STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

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 Complaints IN00463097, IN00462239 and IN00461920. Complaint IN00463097 - No deficiencies related to the allegations are cited. Complaint IN00462239 - State deficiency related to the allegation is cited at R0349. Complaint IN004461920 - No deficiencies related to the allegations are cited. Survey dates: July 14 & 15, 2025 Facility number: 015205 Residential Census: 96 The State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality Review completed on 7/21/2025	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 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure a CNA completed a well check on 1 of 1 residents reviewed for a death at the facility in the past six months. (Resident D) Finding includes: On 7/14/25 at 1:43 P.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to: Chronic Obstructive Pulmonary Disease (COPD), depressed mood, acute respiratory failure with hypoxia (deficiency in the amount of oxygen) and pulmonary hypertension. A Nursing Progress Note, dated 7/5/25 at 5:51 P.M., indicated	R 0349	The community was alleged to be out of compliance by failing to ensure the facility failed to ensure a CNA completed a well check on 1 of 1 residents reviewed for a death at the facility in the past six months. **A A.**Resident B no longer resides in the facility. **B B.**Residents living in community have potential to be affected related to alleged deficient practice. No other residents have been affected. **C C.**Nursing staff were educated by the DON/ designee on "Daily Wellness Check" policy ensuring daily wellness checks are completed. **D** D. An audit will be completed by DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. Variances will be corrected	08/15/2025

	LPN 2 had been asked by QMA 3 to do a welfare check on Resident D at approximately 5:05 P.M. The note indicated "...Resident noted to be lying on the living area floor with oxygen running and on resident via NC [nasal canula]. This writer assessed and discovered there to be no pulse. Body is bloated and modeled (sic) from head to toe...called to 911 right away. 911 operator offered that if this writer thought it could help that CPR could be started but this writer chose that to be a negative based on body's appearance and environment. Police and EMT on scene within 5 minutes...." The EMS paramedics did not initiate CPR when they arrived. A form titled, "Corrective Action Notice," dated 7/6/25, indicated CNA 4 had falsely documented a safety check on Resident D, on 7/5/25. CNA 4 had been given a written warning due to not following the facility policy. During an interview, on 7/14/25 at 2:35 P.M., the Deputy Coroner indicated Resident D's cause of death was COPD and CHF (congestive heart failure) and nothing was "a miss" according to the police officer and his assistant, whom had reported to the scene at the facility. The Coroner indicated he had spoken with the resident's Nurse Practitioner		at the time of observation. QAPI committee to review x 6 months and make recommendations as necessary.	

(NP) who indicated the resident had complained of increased shortness of breath. The NP had ordered a hospital bed, so the resident's head could be elevated to assist with his breathing during sleep. Resident D had already been using oxygen continuously prior to his death. It was the Coroner's understanding Resident D was living at the facility and was independent. The Coroner indicated nothing had been suspicious concerning his death.

During an interview, on 7/15/25 at 10:16 A.M., CNA 4 indicated she had not completed the well check on Resident D, on 7/5/25. She indicated it was someone from the evening shift that had found him deceased. She indicated the resident was very independent and had only come out of his room to smoke. He never ate in the dining room and fixed his own meals.

During an interview, on 7/15/25 at 11:26 A.M., the Director of Nursing (DON) indicated CNA 4 was to have checked on the resident as part of her AM duties. The last time anyone had seen the resident had been on 7/4/25 at 2:46 P.M., according to the hallway camera, which recorded him entering his room at that time. The camera also confirmed CNA 4 had not been to the

resident's room to do the wellness check on 7/5/25

On 7/15/25 at 9:40 A.M., the DON provided a policy titled, "Daily Wellness Check", dated 4/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this community to perform daily welfare check on each resident in order to provide a safe and reassuring environment for each resident. RESPONSIBILITY: A. It is the responsibility of the C.N.A. to check on each Resident, by visually laying eyes on them at least once daily. B. It is the responsibility of the C.N.A. to include date, time and initials on the "Resident Wellness Check"...PROCEDURE: Resident will be checked on at least once daily by staff. The C.N.A. will go to the resident's apartment and knock to ensure resident's privacy and dignity. The C.N.A. must visually check on each resident to consider the "Resident Wellness Check" complete...."

This State Residential finding relates to Complaint IN00462239.

Based on interview and record review, the facility failed to ensure a CNA completed a well check on 1 of 1 residents reviewed for a death at the

facility in the past six months. (Resident D)

Finding includes:

On 7/14/25 at 1:43 P.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to: Chronic Obstructive Pulmonary Disease (COPD), depressed mood, acute respiratory failure with hypoxia (deficiency in the amount of oxygen) and pulmonary hypertension.

A Nursing Progress Note, dated 7/5/25 at 5:51 P.M., indicated LPN 2 had been asked by QMA 3 to do a welfare check on Resident D at approximately 5:05 P.M. The note indicated "...Resident noted to be lying on the living area floor with oxygen running and on resident via NC [nasal canula]. This writer assessed and discovered there to be no pulse. Body is bloated and modeled (sic) from head to toe...called to 911 right away. 911 operator offered that if this writer thought it could help that CPR could be started but this writer chose that to be a negative based on body's appearance and environment. Police and EMT on scene within 5 minutes...." The EMS paramedics did not initiate CPR when they arrived.

A form titled, "Corrective Action

Notice," dated 7/6/25, indicated CNA 4 had falsely documented a safety check on Resident D, on 7/5/25. CNA 4 had been given a written warning due to not following the facility policy.

During an interview, on 7/14/25 at 2:35 P.M., the Deputy Coroner indicated Resident D's cause of death was COPD and CHF (congestive heart failure) and nothing was "a miss" according to the police officer and his assistant, whom had reported to the scene at the facility. The Coroner indicated he had spoken with the resident's Nurse Practitioner (NP) who indicated the resident had complained of increased shortness of breath. The NP had ordered a hospital bed, so the resident's head could be elevated to assist with his breathing during sleep. Resident D had already been using oxygen continuously prior to his death. It was the Coroner's understanding Resident D was living at the facility and was independent. The Coroner indicated nothing had been suspicious concerning his death.

During an interview, on 7/15/25 at 10:16 A.M., CNA 4 indicated she had not completed the well check on Resident D, on 7/5/25. She indicated it was someone from the evening shift that had found him deceased. She

indicated the resident was very independent and had only come out of his room to smoke. He never ate in the dining room and fixed his own meals.

During an interview, on 7/15/25 at 11:26 A.M., the Director of Nursing (DON) indicated CNA 4 was to have checked on the resident as part of her AM duties. The last time anyone had seen the resident had been on 7/4/25 at 2:46 P.M., according to the hallway camera, which recorded him entering his room at that time. The camera also confirmed CNA 4 had not been to the resident's room to do the wellness check on 7/5/25

On 7/15/25 at 9:40 A.M., the DON provided a policy titled, "Daily Wellness Check", dated 4/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this community to perform daily welfare check on each resident in order to provide a safe and reassuring environment for each resident. RESPONSIBILITY: A. It is the responsibility of the C.N.A. to check on each Resident, by visually laying eyes on them at least once daily. B. It is the responsibility of the C.N.A. to include date, time and initials on the "Resident Wellness Check"...PROCEDURE:

	Resident will be checked on at least once daily by staff. The C.N.A. will go to the resident's apartment and knock to ensure resident's privacy and dignity. The C.N.A. must visually check on each resident to consider the "Resident Wellness Check" complete...." This State Residential finding relates to Complaint IN00462239.			

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 SIGNATURE	TITLE	(X6) DATE