apply Collagen to wound bed & cover by a border gauze three days and week and as needed for soilage & dislodgement every day shift every Tuesday, Thursday, Saturday for arterial wound. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Weekly skin assessment to be completed. Documentation to be completed on Weekly Skin Assessment during evening shift every Thursday for Skin Assessment. The record lacked documentation that a weekly skin assessment had been completed as scheduled for 6/9/22. A hospital transfer assessment was dated 6/14/22 at 11:22 a.m., but did not indicate any change in the resident's skin condition. Resident B was sent to the hospital for nausea and vomiting. A nursing progress note, dated 6/14/22 at 12:33 p.m., indicated Resident B called 911 without notifying the nurse. An ambulance arrived to facility by 11:00 a.m., and Resident B stated he was vomiting. No one was aware of that change. The resident left the facility by ambulance to the hospital and the DON was present. A hospital record scanned into Resident B's electronic charting system was dated 6/14/22 at 2:43 p.m. The ED (Emergency Department) summary indicated, Chief complaint: nausea, vomiting, and dark green urine . the patient is a pleasant 61-year male who presented to the ED from a nursing home via ambulance. Patient has not been very well cared for at the facility .per report, the nursing home is sending him in because he had made a mess of himself and they did not feel like cleaning him up. On arrival the ED [Emergency Department], the patient was very disheveled .He has an unstageable sacral ulcer and is complaining of back pain. He reports that he has been having nausea and vomiting and dark green urine for the past 2 days and nobody was willing to get him cleaned, hence why he decided to call 911 himself .Review of present symptoms, positive for: lesions, nauseas, back pain Upon a physical exam the following was noted .skin: gangrenous lower extremity toes, clear wound also noted to the heel .Psychiatric: cooperative and pleasant. Judgement and insight, memory, mood and affect within normal limits A hospital record scanned into Resident B's electronic charting system, dated 6/14/22 at 2:43 p.m., indicated .Assessment and Plan .Problem 11: sacral wound and lower extremity wound. patient with notable sacral wound, no discharge of bleeding, however he has consistently complained of back pain. Similarly, he has a wound on his heel. All lower extremity are gangrenous .wound evaluation pending .Attending physician addendum: presenting to the ED today for nausea, vomiting, and dark urine .We are concerned about his level of hygiene at time of presentation and consequently concerned about the quality of care he has received at facility .patient admitted to the hospital A hospital record scanned into Resident B's electronic charting system, dated 6/15/22 at 11:23 a.m., indicated a wound skin assessment was completed and revealed the following .Wound #2: stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer to the sacrum which measured 0.5 cm long by 0.5 cm wide and 0.1 cm deep. Wound #3: stage II pressure ulcer on the right ankle which measured 3 cm long by 2 cm wide and 0.1 cm deep with serosanguineous drainage .Patient also has a right ankle wound that his nurse pointed out to me prior to seeing the patient (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A hospital record scanned into Resident B's electronic charting system, dated 6/17/22 at 6:42 a.m., indicated, .spoke to patient about disposition and his current facility. He stated that he would like to be in a different facility if other options were available .Problem #12: Social: patient brought in from facility, disheveled, covered in stool and urine .Also, with notable .sacral, and foot wound. Strong concern of neglect at facility .Social Worker referral was made due to abuse/neglect concerns, patient did tell medical team that he does not feel safe returning to Evergreen Crossing at discharge During an interview, on 7/7/22 at 10:43 a.m., Resident B indicated he was still at the hospital. He was going up and down but overall was feeling better. Resident B indicated he had not been feeling well for a couple of days and no one would help him. He called 911 because he knew something wasn't right. During a confidential interview during the survey indicated Resident B's condition upon arrival to the ED was very alarmingly, he arrived covered in stool and urine with several wounds and was septic with a UTI. Resident B indicated he had made a mess of himself, and no one would help him get cleaned up, so he called 911. During an interview, on 7/8/22 at 11:54 a.m., Certified Nursing Assistant (CNA) 23 indicated she had worked with Resident B. He was usually pleasant and cooperative. She had not noticed any sign of a change in his condition before his discharged . During an interview, on 7/8/22 at 12:04 p.m., Wound Nurse 25 indicated he saw Resident B on 6/14/22. At the time of that evaluation, the only open wound being treated at that time was the arterial wound on his ankle. He would have thoroughly evaluated Resident B's whole foot at the time of the assessment and did not notice any concerns related to his toes other than they were extremely dried and had cracked skin. On 7/11/22 at 9:20 a.m., the Pike Township Fire Chief provided a copy of the ambulance Run Report for the day of Resident B's discharge. The Run Report was dated 6/14/22 at 11:25 a.m., and indicated .dispatched to a sick person. Arrived to find [Resident B] alert oriented x4 [oriented to person, place, time and situation]. He complained of nausea, vomiting and weakness .states he was not getting any help from nursing home staff and patient had vomit on self and bed. Patient stated staff did not give him any medication for nausea and vomiting seen after attempts to get staff help .Patient states he has not been able to eat for 2 days On 7/8/22 at 3:15 p.m., the Director of Risk Management (DRM) provided a current policy, dated effective 7/1/16 and reviewed on 10/5/21, titled, Skin Care & Wound Management Overview. This policy indicated .the facility strives to prevent resident/patient skin impairment and to promote the healing of existing wounds. The interdisciplinary team [IDT] works with the resident/patient and/or family/responsible party to identify and implement interventions to prevent and treat potential skin integrity issues. The IDT evaluated and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying conditions contributing to it and descriptions of impartment to determine appropriate treatment .each resident is evaluated upon admission and weekly thereafter for changes in skin condition. Resident/patient skin condition is also re-evaluated with change in clinical condition, prior to transfer to the hospital and upon return from hospital (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/8/22 at 3:15 p.m., the DRM provided a current policy, dated effective 10/31/13 and reviewed on 4/6/16, titled, Routine Resident Care. This policy indicated .It is the policy of this facility to promote resident centered care by attending to the physical emotion, social, and spiritual needs and honor resident lifestyle preferences while in the care of this facility .provide routine daily care by a certified nursing assistant with specialized training in rehabilitation/restorative care under the supervision of a licensed nurse including but not limited to . implementing and maintaining program for skin care .assisting and teaching activities of daily living .toileting, providing care for incontinence with dignity and maintaining skin integrity 37982 2. On 7/5/22 at 10:10 a.m., during an interview and observation, Resident C was observed sitting in a wheelchair in his room playing a video game on a computer. He appeared to be greater than 400 pounds in size/weight and appeared to be middle aged. He was alert and oriented. He spoke clearly and carried a conversation without any difficulty. When asked if he had a recent hospitalization , the resident indicated he had. Resident C indicated his ammonia level was too high and he was feeling bad. He had asked the staff several times to send him out to the hospital, but they would not send him. About 4 hours passed. He was weak and could not reach his phone. He had tried to get up, but his legs were weak and would not support him and he fell on the floor. He had been kept in the hospital for about a week. On 7/6/22 at 3:57 p.m., the medical record was reviewed for Resident C. The diagnoses included, but were not limited to, cirrhosis of the liver (liver damage), nonalcoholic steatohepatitis (damage to the liver not caused by alcohol use-NASH), morbid obesity, diabetes, diastolic (congestive) heart failure, and hypertensive heart disease with heart failure. A nurse progress note, dated 6/16/22 at 11:25 a.m., indicated Resident C was assessed and had plus 2 to 3 pitting edema (large amount of swelling) from bilateral lower extremities (both feet and legs) to the knees. The Nurse Practitioner (NP) had been notified and he was sent to the emergency room due to a change in condition. On 6/16/22 at 10:56 p.m., a nursing note indicated the resident returned to the facility with no medication changes. The hospital records were not scanned into the electronic record and were not in the hard (paper) chart. There were no additional progress notes in the medical record until 6/21/22. A review of Resident C's hospital records, dated 6/16/22, indicated he was sent to the emergency room for reported lab abnormalities. Reported bilirubin in the 150's (tests liver function, a normal range according to A Manual of Laboratory and Diagnostic Tests is 0.3 to 1.0). Emergency Medical Services (EMS) reported when they arrived a low blood pressure was reported to EMS, but it appeared the cuff was slipping when the facility staff tried to obtain the blood pressure. For EMS, the blood pressure was 122/70. Hemoglobin (red blood cell count) was low at 9.8 (normal range according to A Manual of Laboratory and Diagnostic Tests is 14 to 17.4) and his ammonia level was 88 (normal range according to A Manual of Laboratory and Diagnostic Tests is 15 to 60). Diagnosis was dehydration, given fluids and returned to the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/21/22 at 10:10 a.m., a nursing note indicated Resident kept stating his ammonia level was too high and he needed sent to the emergency room (ER). The nurse informed the NP's scribe and indicated she was aware of his high levels and would see him on that day, 6/21/22. On 6/21/22 at 5:04 p.m., a psychiatry provider progress note indicated, reason for visit psych medication management. The note indicated Resident C was seated in his wheelchair and was nude. He was lethargic (sluggish, weak, lack of energy) and had a poor intake. Resident C stated his ammonia levels were high. The auto populated history (baseline) showed Resident C's most recent, Brief Interview for Mental Status (BIMS) score was 14 (mentally intact). The provider note contained Laboratory reports, a prior blood draw from the day before, dated 6/20/22, indicated Resident C's ammonia level was 194 (normal range according to A Manual of Laboratory and Diagnostic Tests is 15 to 60), blood glucose was 180 (normal range is 65-99), BUN 30 (blood urea nitrogen indicates kidney health, normal range according to A Manual of Laboratory and Diagnostic Tests is 6 to 20), creatinine 1.5 (waste product indicates kidney health, normal male range according to A Manual of Laboratory and Diagnostic Tests is to 0.9 to 1.3mg/dl). There were no NP or physician progress notes related to the abnormalities in the lab report from 6/20/22. On 6/21/22 at 7:07 p.m., a post transport note indicated, Resident has been sent to ER per his demands. He was unable to provide a reason to be transferred. He is alert and oriented x3. Signed by the Clinical Nurse Practitioner. On 6/21/22 at 7:42 p.m., a nursing note indicated, Resident kept on asking nurse to go to ER, Nurse informed MD [medical doctor] on the floor and assessed him but did not send him out. Resident kept on asking to out to hospital then slid himself to the floor. Nurse then had no choice but to call 911. Resident went out to hospital. On 6/22/22 at 4:05 a.m., a nursing note indicated admitted to hospital for renal insufficiency (kidneys) and weakness. On 6/30/22 at 9:53 a.m., an Interdisciplinary team (IDT) note indicated, Resident C alleged lack of care. The root cause of incident was identified as .self neglect . false allegation negative comments regarding care Interventions put in place included educate staff on patients care needs. The care plan was updated to include to have CNA bring supplies and encourage resident to care and offer assistance.Per therapy resident able to complete ADLs [activity of daily living] (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident C's hospital records, dated 6/21/22 through 7/1/22, indicated Resident C came to the ER from his nursing facility with complaint of increased weakness, unable to sit upright. He indicated he felt sluggish, his ammonia level was high at the facility. The resident indicated it was always high. Labs in ER showed ammonia level at 137. Record indicated previously 88 on 6/16/22 (last ER visit). Creatine was 2.03 (previous ER visit on 6/16/22 was 1.2, normal male range according to A Manual of Laboratory and Diagnostic Tests is to 0.9 to 1.3mg/dl). Resident was given IV (intravenous) fluids in ER and admitted to the hospital for treatment of acute renal insufficiency and acute encephalopathy (decreased function of the brain due to chemical toxins in the blood) probably related to liver disease. Weakness, right facial droop. The record indicated the hospital was unable to complete an MRI (imaging) test due to the resident's size. He had been referred (in the past) for possible bariatric surgery for liver transplant consideration but was not a candidate due to his heart history. The physician notes indicated he suspected the resident's elevated renal (kidney function) numbers were related to him being over diuresis (dehydration related to medication and fluid excretion). The hospital treatment included holding diuretics and metformin (diabetic oral medication). His ammonia levels were treated with lactulose (a medication to increase excretion of toxins through the bowel). The resident's medical record did not contain a code status order. The face sheet was blank, had nothing documented in the code status section. Upon request, on 7/6/22, the Director of Risk Management provided a POST (Physician Orders for Scope of Treatment) form dated as prepared 2/26/21. Resident C signed the form on 7/5/22 and the NP signed on 7/6/22. A new physician order indicated Full Code and showed Full Code on the face sheet. On 7/8/22 at 3:12 p.m., during an interview, the Infection Preventionist (IP) indicated on 6/21/22 she was at the facility, working. She had been assisting the nurse who was working the floor. She went to Resident C's room to help and then went to office and told the NP's nurse (scribe) Resident C was requesting to go to the hospital because his ammonia level was high. She was told (by the Nurse Scribe) the NP would see him. When a resident requested to go to the hospital they let the doctor or NP know. On 7/8/22 at 3:15 p.m., during an interview, the Director of Risk Management indicated Resident C's ammonia level was always high, he had a chronic condition with his liver. They were aware of his labs from 6/20/22 and he was being treated with his scheduled medication. He often refused to take his lactulose (medication to reduce ammonia level), and then wanted to go to the hospital. A copy of Resident C's Medication Administration record (MAR), for the month of June, was requested, and provided at that time. The MAR indicated from June 1 through June 7th at noon the order was for lactulose 10 gm/15 ml, give 45 ml by mouth four times a day for laxative. The MAR indicated on June 7 at 5:00 p.m. the order changed to lactulose 10 gm/15 ml, give 60 ml by mouth four times a day for laxative. The record reflected all ordered doses were documented as given. On 6/16/22, the record indicated the resident was away from home with meds. The record did not show any missed or refused lactulose doses. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/8/22 at 3:15 p.m., the Director of Risk Management provided a current policy, dated effective 10/30/13 and reviewed on 1/19/22, titled Physician Notification for Change in Condition Reporting. This policy indicated .It is the policy of this facility to promote resident centered care by using evidence based practice for notification of providers for changes in conditions and when to report signs and symptoms to the MD/NP/PA. This facility will make notifications for changes in condition (CIC) based on the AMDA guidelines and the INTERACT protocol On 7/8/22 at 3:15 p.m., the DRM provided a current policy, dated effective 5/19/16 and reviewed on 4/20/17, titled Resident Rights. This policy indicated .It is the policy of this facility to promote resident centered care by protecting and promoting the rights of each resident that falls within the 483.10 standard of care The immediate jeopardy that began on 6/14/22 was removed on 7/9/22 when the facility assessed all residents for a change in condition and skin impairments. Any resident found with a change in condition and/or skin impairments had the physician and responsible party notified. Any new skin impairments identified were immediately assessed, treated, care planned, and a skin grid was completed. All residents with laboratory results in the last 7 days had their labs reviewed to ensure notification to the physician and appropriate orders were obtained. All licensed nurses were educated on follow up assessments and documentation when a resident experiences a change in condition, educated on ensuring that any resident requesting to go to the hospital are assessed, educated all licensed nurses on laboratory services and reporting laboratory results to the physician, and educated all licensed nurses on skin assessments, treatment orders and completing a skin grid. 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 related to Complaints IN00383623 and IN00384312. 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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 38768 Based on observation, interview and record review, the facility failed to ensure thorough assessments of residents with urinary catheters to identify a change in condition, to send residents with a change of condition out to the hospital including upon the residents' request for 2 of 2 residents reviewed for urinary catheters/urinary tract infections (Resident B and D) and failed to ensure catheter care for a resident with a indwelling foley catheter to prevent the development of wounds to the penis and scrotum for 1 of 8 residents reviewed for urinary catheters/urinary tract infections (Resident B). The immediate jeopardy began on 6/14/22 when Resident B called 911 to go the hospital emergency room (ER) for nausea, vomiting, and not feeling well. Upon arrival to the hospital ER, on 6/22/22, the resident was covered in stool and urine. Resident B had green urine in the indwelling urinary catheter, and wounds to the base of the penis and scrotum measuring 0.5 centimeters (cm) by (x) 0.5 cm x 2 cm with minimal serosanguineous drainage, and significant urethral injury. Resident B was admitted to the hospital with a diagnosis of sepsis and urinary tract infection (UTI). The resident remained in the hospital as of 7/8/22 and indicated he was afraid to return to the facility. Resident D had an indwelling urinary catheter and a suprapubic catheter. Resident D was sent to the hospital on 6/18/22 for bloody urine and being lethargic. Resident D went to the hospital on 6/21/22 and returned with a diagnosis of urinary tract infection with antibiotics. Hospital discharge information indicated to return if bloody urine worsened. From 7/5/22 through 7/7/22, Resident D was observed with bloody urine in the urinary catheter bag, and there were multiple observations of the resident's urinary tubing and catheter bag on the floor. On 7/7/22, the Nurse Practitioner (NP) indicated she was unaware of increased hematuria (bloody urine), assessed the resident as lethargic, and sent the resident to the ER. On 7/7/22, at the hospital the resident was diagnosed with a urinary tract infection (UTI) and the hospital removed the indwelling urinary catheter since the suprapubic catheter was functioning. The Administrator (ADM), Director of Nursing (DON), Regional Clinical Risk Manager (RCRM), and the Regional Director of Clinical Operations (RDCO) were notified of the immediate jeopardy on 7/8/22 at 5:20 p.m. The immediate jeopardy was removed on 7/9/22, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. On 7/7/22 at 8:45 a.m., Resident B's medical record was reviewed after his emergent discharge on 6/14/22. He had diagnoses which included, but were not limited to, respiratory failure, type II diabetes mellitus, chronic kidney disease and congestive heart failure. Resident B's annual Minimum Data Set (MDS) assessment, dated 3/9/22, indicated he was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. No behaviors were coded for the 7-day look back and he was at risk for the development of pressure ulcers with 3 open areas at the time of the assessment. (continued on next page)

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	155826	A. Building B. Wing	07/14/2022

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.

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident B was followed by the wound care team and copies of his wound notes were provided on 7/8/22 at 10:00 a.m., by the Director of Risk Management (DRM). The wound notes indicated he had moisture associated skin damage (MASD) on his scrotum, which was healed out on 3/8/22. Resident B had comprehensive care plan which included, but were not limited to: a. A care plan, most recently revised on 1/1/22, indicated he required assistance with his ADLs (activities of daily living). Interventions for this plan of care included, but were not limited to, staff assistance for bed mobility, toileting, bathing, and eating. b. A care plan, most recently revised on 4/13/22, indicated he was at risk for skin break down and had an arterial ulcer on his right ankle, and right lateral foot. Interventions for the plan of care included, but were not limited to, evaluation of the existing wound daily to monitor for signs/symptoms of the wounds worsening and to provide peri-care as needed to avoid skin breakdown due to incontinence. c. A care plan, most recently revised on 9/15/21, indicated he had a foley catheter due to obstructive uropathy. Interventions for this plan of care included, but were not limited to, change catheter per medical doctor (MD) orders, observe/document for pain/discomfort related to the catheter, observe /record/report to MD for signs and symptoms of UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns and to provide catheter care every shift and as needed. Notify medical provider if urine was of abnormal color, consistency, or odor. d. A care plan, most recently revised on 3/16/22, indicated he required the use of a g-tube, (gastrostomy tube, a surgically placed device used to give direct access to the stomach for supplemental feeding) and that he sometimes refused his g-tube feedings. Interventions for this plan of care included, but were not limited to, administer flushes per medical provider's order, administer medications via tube, per orders and Nutritional consults. There was no care plan for Resident B's refusal of care or treatments. The record lacked documentation of Resident B's refusal of care or treatments. The record lacked documentation of any additional open wounds at the time of his discharge on 6/14/22. Resident B had the following physician orders as of 7/7/22: a. Change foley drainage bag monthly every night shift every 4 weeks on Tuesdays. b. Foley catheter care every shift and as needed with soap and water. Secure straps if applicable Empty foley output and document output every shift. c. Treat Scrotum MASD by cleaning with soap and water, apply triad paste every shift and as needed. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. Weekly skin assessment to be completed. Documentation to be completed on Weekly Skin Assessment during evening shift every Thursday for Skin Assessment. Resident B's MAR/TAR (medication/treatment administration records) from May and June were reviewed. Catheter care was checked off as completed on every shift with no abnormalities noted and Resident B's foley drainage bag was checked off as changed on 6/14/22. Resident B's foley drainage bag was checked off as changed on 5/17/22. The record lacked documentation that a weekly skin assessment had been completed as scheduled for 6/9/22. A nursing progress note, dated 6/14/22 at 12:33 p.m., indicated Resident B called 911 without notifying nurse. An ambulance arrived to the facility by 11:00 a.m., and Resident B stated he was vomiting. No one was aware of that change in condition. The resident left facility by ambulance to the hospital and the DON was present. A hospital record was scanned into Resident B's electronic charting system, dated 6/14/22 at 2:43 p.m. The hospital Emergency Department (ED) report indicated .Chief complaint: nausea, vomiting, and dark green urine .the patient is a pleasant 61-year male who presented to the ED from a nursing home via ambulance. Patient has not been very well cared for at the facility .per report, the nursing home is sending him in because he had made a mess of himself and they did not feel like cleaning him up. On arrival the ED, the patient was very disheveled and has an indwelling Foley catheter which is causing significant urethral injury. He has an unstageable sacral ulcer and is complaining of back pain. He reports that he has been having nausea and vomiting and dark green urine for the past 2 days and nobody was willing to get him cleaned, hence why he decided to call 911 himself .Review of present symptoms, positive for: lesions, nausea, back pain Upon a physical exam the following was noted: .skin: gangrenous lower extremity toes, clear wound also noted to the heel .Genitourinary: swollen penis and testicles. Urethral meatus slightly visible, white discharge noted at the creases between the penis and scrotum .Psychiatric: cooperative and pleasant. Judgement and insight, memory, mood and affect within normal limits A comprehensive metabolic blood panel was completed on 6/14/22 at 12:10 p.m., and returned with significantly elevated BUN [blood urea nitrogen-high levels in your blood sample can mean kidneys are not working normally and can also indicate dehydration] level of 59 (normal range 9-20). A urinalysis, completed 6/14/22 at 12:27 p.m., indicated his urine was cloudy with trace amounts of blood. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A hospital record scanned into Resident B's electronic charting system, dated 6/14/22 at 2:43 p.m., indicated .Assessment and Plan: Problem 1: sepsis secondary to UTI. Patient presenting tachycardic [rapid heart rate], tachypnea [rapid breathing] and notable leukocytosis, chief complaint of nausea, vomiting and dark green urine, started on cefepime and vancomycin [antibiotic medications] Problem 2: penile trauma. Patient on chronic foley, at presentation the foley had extended to the posterior of his penis, meatus visible. Swollen scrotum .he has consistently complained of back pain .Attending physician addendum: presenting to the ED today for nausea, vomiting, and dark urine. He is found to have indwelling foley and evidence of UTI and sepsis. He also has acute kidney injury and chronic kidney disease. Further, he has evidence of penile injury/inflammation from his foley. We are concerned about his level of hygiene at time of presentation and consequently concerned about the quality of care he has received at facility .patient admitted to the hospital A hospital record scanned into Resident B's electronic charting system, dated 6/15/22 at 11:23 a.m., indicated a wound skin assessment was completed and revealed the following: Wound #1: base of penis/scrotum which measured 0.5 cm (centimeters) long by 0.5 cm wide, and 2 cm deep with serosanguineous drainage.patient seen today for penis and sacrum .Patient has a split urethra from his chronic catheter and patient also found to have a wound at the base of his penis/scrotum A hospital record scanned into Resident B's electronic charting system, dated 6/17/22 at 6:42 a.m., indicated .spoke to patient about disposition and his current facility. He stated that he would like to be in a different facility if other options were available .Problem #12: Social: patient brought in from facility, disheveled, covered in stool and urine. Foley extending deep into his penis. Also, with notable penile, sacral, and foot wound. Strong concern of neglect at facility .Social Worker referral was made due to abuse/neglect concerns, patient did tell medical team that he does not feel safe returning to Evergreen Crossing at discharge During an interview, on 7/7/22 at 10:43 a.m., Resident B indicated he was still at the hospital. He was going up and down but overall was feeling better. Resident B indicated he had not been feeling well for a couple of days and no one would help him. He called 911 because he knew something wasn't right, and no one would help him. During a confidential interview conducted during the survey indicated Resident B's condition upon arrival to the ED was very alarmingly, he arrived covered in stool and urine with several wounds and was septic with a UTI. Resident B indicated he had made a mess of himself, and no one would help him get cleaned up, so he called 911. During an interview, on 7/8/22 at 11:54 a.m., CNA (certified nursing assistant) 23 indicated she had worked with Resident B. He was usually pleasant and cooperative. She had not noticed any sign of a change in his condition before his discharged . As a CNA, she did complete catheter care for him as needed but had never noticed anything concerning. He was particular about how the catheter bag was repositioned because he did not want it pulled and tugged on, as it caused him pain. During an interview, on 7/8/22 at 12:04 p.m., Wound Nurse 25 indicated he saw Resident B on 6/14/22. At the time of the evaluation, the only open wound being treated at that time was the arterial wound on his ankle. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/11/22 at 9:20 a.m., the Pike Township Fire Chief provided a copy of the ambulance Run Report for the day of Resident B's discharge. The Run Report, dated 6/14/22 at 11:25 a.m., indicated .dispatched to a sick person. Arrived to find [Resident B] alert oriented x4 [oriented to person, place, time and situation]. He complained of nausea, vomiting and weakness .states he was not getting any help from nursing home staff and patient had vomit on self and bed. Patient stated staff did not give him any medication for nausea and vomiting seen after attempts to get staff help .Patient had catheter, tubing and urinary drainage bag were green. Patient states nursing home staff have not changed his tubing or bag in 'a couple of months,' last date on bag was April 2022. Patient states he has not been able to eat for 2 days 37981 2. On 7/05/22 at 9:37 a.m., Resident D's door was observed open, his Foley bag and tubing were visible from the hallway. No dignity bag was in place. His Foley bag and tubing were observed with deep, red urine. The Foley tubing was on the floor. On 7/5/22 at 10:11 a.m., Resident D's door was observed open, his Foley bag and tubing were visible from the hallway. No dignity bag was in place. His Foley bag and tubing were observed with deep, red urine. The Foley tubing was on the floor. On 7/5/22 at 11:09 a.m., Resident D's door was observed open, his Foley bag and tubing were visible from the hallway. No dignity bag was in place. His Foley bag and tubing were observed with deep, red urine. On 7/5/22 at 12:08 p.m., Resident D's door was observed open, his Foley bag and tubing were observed in a pillowcase. The pillowcase was touching the floor. On 7/6/22 at 9:24 a.m., Resident D's door was observed open, his Foley bag was observed in a pillowcase. The tubing was observed laying on the floor with deep, red urine. On 7/7/22 at 10:07 a.m., Resident D's door was observed open. No dignity bag was in place. His Foley bag and tubing were observed with deep, red urine. On 7/7/22 at 11:05 a.m., Resident D's record was reviewed. His diagnoses included, but were not limited to, sepsis (a life-threatening condition of harmful bacteria in the blood), acute kidney failure (condition in which the kidneys suddenly can't filter waste from the blood), benign prostatic hyperplasia (prostate enlargement), inappropriate secretion of antidiuretic hormone (ADH) (increased ADH causes the body to retain water), urine retention (difficulty urinating or completely emptying the bladder), obstructive and reflux uropathy (condition where urine flows backward due to obstruction), and neuromuscular dysfunction of the bladder (lack of bladder control). A care plan, dated 5/23/22, indicated Resident D was in renal failure and to observe for complications and notify the medical provider of abnormal findings. A care plan, dated 5/23/22, indicated Resident D had a suprapubic catheter with a history of UTIs. Interventions indicated to notify the medical provider if the urine was of an abnormal color and to provide a privacy bag. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 6/8/22 at 4:55 p.m., indicated Resident D had a new order to schedule an intervention radiology (IR) appointment related to his suprapubic catheter (a urinary catheter inserted above the pubic bone). A nurse practitioner (NP) note, dated 6/9/2022 at 1:34 p.m., indicated Resident D was seen by her recently due to cloudy urine observed by staff. Over the weekend, staff reported the suprapubic catheter was irrigated due to oliguria (excessive small amounts of urine produced). Staff noted the urine was milky and his white blood cell (WBC) count was elevated yesterday. Last week, the suprapubic catheter insertion site was red. It was evaluated by the wound team and Resident D was started on doxycycline (antibiotic) for cellulitis. Status post (a state that follows an intervention) hospitalization with acute (sudden) kidney injury and sepsis with acute renal (kidney) failure and cystitis (inflammation of the bladder). Per the hospital records, he presented to the Emergency Department (ED) with hypotension (low blood pressure), poor intake by mouth and diarrhea from an extended care facility. He had a chronic (long time) Foley need and his Foley had become displaced. He was given intravenous (inside a vein) fluids. He had a weight loss of 27 pounds in one month. His WBC was up to 28,000 (normal male levels: 5,000-10,000) with creatinine (measure of kidney function) (normal levels: 0.7-1.3 mg/dL) of 3.18. Review of systems from nursing staff indicated no hematuria (blood in the urine) or pain. Resident had frequent urinary tract infections (UTIs). NP 15 indicated the plan of care was to reorder a urinary analysis (urine test) and continue the doxycycline. A nursing progress note, on 6/16/2022 at 2:36 p.m., indicated Resident D's catheter was leaking and draining. An appointment was scheduled for replacement on 6/21/22. A physician's note, on 6/18/2022 at 6:03 p.m., indicated Resident D had a suprapubic catheter. It was reported to have a large amount of hematuria, it cleared up, but was recurring. Resident was lying in bed, slow to respond, more lethargic than usual, and hypotensive (low blood pressure). He was due for IR replacement of catheter on 6/21/22. The resident needed treatment for hypotension and weakness. Further evaluation needed. A nursing progress note, dated 6/18/2022 at 9:59 p.m., indicated Resident D was sent to the hospital for evaluation and treatment for low blood pressure (BP) and blood in in his Foley catheter at 6:00 p.m. Resident D's hospital notes, dated 6/18 to 6/21/22 were reviewed. They indicated Resident D's primary diagnoses were sepsis and UTI. The hospital orders were to start taking sulfamethoxazole-trimethoprim (Bactrim) (antibiotic). To take one tablet by mouth, 2 times a day, for 5 days. A nursing progress note, dated 6/24/2022 at 9:47 p.m., indicated Resident D's suprapubic catheter fell out, it was sutured in place, and he needed to be sent to the hospital for evaluation and treatment. A nursing progress note to the NP on-call, dated 6/29/2022 at 2:33 a.m., indicated Resident D had a suprapubic catheter and a Foley catheter. There was blood-tinged urine in both bags from both sites. Resident complained of chills and pain from the suprapubic site. The urine was dark amber with a minimal amount of blood in tubing. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing progress note, on 6/29/2022 at 8:32 a.m., indicated nursing staff spoke to Licensed Practical Nurse (LPN) 16. The nurse referred to her as the NP. Resident D had a suprapubic and Foley catheter draining blood-tinged urine during the night shift. An order was obtained to start IV fluids of normal saline (NS). This morning the suprapubic and Foley were still draining tinged urine. NP (LPN 16) would assess and possible send resident back to the ED. A nursing progress note, on 6/29/2022 at 6:40 p.m., indicated Resident D returned to the facility. No medicine changes but indicated to return to the ER (emergency room) with new or worsening symptoms. Resident D's 6/24/22 hospital notes were reviewed. They indicated Resident D presented to the ED after his suprapubic catheter came out. The catheter was placed on 5/6/22 after sustaining any [sic] urethral injury from a Foley. He was recently inpatient for sepsis related to a UTI with hematuria, fever of 102 Fahrenheit (F), fatigue, and chills. The UA sample grew proteus (bacteria) and Klebsiella (bacteria) on urine culture. He was treated with Zosyn (antibiotic) for 3 days and then discharged on Bactrim to complete 7 days total. Physical exam on discharge indicated the penile indwelling Foley catheter was in place with a clear, yellow urine output. A nursing progress note, on 6/30/2022 at 8:17 a.m., indicated Resident D's suprapubic catheter was draining dark-tinged (brown) urine, and the Foley was draining light, pink-tinged urine. A nursing progress note, dated 7/5/22 at 10:36 p.m., indicated Resident D's vital signs (VS) were assessed with no concerns. The record lacked documentation in the nursing notes regarding the deep, red urine in his Foley bag. A nursing progress note, dated 7/6/22 at 10:43 p.m., indicated Resident D's VS were assessed with no concerns. The record lacked documentation in the nursing notes regarding the deep, red urine in his Foley bag. During an interview, on 7/7/22 at 11:30 a.m., NP 15 indicated she saw Resident D last week after his trip to the ED. She thought the ED issues of blood in the urine were resolved. No one on the nursing staff had indicated to her the issue was back and worse. During an interview, on 7/7/22 at 11:34 a.m., LPN 16 (scribe for NP 15) indicated we (NP 15 and LPN 16) thought the hematuria was resolved and they had not heard about it all week. We need to order UAs several times, then double check that they are completed. During an interview, on 7/7/22 at 11:40 a.m., LPN 22 indicated she noticed Resident D's Foley bag had deep, red urine in it this morning. On 7/7/22 at 11:45 a.m., NP 15 was in Resident D's room. She indicated there was mucus in the Foley tubing and the resident was difficult to arouse. She tried a sternal rub and yelled in his face. He opened his eyes. She indicated with the increased blood in the Foley bag, he should return to the ED. On 7/7/22 at 2:05 p.m., the Director of Nursing (DON) provided the most recent UAs. One, dated 6/17/22, indicated Resident D had proteus mirabilis (bacteria) in his urine. The second one, indicated the resident had mixed skin flora (skin bacteria) in his urine. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident D's 7/7/22 hospital notes were reviewed. They indicated the patient presented with hematuria for three days. He had a suprapubic and Foley catheter in place. He was positive for mild suprapubic tenderness and abdominal pain. Irritation noted around suprapubic catheter insertion site. The UA was abnormal with increased red blood cells and increased white blood cells. The ED physician indicated .Patient presents thing [sic] with concerns of hematuria. No gross blood in his suprapubic catheter bag her [sic] Foley bag. Suprapubic flashes and drains adequately. UA with a UTI. Patient given Keflex (antibiotic). The Foley was removed ED ordered cephalexin (antibiotic) 500 mg capsule, to take 1 capsule by mouth 4 times a day for 10 days. Diagnosis was acute cystitis with hematuria. During an interview, on 7/8/22 at 11:19 a.m., the Director of Risk Management (DRM) indicated it was her expectation the nursing staff should have let the NP know about the increased blood in the Foley bag. During an interview, on 7/8/22 at 11:40 a.m., the DON indicated it was her expectation for the nurse to have notified the NP when the urine went from light pink to deeper red. The Foley bag, tubing and dignity bag should not have been on the floor. The expectation was for the nurses to keep them off the floor. A current policy, titled Catheter Care, dated 6/2/21, was provided by the DRM at 3:15 p.m., indicated .CAUTI (Catheter Associated Urinary Tract Infections) is the most common adverse event associated with indwelling urinary catheters, including those that are asymptomatic. The risk of bacteremia (bacteria in the blood) in residents with indwelling catheters is 3-36 more likely than residents without an indwelling catheter .prevent symptomatic infections and incorporate antibiotic stewardship recommendations to reduce unnecessary drugs and antibiotics .as well as maintain the dignity and hygiene to the resident .Check that collection bag is not on the floor and is draining properly .Document and report any adverse findings to nurse The immediate jeopardy that began on 6/14/22 was removed on 7/9/22 when the facility assessed all residents with urinary catheters for signs and symptoms of infection, wounds at catheter insertion site, and proper placement of drainage bag. Nursing staff were in-serviced on catheter care, prevention of wounds from catheters, placement of drainage bags, and urinary tract infections. Staff were educated that all residents that request to go to the hospital will be immediately assessed, and the physician will be notified. 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 related to Complaints IN00383623 and IN00384312. 3.1-41(a)(2)