STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155205	A. BUILDING -- B. WING	06/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 06/24/24 and 06/25/24 Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710 At this Emergency Preparedness survey, Greencroft Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 233 certified beds. At the time of the survey, the census was 159. Quality Review completed on 06/28/24	E 0000	**K000** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 7/22/2024.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). This visit was in conjunction with the Life Safety Code Preoccupancy Survey that exited on 06/25/24. Survey Dates: 06/24/24 and 06/25/24 Facility Number: 000112 Provider Number: 155205	K 0000	**K000** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 7/22/2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terry A Tomasi	Administrator	07/29/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	AIM Number: 100288710 At this Life Safety Code survey, Greencroft Healthcare was found not 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. The facility consists of the original one-story building with a partial basement determined to be of Type V (111) and the two-story 2015 addition determined to be of Type II (111). The buildings are separated by a Fire Wall with 2-Hour Fire Resistive Rating. Building 01 (the original building) is fully sprinklered, has a fire alarm system with smoke detection in the corridors, areas open to the corridor, and battery smoke alarms 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 that was not sprinklered. Quality Review completed on 06/28/24			
K 0226 SS=E	NFPA 101 Horizontal Exits			

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Bldg. 01	Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 2 fire door sets located within a horizontal exits were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 66 residents in 4 smoke compartments when occupied. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2 and Maintenance Lead 1, the fire door set marked as X1 by elevator "A" separating the elevator lobby from the corridor between the assisted living facility and the healthcare facility failed to latch into the frame. In addition the fire door set marked as T6 by the Metzler Meeting House separating the "Lea" unit from the "Terrace" unit failed to latch into the frame. Based on interview at the time of observation, the Maintenance Lead 1 confirmed this fire door set did not latch. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference.	K 0226	**K226** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech adjusted fire door set 1x by elevator “A” and T6 by Metzler Meeting House horizontal exit latch mechanism to ensure self-closure and latching of doors. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 66 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Tech conducted a facility audit to validate fire doors properly self-close and latch. Administrator educated maintenance staff on fire doors requiring self-closures and latching. Maintenace Manager has developed a preventative maintenance schedule for inspection of fire doors to validate self-closure and latching. 4. How the corrective action(s) will	07/21/2024

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	3.1-19(b)		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Self-Closure Doors with Secure Latch” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0251 SS=E Bldg. 01	NFPA 101 Dead-End Corridors and Common Path of Travel Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 corridor between the healthcare facility and the assisted living was not	K 0251	**K251** 1. What corrective action will be accomplished for those residents	07/21/2024

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	a dead-end corridor greater than 30 feet. Findings include: Based on observation and interview during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with Maintenance Lead 2 and Maintenance Lead 1, the distance of travel between the corridor to exit 77 in the healthcare facility and the doors to the assisted living was greater than 30 feet. The doors to the assisted living were closed without exit signage or other indication of egress. Based on interview at the time of the observation, the Maintenance lead 2 stated he believed there was an exit sign at this location before. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)		found to have been affected by the deficient practice; Maintenance Tech re-installed exit signage to provide a clear path of egress between the corridor to exit 77 in the healthcare facility to the assisted living. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated exit signage provides clear path of egress. Administrator educated maintenance staff on the safety requirement for exit path signage remaining in place and functional. Maintenance Manager/designee will conduct random audits of exit signage functioning. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Exit Signage, Lights and Doors” weekly for 4	

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			weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 19 egress discharge paths were marked with directional signage. LSC 7.7.3.2 states the exit discharge shall be arranged and marked to make clear the direction of egress travel from the exit discharge to a public way. This deficient practice could affect staff, 1 of 7 smoke compartments. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with Maintenance Lead 2 and Maintenance Lead 1, outside the Elevator A door 77 exit there were two paths of travel and no directional signage to indicate the path of travel. One path was not a complete path to the public way. Based on interview at the time of the observation, the	K 0271	**K271** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Contractor installed exit signage to provide a clear direction path of egress outside the Elevator A door 77 exit in the Household units of the healthcare facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 66 residents and staff have the potential to be affected. 3. What measures will be put into	07/21/2024

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	Maintenance Lead 2 agreed the exit did not have directional signage and someone not familiar with the facility would not know which way to exit. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)		place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated exit signage provides clear direction path of egress. Administrator educated maintenance staff on exit signage safety requirements providing clear direction paths. Maintenance Manager/designee will conduct random audits of exit signage functioning. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Exit Signage, Lights and Doors” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress			

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	155205	A. BUILDING 01 B. WING	06/25/2024

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	Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure continuity of egress lighting for 4 of 19 exits. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect staff and residents in 1 of 7 smoke compartments when occupied. Finding include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with Maintenance Lead 2 and Maintenance Lead 1 the exit discharge sidewalks from doors 25 and 77, did not have egress lighting for portions of the sidewalks from the exit to the public way. Based on interview at the time of observations, the Maintenance Lead 2 confirmed there were no other lighting devices illuminating the sidewalks, and stated it was undetermined if all of the aforementioned exit paths were provided with sufficient lighting. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)	K 0281	**K281 - 2** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech installed egress lighting to provide a clear direction path along the sidewalks from exit doors 75 and 76 to the public way from the Household units of the healthcare facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 64 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated exit lighting provides a clear direction path along the sidewalks from exit doors 75 and 76 to the public way. Administrator/designee will educate staff on exit lighting provides a clear direction path along the sidewalks from exit doors 25 and 77 to the public way on or before 7/21/2024.	07/21/2024

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	155205	A. BUILDING 01 B. WING	06/25/2024

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			Maintenace Manager/designee will conduct random audits of egress lighting functioning. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Exit Signage, Lights and Doors” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 #1) Based on observation and interview, the facility failed to ensure 4 of 4 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections	K 0291	**K291** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech replaced 4 of 4 battery	07/21/2024

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	155205	A. BUILDING 01 B. WING	06/25/2024

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	and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect residents, staff and visitors in 1 of 7 smoke compartments in the facility. Findings include: Based on observation and interview during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2 and Maintenance Lead 1, the battery-operated emergency lights located in the "Metzler Meetinghouse" are not on the monthly test and annual testing log. The lack of monthly and annual testing of the four battery operated emergency lights was verified and acknowledged by the Maintenance Lead 2 at the time of observation and tour. #2) Based on observation and interview, the facility failed to ensure 4 of 4 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be		backup emergency lights with emergency flood lights wired to operate by generator in the Metzler Meetinghouse. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated emergency flood lights operate with generator testing. Administrator educated maintenance staff on the testing of emergency flood lights. Maintenace Manager has developed a preventative maintenance schedule for inspection of emergency flood light operated by the generator. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Exit Signage, Lights and Doors” weekly for 4 weeks, and monthly thereafter for	

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	155205	A. BUILDING 01 B. WING	06/25/2024

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	capable of repeated automatic operation without manual intervention. This deficient practice could affect residents, staff and visitors in 1 of 7 smoke compartments in the facility. Findings include: Based on observation and interview during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2 and Maintenance Lead 1, all four battery-operated emergency lights located in the "Metzler Meetinghouse" failed to function when its respective test buttons were pushed three times. Based on interview at time of the observation, the Maintenance Lead 2 stated the lights were not tested monthly but acknowledged the aforementioned battery-operated emergency lights failed to function when its respective test buttons were pushed. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)		at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of 104 of 104 battery	K 0300	**K300** 1. What corrective action will be accomplished for those residents	07/21/2024

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	operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review and interview from 9:42 a.m. to 12:10 p.m. on 06/24/24 with Maintenance Lead 2, there was no documentation of resident room battery smoke alarms tested for functionality on a weekly basis per manufacturer's recommendations during the past twelve months. The documentation only showed inspection of an annual check. Based on interview at the time of record review, the Maintenance Lead 2 stated he thought he only had to check the devices annually. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)		found to have been affected by the deficient practice; Maintenace Tech tested battery-operated smoke alarms located in resident rooms. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 104 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Tech conducted a facility audit to validate battery-operated smoke alarms in resident rooms tested for functionality. Administrator educated maintenance staff on manufactures recommendation to reference NFPA for testing battery-operated smoke alarms. Maintenace Manager has developed a preventative maintenance schedule for weekly testing battery-operated smoke alarms for functionality. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance	

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	06/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Smoke Alarm Testing” weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)			

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	c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 25 hazardous areas, a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff in the laundry service hall area. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2, the corridor door to the storage room next to the mending room in the laundry service hall was not provided with a self-closing device and failed to automatically close and latch into the door frame when tested. This room was being used for storage of linen and paper goods. The lack of a self-closing automatic device was acknowledged by the Maintenance Lead 2 at the time of observation. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)	K 0321	**K321** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech installed a self-closing device on the corridor door to the storage room in the laundry service hall. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Tech conducted a facility audit to validate doors properly close and latch for hazardous areas and storage rooms with combustible supplies. Administrator educated maintenance staff on proper door closure and latching for hazardous area and storage rooms with combustible supplies. Maintenace Manager has developed a preventative maintenance schedule for inspection of fire	07/21/2024

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	155205	A. BUILDING 01 B. WING	06/25/2024

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			doors to validate self-closure and latching. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Door Self-Closure with Secure Latch” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in			

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	smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 #1) Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood fire suppression system in 1 of 1 kitchens. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff. Findings include: Based on observation and interview during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2, the kitchen was provided with a UL 300 hood fire suppression system. Based on interview, the Food Service Supervisor was asked what he would do if there was a grease fire underneath the hood. He replied he would use baking soda to extinguish the fire. When asked what equipment or devices he might use, he stated he would use the "Red" fire	K 0324	**K324** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech positioned the range with flat top griddle completely under the hood system. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated the range is fully positioned under the hood. Administrator/designee will educate culinary staff on the procedure to use the hood fire suppression system and portable fire extinguishers on or before 7/21/2024. Administrator/designee will educate homestead staff on the procedure to deactivate the	07/21/2024

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	155205	A. BUILDING 01 B. WING	06/25/2024

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	extinguisher. He failed to indicate manually activating the hood pull station or use of the K-class fire extinguisher. #2) Based on observation and interview, the facility failed to ensure staff were instructed on requirements and procedures to deactivate the range in a residential cooking area. LSC 19.3.2.5.3(9) states a switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. Findings include: Based on observation and interview during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2, the activity area in the "Homestead" unit was provided with a residential range. Based on interview, the activity staff was not aware of the requirements or ability to deactivate the range and when instructed by the Maintenance Lead 2 at time of interview, the activity staff member stated she did not have the required key to deactivate the range. #3) Based on observation and interview, the facility failed to ensure 1 of 1 kitchen hood extinguishing system provided complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden		range on or before 7/21/2024. Maintenance Manager/designee will conduct random audits to validate staff understanding of procedure to use the hood fire suppression system and portable fire extinguishers. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Kitchen Hood” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	

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	06/25/2024

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	vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is nonoperational or impaired. This deficient practice could affect kitchen staff. Findings include: Based on observation and interview during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2, one range with a flat-top griddle was not completely under the hood system and was not covered by the fire suppression system. Based on interview at the time of observation, the Maintenance Lead 2 acknowledged the lack of fire suppression for the aforementioned cooking equipment. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____			

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	155205	A. BUILDING 01 B. WING	06/25/2024

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 corridors between the healthcare facility and the assisted living facility. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect residents, staff, and visitors in 1 of 7 smoke compartments. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2, one suspended ceiling tile had a hole approximately 4 ½ by 4 ½ inches in the corridor near the entrance to the assisted living facility. The corridor was fully sprinklered on the suspended ceiling. Based on interview at the time of the observations, the Maintenance lead 2 acknowledged the hole in the ceiling tile and stated he believed that is where an exit sign had been located. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and	K 0353	**K353** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech reinstalled the exit sign covering the hole in the ceiling tile in the corridor near the entrance to the assisted living facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated the hole in the ceiling tile has been covered. Administrator educated maintenance staff of ceilings to be free of irregularities, lumps, and indentations. Maintenance Manager/designee will conduct random audits of ceiling tile coverings. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	07/21/2024

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	06/25/2024

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	Clinical Supervisors at the exit conference. 3.1-19(b)		program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool "Ceiling Repairs" weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 #1) Based on observation and interview, the facility failed to ensure 1 of 1 wet location in the laundry room was provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel,	K 0511	**K511** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech installed a GCFI electrical receptacle and faceplate cover in the laundry room. 2. How other residents having the potential to be affected by the	07/21/2024

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	155205	A. BUILDING 01 B. WING	06/25/2024

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

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	states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those		same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated installation of a GCFI electrical receptable and faceplate. Administrator educated maintenance staff on requirements for GFCI electrical receptable, and faceplate covers. Maintenance Manager/designee will conduct random audits of GCFI electrical receptacle and faceplate cover. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “GCFI/Outlet Plates” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will	

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	155205	A. BUILDING 01 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff in the Laundry Room. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2, there was one electric receptacle within 12 inches of a water supply faucet in the Laundry Room. The electric receptacle was not provided with ground fault circuit interrupter (GFCI). The Maintenance Lead 2 stated a drinking fountain had previously been mounted there. The Maintenance Lead 2 acknowledged the electric receptacle was not a GFCI. #2) Based on observation and interview, the facility failed to ensure 1 of 1 electrical receptacle in the laundry room was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This		be completed: July 22, 2024	

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	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	deficient practice could affect staff in the laundry room. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2, the receptacle cover in the laundry room was missing. Based on interview at the time of the observations, the Maintenance lead 2 acknowledged the aforementioned condition and confirmed that exposed wiring was visible. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)			
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 #1) Based on record review, observation and interview; the facility failed to ensure 2 of 2 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire	K 0521	**K521** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech inspected and changed fusible link to 2 of 2 fire dampers for functionality in the Metzler's Meeting House. 2. How other residents having the potential to be affected by the same deficient practice will be	07/21/2024

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	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect residents, staff and visitors in 1 of 7 smoke compartments. Findings include: Based on record review from 9:42 a.m. to 12:10 p.m. on 6/24/2024 and based on observation and interview from 12:43 p.m. to 3:30 p.m. on 06/24/24 with Maintenance Lead 2 and Maintenance Lead 1, the facility failed to ensure 2 of 2 fire dampers located in the wall above doors to the "Metzler Meetinghouse" were provided maintenance. The lack of four-year maintenance conducted on fire dampers was verified during interview with Maintenance Lead 2 at the time of observation. #2) Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 56 of 104 resident rooms. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating		identified and what corrective action(s) will be taken; No residents were affected. 56 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated fire dampers were inspected and changed the fusible link for functionality. Administrator educated maintenance staff on the NAFP requirements of testing and inspections of fire dampers. Maintenace Manager has developed a preventative maintenance schedule for inspection of fire dampers. Administrator to submit waiver for Ventilation System not meeting return air requirements in NFPA90A on or before 7/29/2024. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Fire Dampers” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not	

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	155205	A. BUILDING 01 B. WING	06/25/2024

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	Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long-term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect as many as 20 residents, as well as staff and visitors. Findings include: Based on observations with the Maintenance Lead 2 during a tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24, resident rooms were using the egress corridor as a return air system in rooms 100-145 in the "LEA" unit and in all rooms in the "Gables" West hall and "Gables" South hall. Based on interview at the time of the observations, the Maintenance Lead 2, acknowledged the aforementioned resident rooms and support offices were using the egress corridor as a return air system. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)		met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required			

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	of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on record review and interview from 9:42 a.m. to 12:10 p.m. on 06/24/24 with Maintenance Lead 2, the Maintenance Lead 2 acknowledged the "Healthcare Fire Safety Plan" did not identify smoke or fire barriers in the facility. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)	K 0711	**K711 - 2** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Safety Officer developed map to identify smoke or fire barrier doors in the healthcare facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 159 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated the “Healthcare Fire Safety Plan” has been updated to identify smoke and fire barrier doors throughout the Healthcare facility. Maintenance Safety Officer updated the “Healthcare Fire Safety Plan” to identify smoke or fire barrier doors. Administrator/designee will educate all staff of the updated “Healthcare Fire Safety Plan” to identify smoke and fire barrier doors throughout the facility on or	07/21/2024

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			before 7/21/2024. Administrator/designee will audit the “Healthcare Fire Safety Plan” to validate staff understand how to identify smoke and fire barrier doors. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Fire Safety Plan” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous			

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	155205	A. BUILDING 01 B. WING	06/25/2024

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	location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on record review, observation and interview, the facility failed to provide ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 areas where smoking is permitted. This deficient practice could affect staff in the "smoke shack" of the facility. Findings include: Based on record review of the facility's "Smoke-Free/Vape-Free Environment" written policy with the Maintenance Lead 2 during record review from 9:42 a.m. to 12:10 p.m. on 06/24/24, smoking and/or vaping is not permitted in the building; however, the policy states "Smoking or vaping will be permitted in personal vehicles or	K 0741	**K741 - 2** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech cleaned cigarette butts from staff smoking area disposing in metal container with a secured metal lid with 2” opening and relocated the non-metal trash receptable. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into	07/21/2024

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	the smoke shack located near Manor III." Based on interview with the Maintenance Lead 2 during a tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24, the Maintenance Lead 2 stated the facility allows smoking in the "smoke shack" which is accessible to staff only. He also stated that a resident is known to smoke outside of the shack where he disposes of his cigarette butts on the ground. Over twenty cigarette butts were strewn on the ground outside the "smoke shack". Inside the "smoke shack" open non-covered ashtrays contained over 10 cigarette butts, a metal container for disposing of cigarette butts was available; however, it did not have a self-closing cover. In addition, an open non-metal trash receptacle contained over 20 cigarette butts with other combustible material. Based on interview at the time of observation, the Maintenance Director acknowledged self-closing metal containers were not provided and cigarette butts were not properly disposed of where staff smoking was taking place. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)		place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance manager validated metal container with a secured metal lid with 2” opening in smoke shack for staff to dispose of cigarette butts and the trash receptable was relocated. Administrator/designee will educate staff on smoking area, disposal of cigarette butts and trash receptable relocation with type of materials allowed for disposal on or before 7/21/2024. Maintenance Manager/designee will conduct random audits the “Smoke Shack”. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Smoking Area” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will	

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	155205	A. BUILDING 01 B. WING	06/25/2024

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			be completed: July 22, 2024	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 #1) Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70 2011 Edition, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents. Findings include:	K 0920	**K920 - 2** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Non-medical grade power-strip was removed from resident room 621. 2. How other residents having the potential to be affected by the same deficient practice will be	07/21/2024

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	155205	A. BUILDING 01 B. WING	06/25/2024

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	Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with Maintenance Lead 2 and Maintenance Lead 1, a lamp was plugged into and supplied power by an extension cord in room 130 on the "Lea" unit. Based on interview at the time of observation, the Maintenance Lead 1 acknowledged an extension cord was in use in a resident room. #2) Based on observation and interview, the facility failed to ensure power strips in 1 of 32 resident rooms used outside the patient care vicinity met UL 1363. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 2 resident who reside in resident room 621. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2, in resident room 130 on the "Lea" unit, a power strip outside the patient care vicinity was used for a resident's personal electrical equipment items that lacked a UL 1363 label on the power strip. This was verified and acknowledged by the Maintenance Lead 1 at the time of observations. #3) Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension		identified and what corrective action(s) will be taken; 1 resident and staff have the potential to be affected 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Tech's conducted an audit to validate no extension cords or non-medical grade power strips in resident care areas. Administrator/designee will educate staff on allowed usage of UL rating medical grade power strips in resident rooms on or before 7/21/2024. Maintenance Manager/designee will conduct random audits of resident rooms to validate no extension cords or non-medical grade power strips in use. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool "Power Strip/Extesion Cord" weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be	

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	155205	A. BUILDING 01 B. WING	06/25/2024

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	cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect up to 2 residents. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2, in resident room 328 on the "Knoll" unit a power strip was being used to power a television and was not secured, dangling from the television wall mount. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Lead 2 acknowledged the power strips in the resident room was dangling, not secured. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)		submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 06/24/24 and 06/25/24	K 0000	**K000** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due	

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	155205	A. BUILDING 02 B. WING	06/25/2024

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	Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710 At this Life Safety Code survey, Greencroft Healthcare was found not 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. The facility consists of the original one-story building with a partial basement determined to be of Type V (111) and the two-story 2015 addition determined to be of Type II (111). The buildings are separated by a Fire Wall with 2-Hour Fire Resistive Rating. Building 02 (the two-story 2015 addition) is fully sprinklered, has a fire alarm system with smoke detection in the corridor, areas open to the corridor, and in all resident rooms. 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 that was not sprinklered. Quality Review completed on 06/28/24		to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 7/22/2024.	
K 0281 SS=E Bldg. 02	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8			

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	155205	A. BUILDING 02 B. WING	06/25/2024

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	and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure continuity of egress lighting for 2 of 5 exits. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect staff and up to 64 residents when occupied. Finding include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with Maintenance Lead 2 and Maintenance Lead 1 the exit discharge sidewalks from doors 75 and 76, and did not have egress lighting for portions of the sidewalks from the exit to the public way. Based on interview at the time of observations, the Maintenance Lead 2 confirmed there were no other lighting devices illuminating the sidewalks, and stated it was undetermined if all of the aforementioned exit paths were provided with sufficient lighting. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)	K 0281	**K281 - 2** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech installed egress lighting to provide a clear direction path along the sidewalks from exit doors 75 and 76 to the public way from the Household units of the healthcare facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 64 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated exit lighting provides a clear direction path along the sidewalks from exit doors 75 and 76 to the public way. Administrator/designee will educate staff on exit lighting provides a clear direction path along the sidewalks from exit doors 25 and 77 to the public way on or before 7/21/2024. Maintenace Manager/designee will conduct random audits of egress	07/21/2024

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	155205	A. BUILDING 02 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			lighting functioning. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Exit Signage, Lights and Doors” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0293 SS=E Bldg. 02	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to install exit signage in 4 of 4 corridors in the facility in accordance with LSC 7.10. LSC	K 0293	**K293** 1. What corrective action will be accomplished for those residents	07/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. BUILDING 02 B. WING	06/25/2024

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

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	7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect staff, visitors and residents in building 2. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2 and Maintenance Lead 1, the living area of the "Oasis", "Dell", "Cove", and Haven" units did not have visible exit signs from all areas indicating the direction of egress. Exit signs were located above egress doors but were not visible from all locations in the corridors. This was acknowledged by the Maintenance Lead 2 at the time of observation. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2 and Clinical Supervisors at the exit conference. 3.1-19(b)		found to have been affected by the deficient practice; Contractor installed exit signage to provide a clear path of egress from the living area of Oasis, Dell, Cove, and Haven in the Household units of the healthcare facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 66 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated exit signage provides clear path of egress. Administrator/designee will educate staff on exit sign clear direction path signage from the living area of Oasis, Dell, Cove, and Haven on or before 7/21/2024. Maintenace Manager/designee will conduct random audits of exit signage is functioning. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155205	A. BUILDING 02 B. WING	06/25/2024

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			will be responsible for completing the QAPI Audit tool “Exit Signage, Lights and Doors” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 #1) Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the lower-level elevator room each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and	K 0355	**K355** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenace Tech inspected and documented on the tag of portable fire extinguisher in the lower-level elevator room and Haven unit next to soiled utility room. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 66 residents and staff have the potential to be affected. 3. What measures will be put into	07/21/2024

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	155205	A. BUILDING 02 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	nozzle for wheeled extinguishers (6) Indicator for non-rechargeable extinguishers using push-to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff in this non-resident area. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2 and Maintenance Lead 1, the monthly inspection tag on the fire extinguisher located in the lower-level elevator room lacked documentation of a monthly inspection for May of 2024. This was acknowledged by the Maintenance Lead 2 and Maintenance Lead 1 at the time of observation. #2) Based on observation and interview, the facility failed to properly inspect 1 of 1 portable fire extinguishers in the "Haven" Unit. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic		place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Tech conducted an audit to validate all portable fire extinguishers have been inspected monthly with documentation on tag. Administrator educated maintenance staff on requirements for portable fire extinguishers inspection and tag documentation. Maintenace Manager has developed a preventative maintenance schedule for inspection of portable fire extinguishers and documentation on tag. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Portable Fire Extinguishers” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. BUILDING 02 B. WING	06/25/2024

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	device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for non-rechargeable extinguishers using push-to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff, visitors, and up to 32 residents. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2 and Maintenance Lead 1, the monthly inspection tag on the fire extinguisher			

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	155205	A. BUILDING 02 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	located in the "Haven" unit next to the soiled utility room showed documentation of regular monthly inspections; however, the pressure gauge indicated it was overcharged. This was acknowledged by the Maintenance Lead 2 and Maintenance Lead 1 at the time of observation. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2 and Clinical Supervisors at the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 02	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department	K 0711	**K711 - 2** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Safety Officer developed map to identify smoke or fire barrier doors in the healthcare facility. 2. How other residents having the	07/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155205	A. BUILDING 02 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	(4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on record review and interview from 9:42 a.m. to 12:10 p.m. on 06/24/24 with Maintenance Lead 2, the Maintenance Lead 2 acknowledged the "Healthcare Fire Safety Plan" did not identify smoke or fire barriers in the facility. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 159 residents and staff have the potential to be affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Manager validated the “Healthcare Fire Safety Plan” has been updated to identify smoke and fire barrier doors throughout the Healthcare facility. Maintenance Safety Officer updated the “Healthcare Fire Safety Plan” to identify smoke or fire barrier doors. Administrator/designee will educate all staff of the updated “Healthcare Fire Safety Plan” to identify smoke and fire barrier doors throughout the facility on or before 7/21/2024. Administrator/designee will audit the “Healthcare Fire Safety Plan” to validate staff understand how to identify smoke and fire barrier doors. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155205	A. BUILDING 02 B. WING	06/25/2024

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

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			Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Fire Safety Plan” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0741 SS=E Bldg. 02	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and			

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	155205	A. BUILDING 02 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on record review, observation and interview, the facility failed to provide ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 areas where smoking is permitted. This deficient practice could affect staff in the "smoke shack" of the facility. Findings include: Based on record review of the facility's "Smoke-Free/Vape-Free Environment" written policy with the Maintenance Lead 2 during record review from 9:42 a.m. to 12:10 p.m. on 06/24/24, smoking and/or vaping is not permitted in the building; however, the policy states "Smoking or vaping will be permitted in personal vehicles or the smoke shack located near Manor III." Based on interview with the Maintenance Lead 2 during a tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24, the Maintenance Lead 2 stated the facility allows smoking in the "smoke shack" which is accessible to staff only. He also stated that a resident is known to smoke outside of the shack where he disposes of his cigarette butts on the ground. Over twenty cigarette butts were strewn on the ground outside the "smoke shack". Inside the "smoke shack" open non-covered ashtrays contained over 10 cigarette butts, a metal container for disposing of cigarette butts was available; however, it did not have a self-closing cover. In addition, an open non-metal trash	K 0741	**K741 - 2** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Maintenance Tech cleaned cigarette butts from staff smoking area disposing in metal container with a secured metal lid with 2” opening and relocated the non-metal trash receptable. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance manager validated metal container with a secured metal lid with 2” opening in smoke shack for staff to dispose of cigarette butts and the trash receptable was relocated. Administrator/designee will educate staff on smoking area, disposal of cigarette butts and trash receptable relocation with type of materials allowed for disposal on or before 7/21/2024.	07/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. BUILDING 02 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	receptacle contained over 20 cigarette butts with other combustible material. Based on interview at the time of observation, the Maintenance Director acknowledged self-closing metal containers were not provided and cigarette butts were not properly disposed of where staff smoking was taking place. This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2, and Clinical Supervisors at the exit conference. 3.1-19(b)		Maintenance Manager/designee will conduct random audits the "Smoke Shack". 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool "Smoking Area" weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	
K 0920 SS=D Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics),			

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	155205	A. BUILDING 02 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure power strips in 1 of 24 resident rooms used outside the patient care vicinity met UL 1363. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 2 resident who reside in resident room 621. Findings include: Based on observation during tour of the facility from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Maintenance Lead 2 and Maintenance Lead 1, in resident room 621 on the "Haven" unit, a power strip outside the patient care vicinity was used for a resident's personal electrical equipment items that lacked a UL 1363 label on the power strip. This was verified and acknowledged by the Maintenance Lead 1 at the time of observations.	K 0920	**K920 - 2** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Non-medical grade power-strip was removed from resident room 621. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 1 resident and staff have the potential to be affected 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Tech's conducted an audit to validate no extension cords or non-medical grade power strips in resident care areas. Administrator/designee will educate staff on allowed usage of UL rating medical grade power	07/21/2024

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	155205	A. BUILDING 02 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	This finding was reviewed with the Administrator, Maintenance Lead 1, Maintenance Lead 2 and Clinical Supervisors at the exit conference. 3.1-19(b)		strips in resident rooms on or before 7/21/2024. Maintenance Manager/designee will conduct random audits of resident rooms to validate no extension cords or non-medical grade power strips in use. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Power Strip/Extesion Cord” weekly for 4 weeks, and monthly thereafter for at least 5 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	