STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING 00 B. WING	03/10/2023

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

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on February 3, 2023. This visit included a PSR to the Investigation of Complaints IN00398951, IN00399180, IN00400347, IN00400636 and IN00400296 completed on February 3, 2023. Complaint IN00398951- Corrected. Complaint IN00399180- Not corrected. Complaint IN00400347- Corrected. Complaint IN00400636- Corrected. Complaint IN00400296- Corrected. Survey dates: March 9 and 10, 2023. Facility number: 013280 Provider number: 155826 AIM number: 201270670 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 12 Medicaid: 71 Other: 4 Total: 87 This deficiency reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 20, 2023.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Cromer	Administrator	03/29/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure residents audited by the facility during their plan of correction for post fall care received the interventions recommended, had safe and functional environments, and resident care was provided according to the plans of care for 2 of 3 residents who were reviewed for post fall assessments and interventions (Residents 45, and 17). Findings include: On 3/9/23 at 9:15 a.m., an entrance conference for the Post Survey Revisit (PSR) was conducted with the Administrator (ADM) who provided the facility's Plan of Correction (POC) binder at that time. From the facilities audit for the week of 3/1/23, the following were randomly sampled: a. Resident 15, who had two falls; one on 2/20/23 and one on 2/25/23. b. Resident 17, who had a fall on 2/22/23. c. Resident 45, who had a fall on 2/10/23. 1. On 3/9/23 at 10:30 a.m., Resident 45 was observed in her room. She was seated on the edge of her bed, near the head of the bed, which was	F 0684	Resident #17 and #45 were not harmed by the alleged deficient practice. Resident #45's call light was fixed, care plan was updated to include preference for sitting on the edge of the bed, and a therapy screen completed. CNA #12 and #14 and RN #13 were educated on proper way to transfer resident. All residents who have a history of falls have the potential to be affected by the deficient practice. The Director of Nursing/Designee will audit the last two weeks of residents who have fallen to ensure all fall interventions are in place and care plans updated. The Director of Nursing/Designee educated all nurses and CNA's on the policy "Fall Prevention and Management", updating care plans and where to find the kardax. The Director of Nursing/Designee will complete audits to ensure interventions are in place and care plans are updated post fall, 5 residents a week times 4 weeks, then 3 residents a week times 4	03/28/2023

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	elevated to an approximate 45-degree angle and was at a regular height, so that her feet could not touch the ground. Her over-bed table was pulled in front of her, so her breakfast tray was within reach. Resident 45 indicated she did not like breakfast and wanted something else. When asked if she could use her call light to request an alternative meal, Resident 45 indicated, "it doesn't work." The soft-touch call light was observed clipped to her pillowcase, but when she picked it up, the bulb from the end of the chord fell off. When pressed the call light did not come on. When asked about the fall she had on 2/10/23, Resident 45 indicated she had been sitting on her bed, like she was at that time, and slid off the edge of the bed to the floor. She was behind the bed so no one could see her, and her call light was out of reach, "but it wouldn't have mattered since it doesn't work." She just hollered for help and the nurses came. During an interview on 3/9/23 at 10:40 a.m., Licensed Practical Nurse (LPN) 8 was informed Resident 45 did not like her breakfast meal and would like something else. LPN 8 entered Resident 45's room at that time and asked what else she might like to have. When Resident 45 agreed to wait until lunch LPN 8 left the room and indicated, "ok just let us know if you need anything else." LPN 8 did not notice that the call light bulb had fallen off. When asked if Resident 45 always sat at the edge of her bed like that, LPN 8 indicated, "yes." On 3/9/23 at 12:07 p.m., Resident 45 was observed. Her bed was in the same position, with the head of the bed elevated at an approximate 45-degree angle, and regular height, so that her feet could not touch the ground. She remained seated on the edge of her bed but leaned over to her right side		weeks then 1 resident a week monthly times 4 months. The Director of Nursing/Designee will complete observation of transfers to ensure resident is transferred appropriately, 5 residents a week times 4 weeks, then 3 residents a week times 4 weeks then 1 resident a week monthly times 4 months. All variances will be corrected upon discovery, and additional training/follow-up will be provided as deemed necessary. The Director of Nursing/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.	

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	and rested her head on the elevated mattress. Her eyes were closed, and she appeared to be asleep. The bulb of her call light remained off, and the light was not functioning. On 3/9/23 at 2:50 p.m., Resident 45 was observed a third time. Although she remained seated on the edge of her bed, she was folded forward, with her arms crossed and her head rested on her arms, as she laid her head on top of the over-bed table. The bulb of her call light had been replaced and was clipped to her pillowcase but did not illuminate when pressed. The following day, on 3/10/23 at 9:18 a.m., Resident 45 was observed. She remained in the same outfit and sat in the same position at the edge of her bed, with her over-bed table pulled close. She was eating cereal at that time and indicated her call light was still not working. When pressed, the call light did not illuminate. During an interview on 3/10/23 at 9:26 a.m., a Maintenance Technician, (MT) indicated LPN 5 told him yesterday that Resident 45's call light was broken. He went in a put the bulb back on and it had been working at that time. On 3/10/23 at 9:28 a.m., Resident 45's call light was observed with the MT. The light was not functioning, and the MT indicated he did not know why, but he could just replace the chord. He returned shortly with a new call light cord, but when replaced, the light still did not illuminate when pressed. At that time, the MT indicated it must not be the cord that was broken, but something within the outlet or wall. He could not fix it and would need to call the company who serviced the call light system.			

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	During an interview on 3/10/23 at 9:30 a.m., Unit Manager (UM) 11 indicated Resident 45 did sit on the edge of her bed quite a bit. She could move in and out of her bed independently, but she was encouraged to call staff for assistance. When asked how she would call for help, UM 11 indicated by using her call light. UM 11 was unaware the call light was not working. UM 11 indicated sitting on the edge of the bed could put her at a higher risk for falls since she slid out of bed before. During an interview on 3/10/23 at 11:14 a.m., a technician from the call light service company indicated he had just finished service on Resident 45's call light. He indicated it was a "puffer" call cord, and the "puffer" part was pushed all the way into the call chord which did not allow air down the tube to activate the light. The call chord was replaced and functioning at that time. On 3/9/23 at 11:00 a.m., Resident 45's record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, hemiplegia/hemiparesis (Muscle weakness or partial paralysis on one side of the body) which affected her right dominant side, muscle weakness and lack of coordination. A nursing progress note, dated 2/10/23 at 11:30 a.m., indicated Resident 45 had a change of condition by evidence of altered mental status and had a fall. A STAT (immediate) x-ray was ordered along with labs. A Nurse Practitioner (NP) progress note, dated 2/10/23 at 1:00 p.m., indicated the NP had been notified by nursing staff that Resident 45 had fallen and hit the right side of her body. A STAT x-ray had been completed with no evidence of			

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	fractures, so no new orders were generated at that time. Resident 45 was "provided education to ask for help before getting up." An interdisciplinary team (IDT) progress note, dated 2/10/23 at 3:21 p.m., indicated the root cause of the fall was "resident states she was eating," and the intervention put into place was a therapy evaluation. Resident 45 had a comprehensive care plan, revised 1/10/23, which indicated she was at risk for falls. Interventions that were already in place at the time of her fall on 2/10/23 included but were not limited to: assess risk for falls as needed and place call bell within reach, remind resident to call for assistance. A therapy evaluation was added as an intervention on 2/10/23. The comprehensive care plan lacked documentation of person-centered revisions to include Resident 45's preference for sitting on the edge of her bed, and that her previous fall had been from sliding out of bed while eating off her over-bed side table. A Post Fall Evaluation, dated 2/10/23 at 11:30 a.m., indicated, "patient was in a sitting position on the side of the bed with tray in front of her, patient is a fall risk patient was educated on how important to call us if you need to move around." The record lacked documentation that a therapy evaluation had been ordered or completed. During an interview on 3/9/233 at 4:05 p.m., Physical Therapist (PT) 10 indicated Resident 45 had not received a therapy screen or evaluation after her fall on 2/10/23. Unfortunately, the person covering for him during his absence must have			

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missed the referral if there had been one.

A nursing progress note, dated 3/9/23 at 2:47 p.m., indicated, Resident 45 was sitting on the edge of her bed, eating independently with set-up and ques from staff.

A nursing progress note, dated 3/9/23 at 7:30 p.m., indicated, Resident 45 was sitting on the edge of her bed eating her dinner.

2. On 3/9/23 at 10:45 a.m., Resident 17's empty room was observed, and a passing nursing staff member indicated the resident was LOA (leave of absence) at that time to an oncology appointment.

On 3/9/23 at 2:52 p.m., Resident 17 was observed in her room. She was seated in a regular wheelchair and although she was neat, clean and odor free, she appeared tired. Resident 17 indicated she was in fact, "very tired," as she had been out all morning to an appointment. When asked about the fall she sustained on 2/22/23, Resident 17 indicated it was really more of a "slide." A CNA (certified nursing assistant) had been helping her get out of bed into her wheelchair, but as she got the edge of her wheelchair seat to sit down her legs got weak and the CNA couldn't hold her, so she slid to the floor. Resident 17 indicated there was only 1 CNA and no mechanical lift, but that was how they always transferred her.

On 3/9/23 at 3:37 p.m., Resident 17's call light was observed on, and she indicated she wanted to lay down. At that time CNA 12 came to assist Resident 17 into bed. When asked, CNA 12 indicated the resident only needed 1 staff person for her transfers because she could stand up on her own. CNA 12 got the resident into position,

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	but Resident 17 requested to be brought closer the head of the bed to reach the mobility bar, and closer to the side of the bed. CNA 12 repositioned her. Without a gait belt, CNA 12 grabbed the top of the resident's sweatpants and pulled up as the resident stood. Upon standing, Resident 17 was noted to lean far forward, and could not stand up straight. She braced herself by using her left hand to grab the mobility bar, and her right hand on the mattress. Her right arm shook with effort. CNA 12 helped her pivot and sit down on the mattress and continued to help her get comfortable. During an interview on 3/9/23 at 3:50 p.m., the Assistant Director of Nursing (ADON) indicated, the facility did not have a CNA assignment sheet, instead, CNAs were supposed to use the "Kardex" where the key components of the resident's care were located. Transfer status, and other safety interventions would be included on the Kardex. She provided a copy of Resident 17's Kardex at this time. The Kardex was briefly reviewed and indicated, Resident 17 required two staff members and a mechanical lift for transfers. On 3/1023 at 9:20 a.m., Resident 17 was observed. She was seated in her wheelchair, in her room beside her bed. She appeared paler than the previous day and she indicated she was very tired, and in a lot of pain. She thought the pain was due to her being up so long the day before and riding on the bumpy bus. Her call light was on, and at this time, Registered Nurse (RN) 13 entered the room. Resident 17 indicated she was in a lot of pain; she was tired and wanted to lay down. RN 13 asked on a scaled of 1-10 what her pain level was, and the resident replied, "10." RN 13 indicated she had already had her morning pain			

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	medication but would check to see if there was a PRN (as needed) order. A brief review of Resident 17's MAR (medication administration record) revealed she had received an Oxycodone-Acetaminophen (a narcotic pain medication) 5-325 mg (milligram) tablet 9:57 a.m. On 3/10/23 at 10:08 a.m., CNA 14 entered Resident 17's room to assist her into bed. When asked about the resident's transfer status, CNA 14 indicated that was determined by therapy and if she had a question, she would ask the nurse, but she was sure Resident 17 was a 1-person assist. Resident 17 indicated she was glad to see the CNA because she was very tired and wanted to lay down. CNA 14 got the resident into position, and with a gait belt attempted to help Resident 17 to stand. On the first try, Resident 17 could not stand up, she moaned out loud and indicated, "my legs hurt so bad." CNA 14 moved behind the resident's wheelchair and reached over the back of the wheelchair to hold onto the gait belt. On the second attempt, CNA 14 and Resident 17 exerted a lot of effort and was maximum assistance to stand up. Resident 17 could not stand up straight, her arms shook, and she was unable to wait for the CNA before she pivoted and dropped herself heavily onto the bed. Her face was grimaced, and she moaned in pain. During an interview on 3/1023 at 10:13 a.m., RN 13 indicated she believed Resident 17 was a 1-person assist for her transfers. During an interview on 3/10/23 at 10:15 a.m., PT 10 indicated Resident 17 came to the facility after a fall at home, so she was receiving therapy at that time to work on building strength and transfers. She was falling frequently at home because she			

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	has a lot of pain and spasms in her legs. The pain and spasm were still present and unpredictable, so for the time being she was to remain a 2-person assist with a mechanical lift for nursing staff while in therapy she was a 1 to 2 person max assist. On 3/9/23 at 11:37 a.m., Resident 17's record was reviewed. Resident 17 had diagnoses which included, but were not limited to, malignant neoplasm (cancer) of her connective and soft tissue, reduced mobility, and muscle weakness. A nursing progress note, dated 2/22/23 at 8:10 a.m., indicated Resident 17 was lowered to the floor to avoid a fall after she missed the chair when she was being transferred by a CNA. A NP progress note, dated 2/22/23 at 11:34 a.m., indicated, the NP was informed by nursing staff that Resident 17 fell, "slid out of her wheelchair while transferring with a staff member." She landed on her bottom and complained of back pain. Although a nursing note, dated 2/22/23 at 2:55 p.m., indicated Resident 17 was transferred to the hospital, she was not sent to the hospital but instead, received an x-ray in the facility. The results were negative for a fracture. An IDT progress note, dated 2/23/23 at 12:13 p.m., indicated the root cause of the fall was due to her sliding out of the wheelchair when transferring. The intervention put in place at that time was for therapy to screen her. She was already receiving PT and OT at that time. An IDT progress note, dated 2/23/23 at 2:47 p.m., was an addendum to the first IDT note, which indicated, "wrong intervention [initially therapy			

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	screen], placed in IDT- Correct intervention is therapy to add dycem to her wheelchair." Resident 17 had a comprehensive care plan, revised 1/24/23 which indicated, she was at risk for falls and the intervention to add dycem to her wheelchair was appropriately added on 2/23/23. Resident 17 had a comprehensive care plan, revised 1/24/23 which indicated, she had an ADL (activities of daily living) self-care performance deficit and required assistance with ADLs related to her weakness. Interventions for her ADL care included, but was not limited to, 2-person staff assistance with a stand-up mechanical lift with transfers. Copies of the facilities current policies were included in the plan of correction binder as staff education and in-service material. A policy titled, "Fall Prevention and Management," revised 6/1/22 indicated, " ...it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Fall prevention and management is the process of identifying risk factors that can minimize the potential for falls and also a process to manage a resident's care if a fall occurs ... if the resident is identified to be at risk for falls, a care plan should be initiated that include a plan to potentially diminish the risk for falls. The care plan can include interventions that address environmental factors, ADL factors, risk factors that result from dementia and other mental diagnosis, medical diagnosis that put the resident at higher risk. Issues such as toileting, eating, transferring and impulsiveness should be considered. The care plan can address furniture			

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	arrangements, footwear, medications that can cause dizziness, drowsiness and instability ... therapy should screen the resident to assist with identification of potential ADL issues that can be addressed by either therapy or restorative services. They can also assist with identification of how a resident can transfer and make recommendations for equipment ... The IDT team should review all information for all falls at the next Daily Clinical Meeting. The team should discuss the fall, potential causes of the fall, interventions put into place and if they are effective. A deep root cause investigation should be discussed ...." This Federal tag relates to Complaint IN00399180. This deficiency was cited on February 3, 2023. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)			