STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. BUILDING **01** B. WING _____	**11/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENCROFT HEALTHCARE	**1225 GREENCROFT DR** **GOSHEN, IN 46527**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A LSC Preoccupancy survey for the newly remodeled therapy center and a newly constructed smoke barrier wall in Building One, was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/22/24 Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710 At this Preoccupancy survey, Greencroft Healthcare was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. Build #1 Type V (111) with a partial basement determined is fully sprinklered, has a fire alarm system with smoke detection in the corridors, areas open to the corridor, and hard-wired smoke detectors in all resident rooms that are not connected to the fire alarm system but provides a visual and audible signal at the nurses' station. This building is separated from independent living by a Fire Wall with 2-Hour Fire Resistive Rating. The facility has a capacity of 233 and had a census of 159 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. There is a staff only smoking shack separate from the building	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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	155205	A. BUILDING **01** B. WING _____	**11/22/2024**

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K 000	Continued From page 1 that was not sprinklered. Quality Review completed on 11/27/24	K 000		