STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN OAKS OF GOSHEN	282 JOHNSTON STREET, GOSHEN, , 46528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00464740. Complaint IN00464740 - State deficiencies related to the allegations are cited at R0241 & R0296. Survey date: September 23, 24 & 29, 2025. Facility number: 015205 Residential Census: 102 These State Residential Findings are cited in accordance with 410 IAC 16.2-5 Quality Review completed on 10/02/2025.	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.	
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as	R 0241	The community is alleged to be out of compliance by failing to ensure medications were administered by qualified staff members providing care	10/24/2025

	ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to medictions were administered by qualified staff members providing care within their scope of practice for 1 of 1 staff members reviewed. (CNA 3) This deficient practice resulted in a resident requiring transfer and treatment from an acute care center including intubation and Intensive Care monitoring due an opiod overdose. (Resident D) Finding includes: A record review was completed for Resident D on 9/24/2025 at 1:04 P.M. Diagnoses included, but were not limited to: chronic pain syndrome, inverted disc stenosis of neural canal of lumbar region, spinal stenosis of lumbar region, degeneration of lumbar intervertebral disc and lumbar radiculopathy. A Physician's Order, dated 8/29/2024 indicated Resident D was to be administered Naloxone 4 mg (milligrams)nasal spray one spray into nostril as needed for		within their scope of practice for 1 of 1 staff members reviewed. (CNA 3) A CNA 3 has not worked as a QMA since December 2024. B The BOM/ designee audited all personnel files to ensure active licensure. All other licenses were found to be in compliance with the regulation. C Nursing staff were educated by DON/ designee on CNA and QMA scope of practice. D An audit will be completed by the Business Office Manager weekly for 4 weeks and monthly thereafter 6 months. Variances will be corrected at the time of observation. The QAPI committee to review audits monthly and will make recommendations as	

	opioid overdose and to repeat in 30 minutes if there was minimal or no response. A Physician's Order, dated 8/30/2024 indicated Resident D was to be administered oxycodone acetaminophen (a narcotic pain medication) 10-325 mg one tablet by mouth three times per day. A Physician's Order, dated 9/12/2024 indicated Resident D was to be administered Morphine Sulfate ER (extended release) (a narcotic pain medication) 15 mg one tablet by mouth twice daily at 10:00 A.M. and 10:00 P.M. A Nurse Practitioner's (NP) Visit Note, dated 9/20/2024 at 6:00 A.M., indicated the NP was called into the clinic room by the DON due to a concern of Resident D's worsening respiratory status. The note indicated staff reported the resident had been extremely drowsy for the past hour after taking medications. Staff had been unable to obtain a blood pressure on Resident D on either arm. The note indicated Resident D's condition changed after she had been administered Morphine Sulfate ER 15 mg (milligrams) tablet at 11:08 A.M. and her normal oxycontin 10-325 mg tablet at 11:00 A.M. The DON reported that she tried to find Resident D's Narcan		necessary.	

	nasal spray, as there was an order for the medication on file, but she was unable to find the mediction in the Resident's lock box in her room. The note indicated Resident D's consciousness was drifting, she was diaphoretic and was mumbling her words. The note indicated that on exam, Resident D appeared to have difficulty staying awake and breathing. The note further indicated, "Plan: opioid overdose event- called emergency medical services for further evaluation and emergent transfer to the hospital." The note indicated prior to the arrival of the NP, staff had been with the resident for approximately 30 minutes with her condition worsening. The resident was diaphoretic, breathing cyclical from labored breathing to agonal breaths. Resident D's pupils were nonreative to light. Listening of the heart showed very weak beats and it was very difficult to make out a heartbeat. A review of Resident D's EMAR (electronic medication administration record) indicated CNA 3 had administered oxycodone acetaminophen 10-325 mg one tablet by mouth on 9/20/2024 at 9:21 A.M., Morphine Sulfate 15 mg tablet by mouth on 9/20/2024 at 11:08 A.M. and oxycodone acetaminophen 10-325 mg one tablet by mouth on 9/20/2024 at			

	11:08 A.M. A Nursing Progress Note, dated 9/20/2024 at 12:38 P.M. indicated the nurse heard a crash from the nurses station. When the nurse arrived to the resident's room, Resident D was found lying on her left side in the clinic where she was waiting to be seen by the NP. The resident was asked if she had fallen out of her chair and she indicated she had not. The NP was currently evaluating the resident and indicated Resident D was hypertensive and diaphoretic, had altered mental status, was responding slowly to commands, her pupils were non reactive to light and she had tremors to her hands and arms. The note indicated Resident D's blood pressure and heart rate were hard to find, her oxygen saturation was 91% on room air and her respiratory rate was 8-10 breaths per minute. A Nursing Progress Note, dated 9/20/2024 at 1:00 P.M. indicated Resident D had been transferred to (hospital name) due to confusion and altered mental status and resident was "possibly having an interaction with pain medications." A review of Resident D's Emergency Department (ED) Triage Note, dated 9/20/2024, indicated the resident had presented to the Emergency			

	Department with an altered mental status. The resident had been evaluated at (facility name) where she resided by the provider there and there had been concern that the resident was suffering from an opioid overdose. Emergency medical services were contacted and the resident had been administered Narcan (a medication used to repidly reverse the effect of opiod overdoses) which did cause the resident to wake up and caused her oxygen saturations to improve. An ED Physician's Progress Note, dated 9/20/2024 at 1:32 P.M. indicated Resident D was initially placed on oxygen. The patient was given Narcan, which provided slight improvement in her mental status. She was becoming less responsive and was not responding to verbal or painful stimuli. Therefore, the decision was made to intubate the patient. The patient was admitted to the Intensive Care Unit for opioid overdose, altered mental status and acute hypoxic respiratory failure. During an interview, on 9/25/2025 at 8:50 A.M. Resident D indicated sometime in the fall of 2024 she had been administered a dose of percocet and then eight minutes later she was administered a dose of morphine. She indicated she was unsure which staff member			

	had administered the medications to her at the time. She indicated she was transferred to the ED and intubated due to an opioid overdose. She indicated CNA 3 had administered medications to her several times in the past, including narcotics, but it had been a while since CNA 3 had administered medications to her. During an interview, on 9/25/2025 at 10:03 A.M., the DON indicated when she began working for the facility in December 2024, it had been brought to her attention that CNA 3 had been working on the floor as a QMA (Qualified Medication Aide) and administering medications to residents. She indicated after further investigation, she discovered that CNA 3 had not been certified as a QMA. The DON indicated upon finding out CNA 3 was not certified as a QMA, she immediately removed the staff member from the schedule working as a QMA and CNA has not passed medications since. She indicated CNA 3 should not have been administering medications to residents without the proper certification. A review of CNA 3's professional licensing indicated she was not certified as a QMA in Indiana and did not possess			

	the proper certification to administer medications to residents. On 9/29/2025 at 10:18 A.M., the Administrator provided the policy titled, " Medication Management, Administration & Storage" dated 1/2024 and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: the purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines. The community will have available, on the premises or on call, the services of a licensed nurse at all times. 2. If a resident is assessed as Needing Assistance with Medication Administration, it is the responsibility of the licensed nurse or Qualified Medication Aide (QMA) to administer the medications to the resident. B. Medication Administration: Medication Administration will be administered as ordered by a licensed nurse or QMA...." Based on record review and interview, the facility failed to medictions were administered by qualified staff members providing care within their scope of practice for 1 of 1 staff members reviewed. (CNA 3) This deficient practice resulted			

in a resident requiring transfer and treatment from an acute care center including intubation and Intensive Care monitoring due an opiod overdose. (Resident D)

Finding includes:

A record review was completed for Resident D on 9/24/2025 at 1:04 P.M. Diagnoses included, but were not limited to: chronic pain syndrome, inverted disc stenosis of neural canal of lumbar region, spinal stenosis of lumbar region, degeneration of lumbar intervertebral disc and lumbar radiculopathy.

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R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on record review and interview, the facility failed to ensure oncoming and off-going licensed staff members reconciled the narcotic count sheets for 1 of 2 narcotic count sheets reviewed. (1st/2nd floor medication cart) Finding includes: During a review of the first and second floor medication cart on 9/24/2025 at 9:42 A.M. with	R 0296	The community is alleged to be out of compliance by failing to ensure oncoming and off-going licensed staff members reconciled the narcotic count sheets for 1 of 2 narcotic count sheets reviewed. (1^{st}/2^{nd} floor medication cart) A. The director of nursing was educated by the executive director regarding a policy titled " Medication Management, Administration, & Storage." B. Audits of all narcotic books were conducted to identify any other counts.	10/24/2025

	QMA 2, signatures for oncoming and off-going nurses were missing on the narcotic reconciliation sheet for the following dates and shifts: - 9/22/2025 from 2:00 P.M. to 10:00 P.M. - 9/22/2025 from 10:00 P.M. to 6:00 A.M. - 9/23/2025 from 10:00 P.M. to 6:00 A.M. - 9/24/2025 from 6:00 A.M. to 2:00 P.M. During an interview, on 9/24/2025 at 9:45 A.M. QMA 2 indicated the narcotic count sheets should have had staff signatures in the blank areas. On 9/29/2025 at 10:18 A.M., the Administrator provided the policy titled, "Medication Management, Administration & Storage," dated 1/2024 and indicated it was the policy currently being used by the facility. The policy indicated, "...F. Controlled Substances-Hand Off Procedure. 1. Memory Care. At shift change, the oncoming licensed nurse responsible for medications administration will verify the resident, medication, dosage and count of all controlled substances in the narcotic lock box by physically counting each medication in the direct presence of an offgoing		C. Nursing staff were educated by DON/ Designee on The Medication Management, Administration & Storage policy. D. An audit of the narcotic count sheets will be completed by the DON/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and monthly thereafter for 6 months. Variations will be corrected at the time of observation and the results will be reviewed and reported to the QAPI committee.	

licensed nurse or QMA. 2. Upon completion of the controlled substance count, each party, both oncoming and outgoing, should provide their signature, date and time on the Controlled Medication Shift to Shift Change Log...."

Based on record review and interview, the facility failed to ensure oncoming and off-going licensed staff members reconciled the narcotic count sheets for 1 of 2 narcotic count sheets reviewed. (1st/2nd floor medication cart)

Finding includes:

During a review of the first and second floor medication cart on 9/24/2025 at 9:42 A.M. with QMA 2, signatures for oncoming and off-going nurses were missing on the narcotic reconciliation sheet for the following dates and shifts:

- 9/22/2025 from 2:00 P.M. to 10:00 P.M.

- 9/22/2025 from 10:00 P.M. to 6:00 A.M.

- 9/23/2025 from 10:00 P.M. to 6:00 A.M.

- 9/24/2025 from 6:00 A.M. to 2:00 P.M.

During an interview, on 9/24/2025 at 9:45 A.M. QMA 2 indicated the narcotic count

	sheets should have had staff signatures in the blank areas. On 9/29/2025 at 10:18 A.M., the Administrator provided the policy titled, "Medication Management, Administration & Storage," dated 1/2024 and indicated it was the policy currently being used by the facility. The policy indicated, "...F. Controlled Substances-Hand Off Procedure. 1. Memory Care. At shift change, the oncoming licensed nurse responsible for medications administration will verify the resident, medication, dosage and count of all controlled substances in the narcotic lock box by physically counting each medication in the direct presence of an offgoing licensed nurse or QMA. 2. Upon completion of the controlled substance count, each party, both oncoming and outgoing, should provide their signature, date and time on the Controlled Medication Shift to Shift Change Log...."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURECarlos Romero	TITLEExecutive Director	(X6) DATE10/14/2025