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	04/17/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure eggs were pasteurized and foods were stored safely during 1 of 3 kitchen observations. This deficient practice had the potential to affect 97 of 99 residents who received food from the kitchen. Findings include:During an initial kitchen observation, on 4/13/26 at 6:45 a.m., the following was observed with [NAME] 12. The walk-in cooler's door was propped open, and the floor was wet. [NAME] 12 indicated the floor in the walk-in was wet because the door was propped open, and it had been propped open for about 30 minutes. [NAME] 12 indicated the temperature in the walk-in was 55 degrees Fahrenheit (F) per the electronic temperature reading. [NAME] 12 was unable to find a second thermometer inside the walk-in cooler. A box of eggs with 18 remaining was observed in the walk-in cooler. The eggs were not noted to be pasteurized. There was no stamped p on the eggs and no note on the box to indicate they were pasteurized. [NAME] 12 observed the eggs and the box and confirmed there was no documentation to indicate the eggs were pasteurized. [NAME] 12 indicated eggs were sometimes cooked to order, and some residents requested eggs with the yolks not completely cooked. A pizza, dated 3/4/26, was observed in the walk-in cooler. [NAME] 12 indicated the pizza should have been removed. During an observation, on 4/13/26 at 8:06 a.m., the walk-in cooler was observed with [NAME] 12. The electronic temperature reading indicated 33 degrees F. [NAME] 12 also checked a thermometer inside the walk-in cooler, hanging from a shelf near the door, and indicated it also read a temperature of 33 degrees F. During an observation, on 4/15/26 at 9:27 a.m., the walk-in cooler was observed with [NAME] 12. There were no eggs in the cooler. At the same time, [NAME] 12 indicated if they ran out of eggs, and there was no delivery coming, then someone would go purchase eggs from the store. On 4/15/26 at 9:45 a.m., the Administrator provided a receipt, dated 4/3/26, which indicated a case of pasteurized eggs was delivered. The Administrator was unable to provide documentation of where the box of eggs observed upon entrance came from. During an interview, on 4/15/26, the Dietary Manager indicated the pizza should have been discarded about a week after the date indicated on the pizza. The door to the walk-in cooler should not have been left open, and 55 degrees F was too warm for the cooler. As far as he knew, all the eggs were pasteurized. The Dietary Manager indicated maybe the dye on the eggs that indicated P for pasteurized had been rubbed off or maybe the box was not labeled correctly. On 4/16/26 at 11:30 a.m., the walk-in cooler was observed with the Corporate Dietary Support. The new case of eggs were in a box with PASTEURIZED in large letters across the side of the box. Each egg had a clearly stamped P. At the same time, the Corporate Dietary Support indicated maybe the other eggs had been placed in an ice bath and the P had come off each egg. On 4/16/26 at 2:16 p.m., the Administrator provided a policy titled, Food: Preparation, last revised in February 2026, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedures.4. The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F.8. Only pasteurized egg products will be used for soft cooked egg items. On 4/16/26 at 2:16 p.m., the Administrator provided a document titled, Food Storage: Cold Foods, last revised in February 2026, and indicated it was the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	policy currently being used by the facility. The policy indicated, .Procedures.2. All perishable foods will be maintained at a temperature of 41 degrees F or below, except during necessary periods of preparation and service. On 4/16/26 at 2:16 p.m., the Administrator provided a document titled, Cold Food Storage Chart, last revised on 9/19/23, and indicated it was the policy currently being used by the facility. The policy indicated leftover pizza was able to be stored in the refrigerator for three to four days. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Evergreen Crossing and the Lofts		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received showers and bathing per their preference for 1 of 32 residents reviewed for choices (Resident 7). Findings include:During an interview, on 4/13/26 at 8:46 a.m., Resident 7 indicated he received showers twice weekly. Resident 7 indicated he wanted three showers a week. The resident did not remember the staff asking him about his shower and bathing preferences. Resident 7's record was reviewed on 4/16/26 at 12:24 p.m. Census information indicated the resident was admitted to the facility on [DATE]. A nursing admission assessment, dated 10/31/25, indicated the resident's bathing preference was to receive a bed bath three times weekly. A care plan, last revised on 11/10/25, indicated the resident had an activities of daily living (ADL) self-care performance deficit. Interventions included, but were not limited to, staff provide substantial/maximal assistance with showering/bathing. A quarterly Minimum Data Set (MDS) assessment, dated 2/7/26, indicated the resident was cognitively intact. Bathing documentation in the electronic record, dated 3/1/26 to 4/16/26, indicated the resident was scheduled for and received showers twice weekly. During an interview, on 4/17/26 at 11:25 a.m., the [NAME] President (VP) of Risk Management indicated the resident received showers twice weekly. If a resident told the admitting nurse they wanted a shower three times a week then it should have been scheduled accordingly. On 4/17/26 at 11:45 a.m., the VP of Risk Management provided an undated document titled, Resident Rights, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: 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. a. Residents have a Right to.Be treated with respect 1. Including make their own schedule. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(v)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's code status and resident representative information was appropriately communicated during a transfer to the hospital for 1 of 5 residents reviewed for hospitalization (Resident 59).Findings include:During an interview on [DATE] at 9:31 a.m. Resident 59's legal guardian indicated the facility called Resident 59's nephew, not her, to notify a resident representative of Resident 59's transfer to the hospital. The resident's legal guardian was not notified of Resident 59's transfer until the following Monday when the social worker from the facility called to get an update on the resident. Resident 59's legal guardian indicated once she talked to the hospital staff they indicated to her that they were told Resident 59 was a full code.On [DATE] at 11:59 a.m. Resident 59's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (a progressive, incurable lung disease) and dementia. Resident 59 had a legal guardian. Resident 59 had an active order for a Do Not Resuscitate (DNR) code status.On [DATE] a Physicians Order for Scope of Practice (POST) form signed by Resident 59's legal guardian was scanned into the resident's medical chart. That form indicated Resident 59 had elected a code status of DNR and the form was signed on [DATE].A progress note, dated [DATE] at 3:16 p.m., indicated Resident 59 had been transferred to the hospital at 12:00 p.m. that day for complaints of shortness of breath.A physician's note, dated [DATE] at 1:00 a.m., indicated during Resident 59's hospitalization on [DATE] she had respiratory failure and underwent a Rapid Sequence Intubation (RSI) (an emergency procedure used to quickly induce unconsciousness and paralysis to secure an airway in patients at risk of aspiration) which required 4 attempts due to stenotic airway (a serious, often acquired narrowing of the trachea or larynx, restricting airflow to the lungs).A transfer form, dated [DATE] at 2:54 p.m., indicated Resident 59 had been transferred to the local hospital at 12:00 p.m. for shortness of breath via ambulance. The form indicated Resident 59's code status was Cardiopulmonary Resuscitation (CPR). The form also indicated the resident representative who was notified of Resident 59's transfer to the hospital was a male family member of the resident.During an interview on [DATE] at 12:22 p.m. the [NAME] President of Risk Management indicated the transfer form that was in the resident's medical record was not accurate. She indicated it was filled out at 2 p.m. but the resident had been transferred at 12 p.m. The [NAME] President of Risk Management indicated they always sent a packet of paperwork with the resident when they were transferred to the hospital and that packet would include a POST form if applicable. She indicated she would find the packet and show that the facility provided the appropriate paperwork to the ambulance staff.On [DATE] at 1:26 p.m. a copy of a current facility policy titled, Transfer and Discharge Policy, undated, was provided. That policy indicated, .7. Emergency Transfer/Discharges. e. A copy of any Advance Directive,. DNR. forms should be sent with the resident. F. The original copies of the transfer form and Advance Directive accompany the resident. Copies are retained in the medical record.At the time of exit additional time was allotted to the facility to submit documentation related to the deficient practice. The facility was asked to submit any additional documentation by end of business day on [DATE].At the end of business day [DATE] no additional documentation had been provided from the facility related to this deficient practice. A copy of the packet sent with the resident to the hospital was not provided.410 IAC (Indiana Administrative Code) 16.2-3.1-80

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	04/17/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to code a Minimum Data Set (MDS) correctly when a resident was not taking an antidepressant and failed to code a resident who was edentulous (no teeth or dentures) for 2 of 20 residents reviewed for MDS accuracy (Residents 2 and 7).Findings include:1. On 4/15/26 at 1:18 p.m., a record review was completed for Resident 2. He had the following diagnoses which included, but were not limited to, dementia, anxiety, diabetes, major depressive disorder, traumatic brain injury, insomnia, and kidney disease.Resident's medication orders did not include an antidepressant.Resident's MDS, dated [DATE], indicated he was prescribed an antidepressant.On 4/15/26 at 2:02 p.m., the Corporate MDS Coordinator indicated she corrected the MDS.2. During an interview, on 4/13/26 at 8:57 a.m., Resident 7 indicated he had dentures, but they had broken.Resident 7's record was reviewed on 4/16/26 at 12:24 a.m. A nursing admission assessment, dated 10/31/25, indicated the resident did not have natural teeth or tooth fragments and was edentulous.A comprehensive Minimum Data Set (MDS) assessment, dated 11/7/25, indicated the resident was not edentulous (no teeth or tooth fragments).During an interview, on 4/17/26 at 10:20 a.m., the [NAME] President (VP) of Risk Management indicated the resident was edentulous.During an interview, on 4/17/26 at 11:04 a.m., the Regional MDS Coordinator indicated the staff member who completed the resident's assessment was not able to physically assess him because he was out of the building often. The resident's assessment should have indicated he was edentulous. If the MDS Coordinator was unable to assess a resident they should code as unable to assess. The facility used the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) manual for their policy on MDS coding.The CMS MDS RAI Manual, version 3.0, dated October 2025, indicated, .Section L: Oral/Dental Status. Intent: This item is intended to record any dental problems present in the 7-day look-back period. Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth.410 IAC (Indiana Administrative Code) 16.2-3.1-31(c)(9)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Evergreen Crossing and the Lofts		STREET ADDRESS, CITY, STATE, ZIP CODE 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. Based on observation, interview, and record review, the facility failed to ensure medications were not left at residents' bedside for 2 of 32 residents observed for potential accidents (Residents 60 and 3). Findings include:1. On 4/13/26 at 10:08 a.m., Resident 60 was observed lying in bed. There was a cup with several oral medication pills on his bedside table. At the same time, the resident indicated the nurse brought the medications about 15 minutes earlier, and he had told them he would take them later. Resident 60's record was reviewed on 4/15/26 at 11:45 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 3/29/26, indicated the resident was cognitively intact. A care plan, last revised on 2/5/26, indicated the resident had behaviors, included but not limited to, refusing medications. Interventions included, but were not limited to, administer medications as ordered. An admission nursing assessment, dated 3/25/26, indicated the resident was able to self-administer his inhaler, but not his oral medication pills. The resident's electronic record lacked documentation the resident was assessed as safe to self-administer medication, other than the inhaler. The Medication Administration Record (MAR), dated April 2026, indicated the resident was scheduled to receive allopurinol (lowers uric acid), aspirin, cholecalciferol (supplement), empagliflozin (lowers blood glucose), famotidine (treats excess stomach acid), gabapentin (nerve pain medication), lisinopril (blood pressure medication), metformin (lowers blood glucose), metoprolol (blood pressure medication), on 4/13/26 at 8:00 a.m. The MAR indicated the resident was scheduled to receive sertraline (antidepressant), spironolactone (diuretic), Xarelto (blood thinner) on 4/13/26 in the AM (morning). During an interview, on 4/16/26 at 9:42 a.m., Licensed Practical Nurse (LPN) 15 indicated medications should not have been left at residents' bedsides. The nurses were supposed to watch the residents take their medications. If a resident asked to take their medication later, then the nurse should have removed the medication from the room and returned at a later time. LPN 15 was not aware of any residents who were able to safely self-administer their oral medication pills. Residents normally were able to self-administer things like inhalers. 2. On 4/13/25 at 7:32 a.m., Resident 3 was observed sitting in her chair with her bedside table over her legs. She was eating breakfast and had a medicine cup containing 9 different oral medications pills, sitting next to her breakfast tray, along with a medicine cup of an orangish liquid. On 4/15/26 at 9:47 a.m., a record review was completed for Resident 3. She had the following diagnoses which included, but were not limited to, diabetes type 2, hyperlipidemia (high cholesterol), hypertension (high blood pressure), acute kidney failure, major depressive disorder. A review of her Medication Administration Record (MAR), dated April 2026, revealed she was prescribed the following morning medications: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Evergreen Crossing and the Lofts		STREET ADDRESS, CITY, STATE, ZIP CODE 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	a. Cilostazol (used to improve blood flow and leg pain from limited circulation)100 milligrams (mg) b. Eliquis (used as a blood thinner) 5 mg c. Famotidine (used to stomach concerns)20 mg d. Ferrous Sulfate (used as a supplement) 325 mg e. Lyrica (used to treat pain) 100 mg f. Potassium Chloride Extended Release (used as a supplement) 20 milliequivalents (meq) g. Vitamin C (a supplement) 500 mg h. Vitamin E (a supplement) 180 mg i. Zinc Sulfate (a supplement) 220 mg There was no current medication order found on the April MAR for the cup of orangish cup of liquid. The medical record lacked a self-administration of medication assessment. The medical record lacked a care plan indicating the resident could self-administer her medications. On 4/15/26 at 1:32 p.m., the [NAME] President of Risk Management indicated the orangish liquid was Pro-Stat (a supplement) and she did not require an order to take it. A policy titled, Bedside Medication Storage, dated September 2025, was provided by the Administrator on 4/16/26 at 9:22 a.m. The policy indicated, Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been evaluated and deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident received person-centered dementia specific care and services for 1 of 1 residents reviewed for dementia care services (Resident 72). Findings include:On 4/13/26 at 11:35 a.m., Resident 72 was initially observed. She was lying in bed with her eyes closed and appeared to be asleep. She wore a hospital gown, her hair was tangled, flattened on one side, and appeared to be greasy. There was a band aide on her upper right forehead with a dried dark substance around the edges and into her scalp at her hairline. Her fingernails were long and observed to have dark debris under them. Her television was on a news station. No other sensory stimulation for the resident was observed in the room. On 4/14/26 at 9:12 a.m., the Wound Nurse Practitioner (W-NP) exited Resident 72's room. She indicated they had just finished assessing and dressing a pressure, located on her sacrum. She indicated Resident 72 had experienced a significant decline since her return from the hospital. She was confused and often refused turning/repositioning care, as well as medications, specifically, insulin. The W-NP indicated Resident 72's dementia seemed to have progressed quite a bit and she was no longer able to have mildly coherent conversation. Instead, she just repeated, help help, please help me, even when all of her needs had been met. On 4/14/26 at 12:37 p.m., Resident 72 was observed. She remained in bed. She wore a hospital gown. Her hair had been done in two neat French braids, but the soiled band aide with dried dark substance remained. She called out repeatedly, help, help, help. Although her television was on a news station. No other sensory stimulation for the resident was observed in the room. On 4/14/26 at 12:40 p.m., Licensed Practical Nurse (LPN) 7 entered Resident 72's room. At that time she indicated Resident 72 had severe dementia which seemed worse since her return from the hospital. She used to be able to answer some yes/no questions, but now all she seemed to say was help help help. Her television was on a news station. No other sensory stimulation for the resident was observed in the room. LPN 7 indicated she did not know what kind of activities Resident 72 would like besides just visiting with her. On 4/15/26 at 8:45 a.m., Resident 72 remained in bed. She called out, help, help, help me please repeatedly. She closed her eyes between her calls for help. In between her bouts of drowsiness and calls for help, she appeared more alert than the previous days. Resident 72 indicated she was from Bulgaria, she moved to America when she was young, she had been a librarian and library director for over 30 years and gave the title of her favorite book. She indicated she could not see the TV or books anymore because she was totally blind with diabetic blindness. On 4/15/26 at 9:36 a.m., Resident 72 was up out of bed. She was seated in a regular wheelchair in her room with her over-bed table locked in place in front of her. Her eyes were closed, her head was tucked down and she leaned far forward in her chair, her forehead nearly resting on the arm rest of the chair. She remained in a hospital gown, which was untied at the neck and allowed the material to slip off her shoulder revealing her entire upper back, her left shoulder, and left upper arm. During an interview on 4/15/26 at 10:28 a.m., LPN 8 indicated Resident 72 was easily overstimulated and preferred a lot of one-on-one time with staff. Once anyone went into her room it was hard to leave without her getting upset. LPN 8 indicated she usually waited until last to administer Resident 72's medications for the morning since getting her cleaned up, out of bed, and her eating breakfast often caused increased anxiety and distress for her. Resident 72 most enjoyed someone sitting with her or holding her hand at all times. During an interview on 4/15/26 at 12:03 p.m., LPN 7 and Certified Nursing Aide (CNA) 9 exited Resident 72's room. They indicated she had just been put back in bed. Resident 72 was heard from the hallway calling out help, help, help, per her baseline. LPN 7 and CNA 9 indicated they did not know what else to do to ease her anxiety. Resident 72 was observed at this time. She remained in a hospital gown, the soiled band aide remained in place on her forehead. The television was on. No other sensory stimulation for the resident was observed in the room. On (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Evergreen Crossing and the Lofts		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/15/26 at 12:38 p.m., LPN 8 entered Resident 72's room to administer medication and check her blood glucose. Initially Resident 72 refused her insulin, but with patience and encouragement, LPN 8 was able to get Residet 72 to accept her insulin. Resident 72 called out for help continuously, even though LPN 8 was in the room. LPN 8 indicated Resident 72 really needed one-on-one and she wished she could stay with her longer, but needed to finish her duties. When LPN 8 left the room, the television was on, but no other sensory stimulation for the resident was observed in the room. On 4/16/26 at 8:45 a.m., Resident 82 remained in bed in a hospital gown. Her eyes were closed and she appeared to be asleep. There was a breakfast tray on the over-bed table beside her. Her breakfast tray was observed to have zero of the scrambled eggs eaten, less than 25 percent (%) of the oatmeal eaten, and zero of the muffin eaten. The television was on, but no other sensory stimulation for the resident was observed in the room. On 4/16/26 at 11:31 a.m., the IP was in Resident 72's room and observed her band aide and fingernails. She indicated there should not be a band aide in place so that staff could monitor for signs/symptoms of infection and her fingernails needed to be trimmed and cleaned. On 4/16/26 at 11:50 a.m., Resident 72 was observed out of her room and sat in her wheelchair at the end of a table in the main activity/dining area. The area she sat was densely populated and had high foot-traffic patterns of residents, staff and visitors walking talking and passing by. Current popular songs were playing on a speaker. Resident 72 was heard calling for help per her baseline, but more loudly, and with more anxiety in her voice. On 4/16/26 at 11:52 a.m., the Assistant Business Office Manager (ABOM) indicated, she was Resident 72's Angel and knew her well. She indicated Resident 72 needed to be in a memory care setting, something that was less overstimulating and able to meet her needs with more attention. Big activities like the one she was sitting in, often overwhelmed her and she would ask to go back to her room, but now all she could say was help. On 4/17/26 at 10:20 a.m., Resident 72 was observed. She had been brought back to the main dining/activity room. She sat at the end of a table. At the opposite end sat two of her peers, Residents 13 and 79. When Resident 72 called out, help, help me, please, help me, Residents 13 and 79 mimicked her please in a mocking tone. There was a slight altercation between two male peers at the same table, and when one of the men were redirected and taken away from the table, Resident 13 and 79 indicated, they should have taken her away instead, pointing to Resident 72. On 4/14/26 at 12:40 p.m., Resident 72's record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, type II diabetes mellitus with diabetic neuropathy, unspecified dementia with agitation, and anxiety disorder. A nursing progress note, dated 12/18/25 at 1:17 p.m., indicated Resident 72's guardian and the facility agreed that another facility with an all-female dementia care unit was better suited for the resident's needs and behaviors. A nursing progress note, dated 1/13/26 at 12:16 p.m., indicated Resident 72 would benefit from a dementia unit. That was discussed with facility staff who were in agreement with the social worker. A nursing progress note, dated 2/19/26 at 1:38 p.m., indicated Resident 72 was a long term care resident who will possibly transition to a dementia unit once her Medicaid was approved. Her team was working on finalizing her assets. The resident enjoyed classical music and she preferred to stay in her room. She had an active care plan, initiated on 7/20/25 and revised on 8/11/25, which indicated, she was self-directed for activities in and out of room daily, and indicated the resident was dependent on staff for activities, cognitive stimulation or social interaction due to her disease process. She had a conflicting care plan, initiated on 3/6/26, which indicated she engaged in self-initiated leisure activities and preferred independent leisure pursuits. Neither activity care plans were revised to include some of her person-centered preferences such as the Beatles, classical music, one-on-one discussion approaches, or other sensory interventions. On 4/16/26 at 10:52 a.m. the one-on-one activity binder was reviewed. Resident 72 had not been placed one-on-one activities and was therefore not included in individual activity rounds. Resident 72 activity participation log in the electronic record for activity participation was reviewed. No activities for the previous 30 days were coded. Resident 72 was not observed in activities on 4/13/26, 4/14/26, or 4/15/26. During an interview on 4/16/26 at 11:02 a.m., (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER: Evergreen Crossing and the Lofts		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Social Service Director (SSD) with her Regional Support Staff present, indicated Resident 72 really needed to be in a special memory care unit, but because she had been private pay for so long, no one would accept her with the amount of money she owed. In the meantime, the SSD indicated they were just waiting for her to be approved for Medicaid, so she could be transferred to a more appropriate setting. In the meantime, the SSD indicated she did not know of any other dementia-specific interventions which were in place for her besides routine activities. At that time, the Regional Support Staff reviewed Resident 72's activity care plans and agreed that they were contradicting as one care plan indicated she was self-directed for activities, while the second indicated she was dependent on staff for activities. During an interview on 4/16/26 at 1:20 p.m., Resident 72's guardian indicated she and the facility had been trying to get her into a memory care unit for a while, but due to the amount of money she owed from being private pay while trying to get on Medicaid, no one would accept her. While staff were very kind and patient with her, the [NAME] indicated, they needed to be more proactive and dementia-aware and instead of giving up the first time she says no to something, they should try to encourage her, or redirect with a different options. Instead of going into her room and asking do you want to take a shower? staff should take the approach to go in and say things like, it's time to get a shower. The guardian indicated, she had multiple conversations with the staff to just stop asking her if and what she wants and help her do them instead, especially considering the severity of her dementia they need to just go in and say, hey it's time for . or let's go ahead and get up to do . Resident 72 did better in small quiet environments, she loved the Beatles, classical music, and traditional Bulgarian music. She used to be a librarian, and although she was legally blind, she might like to hold books, or have her favorite book read to her. On 4/17/26 at 11:13 a.m., the Administrator provided a copy of current, but undated, facility policy titled, Dementia Care, Resident Rights and Privileges. The policy 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. Residents with dementia and/or dementia-related diagnosis will be treated with the same respect and dignity and afforded the same resident rights regardless of diagnosis, severity of condition or payment source. Residents will receive care to maintain grooming and health including bathing/showering, nail grooming, oral care, and clean clothing. Individual goals will be addressed on the care plan that meet the needs of the resident for quality of life and quality of care. 410 Indiana Administrative Code (IAC) 16.2-3.1-37.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Evergreen Crossing and the Lofts		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review, the facility failed to ensure medications were properly labeled and stored in 3 of 6 carts reviewed for appropriate storage and labeling of medications (Residents 100 and 112).Findings include:On 4/16/26 at 8:50 a.m. [NAME] Medication Cart 1 was observed. Resident 100 had a bottle of Sevelamer Carbonate (a prescription medication used to control high phosphorus levels in adults with chronic kidney disease) 800 milligrams (mg) that did not have a written or prescription label on it.On 4/16/26 at 9:10 a.m. [NAME] Medication Cart 2 was observed. Resident 112 had an open Budesonide and Formoterol inhaler (a combination inhaler used to manage asthma and chronic obstructive pulmonary disease) with an open date of 11/15/26.On 4/16/26 at 9:30 a.m. Heritage Medication Cart 2 was observed. An unknown resident had a bottle of liquid guaifenesin (an expectorant used to relieve chest congestion by thinning and loosening mucus in the airways) that had a pharmacy label that had been ripped off the bottle. Only a small portion of the top left corner of the label was left on the bottle.On 4/17/26 at 10:23 a.m. a copy of a current facility policy titled, Storage of Medications, dated 9/2025, was provided. That policy indicated, .C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label.H. Outdated. or deteriorated medications. are immediately removed from inventory, disposed of according to procedures for medication disposal . And reordered from the pharmacy. if a current order exists.F. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining.On 4/17/26 at 10:23 a.m. a copy of a current facility reference guide untitled, dated 8/2025, was provided. That guide indicated, .Budesonide/Formoterol. Discard 90 days after removal from protective pouch.410 IAC (Indiana Administrative Code) 16.2-3.1-25(j)410 IAC (Indiana Administrative Code) 16.2-3.1-25(m)410 IAC (Indiana Administrative Code) 16.2-3.1-25(n)