

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00169684.</p> <p>Complaint IN00169684 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309 and F157.</p> <p>Survey dates: April 8, 9, and 13, 2015.</p> <p>Facility number: 013280 Provider number: 155826 AIM number: 201270670</p> <p>Census bed type: SNF: 14 SNF/NF: 3 Residential: 4 Total: 21</p> <p>Census payor type: Medicare: 16 Other: 1 Total: 17</p> <p>Sample: 3</p> <p>This deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0157 SS=D Bldg. 00	<p>Tammy Alley RN on April 15, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a physician of</p>	F 0157	<b>F157 NOTIFICATION OF CHANGES</b> • Staff nurses were educated on the 'GUIDELINES	05/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>a resident's change of condition for 1 of 3 residents reviewed for physician notification of status change (Resident C).</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 4/9/15 at 11:20 a.m. Resident C had diagnoses which included, but were not limited to, aftercare for traumatic bone fracture and high blood pressure. The record indicated Resident C was a full code.</p> <p>A Minimum Data Set (MDS) assessment tool dated 1/20/15, indicated Resident C was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>A nurse's note dated 1/26/15 at 2:26 p.m., indicated a physician was notified and informed Resident C's heart rate was 140 beats per minute. This note further indicated the physician ordered Coreg 3.125 Milligrams twice a day (beta blocker used to slow the heart rate and also decrease blood pressure).</p> <p>An untimed telephone physician's order dated 1/26/15, indicated an order for Coreg tablet 3.125 milligrams to be given twice a day for high blood pressure.</p>		<p>FOR PHYSICIAN NOTIFICATION OF CHANGE IN RESIDENT CONDITION' beginning 4/17/2015. Information covered in the in-service included notification of physician 'it is the responsibility to notify the physician of significant change in condition before end of shift', recognition and response to changes in condition for abnormal vital signs, what constitutes abnormal vital signs, frequency for monitoring vital signs after administration of medication known to impact vital signs, when to report vital signs to the physician and when to send the resident for emergency evaluation/treatment. · All residents have the potential to be affected by this practice. A patient with unstable vital signs with a potential for life threatening complications will be rechecked every 15 minutes until the identified abnormal vital signs are stable. The physician will be notified if the abnormal vital signs are identified twice within 30 minutes. Once a resident has experienced stable vital signs, the licensed nurse will assess hourly times two, every two hours times two, every four hours times two and one time each shift until symptom free for three consecutive shifts (24 hours). · The Director of Nurses or designee will audit 1 resident record daily (Monday through Friday) for two months, then 4</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A nurse's note dated 1/26/15 at 5:45 p.m., indicated on 1/26/15 at 4:00 p.m., Resident C was assessed and noted to have a blood pressure of 98/63, a heart rate that was "tachy" (heart rate beating too fast) at 141 beats per minute, respirations of 20, and an elevated temperature of 99.4. This note indicated a physician was notified and orders were obtained for Coreg and at 4:45 p.m. the Coreg was administered. This note indicated at 5:45 p.m., Resident C's heart rate continued to be "tachy" at 139 beats per minute. This note indicated Licensed Practical Nurse (LPN) #2 had another nurse assess Resident C and was informed that his heart rate continued to be "tachy." This note indicated Resident C's son called the facility with concerns regarding his father's elevated heart rate. This note further indicated at 7:45 p.m., Resident C indicated to LPN #2 he felt like he had a "temperature." LPN #2 assessed his temperature and indicated it was 101.6. This note indicated LPN #2 informed LPN #1 Resident C's heart rate continued to be "tachy." The record lacked indication a physician was notified of Resident C's elevated temperature and continued tachy heart rate.</p> <p>A late entry nurse's note dated 1/27/15 at 2:39 p.m., indicated on 1/26/15 at 6:15</p>		<p>resident records weekly for two months and 3 resident records weekly for two months to ensure prompt physician notification for resident change of condition has occurred. · The above mentioned audits will be presented to the Quality Assurance Committee monthly for six months for additional recommendations. · Date of completion is 5/13/2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>p.m., LPN #2 assessed Resident C's heart rate and indicated it was "beating in the low to mid 90's." This note further indicated LPN #1 reported his findings to LPN #1.</p> <p>A nurse's note dated 1/26/15 at 8:44 p.m., indicated Resident C called 911 from his room and "demanded" to be taken to the hospital.</p> <p>A run report document from the fire department dated 1/26/15, indicated at 8:20 p.m., the Emergency Medical Technicians arrived at the facility and assessed Resident C. This note indicated at 8:20 p.m., Resident C's blood pressure was 72/56, his heart rate was 200. This note further indicated a 12 lead EKG (diagnostic test for the heart) indicated "MI (myocardial infarct) Suspected...complex tachycardia at 142...."</p> <p>During an interview on 4/13/15 at 12:08 p.m., LPN #1 indicated he was asked by LPN #2 to assess Resident C's heart rate. LPN #1 indicated "approximately" 6:00 p.m. he assessed Resident C's heart rate and reported to LPN #2 his heart rate remained "tachy in the 90s." He indicated a tachy heart rate in the 90s "bears watching." LPN #1 indicated he was assigned to another hall and not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>responsible for Resident C and did not notify a physician of his condition.</p> <p>During an interview on 4/13/15 at 1:11 P.M., LPN #2 indicated she was informed by LPN #1 that Resident C's heart rate remained "tachy in the 90's." She indicated it was "the end of her shift" and she left without notifying a physician of Resident C's elevated temperature and continued tachy heart rate.</p> <p>During an interview on 4/13/15 at 12:20 p.m., the Director of Nursing (DON) indicated the physician was not notified of Resident C's elevated temperature or continued tachy heart rate.</p> <p>A policy titled "Guidelines for Physician notification of change in resident condition" identified as current by the Administrator on 4/13/15 at 12:57 p.m., indicated, "...Purpose: to define resident care situations that require physician notification. Standard: Staff observe, documental and communicate to the physician changes in resident condition promptly... Change in condition may include, but is not limited to the following: elevated temperature- 2 degrees over baseline... abnormal or deviation from normal vital signs...."</p> <p>This Federal tag relates to Complaint</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0309 SS=G Bldg. 00	<p>IN00169684.</p> <p>3.1-5(a)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to monitor and assess a resident who exhibited abnormal vital signs and was administered medication known to lower blood pressure. This deficient practice resulted in harm with an emergency transport to an acute care hospital and delayed treatment for a myocardial infarct (heart attack) for 1 of 3 residents reviewed for assessments and interventions when presenting with acute physical changes (Resident C).</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 4/9/15 at 11:20 a.m. Resident C had diagnoses which included, but were not limited to, aftercare for traumatic bone fracture and high blood pressure. The record indicated Resident C was a full</p>	F 0309	<p><b>F309 CARE AND SERVICES</b> • Staff nurses were educated on the 'GUIDELINES FOR PHYSICIAN NOTIFICATION OF CHANGE IN RESIDENT CONDITION' beginning 4/17/2015. Information covered in the in-service included notification of physician 'it is the responsibility to notify the physician of significant change in condition before end of shift', recognition and response to changes in condition for abnormal vital signs, what constitutes abnormal vital signs, frequency for monitoring vital signs after administration of medication known to impact vital signs, when to report vital signs to the physician and when to send the resident for emergency evaluation/treatment. · All residents have the potential to be affected by this practice. A patient with unstable vital signs</p>	05/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>code.</p> <p>A Minimum Data Set (MDS) assessment tool dated 1/20/15, indicated Resident C was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>A nurse's note dated 1/26/15 at 2:26 p.m., indicated a physician was notified and informed Resident C's heart rate was 140 beats per minute. This note further indicated the physician ordered Coreg 3.125 Milligrams twice a day (beta blocker used to slow the heart rate and also decrease blood pressure).</p> <p>An untimed telephone physician's order dated 1/26/15, indicated an order for Coreg tablet 3.125 milligrams to be given twice a day for high blood pressure.</p> <p>A nurse's note dated 1/26/15 at 5:45 p.m., indicated on 1/26/15 at 4:00 p.m., Resident C was assessed and noted to have a blood pressure of 98/63, a heart rate that was "tachy" (heart rate beating too fast) at 141 beats per minute, respirations of 20, and an elevated temperature of 99.4. This note indicated a physician was notified and orders were obtained for Coreg and at 4:45 p.m., the Coreg was administered. This note indicated at 5:45 p.m., Resident C's heart</p>		<p>with a potential for life threatening complications will be rechecked every 15 minutes until the identified abnormal vital signs are stable. The physician will be notified if the abnormal vital signs are identified twice within 30 minutes. Once a resident has experienced stable vital signs, the licensed nurse will assess hourly times two, every two hours times two, every four hours times two and one time each shift until symptom free for three consecutive shifts (24 hours). The Director of Nurses or designee will audit 1 resident record daily (Monday through Friday) for two months, then 4 resident records weekly for two months and 3 resident records weekly for two months to ensure appropriate follow up for a patient with unstable vital signs with a potential for life threatening complications. The above mentioned audits will be presented to the Quality Assurance Committee monthly for six months for additional recommendations. Date of completion: 5/13/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>rate continued to be "tachy" at 139 beats per minute. This note indicated Licensed Practical Nurse (LPN) #2 had another nurse assess Resident C and was informed that his heart rate continued to be "tachy." This note indicated Resident C's son called the facility with concerns regarding his father's elevated heart rate. This note further indicated at 7:45 p.m., Resident C indicated to LPN #2 he felt like he had a "temperature." LPN #2 assessed his temperature and indicated it was 101.6. The record lacked indication Resident C's blood pressure was reassessed after the Coreg was administered and lacked indication Resident C's pulse was reassessed after LPN #2 informed LPN #1 Resident C's heart rate continued to be "tachy."</p> <p>A late entry nurse's note dated 1/27/15 at 2:39 p.m., indicated on 1/26/15 at 6:15 p.m., LPN #2 assessed Resident C's heart rate and indicated it was "beating in the low to mid 90's." This note further indicated LPN #1 reported his findings to LPN #1.</p> <p>A nurse's note dated 1/26/15 at 8:44 p.m., indicated Resident C called 911 from his room and "demanded" to be taken to the hospital.</p> <p>A run report document from the fire</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>department dated 1/26/15, indicated at 8:12 p.m., the Emergency Medical Technicians arrived at the facility and assessed Resident C. This note indicated at 8:12 p.m., Resident C's blood pressure was 72/56, his heart rate was 200. This note further indicated a 12 lead EKG (diagnostic test for the heart) indicated "MI (myocardial infarct) Suspected...complex tachycardia at 142...."</p> <p>During an interview on 4/13/15 at 12:08 p.m., LPN #1 indicated he was asked by LPN #2 to assess Resident C's heart rate. LPN #1 indicated at "approximately" 6:00 p.m., he assessed Resident C's heart rate and reported to LPN #2 his heart rate remained "tachy in the 90s." He indicated a tachy heart rate in the 90s "bears watching." LPN #1 indicated he did not check Resident C's blood pressure. He indicated he was assigned to another hall and did not re-assess Resident C's status again.</p> <p>During an interview on 4/13/15 at 1:11 P.M., LPN #2 indicated she was informed by LPN #1 that Resident C's heart rate remained "tachy in the 90's." She indicated it was "the end of her shift" and she left without reassessing Resident C's status. She indicated she did not take his blood pressure after the Coreg was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155826	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>administered.</p> <p>During an interview on 4/13/15 at 12:20 p.m., the Director of Nursing (DON) indicated she would have expected Resident C's blood pressure to be monitored after he was administered the beta blocker.</p> <p>During the exit conference on 4/13/15 at 1:30 p.m., with the Administrator and DON present, the DON indicated she did not have indication Resident C's status was assessed after LPN #1 assessed him and prior to the Emergency Medical Technicians arrived at the facility at 8:12 p.m.</p> <p>A policy titled "Vital Signs..." and identified as current by the Administrator on 4/13/15 at 12:57 p.m., indicated, "...objective: To monitor resident status. To determine resident's response to treatment. To assess a potential change in condition... It is the policy of this facility to maintain the highest quality of care for its residents in regards to vital signs..."</p> <p>This Federal tag relates to Complaint IN00169684.</p> <p>3.1-37(a)</p>			