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	11/14/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care plan interventions were personalized, implemented, and updated to include changes to wound management for 1 of 3 residents reviewed for care plans (Resident B). This deficient practice was corrected by 10/31/25 prior to the start of the survey and was therefore Past Noncompliance. Findings include:Resident B's clinical record was reviewed on 11/7/25 at 2:00 p.m. Diagnoses on Resident B's profile included hemiplegia and hemiparesis (paralysis) following a cerebral infarction (stroke - death of brain tissue caused by a lack of blood flow) affecting the left dominant side, type 2 diabetes mellitus with diabetic neuropathy, Parkinson's disease, encephalopathy (disfunction of the brain that caused confusion and memory loss), and dysphagia (difficulty swallowing). A care plan for Resident B, dated 9/5/25, indicated the resident was at risk for altered skin integrity related to impaired mobility, and type 2 diabetes mellitus. The goal was for the resident to have improved skin or maintain the current skin status through the next review. Interventions included, complete a skin at risk assessment upon admission / readmission, quarterly, and as needed. Complete weekly skin checks, encourage the resident to turn and reposition or assist as needed as resident allows, and to provide an appropriate off-loading mattress and off-loading cushion, if applicable. Physician's order, dated 9/9/25, indicated to apply Triad cream (a multipurpose skin protectant) to the buttocks every shift and as needed after incontinent episodes. A nursing progress notes, dated 9/17/25 at 4:04 p.m., indicated there had been skin breakdown observed on Resident B's buttocks. A Post Wound Round report, dated 9/19/25, indicated a new full thickness dermatosis on the coccyx, measured 3.5 cm x 2.5 cm x 0.1 cm. Physician's order, dated 9/19/25, indicated to cleanse the coccyx with soap and water, then pat dry. Apply Triad paste to the coccyx affected area three times a day (TID) for wound care and as needed for soilage. Leave open to air. A Post Wound Round report, dated 9/26/26, indicated a new in-house acquired unstageable pressure ulcer on the coccyx, that measured 6.5 cm x 8 cm x 0.1cm. Physician's order, dated 9/26/25, indicated to cleanse the coccyx with wound cleanser then apply medical grade honey and cover with boarder foam every shift for wound care and as needed for soilage or dislodgement. Daily wound assessment and document abnormalities in the progress notes to include drainage, necrotic tissue, signs of infection, odor, surrounding skin, pain level, and if the dressing was dry and intact. Physician's order, dated 10/3/25, indicated to use a low air loss mattress, and check every shift for placement and function. A Post Wound Round report, dated 10/3/25, indicated the in-house acquired unstageable pressure ulcer on the coccyx, measured 10 cm x 3.5 cm x 0.1 cm. A local hospital Physician's Progress Notes, dated 10/6/25 at 3:18 p.m., indicated Resident B presented to the hospital with concerns for hypoxia (low oxygen saturations) and difficulty breathing. The resident was subsequently admitted to the Intensive Diagnostic Treatment Unit (IDTU) to receive treatment for pneumonia (PNA) and a change in mental status. On 10/7/25 at 8:40 a.m., orders were received to initiate the skin and wound care protocol. The reason for the consultation was an unstageable pressure injury on the sacrum and a DTI on the right heel. On 10/8/25 at 4:22 p.m. wound care consult photos included,a. A general assessment indicated the patient's left heel, bilateral ears, and elbows were intact. The left ear and knee had some hyperpigmentation.b. An unstageable sacral/bilateral buttocks pressure ulcer, that measured 8.1 cm x 9.3 cm x 0.4 cm. A minimal amount of tissue was removed with sharps, but remaining necrosis was crosshatched to allow for deeper dressing penetration.c. An unstageable right heel pressure injury was firm and intact with adherent eschar. d. There was a small oval area on the left lateral lower exterior, that presented like an old wound with a hard scab, and measured approximately 3.0 cm x 1.0 cm.e. Nursing was to turn the patient every 2 hours using 2 pillows as wedges, no pillow to the sacrum/buttocks only back and posterior legs, and no back time. Waffle boots were in place to assist with offloading while in bed. A nursing progress notes by LPN 15, dated 10/10/25 at 1:50 p.m., indicated Resident B had returned on a stretcher from a nearby hospital. The resident was alert to herself only and non-verbal per her baseline. The resident had a hard calloused area on the left heel and boots were applied as preventative. Physician's order, dated 10/10/25, indicated weekly skin assessments were to be completed every Friday, wound care consult, the resident was to be on a standard facility mattress that was supposed to be pressure reducing/relieving, and daily wound assessment and document abnormalities. Cleanse the sacral wound daily with wound cleanser, apply medical grade honey, and cover with a bordered foam daily and as needed for soiling and as needed. A Post Wound Round report, dated 10/14/25, indicated the in-house acquired unstageable pressure ulcer on

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to identify wounds, and complete skin assessments for 1 of 3 residents resulting in harm when the resident developed skin breakdown on her buttocks that progressed to an unstageable pressure ulcer/injury (a full thickness tissue loss where the extent of the damage is hidden by dead tissue) that required surgical debridement and the facility failed to assess and treat a Deep Tissue Injury (a pressure-related injury to sub-cutaneous tissue under intact skin, as a result of prolonged compression of bony prominences on underlying soft tissue, particularly muscle) to the right heel for 1 of 3 residents reviewed for pressure ulcers (Resident B). This deficient practice was corrected by 10/31/25 prior to the start of the survey and was therefore Past Noncompliance. Findings include: A confidential interview conducted during the survey indicated a resident representative had been upset when Resident B had developed pressure wounds on her bottom and right heel. Staff had not kept the resident representative informed regarding the extent of the wounds on the resident's bottom, or that the resident had acquired a wound on her right heel. Resident B's clinical record was reviewed on 11/7/25 at 2:00 p.m. Diagnoses on Resident B's profile included hemiplegia and hemiparesis (paralysis) following a cerebral infarction (stroke - death of brain tissue caused by a lack of blood flow) affecting the left dominant side, type 2 diabetes mellitus with diabetic neuropathy, Parkinson's disease, encephalopathy (disfunction of the brain that caused confusion and memory loss), and dysphagia (difficulty swallowing). A Nursing admission Evaluation, dated 9/5/25, indicated there were no skin areas noted, and the resident had no skin issues in the past year. Resident B was unresponsive to painful stimuli due to diminished level. The skin was occasionally moist, and she was bedfast. Mobility was very limited, and she could make occasional slight changes in body or extremity position but was unable to make frequent or significant changes independently. During a move skin probably slid to some extent against sheets, chair, restraints or other devices. The resident maintained relatively good position in a chair or bed most of the time but occasionally slid down. A care plan for Resident B, dated 9/5/25, indicated the resident was at risk for altered skin integrity related to impaired mobility, and type 2 diabetes mellitus. The goal was for the resident to have improved skin or maintain the current skin status through the next review. Interventions included, complete a skin at risk assessment upon admission / readmission, quarterly, and as needed; complete weekly skin checks; encourage the resident to turn and reposition or assist as needed as resident allows; and to provide an appropriate off-loading mattress and off-loading cushion, if applicable. Physician's orders, dated 9/8/25, included weekly skin assessments to be completed every Thursday, and that the resident was to be on a standard facility mattress that was supposed to be pressure reducing/relieving. Wound Assessment Reports, documented by Wound Nurse Practitioner (NP) 13, dated 9/8/25, indicated there were no pressure ulcers noted. A Physician's order, dated 9/9/25, indicated to apply Triad cream (a multipurpose skin protectant) to the buttocks every shift and as needed after incontinent episodes. A Weekly Skin assessment, dated 9/12/25, indicated Resident B had skin areas noted that were not new since the last documented skin assessment. A nursing progress note, dated 9/17/25 at 4:04 p.m., indicated there had been skin breakdown observed on Resident B's buttocks. A physician's order, dated 9/19/25, indicated to cleanse the coccyx with soap and water, then pat dry, apply Triad paste to the coccyx affected area three times a day (TID) for wound care and as needed for soilage, and leave open to air. A Dietary Progress note, dated 9/19/25 at 2:09 p.m., indicated Resident B had no skin issues notes. A Post Wound Round report, dated 9/19/25, indicated new full thickness dermatosis on the coccyx, measured 3.5 centimeters (cm) by (x) 2.5 cm x 0.1 cm. Wound Assessment Reports, documented by Wound NP 13, dated 9/19/25, indicated the resident had an open area to the coccyx, and scarring to the peri wound suggestive of gluteal dermatosis, that measured 3.5 cm x 2.5 cm x 0.10 cm. A Skin Grid Non-Pressure assessment, dated 9/22/25, indicated Resident B had a non-pressure area on the sacrum (situated just above the crack of the butt and coccyx/tailbone) that was not new. Gluteal dermatosis (general term for skin diseases) was first been observed on 9/19/25 and measured 3.5 cm x 2.5 cm x 0.1cm, with full thickness skin loss. The assessment did not indicate if the primary care physician had been notified. A Post Wound Round report, dated 9/26/26, indicated a new in-house acquired unstageable (full thickness skin and tissue loss where the wound depth is obscured by dead tissue) pressure ulcer on the coccyx, that measured 6.5 cm x 8 cm x 0.1cm. A nursing progress notes by the prior in-house wound nurse, Licensed Practical Nurse (LPN) 15, dated 9/26/25 at 2:19 p.m., indicated she had called