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	12/31/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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F 0689 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 all medications, painting supplies, and cleaner/degreaser sprays were secured for 3 of 3 random observations for potential accidents. This deficient practice had the potential to affect 2 of 2 residents randomly observed (Residents G and N). Findings include: 1. On 12/30/25 at 11:15 a.m. Resident G was observed lying on his bed closing his eyes on and off. There was a medication cup of 5 unidentified pills observed on the over-the-bed table among the resident's personal items. The resident indicated the staff had left the medications for him to take when he wanted, and this was his usual routine. The resident deflected and changed the topic when he was asked to identify the medications. There was also a medication cup containing 2 unidentified white tablets on the bedside stand between the resident's BiPAP machine (a non-invasive ventilator used to help people breathe easier) and a push-button desk telephone, out of reach and sight of the resident. On 12/30/25 at 12:33 p.m., a second observation of Resident G lying on the bed scrolling on his cellphone. The medication cup of 2 unidentified white tablets remained on the bedside stand between the resident's BiPAP machine and a push-buttoned desk telephone, out of reach and sight of the resident. On 12/30/25 at 3:55 p.m., a third observation of Resident G lying on the bed scrolling on his cellphone. The medication cup of 2 unidentified white tablets remained on the bedside stand between the resident's BiPAP machine and a push-buttoned desk telephone, out of reach and sight of the resident. On 12/30/25 at 3:58 p.m., the Regional Nurse Consultant and Director of Nursing Services were informed that medications had been observed at Resident G's bedside. Nursing staff were observed in the resident's room but had not removed the medications. Resident G's clinical record was reviewed on 12/31/25 at 1:30 p.m. Diagnoses on Resident G's profiled included osteomyelitis of lumbar vertebra, respiratory failure, and dependence on renal dialysis. An entry Minimum Data Set (MDS) assessment, completed on 10/4/25, assessed Resident G as having moderately impaired cognition. Resident G's clinical record lacked a physician's order or care plan for self-administration of medications. On 12/31/25 at 2:15 p.m., the Regional [NAME] President of Risk Management provided a Medication Administration policy, undated, and indicated the policy was the one being used by the facility. The policy indicated, The purpose of this policy guidance for general medication administration .w. Never leave medications unattended .cc. Do not leave medications at bedside . 2. On 12/30/25 at 11:38 a.m., a utility cart was observed at the end of the hallway, parked in an alcove beside Resident N's room. Resident N was observed in a manual wheelchair (WC) rolling himself up and down the hallway unsupervised. The resident was carrying a bible, confused, wandering aimlessly around the unit, and muttering to himself. The resident was observed stopping next to the utility cart for extended periods of time. Painting supplies on the cart included 2 buckets of wall putty, an opened tube of caulking in a metal holder ready for use, an opened bottle of M1 Tough Job remover (used to strip latex paint - a hazardous statement indicated highly flammable liquid and vapor, caused serious eye irritation, keep container tightly closed, and if the liquid got on skin shower immediately), an opened spray bottle of Krud [NAME] cleaner (a cleaner/degreaser - a hazardous statement indicated caused eye irritation, potential harm if swallowed or inhaled, and avoid getting on skin or breathing), a bucket of paint, and a bucket of dirty water sitting among blankets, trash bags, trash, dirty rags, and painting supplies. There was also an opened blue 5-gallon bucket of paint with a roller inside, there was no lid on the bucket. On 12/30/25 at 11:45 a.m., Resident N was observed propelling himself from near the nurse's station in the center of the unit, to the end of the hallway and he stopped near the utility cart. Licensed Practical Nurse (LPN) 4 indicated Resident N was confused and wandered up and down the hallways all the time. On 12/30/25 at 12:30 p.m., a third observation of the utility cart with painting supplies parked near Resident N's room. Resident N's clinical record was reviewed on 12/31/25 at 2:10 p.m. Diagnoses on Resident N's profile included autistic disorder, unspecified dementia, and intellectual disabilities. A quarterly MDS, completed on 11/28/25, indicated Resident N had severe cognitive impairment. The resident required moderate to significant assistance from staff for most ADL's (activities of daily living) and could propel himself in a wheelchair after setting him up. On 12/30/25 at 3:50 p.m., the Executive Director (ED) indicated the utility cart was being used by a painter working on the vacant room next to Resident N. The cart should have been secured in the room being refurbished, not left in the hallway unsupervised. On 12/31/25 at 2:15 p.m., the Regional [NAME] President of Risk Management provided a Hazardous Material and Waste Management policy, revised 10/7/19, and indicated the policy was the one

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 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, record review, and interview, the facility failed to ensure insulin was administered in accordance with physician's orders and by manufacturer's instructions for 3 of 3 residents observed for insulin administration (Residents B, H, and T). Findings include:1. A concern brought up during the survey indicated Resident B had complained to the staff daily about his high blood sugar readings, not getting his insulin timely, the physician not being contacted for extra insulin coverage when his blood sugar readings were high, and not receiving the proper diet to help control his diabetes. On 12/30/25 at 12:36 p.m., Resident B was observed returning to his room. The resident indicated his blood sugar readings were always high due to not getting his insulin correctly. That morning at 4:00 a.m., his blood sugar had read high which meant over 600, he had cold sweats, and the staff had responded by turning on the air conditioner but had refused to call the physician and get insulin coverage. The resident indicated until this past week he had worn an electronic glucose monitoring device on his arm, but it had come apart when he was removing his shirt last week. The facility was supposed to have got him a replacement, but that had not yet happened. On 12/30/25 at 12:42 p. m., Registered Nurse (RN) 6 was observed to enter Resident B's room with an electronic pad so the resident could participate in a telehealth visit with the attending physician's Nurse Practitioner (NP) about his pain medication. Resident B was overheard reporting his blood sugar reading of 399, and the NP recommended administering an additional 9 units of insulin to supplement the noon insulin he'd already received. The resident indicated his A1C (a lab test to measure the average blood sugar over the past 2-3 months) was running over 9 and going up, and in the past, it had never been over 6.5 (normal range 4.8 - 5.6). The resident indicated he was currently managing his diet, but the nurses were not listening to him and refused to call the MD/NP when he knew he needed additional insulin. On 12/31/25 at 8:59 a.m., Resident B was observed to be upset and voicing his displeasure to Licensed Practical Nurse (LPN) 8 as she prepared to administer his Lantus insulin 20 units and Humalog insulin 3 units that were ordered for 8:00 a.m. Resident B also indicated that the night nurse had not taken his blood sugar reading before he went to breakfast. LPN 8 performed a finger stick blood sugar with a reading of 410, and an additional 9 units of Humalog insulin was administered. Resident B indicated, he was supposed to have his insulin administered 15 - 30 minutes before meals to get a proper reading as getting the blood sugar reading after he ate would affect the amount of sliding scale coverage he received, but that rarely happened. LPN 8 responded that she had other residents with diagnoses of diabetes that required insulin, and she would get them all when she had time. Resident B asked when his electronic glucose monitoring device for his arm would be available, and LPN 8 indicated she would call the pharmacy for an update. Resident B indicated this was a daily fight he had with the nurses, of his blood sugar being high, the nurses giving his insulins late, and them refusing to notify the MD/NP of high readings to get additional insulin coverage. Resident B's clinical record was reviewed on 12/30/25 at 2:25 p.m. Diagnoses on Resident B's profile included type 2 diabetes mellitus with hyperglycemia. A care plan for Resident 8, dated 9/18/25, indicated the resident had diabetes. The goal was for the resident to be able to articulate potential complications of not following prescribed regimen and to be free from signs and symptoms of hypoglycemia and hyperglycemia. Interventions included administering insulin injections per orders, administering medications per medical provider's orders, and monitoring symptoms of hyperglycemia and hypoglycemia. The resident's care plan lacked documentation it had been updated after his admission on [DATE]. A Nursing admission Evaluation, dated 11/25/25, indicated Resident B's admitting diagnoses was ketoacidosis (a life-threatening medical emergency where the body was unable to use glucose). The resident was cognitively intact and had no behaviors or rejection of care. The resident did not have a CGMD (Continuous Glucose Monitoring Device) he choose to self-manage. Physician's orders included:a. On 11/25/25, a consistent carbohydrate diet (CCD diet - designed to help manage high blood sugar levels). The order was discontinued on 11/26/25 and the diet order changed to a regular diet with thin consistency liquids.b. On 11/25/25, perform a fingerstick blood glucose test before meals and at bedtime. If the blood glucose is less than 70 or greater than 410, staff were to notify the primary care physician. c. On 11/25/25, monitor for signs or symptoms of hypoglycemia/hyperglycemia (i.e. sweating, tremor, pallor, tachycardia, palpitations, nervousness, headache, confusion, lightheadedness, slurred speech, lack of concentration, irritability, staggering gait etc.) every shift.d. On 11/25/25, an order for a FreeStyle Libre 3 Reader Device (Continuous Glucose System Receiver) e. On 11/25/25, Humalog insulin