PRINTED: 07/30/2024

	PARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155205	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527					
(X4) ID	1	STATEMENT OF DEFICIENCIE	1	ID	1			
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
E 0000								
Bldg	conducted by the In accordance with 42 Survey Dates: 06/2 Facility Number: 0 Provider Number: 100 At this Emergency Greencroft Healthc with Emergency Production Medicare and Medicand Suppliers, 42 C The facility has 233 the survey, the cens	4/24 and 06/25/24 00112 155205 288710 Preparedness survey, are was found in compliance eparedness Requirements for caid Participating Providers FR 483.73 c certified beds. At the time of	E 0	000	K000 The creation and submission this plan of correction does n constitute an admission by the provider of any conclusion see in the statement of deficiencity of any violation of regulation. To the relative low scope and severity of this survey, the face respectfully requests a desk review in lieu of a post-survey revisit on or after 7/22/2024.	ot nis et forth es, or Due cility		
K 0000								
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). This visit was in co	Recertification and State vas conducted by the Indiana th in accordance with 42 CFR injunction with the Life Safety Survey that exited on	K 0	000	K000 The creation and submission this plan of correction does n constitute an admission by the provider of any conclusion see in the statement of deficiencity of any violation of regulation. To the relative low scope and severity of this survey, the face respectfully requests a desk	ot iis et forth es, or Due		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility Number: 000112

Provider Number: 155205

TITLE (X6) DATE

review in lieu of a post-survey

revisit on or after 7/22/2024.

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7IDH21 Facility ID: 000112 If continuation sheet Page 1 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		A. BUILDING 01 COMPLETED B. WING 06/25/2024			ETED		
	ROVIDER OR SUPPLIER			1225 GF	.ddress, city, state, zip cod REENCROFT DR N, IN 46527		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 288710		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
	At this Life Safety O Healthcare was four Requirements for Pa Medicare/Medicaid Life Safety from Fir National Fire Protect	Code survey, Greencroft and not in compliance with articipation in 42 CFR Subpart 483.90(a), we and the 2012 edition of the extion Association (NFPA) 101, SC), Chapter 19, Existing					
	building with a part of Type V (111) and determined to be of	of the original one-story ial basement determined to be I the two-story 2015 addition Type II (111). The buildings ire Wall with 2-Hour Fire					
	sprinklered, has a fidetection in the corricorridor, and battery rooms that are not c system but provides the nurses' station. I from independent li 2-Hour Fire Resistiv	ginal building) is fully re alarm system with smoke idors, areas open to the system sin all resident connected to the fire alarm a visual and audible signal at this building is separated ving by a Fire Wall with see Rating. The facility has a had a census of 159 at the					
	access were sprinkle facility services wer only smoking shack that was not sprinkle						
K 0226 SS=E	Quality Review con NFPA 101 Horizontal Exits	npleted on 06/28/24					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 2 of 46

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIER		1225 (SADDRESS, CITY, STATE, ZIP COD GREENCROFT DR IEN, IN 46527	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	with 7.2.4 and the through 18.2.2.5.7 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation failed to ensure 2 of	used, are in accordance provisions of 18.2.2.5.1 on and interview, the facility are arranged to automatically	K 0226	K226 1. What corrective action will accomplished for those reside	
	close and latch. LS fire door assemblies self-closing or autor NFPA 80, the Stand Opening Protective self-closing doors stand shall be equipped cause the door to close.	C section 7.2.4.3.10 requires all s in horizontal exits shall be matic-closing. In addition lard for Fire Doors and Other s, section 6.1.4.2.1 states hall swing easily and freely ed with a closing device to ose and latch each time it is ent could affect 66 residents in		found to have been affected by deficient practice; Maintenand Tech adjusted fire door set 12 elevator "A" and T6 by Metzle Meeting House horizontal exilatch mechanism to ensure self-closure and latching of do 2. How other residents having potential to be affected by the same deficient practice will be identified and what corrective	by the ce
	from 12:43 p.m. to Maintenance Lead 2 fire door set marked separating the eleval between the assisted healthcare facility for addition the fire door Metzler Meeting Ho from the "Terrace" frame. Based on into observation, the Ma	on during tour of the facility 3:30 p.m. on 06/24/24 with the 2 and Maintenance Lead 1, the 3 as X1 by elevator "A" tor lobby from the corridor 3 living facility and the ailed to latch into the frame. In or set marked as T6 by the buse separating the "Lea" unit unit failed to latch into the erview at the time of intenance Lead 1 confirmed		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 place and what systemic charwill be made to ensure that the deficient practice does not reconstructed facility audit to validate fire do properly self-close and latch. Administrator educated maintenance staff on fire door requiring self-closures and	nges ne cur; d a pors
	Maintenance Lead	viewed with the Administrator, I, Maintenance Lead 2, and s at the exit conference.		latching. Maintenace Manage has developed a preventative maintenance schedule for inspection of fire doors to vali self-closure and latching. 4. How the corrective action(s	date

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

112

If continuation sheet Page

Page 3 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155205	A. BUILDING B. WING	01	COMPL: 06/25/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	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 monitor through the facility Quality Assurance and Performance Improvement Program (QAPI) Maintenance Director/designe will be responsible for complete the QAPI Audit tool "Self-Clost Doors with Secure Latch" wee for 4 weeks, and monthly thereafter for at least 5 months threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review are follow up. 5. By what date the systemic changes for each deficiency we be completed: July 22, 2024	ored The e ing ure kly s. If n	
K 0251 SS=E Bldg. 01	Travel Dead-End Corrido Travel 2012 EXISTING Dead-end corridor Existing dead-end feet shall be perm used if it is impract them. 19.2.5.2	ors and Common Path of ors and Common Path of ors shall not exceed 30 feet. I corridors greater than 30 itted to be continued to be stical and unfeasible to alter on and interview, the facility	K 0251	K251		07/21/2024
	failed to ensure 1 of	f 1 corridor between the nd the assisted living was not	IX 0231	What corrective action will be accomplished for those reside		0 / / 2 1 / 2 U 2 1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21 I

Facility ID: 000112

If continuation sheet

Page 4 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/25/2024			
		ROVIDER OR SUPPLIER		12	225 GF	DDRESS, CITY, STATE, ZIP COD REENCROFT DR N, IN 46527	•	
	(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE TAG DEFICIENCY)			(X5) COMPLETION
	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION				TE	DATE
		a dead-end corridor	greater than 30 feet.			found to have been affected b deficient practice; Maintenanc	-	
		Findings include:				Tech re-installed exit signage		
		Based on observation	on and interview during tour			provide a clear path of egress between the corridor to exit 77	' in	
			12:43 p.m. to 3:30 p.m. on			the healthcare facility to the		
		06/24/24 with Mair	ntenance Lead 2 and			assisted living.		
			1, the distance of travel			2. How other residents having	the	
			or to exit 77 in the healthcare			potential to be affected by the		
		_	rs to the assisted living was			same deficient practice will be		
greater than 30 feet. The doors to the assisted					identified and what corrective			
	living were closed without exit signage or other					action(s) will be taken; No		
	indication of egress. Based on interview at the					residents were affected.		
		time of the observation, the Maintenance lead 2				3. What measures will be put i		
		location before.	here was an exit sign at this			place and what systemic chan	-	
		location before.				will be made to ensure that the deficient practice does not recur;		
		This finding was re	viewed with the Administrator,					
		_	1, Maintenance Lead 2, and			Maintenance Manager validated		
			s at the exit conference.			exit signage provides clear path of egress. Administrator educated		
		Cimical Supervisor	s at the exit conference.			maintenance staff on the safet		
		3.1-19(b)				requirement for exit path signa	•	
						remaining in place and function	-	
						Maintenance Manager/design		
						will conduct random audits of exit		
						signage functioning.		
						4. How the corrective action(s) will	
						be monitored to ensure the		
						deficient practice will not recui	-,	
						i.e., what quality assurance		
						program will be put into place;		
						Ongoing compliance with this		
						corrective action will be monitor	ored	
						through the facility Quality		
						Assurance and Performance	The	
						Improvement Program (QAPI)		
						Maintenance Director/designe		
						will be responsible for complete	•	
						the QAPI Audit tool "Exit Signating Lights and Doors" weekly for 4	-	
		1		ı		LIGHTS AND DOORS WEEKIY 101 4	t	1

PRINTED: 07/30/2024

T OF HEALTH AND HU R MEDICARE & MEDIO				OMB NO. 0938-039	
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155205	(X2) MULTIPLE C A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 06/25/2024	
		1225 (
CROFT HEALTHC	ARE	GOSH	EN, IN 46527		
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
			weeks, and monthly thereafter at least 5 months. If threshold of 90% is not met, an action plan be developed. Findings will be submitted to the QAPI Committed for review and follow up. 5. By what date the systemic changes for each deficiency will be completed: July 22, 2024	of will tee	
Discharge from E Exit discharge is 7.7, provides a le the provisions of changes in elevar free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observati failed to ensure 1 c were marked with states the exit disch marked to make cle from the exit disch deficient practice of compartments. Findings include: Based on observati from 12:43 p.m. to Maintenance Lead	arranged in accordance with vel walking surface meeting 7.1.7 with respect to tion and shall be maintained ins. Additionally, the exit is a hard packed all-weather on and interview, the facility of 19 egress discharge paths directional signage. LSC 7.7.3.2 marge shall be arranged and is ear the direction of egress travel arge to a public way. This ould affect staff, 1 of 7 smoke on during tour of the facility 3:30 p.m. on 06/24/24 with 2 and Maintenance Lead 1,	K 0271	K271 1. What corrective action will be accomplished for those resider found to have been affected by deficient practice; Contractor installed exit signage to provide clear direction path of egress outside the Elevator A door 77 in the Household units of the healthcare facility. 2. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective	e a exit	
	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIE CROFT HEALTHCA SUMMARY (EACH DEFICIEN REGULATORY OF Discharge from E Exit discharge is a regulation of changes in elevate free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observating failed to ensure 1 of were marked with a states the exit discharge to make clearly the compartments. Findings include: Based on observating from 12:43 p.m. to Maintenance Lead	R MEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155205 PROVIDER OR SUPPLIER CROFT HEALTHCARE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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.	REMEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155205 PROVIDER OR SUPPLIER CROFT HEALTHCARE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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,	TO DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155205 STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Discharge from Exits 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,	

FORM CMS-2567(02-99) Previous Versions Obsolete

paths of travel and no directional signage to

complete path to the public way. Based on

interview at the time of the observation, the

indicate the path of travel. One path was not a

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

residents were affected; 66

residents and staff have the

3. What measures will be put into

potential to be affected.

Page 6 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155205	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY PLETED 5/2024
	PROVIDER OR SUPPLIEF		1225 0	ADDRESS, CITY, STATE, ZIP CO GREENCROFT DR EN, IN 46527	OD	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Maintenance Lead directional signage the facility would n This finding was re Maintenance Lead	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION 2 agreed the exit did not have and someone not familiar with ot know which way to exit. viewed with the Administrator, 1, Maintenance Lead 2, and s at the exit conference.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AIDEFICIENCY) place and what system will be made to ensure deficient practice does Maintenance Manager exit signage provides or direction path of egress Administrator educated maintenance staff on exafety requirements prodirection paths. Maintel Manager/designee will random audits of exit si functioning. 4. How the corrective a be monitored to ensure deficient practice will not i.e., what quality assurate program will be put into Ongoing compliance with corrective action will be through the facility Quance Assurance and Perform Improvement Program Maintenance Director/divill be responsible for of the QAPI Audit tool "Exalights and Doors" week weeks, and monthly the at least 5 months. If the 90% is not met, an active developed. Findings submitted to the QAPI for review and follow up 5. By what date the systhanges for each deficible completed: July 22,	ic changes that the not recur; validated lear s. learn seconduct ignage conduct ignage conduct ignage conduct ignage it the ot recur, ance oplace; ith this emonitored dility nance (QAPI). The designee completing cit Signage, kly for 4 ereafter for eshold of on plan will second will be committee on the committee	(X5) COMPLETION DATE
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Me Illumination of Me	_				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 7 of 46

07/30/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/25/2024 155205 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1225 GREENCROFT DR **GREENCROFT HEALTHCARE** GOSHEN, IN 46527 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0281 K281 - 2 07/21/2024 failed to ensure continuity of egress lighting for 4 1. What corrective action will be of 19 exits. For the purposes of this requirement, accomplished for those residents exit discharge shall include only designated stairs, found to have been affected by the aisles, corridors, ramps, escalators, walkways and deficient practice; Maintenance exit passageways leading to a public way. This Tech installed egress lighting to deficient practice could affect staff and residents provide a clear direction path along in 1 of 7 smoke compartments when occupied. the sidewalks from exit doors 75 and 76 to the public way from the Finding include: Household units of the healthcare facility. Based on observation during tour of the facility 2. How other residents having the from 12:43 p.m. to 3:30 p.m. on 06/24/24 with potential to be affected by the Maintenance Lead 2 and Maintenance Lead 1 the same deficient practice will be exit discharge sidewalks from doors 25 and 77, did identified and what corrective not have egress lighting for portions of the action(s) will be taken; No sidewalks from the exit to the public way. Based residents were affected; 64 on interview at the time of observations, the residents and staff have the Maintenance Lead 2 confirmed there were no potential to be affected. other lighting devices illuminating the sidewalks, 3. What measures will be put into and stated it was undetermined if all of the place and what systemic changes aforementioned exit paths were provided with will be made to ensure that the sufficient lighting. deficient practice does not recur; Maintenance Manager validated This finding was reviewed with the Administrator, exit lighting provides a clear Maintenance Lead 1, Maintenance Lead 2, and direction path along the sidewalks Clinical Supervisors at the exit conference. from exit doors 75 and 76 to the public way. 3.1-19(b)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.

7IDH21

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155205	B. WI	NG		06/25/	/2024
		L	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		1225 G	REENCROFT DR		
GREENO	CROFT HEALTHCA	ARE		GOSHE	EN, IN 46527		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	Maintenace Manager/designe		DATE
					conduct random audits of egre		
					lighting functioning.	,33	
					4. How the corrective action(s) will	
					be monitored to ensure the	,	
					deficient practice will not recur	r.	
					i.e., what quality assurance	,	
					program will be put into place;		
					Ongoing compliance with this		
					corrective action will be monitor	ored	
					through the facility Quality		
			Assurance and Performance				
					Improvement Program (QAPI)		
			Maintenance Director/designe				
					will be responsible for complete	-	
					the QAPI Audit tool "Exit Signa	-	
					Lights and Doors" weekly for 4 weeks, and monthly thereafter		
					at least 5 months. If threshold		
					90% is not met, an action plan		
					be developed. Findings will be		
					submitted to the QAPI Commi		
					for review and follow up.		
					5. By what date the systemic		
					changes for each deficiency w	/ill	
					be completed: July 22, 2024		
IZ 0204	NEDA 404						
K 0291 SS=E	NFPA 101						
SS=E Bldg. 01	Emergency Lighti Emergency Lighti	_					
Diag. 01		ing ng of at least 1-1/2-hour					
		ed automatically in					
	accordance with						
	18.2.9.1, 19.2.9.1						
		rvation and interview, the	K 02	291	K291		07/21/2024
		sure 4 of 4 battery backup		-/ -	What corrective action will be a control of the corrective action.	е	3772172021
		monthly and annually for 90			accomplished for those reside	nts	
		ast year to ensure the light			found to have been affected b		
	would provide ligh	ting during periods of power			deficient practice; Maintenanc	-	
	outages and a writt	en record of visual inspections			Tech replaced 4 of 4 battery		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 9 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155205	B. W	ING		06/25/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			REENCROFT DR		
GREENC	CROFT HEALTHCA	RF			EN, IN 46527		
	1				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ded. Section 7.9.3.1.1 (1)			backup emergency lights with		
	_	testing shall be conducted			emergency flood lights wired t	0	
	1	nimum of 3 weeks and a			operate by generator in the		
		ks between tests, for not less			Metzler Meetinghouse.		
		Functional testing shall be			2. How other residents having		
		for a minimum of 1 1/2 hours			potential to be affected by the		
		ghting system is battery			same deficient practice will be		
	* ` '	ritten records of visual			identified and what corrective		
	_	s shall be kept by the owner			action(s) will be taken; No		
	for inspection by th				residents were affected.		
		eficient practice could affect			3. What measures will be put i		
	residents, staff and visitors in 1 of 7 smoke				place and what systemic chan	-	
	compartments in the facility.				will be made to ensure that the		
	F' 1' ' 1 1				deficient practice does not rec		
	Findings include:				Maintenance Manager validate		
	D1	1 i 4			emergency flood lights operate	е	
		on and interview during tour			with generator testing.		
		12:43 p.m. to 3:30 p.m. on Maintenance Lead 2 and			Administrator educated	f	
					maintenance staff on the testin	ng of	
		1, the battery-operated			emergency flood lights.		
		ocated in the "Metzler			Maintenace Manager has		
	-	not on the monthly test and The lack of monthly and			developed a preventative		
		e four battery operated			maintenance schedule for		
		as verified and acknowledged			inspection of emergency flood	lignt	
		Lead 2 at the time of			operated by the generator. 4. How the corrective action(s	النمدا	
	observation and tou				be monitored to ensure the) WIII	
	oosei valion and lou	и.			deficient practice will not recur		
	#2) Rosed on obser	vation and interview, the			-	,	
		sure 4 of 4 battery powered			i.e., what quality assurance		
		ere maintained in accordance			program will be put into place;		
		7.9.2.6 states battery operated			Ongoing compliance with this corrective action will be monitored.	arad	
		nall use only reliable types of				Jieu	
		ies provided with suitable			through the facility Quality Assurance and Performance		
		ining them in properly charged				The	
		s used in such lights or units			Improvement Program (QAPI)		
		or their intended use and shall			Maintenance Director/designe		
		70 National Electric Code. LSC			will be responsible for complete	-	
		nergency lighting system shall			the QAPI Audit tool "Exit Signa	~ '	
		nergency lighting system shall be			Lights and Doors" weekly for 4		
	be either be continu	lously in operation or snall be	1		weeks, and monthly thereafter	101	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 10 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155205	B. W	ING		06/25/	2024
	PROVIDER OR SUPPLIER		•	1225 GI	ADDRESS, CITY, STATE, ZIP COD REENCROFT DR EN, IN 46527		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
	capable of repeated	automatic operation without			at least 5 months. If threshold	of	
	manual intervention	. This deficient practice could		90% is not met, an action plan will			
	affect residents, staff and visitors in 1 of 7 smoke			be developed. Findings will be			
	compartments in the	e facility.			submitted to the QAPI Commi	ttee	
					for review and follow up.		
	Findings include:				5. By what date the systemic		
					changes for each deficiency w	ill	
		on and interview during tour			be completed: July 22, 2024		
	•	12:43 p.m. to 3:30 p.m. on					
		Maintenance Lead 2 and					
		l, all four battery-operated cated in the "Metzler					
		ed to function when its					
	_	ons were pushed three times.					
	•	at time of the observation, the					
		2 stated the lights were not					
	tested monthly but a						
	-	tery-operated emergency					
		tion when its respective test					
	buttons were pushed	d.					
	Maintenance Lead 1	viewed with the Administrator, 1, Maintenance Lead 2, and s at the exit conference.					
	3.1-19(b)						
K 0300	NFPA 101						
SS=F	Protection - Other						
Bldg. 01	Protection - Other						
	List in the REMAR	RKS section any LSC					
	Section 18.3 and	19.3 Protection					
	requirements that	are not addressed by the					
		out are deficient. This					
		with the applicable Life					
	,	FPA standard citation,					
		d on Form CMS-2567.					
		view and interview, the facility	K 0	300	K300		07/21/2024
	failed to ensure doc				1. What corrective action will be		
	preventative mainte	nance of 104 of 104 battery			accomplished for those reside	nts	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 11 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE CO A. BUILDING B. WING	Onstruction 01	(X3) DATE SURVEY COMPLETED 06/25/2024	
		199209	B. WING		00/25/2024
	PROVIDER OR SUPPLIER		1225 G	ADDRESS, CITY, STATE, ZIP COD REENCROFT DR EN, IN 46527	
	1			, <u>-</u>	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
TAG		rms in resident rooms was	TAG	found to have been affected by	5.112
	-	Of in 4.6.12.3 states existing life		deficient practice; Maintenace	uio .
	_	ious to the public, if not		Tech tested battery-operated	
		de, shall be maintained. This		smoke alarms located in reside	ent l
		ould affect all residents, staff,		rooms.	
	and visitors.	,		2. How other residents having	the
				potential to be affected by the	
	Findings include:			same deficient practice will be	
				identified and what corrective	
	Based on record rev	view and interview from 9:42		action(s) will be taken; No	
	a.m. to 12:10 p.m.	on 06/24/24 with Maintenance		residents were affected; 104	
Lead 2, there was no documentation of resident room battery smoke alarms tested for functionality			residents and staff have the		
			potential to be affected.		
	on a weekly basis p	per manufacturer's		3. What measures will be put in	nto
		luring the past twelve months.		place and what systemic chang	
		only showed inspection of an		will be made to ensure that the	
	annual check. Base	d on interview at the time of		deficient practice does not recu	ır;
	record review, the I	Maintenance Lead 2 stated he		Maintenance Tech conducted a	a
	thought he only had	d to check the devices		facility audit to validate	
	annually.			battery-operated smoke alarms	s in
				resident rooms tested for	
	This finding was re	viewed with the Administrator,		functionality. Administrator	
	Maintenance Lead	1, Maintenance Lead 2, and		educated maintenance staff on	I
	Clinical Supervisor	s at the exit conference.		manufactures recommendation	ı to
				reference NFPA for testing	
	3.1-19(b)			battery-operated smoke alarms	š.
				Maintenace Manager has	
				developed a preventative	
				maintenance schedule for wee	-
				testing battery-operated smoke	;
				alarms for functionality.	
				4. How the corrective action(s)	WIII
				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	rod
				corrective action will be monito	ieu
				through the facility Quality Assurance and Performance	
	I		I	L vosniance and Lenonnance	I

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		A. BUILDING <u>01</u> B. WING		COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIER		1225 G	ADDRESS, CITY, STATE, ZIP COD GREENCROFT DR EN, IN 46527	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a do not exceed 48 if the door. Describe the floor hazardous areas the REMARKS. 19.3.2.1, 19.3.5.9	are protected by a fire pur fire resistance rating rated doors) or an anguishing system in areas shall be separated by smoke resisting rs in accordance with 8.4. If-closing or and permitted to have pplied protective plates that inches from the bottom of		Improvement Program (QAPI Maintenance Director/designe will be responsible for comple the QAPI Audit tool "Smoke A Testing" weekly for 6 months. threshold of 90% is not met, a action plan will be developed. Findings will be submitted to the QAPI Committee for review a follow up. 5. By what date the systemic changes for each deficiency where the completed: July 22, 2024	ting larm If an the
	a. Boiler and Fuel-	Fired Heater Rooms or than 100 square feet)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 13 of 46

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	
		155205	B. W	ING	_	06/25	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
TAG	c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square for g. Laboratories (if Hazard - see K32). Based on observation failed to ensure the hazardous areas, a supplies over 50 square for door to automatical frame. This deficie the laundry service Findings include: Based on observation from 12:43 p.m. to Maintenance Lead 2 storage room next to laundry service hall self-closing devices close and latch into This room was bein paper goods. The laundry was acknown Lead 2 at the time of Maintenance Lead 2.	nance, and Paint Shops coms (exceeding 64 In Rooms lons) orage Rooms/Spaces eet) classified as Severe 2) on and interview, the facility corridor door to 1 of over 25 storage room of combustible uare feet in size, was provided device which would cause the ly close and latch into the door ent practice could affect staff in hall area. on during tour of the facility 3:30 p.m. on 06/24/24 with the 2, the corridor door to the othe mending room in the lawas not provided with a and failed to automatically the door frame when tested. In gused for storage of linen and lock of a self-closing automatic ledged by the Maintenance	K 0		K321 1. What corrective action will be accomplished for those reside found to have been affected be deficient practice; Maintenance Tech installed a self-closing don the corridor door to the sto room in the laundry service has 2. How other residents having 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 place and what systemic char will be made to ensure that the deficient practice does not recomplished the made to ensure that the deficient practice does not recomplished the made to ensure that the deficient practice does not recomplished to a compare the made to the conducted facility audit to validate doors properly close and latch for hazardous areas and storage rooms with combustible supple Administrator educated maintenance staff on proper of closure and latching for hazardous area and storage rooms with combustible supplies. Mainter Manager has developed a preventative maintenance schedule for inspection of fire	be ents by the se evice rage all. In the se evice rage all. In the se evice rages a lies. In the se evice rage all and the se evice rages a lies. In the se evice rage all and	07/21/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 14 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155205	B. WI	NG		06/25	/2024
NAME OF I	PROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP COD		
					REENCROFT DR		
GREENC	CROFT HEALTHCA	AKE		GOSH	EN, IN 46527		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION		TAG	doors to validate self-closure	and	DATE
					latching.	and	
					4. How the corrective action(s) will	
					be monitored to ensure the	,	
					deficient practice will not recu	r,	
					i.e., what quality assurance		
					program will be put into place	;	
					Ongoing compliance with this		
					corrective action will be monit through the facility Quality	orea	
					Assurance and Performance		
					Improvement Program (QAPI)). The	
					Maintenance Director/designe		
					will be responsible for comple		
					the QAPI Audit tool "Door		
					Self-Closure with Secure Late		
					weekly for 4 weeks, and mont	-	
					thereafter for at least 5 month		
					threshold of 90% is not met, a action plan will be developed.	ın	
					Findings will be submitted to t	he	
					QAPI Committee for review a		
					follow up.		
					5. By what date the systemic		
					changes for each deficiency w	/ill	
					be completed: July 22, 2024		
K 0324	NFPA 101						
SS=E	Cooking Facilities	.					
Bldg. 01	Cooking Facilities						
	Cooking equipme						
		NFPA 96, Standard for					
	Ventilation Contro	ol and Fire Protection of					
		king Operations, unless:					
		ing equipment (i.e., small					
		as microwaves, hot plates,					
		d for food warming or limited					
	19.3.2.5.2	ance with 18.3.2.5.2,					
		s open to the corridor in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 15 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIEF		1225 0	ADDRESS, CITY, STATE, ZIP COD GREENCROFT DR EN, IN 46527	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	patients comply w 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer p conditions under Cooking facilities NFPA 96 per 9.2.3 enclosed as hazal be open to the cool 18.3.2.5.1 through through 19.3.2.5.5 #1) Based on obser- facility failed to ensuse of the UL 300 h 1 of 1 kitchens. NFI Control and Fire Pr Cooking Operations instruction shall be regarding the prope extinguishers and the fire-extinguishing estimates instructions for man extinguishing system conspicuously in the reviewed with empl deficient practice cool Findings include: Based on observation of (24/24 with the N was provided with a system. Based on ir Supervisor was ask was a grease fire un he would use bakin When asked what e	in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not rridor. 18.3.2.5.4, 19.3.2.5.1 19.9.2.3, TIA 12-2 vation and interview, the sure staff were instructed in the mod fire suppression system in PA 96, Standard for Ventilation potection of Commercial states, Section 10.5.7 states provided to employees are use of portable fire the manual activation of quipment. Section 11.1.4 states anally operating the fire	K 0324	K324 1. What corrective action will accomplished for those reside found to have been affected by deficient practice; Maintenance Tech positioned the range with top griddle completely under thood system. 2. How other residents having 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 place and what systemic chain will be made to ensure that the deficient practice does not remain the range is fully positioned up the hood. Administrator/designed will educate culinary staff on a procedure to use the hood fire suppression system and portafire extinguishers on or before 7/21/2024. Administrator/designed will educate homestead staff the procedure to deactivate the	ents by the ce th flat the g the g the ce into nges ne cur; ted nder nnee the e able e ggnee on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 16 of 46

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155205	B. W	ING		06/25/	2024
				CED FIFT	A DDD FOR CVTV OT A TE JUD COD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
005511		DE			REENCROFT DR		
GREENC	CROFT HEALTHCA	RE		GOSHE	EN, IN 46527		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	extinguisher. He fai	iled to indicate manually			range on or before 7/21/2024.		
	activating the hood	pull station or use of the			Maintenance Manager/designe	ee	
	K-class fire extingu	-			will conduct random audits to		
					validate staff understanding of	:	
	#2) Based on obser	vation and interview, the			procedure to use the hood fire		
		sure staff were instructed on			suppression system and porta		
	requirements and procedures to deactivate the				fire extinguishers.	2.0	
	range in a residential cooking area. LSC				How the corrective action(s)) will	
	_	a switch meeting all of the			be monitored to ensure the	,	
	following is provide				deficient practice will not recur		
	(a) A locked switch, or a switch located in a				i.e., what quality assurance	,	
	restricted location, is provided within the cooking				program will be put into place;		
	facility that deactivates the cooktop or range.				Ongoing compliance with this		
	(b) The switch is used to deactivate the cooktop				corrective action will be monitor	ored	
		the kitchen is not under staff			through the facility Quality	лса	
	supervision.	the Ritchell is not under starr			Assurance and Performance		
	_	a timer, not exceeding a			Improvement Program (QAPI)	Tho	
		y, that automatically			Maintenance Director/designe		
		ktop or range, independent of			9		
	staff action.	ktop of range, independent of			will be responsible for complet the QAPI Audit tool "Kitchen	ing	
	starr action.					1	
	Eindings in abids				Hood" weekly for 4 weeks, and		
	Findings include:				monthly thereafter for at least months. If threshold of 90% is		
	Događan obsamjeti	on and interview during town				HOL	
		on and interview during tour			met, an action plan will be		
	1	12:43 p.m. to 3:30 p.m. on			developed. Findings will be		
		Maintenance Lead 2, the activity			submitted to the QAPI Commit	uee	
		tead" unit was provided with a ased on interview, the activity			for review and follow up.		
	_				5. By what date the systemic	•11	
		of the requirements or ability			changes for each deficiency w	111	
		nge and when instructed by			be completed: July 22, 2024		
		ead 2 at time of interview, the					
		er stated she did not have the					
	required key to dead	ctivate the range.					
	//2\ D 1 1	ar ar a					
	· · ·	vation and interview, the					
	•	sure 1 of 1 kitchen hood					
		m provided complete coverage					
		produces grease-laden vapors.					
		tion, Section 10.1.2 requires					
	cooking equipment	that produces grease-laden					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 17 of 46

		X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155205	A. BU B. WI	JILDING NG	01	COMPL 06/25/	
		100200	D. W			00/25/	2U2 1
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD REENCROFT DR		
GREENC	ROFT HEALTHCA	RE			EN, IN 46527		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		ht be a source of ignition of		TAG	DEI ICIERCI I		DATE
	-	grease removal device, or duct					
	shall be protected by fire-extinguishing						
		11.1.6 states cooking					
		be operated while its					
		ystem or exhaust system is					
	_	mpaired. This deficient practice					
	could affect kitchen staff. Findings include:						
	of the facility from 06/24/24 with the M with a flat-top gridd the hood system and suppression system, time of observation, acknowledged the la aforementioned cool. This finding was rev. Maintenance Lead M. Clinical Supervisors	on and interview during tour 12:43 p.m. to 3:30 p.m. on Maintenance Lead 2, one range Ille was not completely under d was not covered by the fire Based on interview at the the Maintenance Lead 2 ack of fire suppression for the oking equipment. Wiewed with the Administrator, I, Maintenance Lead 2, and s at the exit conference.					
	3.1-19(b)						
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a nd readily available. system last checked					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 18 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155205	B. W	ING		06/25	/2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TT.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE	DATE
	b) Who provided	system test					
	c) Water system	supply source					
		RKS information on					
		non-required or partial					
	automatic sprinkle	-					
	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			2.52			07/01/2021
			K 0	353	K353	ı	07/21/2024
					What corrective action will I		
	corridors between the healthcare facility and the				accomplished for those reside		
	assisted living facility. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a				found to have been affected be deficient practice; Maintenance	•	
	continuous ceiling free from significant				Tech reinstalled the exit sign	æ	
	_	s, or indentations. The ceiling			covering the hole in the ceiling	a tilo	
	-	ses around the sprinkler and			in the corridor near the entran	_	
	-	to operate at a specified			the assisted living facility.	ce to	
	_	n 8.5.4.1.1 states the distance			How other residents having	ı the	
	-	er deflector and the ceiling			potential to be affected by the		
	_	eted based on the type of			same deficient practice will be		
		pe of construction. This			identified and what corrective		
		ould affect residents, staff, and			action(s) will be taken; No		
	visitors in 1 of 7 sm				residents affected.		
		•			What measures will be put	into	
	Findings include:				place and what systemic char	•	
					will be made to ensure that the		
		on during tour of the facility			deficient practice does not rec		
	_	3:30 p.m. on 06/24/24 with the			Maintenance Manager validat	ed	
		2, one suspended ceiling tile			the hole in the ceiling tile has		
		nately 4 ½ by 4 ½ inches in the			been covered. Administrator	_	
		trance to the assisted living			educated maintenance staff o	-	
		or was fully sprinklered on the			ceilings to be free of irregulari	ties,	
		Based on interview at the time			lumps, and indentations.		
	· · · · · · · · · · · · · · · · · · ·	the Maintenance lead 2			Maintenance Manager/design		
		nole in the ceiling tile and			will conduct random audits of		
		hat is where an exit sign had			ceiling tile coverings.	A vedill	
	been located.				4. How the corrective action(s) WIII	
	This find:	viewed with the Advisionint			be monitored to ensure the	_	
	_	viewed with the Administrator,			deficient practice will not recu	r,	
	Maintenance Lead	1, Maintenance Lead 2, and			i.e., what quality assurance		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 19 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/25/2024	
		155205	B. WINC	J		06/25/	/2024
	PROVIDER OR SUPPLIE CROFT HEALTHCA			1225 GF	ADDRESS, CITY, STATE, ZIP COD REENCROFT DR EN, IN 46527		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
		rs at the exit conference.			program will be put into place; Ongoing compliance with this corrective action will be monitor through the facility Quality Assurance and Performance Improvement Program (QAPI) Maintenance Director/designe will be responsible for complete the QAPI Audit tool "Ceiling Repairs" weekly for 4 weeks, a monthly thereafter for at least months. If threshold of 90% is met, an action plan will be developed. Findings will be submitted to the QAPI Commi for review and follow up. 5. By what date the systemic changes for each deficiency we be completed: July 22, 2024	ored The reting and 5 not ttee	
K 0511 SS=E Bldg. 01	complies with NF Code, electrical v complies with NF Code. Existing in service provided 18.5.1.1, 19.5.1.1 #1) Based on obser facility failed to en laundry room was circuit interrupter (electric shock. LSC comply with Section electrical wiring an NFPA 70, National NEC 2011 Edition	d Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life.	K 051	1	K511 1. What corrective action will be accomplished for those reside found to have been affected be deficient practice; Maintenance Tech installed a GCFI electrical receptacle and faceplate cover the laundry room. 2. How other residents having potential to be affected by the	ents y the e al er in	07/21/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

2

If continuation sheet Page 20 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155205	B. W	ING		06/25/	2024
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					REENCROFT DR		
GREENC	ROFT HEALTHCA	RE		GOSHE	EN, IN 46527		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	_	circuit-interruption for			same deficient practice will be	!	
	personnel shall be provided as required in				identified and what corrective		
	210.8(A) through (C). The ground-fault				action(s) will be taken; No		
	-	hall be installed in a readily			residents were affected.		
	accessible location.				3. What measures will be put		
		velling Units. All 125-volt,			place and what systemic chan	iges	
		nd 20-ampere receptacles			will be made to ensure that the	е	
		tions specified in 210.8(B)(1)			deficient practice does not rec		
	through (8) shall ha	_			Maintenance Manager validate	ed	
	circuit-interrupter p	rotection for personnel.			installation of a GCFI electrica	ıl	
	(1) Bathrooms				receptable and faceplate.		
	(2) Kitchens			Administrator educated			
	(3) Rooftops			maintenance staff on requirements			
	(4) Outdoors				for GFCI electrical receptable,	and	
	Exception No. 1 to	(3) and (4): Receptacles that are	faceplate covers. Maintenance				
	not readily accessib	le and are supplied by a	Manager/designee will conduct				
	branch circuit dedic	eated to electric snow-melting,	random audits of GCFI electrical				
	deicing, or pipeline	and vessel heating equipment			receptacle and faceplate cove	r.	
	shall be permitted to	o be installed in accordance			4. How the corrective action(s) will	
	with 426.28 or 427.	22, as applicable.			be monitored to ensure the		
	Exception No. 2 to	(4): In industrial establishments			deficient practice will not recui	۲,	
	only, where the con	ditions of maintenance and			i.e., what quality assurance		
	supervision ensure t	that only qualified personnel			program will be put into place;		
	are involved, an ass	ured equipment grounding			Ongoing compliance with this		
	conductor program	as specified in 590.6(B)(2)			corrective action will be monite	ored	
	shall be permitted for	or only those receptacle			through the facility Quality		
	outlets used to supp	ly equipment that would			Assurance and Performance		
	create a greater haza	ard if power is interrupted or			Improvement Program (QAPI)	. The	
	having a design that	t is not compatible with GFCI			Maintenance Director/designe	е	
	protection.				will be responsible for comple	ting	
	(5) Sinks - where re	eceptacles are installed within			the QAPI Audit tool "GCFI/Ou	tlet	
	1.8 m (6 ft.) of the o	outside edge of the sink.			Plates" weekly for 4 weeks, ar	nd	
	Exception No. 1 to	(5): In industrial laboratories,			monthly thereafter for at least		
	receptacles used to	supply equipment where			months. If threshold of 90% is	not	
	removal of power w	vould introduce a greater			met, an action plan will be		
	hazard shall be pern	nitted to be installed without			developed. Findings will be		
	GFCI protection.				submitted to the QAPI Commi	ttee	
	Exception No. 2 to	(5): For receptacles located in	for review and follow up.				
	_	s of general care or critical			5. By what date the systemic		
		care facilities other than those			changes for each deficiency w	/ill	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 21 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	- 1	ILDING	01	COMPLETED	
		155205	B. WI	NG		06/25/2024	
NAME OF P	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP COD		
					REENCROFT DR		
GKEENC	ROFT HEALTHCA	KE		GOSHE	EN, IN 46527		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		1
TAG	covered under	R LSC IDENTIFYING INFORMATION		TAG	be completed: July 22, 2024	DATE	
		protection shall not be required.			be completed. July 22, 2024		
	(6) Indoor wet local						
	` ′	with associated showering					
	facilities	S					
	(8) Garages, service	e bays, and similar areas where					
	electrical diagnostic	e equipment, electrical hand					
		ghting equipment are to be					
	used.						
	NEDA 70 517 20 V	Vat I apptions mag-:11					
	i ·	Vet Locations, requires all equipment within the area of					
	1 -	have ground-fault circuit					
		protection. Note: Moisture can					
		resistance of the body, and					
		is more subject to failure.					
	This deficient pract	ice could affect staff in the					
	Laundry Room.						
	Findings include:						
		on during tour of the facility					
	_	3:30 p.m. on 06/24/24 with the 2, there was one electric					
		2, there was one electric 2 inches of a water supply					
	1 -	ry Room. The electric					
		provided with ground fault					
		GFCI). The Maintenance Lead					
		fountain had previously been					
	mounted there. The	Maintenance Lead 2					
	_	electric receptacle was not a					
	GFCI.						
	#2) Based on obser	vation and interview, the					
	· ·	sure 1 of 1 electrical receptacle					
		was protected. NFPA 70, 2011					
	1	5.6, Receptacle Faceplates					
		ires receptacle faceplates shall					
	be installed so as to	completely cover the opening					
	and seat against the	mounting surface. This					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 22 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/25/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	deficient practice coroom. Findings include:	ould affect staff in the laundry					
K 0521 SS=E Bldg. 01	Based on observation from 12:43 p.m. to Maintenance Lead 2 laundry room was not the time of the observation and confirmed to the condition and confirmed to the con		K 0521	K521 1. What corrective action will accomplished for those reside found to have been affected by deficient practice; Maintenance Tech inspected and changed fusible link to 2 of 2 fire damp for functionality in the Metzler Meeting House. 2. How other residents having potential to be affected by the same deficient practice will be	ents by the ce ers c's		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 23 of 46

07/30/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/25/2024 155205 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1225 GREENCROFT DR **GREENCROFT HEALTHCARE** GOSHEN, IN 46527 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Doors and Other Opening Protectives. NFPA 80, identified and what corrective 2010 Edition, Section 19.4.1 states each damper action(s) will be taken; No shall be tested and inspected 1 year after residents were affected. 56 installation. Section 19.4.1.1 states the test and residents and staff have the inspection frequency shall then be every 4 years potential to be affected. except for hospitals where the frequency is every 3. What measures will be put into 6 years. If the damper is equipped with a fusible place and what systemic changes link, the link shall be removed for testing to ensure will be made to ensure that the full closure and lock-in-place if so equipped. The deficient practice does not recur; damper shall not be blocked from closure in any Maintenance Manager validated way. All inspections and testing shall be fire dampers were inspected and documented, indicating the location of the fire changed the fusible link for damper, date of inspection, name of inspector and functionality. Administrator deficiencies discovered. The documentation shall educated maintenance staff on the have a space to indicate when and how the NAFP requirements of testing and deficiencies were corrected. This deficient inspections of fire dampers. practice could affect residents, staff and visitors Maintenace Manager has in 1 of 7 smoke compartments. developed a preventative maintenance schedule for Findings include: inspection of fire dampers. Administrator to submit waiver for Based on record review from 9:42 a.m. to 12:10 Ventilation System not meeting p.m. on 6/24/2024 and based on observation and return air requirements in interview from 12:43 p.m. to 3:30 p.m. on 06/24/24 NFPA90A on or before 7/29/2024. with Maintenance Lead 2 and Maintenance Lead 4. How the corrective action(s) will 1, the facility failed to ensure 2 of 2 fire dampers be monitored to ensure the located in the wall above doors to the "Metzler deficient practice will not recur. Meetinghouse" were provided maintenance. The i.e., what quality assurance lack of four-year maintenance conducted on fire program will be put into place; dampers was verified during interview with Ongoing compliance with this Maintenance Lead 2 at the time of observation. corrective action will be monitored through the facility Quality #2) Based on observation and interview, the Assurance and Performance facility failed to ensure egress corridors were not Improvement Program (QAPI). The used as a portion of a return air system serving Maintenance Director/designee adjoining rooms for 56 of 104 resident rooms. LSC will be responsible for completing

FORM CMS-2567(02-99) Previous Versions Obsolete

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

Event ID:

7IDH21

Facility ID: 000112

the QAPI Audit tool "Fire

Dampers" weekly for 4 weeks, and

months. If threshold of 90% is not

monthly thereafter for at least 5

If continuation sheet

Page 24 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIER		1225 G	ADDRESS, CITY, STATE, ZIP COD GREENCROFT DR EN, IN 46527	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	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.			met, an action plan will be developed. Findings will be submitted to the QAPI Comr for review and follow up. 5. By what date the systemic changes for each deficiency be completed: July 22, 2024	will
	Findings include:				
	Lead 2 during a tou to 3:30 p.m. on 06/2 using the egress cor rooms 100-145 in the "Gables" Wes hall. Based on inter observations, the M acknowledged the a	forementioned resident rooms were using the egress corridor			
	Maintenance Lead	viewed with the Administrator, 1, Maintenance Lead 2, and s at the exit conference.			
	3.1-19(b)				
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are perkept informed with and a copy of the with telephone op-				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 25 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIEF		1225 0	ADDRESS, CITY, STATE, ZIP COD GREENCROFT DR EN, IN 46527	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	of staff per 18/19. of the fire safety p 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3 19.7.2.1.2, 19.7.2. Based on record reversible failed to provide a vector of the components in 1 of 19.7.2.2 requires a strict fire safety plan that following: (1) Use of alarms (2) Transmission of (3) Emergency photo (4) Response to alart (5) Isolation of fire (6) Evacuation of it (7) Evacuation of it (7) Evacuation of strict (8) Preparation of fire evacuation (9) Extinguishment This deficient pract Findings include: Based on record reversible failure in the "Healthcare Fires smoke or fire barries This finding was remaintenance Lead	7.2.1.2 and provides for all lan components per 8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 2, 19.7.2.3 riew and interview, the facility vritten plan that addressed all 1 written fire plans. LSC written health care occupancy shall provide for the Calarm to fire department me call to fire department me call to fire department moves and building for of fire ice could affect all occupants. All of the could affect all occupants. All of the could affect all occupants.	K 0711	K711 - 2 1. What corrective action will accomplished for those reside found to have been affected a deficient practice; Maintenance Safety Officer developed may identify smoke or fire barrier of in the healthcare facility. 2. How other residents having 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 place and what systemic chawill be made to ensure that the deficient practice does not remaintenance Manager validate "Healthcare Fire Safety Phas been updated to identify smoke and fire barrier doors throughout the Healthcare factory and the "Healthcare Fire Safety Plan" to identify smoke fire barrier doors. Administrator/designee will educate all staff of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire Safety Plan" identify smoke and fire barrier doors throughout the facility of the update "Healthcare Fire	be ents by the ce or to doors ne cur; ted Plan" cility.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 26 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE				
		155205	B. WING 06/25/2024				/2024
GREENC	ROVIDER OR SUPPLIER	RE	STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	before 7/21/2024. Administrator/designee will au the "Healthcare Fire Safety Plato validate staff understand ho identify smoke and fire barrier doors. 4. How the corrective action(s) 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) Maintenance Director/designe will be responsible for complete the QAPI Audit tool "Fire Safet Plan" weekly for 4 weeks, and monthly thereafter for at least months. If threshold of 90% is met, an action plan will be developed. Findings will be submitted to the QAPI Commifor review and follow up. 5. By what date the systemic changes for each deficiency we be completed: July 22, 2024	an" bw to) will f, bred the eting ty 5 not	DATE
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		·			ETED
		155205	B. WIN	IG		06/25/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		Ι	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	signs that read NC posted with the int smoking. (2) In health care of smoking is prohibit prominently placed secondary signs where smoking shall not (3) Smoking by paresponsible shall the (4) The requirement apply where the paresponsible shall the where smoking is (6) Ashtrays of note safe design shall the where smoking is (6) Metal contained devices into which shall be readily away smoking is permitted and metal contained devices into which shall be readily away smoking is permitted and metal contained devices into which and metal contained devices into which an oncombustible material areas where smoking practice could affect the facility. Findings include: Based on record reversible material smoking include: Based on record reversible material smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and/or vapulating; however, state of the facility is smoking and state of the facility is smo	d at all major entrances, with language that prohibits be required. Intents classified as not be prohibited. Int of 18.7.4(3) shall not attent is under direct attent is under direct uncombustible material and be provided in all areas permitted. In with self-closing cover a ashtrays can be emptied attailable to all areas where ted. In the with self-closing cover ashtrays can be emptied of terial and safe design in 1 of 1 and safe design in 1 of 1 are is saff in the "smoke shack" of	K 07	41	K741 - 2 1. What corrective action will be accomplished for those reside found to have been affected be deficient practice; Maintenance Tech cleaned cigarette butts for staff smoking area disposing is metal container with a secure metal lid with 2" opening and relocated the non-metal trash receptable. 2. How other residents having 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 if the part is accomplished.	ents y the e rom n d	07/21/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112 If continuation sheet Page 28 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155205	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/25/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE			
	on interview with the a tour of the facility 06/24/24, the Maint facility allows smole which is accessible that a resident is knew shack where he dispute the ground. Over two strewn on the ground Inside the "smoke seashtrays contained container for dispose available; however, cover. In addition, a receptacle contained other combustible in the time of observate acknowledged self-not provided and ciproperly disposed of taking place.	rated near Manor III." Based ne Maintenance Lead 2 during from 12:43 p.m. to 3:30 p.m. on enance Lead 2 stated the ting in the "smoke shack" to staff only. He also stated own to smoke outside of the boses of his cigarette butts on renty cigarette butts were d outside the "smoke shack". hack" open non-covered over 10 cigarette butts, a metal ing of cigarette butts was it did not have a self-closing on open non-metal trash d over 20 cigarette butts with naterial. Based on interview at ion, the Maintenance Director closing metal containers were garette butts were not f where staff smoking was wiewed with the Administrator, I, Maintenance Lead 2, and s at the exit conference.		place and what systemic chewill be made to ensure that deficient practice does not a Maintenance manager valid metal container with a secumetal lid with 2" opening in shack for staff to dispose of cigarette butts and the trast receptable was relocated. Administrator/designee will educate staff on smoking and disposal of cigarette butts at trash receptable relocation type of materials allowed for disposal on or before 7/21/2 Maintenance Manager/desi will conduct random audits "Smoke Shack". 4. How the corrective action be monitored to ensure the deficient practice will not reiven, what quality assurance program will be put into plan Ongoing compliance with the corrective action will be monitored to ensure the deficient practice will not reiven, what quality assurance program will be put into plan Ongoing compliance with the corrective action will be monitored to ensure the deficient practice will not reiven and Performance Improvement Program (QA Maintenance Director/design will be responsible for compliance with the QAPI Audit tool "Smokin Area" weekly for 4 weeks, a monthly thereafter for at least months. If threshold of 90% met, an action plan will be developed. Findings will be submitted to the QAPI Comfor review and follow up. 5. By what date the system changes for each deficiency	the recur; dated red smoke rea, and with r 2024. gnee the a(s) will cur, ce; ais aitored e PI). The anee bleting ag and ast 5 a is not mittee ic			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 29 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING 01				X3) DATE SURVEY COMPLETED	
		155205				06/25/	2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDENCE NAME CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG			DATE	
			be completed: July 2		be completed: July 22, 2024			
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vio non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity) non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the p installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3(#1) Based on observ facility failed to ens not used as a substit 2011 Edition, 400.8 permitted in 400.7 f not be used for (1) as	d electrical equipment	K 09	920	K920 - 2 1. What corrective action will be accomplished for those resider found to have been affected by deficient practice; Non-medical grade power-strip was remove from resident room 621. 2. How other residents having potential to be affected by the same deficient practice will be	nts y the al ed the	07/21/2024	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 30 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIER		1225 G	ADDRESS, CITY, STATE, ZIP COD GREENCROFT DR EN, IN 46527	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
1AG	Based on observation from 12:43 p.m. to Maintenance Lead 2 lamp was plugged in extension cord in role Based on interview Maintenance Lead 2 cord was in use in a #2) Based on observation facility failed to ensure in the examination and extending 6 feet beyone bed, chair, table, tresupports the patient vertically to 7 feet 6 deficient practice after resident room 621. Findings include: Based on observation from 12:43 p.m. to Maintenance Lead 2 "Lea" unit, a power vicinity was used for electrical equipment label on the power sacknowledged by the time of observation #3) Based on observation #3) Based on observation #3) Based on observation #3) Based on observation facility failed to ensinstalled properly and sacknowledged properly and sacknow	on during tour of the facility 3:30 p.m. on 06/24/24 with 2 and Maintenance Lead 1, a not and supplied power by an som 130 on the "Lea" unit. at the time of observation, the 1 acknowledged an extension resident room. Vation and interview, the sure power strips in 1 of 32 loutside the patient care 63. Patient care vicinity is within a location intended for 1 treatment of patients, wond the normal location of the admill, or other device that during examination and a care vicinity extends inches above the floor. This fects 2 resident who reside in the strip outside the patient care or a resident's personal titems that lacked a UL 1363 strip. This was verified and the Maintenance Lead 1 at the	IAG	identified and what corrective action(s) will be taken; 1 resident staff have the potential to affected 3. What measures will be put place and what systemic charwill be made to ensure that the deficient practice does not recommend and to validate no extension cords or non-medical grade patrips in resident care areas. Administrator/designee will educate staff on allowed usage UL rating medical grade powers strips in resident rooms on or before 7/21/2024. Maintenance Manager/designee will condurandom audits of resident rooms to validate no extension cords non-medical grade power striuse. 4. How the corrective action(she monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place Ongoing compliance with this corrective action will be monitored the facility Quality Assurance and Performance Improvement Program (QAPI Maintenance Director/designed will be responsible for completing the QAPI Audit tool "Power Strip/Extesion Cord" weekly for weeks, and monthly thereafted at least 5 months. If threshold 90% is not met, an action plan be developed. Findings will be developed. Findings will be developed. Findings will be developed.	lent be into nges e cur; ed an ower ge of er ce ct ms s or ps in s) will r, ; cored). The ee etting or 4 r for l of n will

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 31 of 46

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	· ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
TEREST EAST		155205		B. WING 06/25/20				
NAME OF F	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR					
GREENC	ROFT HEALTHCA	ARE		GOSHEN, IN 46527				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
	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				submitted to the QAPI Comm for review and follow up. 5. By what date the systemic changes for each deficiency versions are smallered to live 22, 2024.			
	cord to the appliance either pull, twist, or	ce so that mechanical stress, r bend, is not transmitted to s. This deficient practice could			be completed: July 22, 2024			
	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.							
K 0000								
Bldg. 02	Licensure Survey v	e Recertification and State was conducted by the Indiana lth in accordance with 42 CFR	K 0	000	K000 The creation and submission this plan of correction does not constitute an admission by the provider of any conclusion see in the statement of deficiencies of any violation of regulation.	ot is t forth es, or		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 32 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	COM	(X3) DATE SURVEY COMPLETED 06/25/2024			
	PROVIDER OR SUPPLIER		1225 G	STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION		
TAG	Facility Number: 0 Provider Number: 100 At this Life Safety of Healthcare was four Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protectife Safety Code (I Health Care Occupation of Type V (111) and determined to be of are separated by a F Resistive Rating. Building 02 (the two sprinklered, has a find detection in the correction of this survey. All areas where the access were sprinklered was not s	Code survey, Greencroft and not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the etion Association (NFPA) 101, asc), Chapter 19, Existing ancies. Is of the original one-story ial basement determined to be do the two-story 2015 addition artype II (111). The buildings are Wall with 2-Hour Fire To-story 2015 addition) is fully are alarm system with smoke aridor, areas open to the resident rooms. The facility has and had a census of 159 at the areas providing are sprinklered. There is a staff a separate from the building	TAG	to the relative low so severity of this surve respectfully requests review in lieu of a por revisit on or after 7/2	cope and ey, the facility s a desk ost-survey	DATE		
K 0281 SS=E Bldg. 02		•						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 33 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED		
		155205	B. W	B. WING			06/25/2024	
				STREET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			REENCROFT DR			
GREENIC	CROFT HEALTHCA	RE			EN, IN 46527			
OILLING		u \ ⊑		COSITE	-14, 114 70021			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE	
		r continuously in operation						
	-	omatic operation without						
	manual intervention	on.						
	18.2.8, 19.2.8							
		on and interview, the facility	K 0	281	K281 - 2		07/21/2024	
		tinuity of egress lighting for 2			What corrective action will be a continuous action.			
		purposes of this requirement,			accomplished for those reside			
	_	include only designated stairs,			found to have been affected b	-		
		mps, escalators, walkways and			deficient practice; Maintenanc			
		eading to a public way. This			Tech installed egress lighting			
	_	ould affect staff and up to 64			provide a clear direction path	_		
	residents when occupied.				the sidewalks from exit doors	_		
					and 76 to the public way from			
	Finding include:				Household units of the healtho	care		
					facility.			
		on during tour of the facility		2. How other residents having the		the		
	_	3:30 p.m. on 06/24/24 with			potential to be affected by the			
		2 and Maintenance Lead 1 the			same deficient practice will be			
	_	walks from doors 75 and 76, and			identified and what corrective			
	_	lighting for portions of the			action(s) will be taken; No			
		exit to the public way. Based			residents were affected; 64			
		time of observations, the			residents and staff have the			
		2 confirmed there were no			potential to be affected.			
		es illuminating the sidewalks,			3. What measures will be put i			
		determined if all of the			place and what systemic chan	_		
		t paths were provided with			will be made to ensure that the			
	sufficient lighting.				deficient practice does not rec			
	This finding was ra	viewed with the Administrator,			Maintenance Manager validate exit lighting provides a clear	c u		
	_	1, Maintenance Lead 2, and			direction path along the sidew	alke		
		s at the exit conference.			from exit doors 75 and 76 to the			
	Cimical Supervisor	s at the Cart Conference.			public way.	IC		
	3.1-19(b)				Administrator/designee will			
	3.1-17(0)				educate staff on exit lighting			
					provides a clear direction path			
					along the sidewalks from exit			
					doors 25 and 77 to the public	wav		
					on or before 7/21/2024.	vvay		
					Maintenace Manager/designe	e will		
					conduct random audits of egre			
	I		1		conduct random addits of egit	,33	ĺ	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 34 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/30/2024 FORM APPROVED

ENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING <u>02</u>	COMPLETED
	155205	B. WING		06/25/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
			1225 GREENCROFT DR	

GREENCROFT HEALTHCARE			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		
			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		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21 Facility ID: 000112

If continuation sheet Page 35 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	02	COMPLETED	
		155205	B. W	ING		06/25/2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8					
ODEENIG		DE			REENCROFT DR		
GREENCROFT HEALTHCARE			GOSHE	EN, IN 46527			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	7.10.1.2.1 exits, oth	er than main exterior exit doors			found to have been affected b	v the	
	that obviously and o	clearly are identifiable as exits,			deficient practice; Contractor		
		an approved sign that is			installed exit signage to provid	le a	
		any direction of exit access.			clear path of egress from the I		
	*	es horizontal components of the			area of Oasis, Dell, Cove, and	-	
		nn exit enclosure shall be			Haven in the Household units		
		d exit or directional exit signs			the healthcare facility.	0.	
		ion of the egress path is not			2. How other residents having	the	
		ient practice could affect staff,			potential to be affected by the		
	visitors and residen	-			same deficient practice will be		
					identified and what corrective		
	Findings include:				action(s) will be taken; No		
	i maings metade.				residents were affected; 66		
	Based on observation	on during tour of the facility			residents and staff have the		
		3:30 p.m. on 06/24/24 with the			potential to be affected.		
	-	2 and Maintenance Lead 1, the			3. What measures will be put i	into	
		Dasis", "Dell", "Cove", and			place and what systemic chan		
	-	ot have visible exit signs from			will be made to ensure that the	-	
		the direction of egress. Exit			deficient practice does not rec		
	_	above egress doors but were			Maintenance Manager validate		
	-	locations in the corridors. This			exit signage provides clear pa		
		by the Maintenance Lead 2 at			egress. Administrator/designe		
	the time of observat	-			will educate staff on exit sign of		
	the time of observat	non.			direction path signage from the		
	This finding was re	viewed with the Administrator,			living area of Oasis, Dell, Cov		
	_	1, Maintenance Lead 2 and			and Haven on or before 7/21/2		
		s at the exit conference.			Maintenace Manager/designe		
	Cililical Supervisor	s at the exit conference.			conduct random audits of exit		
	3.1-19(b)				signage is functioning.		
	3.1-17(0)				4. How the corrective action(s	النبدا	
					be monitored to ensure the) WIII	
					deficient practice will not recur	r	
					•	• •	
					i.e., what quality assurance		
					program will be put into place;		
					Ongoing compliance with this		
					corrective action will be monito	siea	
					through the facility Quality		
					Assurance and Performance	T.	
					Improvement Program (QAPI)		
					Maintenance Director/designe	е	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 36 of 46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155205	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
K 0355 SS=E Bldg. 02	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. #1) Based on observation facility failed to inspect in the each month. NFPA Extinguishers in the each month. NFPA Extinguishers, Sective extinguishers shall by means of an electron minimum of 30-day periodic inspection extinguishers shall in following items: (1) Location in desi (2) No obstruction to (3) Pressure gauge to operable range or portable range or portable range or portable expelling-type in the second proper secon	orguishers guishers are selected, d, and maintained in IFPA 10, Standard for orguishers. 12, NFPA 10 Vation and interview, the pect 1 of 1 portable fire lower-level elevator room 10, Standard for Portable Fire on 7.2.1.2 states fire be inspected either manually or tronic device / system at a reintervals. Section 7.2.2 states or electronic monitoring of fire nclude a check of at least the gnated place o access or visibility reading or indicator in the osition ined by weighing or hefting for	K 0355	will be responsible for complete the QAPI Audit tool "Exit Signal Lights and Doors" weekly for 4 weeks, and monthly thereafter at least 5 months. If threshold 90% is not met, an action plan be developed. Findings will be submitted to the QAPI Commi for review and follow up. 5. By what date the systemic changes for each deficiency who be completed: July 22, 2024 K355 1. What corrective action will be accomplished for those reside found to have been affected by deficient practice; Maintenace Tech inspected and document on the tag of portable fire extinguisher in the lower-level elevator room and Haven unit to soiled utility room. 2. How other residents having 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.	age, for of of owill extree oe onts y the ted next the	07/21/2024	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

(5) Condition of tires, wheels, carriage, hose, and

7IDH21

Facility ID: 000112

3. What measures will be put into

If continuation sheet

Page 37 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 02 COMPLETED 155205 B. WING 06/25/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1225 GREENCROFT DR **GREENCROFT HEALTHCARE** GOSHEN, IN 46527 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE nozzle for wheeled extinguishers place and what systemic changes (6) Indicator for non-rechargeable extinguishers will be made to ensure that the using push-to-test pressure indicators. deficient practice does not recur; Section 7.2.4.1 states personnel making manual Maintenance Tech conducted an inspections shall keep records of all fire audit to validate all portable fire extinguishers inspected, including those found to extinguishers have been inspected require corrective action. Section 7.2.4.3 requires monthly with documentation on where at least monthly manual inspections are tag. Administrator educated conducted, the date the manual inspection was maintenance staff on requirements performed and the initials of the person for portable fire extinguishers performing the inspection shall be recorded. inspection and tag documentation. Section 7.2.4.4 requires where manual inspections Maintenace Manager has are conducted, records for manual inspections developed a preventative shall be kept on a tag or label attached to the fire maintenance schedule for extinguisher, on an inspection checklist inspection of portable fire maintained on file, or by an electronic method. extinguishers and documentation Section 7.2.4.5 requires records shall be kept to on tag. 4. How the corrective action(s) will demonstrate that at least the last 12 monthly inspections have been performed. This deficient be monitored to ensure the practice could affect staff in this non-resident deficient practice will not recur, area. i.e., what quality assurance program will be put into place; Findings include: Ongoing compliance with this corrective action will be monitored Based on observation during tour of the facility through the facility Quality from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the Assurance and Performance Maintenance Lead 2 and Maintenance Lead 1, the Improvement Program (QAPI). The monthly inspection tag on the fire extinguisher Maintenance Director/designee located in the lower-level elevator room lacked will be responsible for completing documentation of a monthly inspection for May the QAPI Audit tool "Portable Fire of 2024. This was acknowledged by the Extinguishers" weekly for 4 Maintenance Lead 2 and Maintenance Lead 1 at weeks, and monthly thereafter for the time of observation. at least 5 months. If threshold of 90% is not met, an action plan will #2) Based on observation and interview, the be developed. Findings will be facility failed to properly inspect 1 of 1 portable submitted to the QAPI Committee fire extinguishers in the "Haven" Unit. NFPA 10, for review and follow up. Standard for Portable Fire Extinguishers, Section 5. By what date the systemic 7.2.1.2 states fire extinguishers shall be inspected changes for each deficiency will either manually or by means of an electronic be completed: July 22, 2024

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 02 COMPLETED B. WING 06/25/2024
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall	1225 GREENCROFT DR
Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION
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 of the control of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for non-rechargeable extinguishers using push-to-fest 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 inspections are conducted, the date the manual inspections are conducted, requires where manual inspections are conducted, records for 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	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 39 of 46

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIER		1225 G	ADDRESS, CITY, STATE, ZIP COD GREENCROFT DR EN, IN 46527	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	utility room showed monthly inspections gauge indicated it w acknowledged by th	en" unit next to the soiled documentation of regular s; however, the pressure vas overcharged. This was ne Maintenance Lead 2 and 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	patients and for the of an emergency. Employees are perkept informed with and a copy of the with telephone opplan addresses the of staff per 18/19.0 of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2.	elocation Plan plan for the protection of all peir evacuation in the event eriodically instructed and in their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all plan components per 18.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 1.2, 19.7.2.3			
	failed to provide a v components in 1 of 19.7.2.2 requires a v fire safety plan that following: (1) Use of alarms (2) Transmission of	view and interview, the facility written plan that addressed all 1 written fire plans. LSC written health care occupancy shall provide for the falarm to fire department ne call to fire department	K 0711	K711 - 2 1. What corrective action will be accomplished for those reside found to have been affected be deficient practice; Maintenance Safety Officer developed maperidentify smoke or fire barrier do in the healthcare facility. 2. How other residents having	nts y the e to oors

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 40 of 46

PRINTED: 07/30/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
				A. BUILDING <u>02</u>			ETED	
		155205	B. W	ING		06/25/	/2024	
NAME OF	PROVIDER OR SUPPLIE	FR.		STREET	ADDRESS, CITY, STATE, ZIP COD			
					GREENCROFT DR			
GREEN	CROFT HEALTHC	ARE		GOSHI	EN, IN 46527			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION	
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	(4) Response to ala				potential to be affected by the			
	(5) Isolation of fire				same deficient practice will be			
	(6) Evacuation of i				identified and what corrective			
		smoke compartment floors and building for			action(s) will be taken; No			
	evacuation	floors and building for			residents were affected; 159 residents and staff have the			
	(9) Extinguishmen	at of fire			potential to be affected.			
		etice could affect all occupants.			3. What measures will be put i	nto		
	This deficient prac	thee could affect an occupants.			place and what systemic change			
	Findings include:				will be made to ensure that the	•		
	i manigs merade.				deficient practice does not reci			
	Based on record re	eview and interview from 9:42			Maintenance Manager validate			
	a.m. to 12:10 p.m. on 06/24/24 with Maintenance				the "Healthcare Fire Safety Pla			
	Lead 2, the Maintenance Lead 2 acknowledged				has been updated to identify			
	the "Healthcare Fire Safety Plan" did not identify				smoke and fire barrier doors			
	smoke or fire barriers in the facility.				throughout the Healthcare faci	lity.		
		•			Maintenance Safety Officer	,		
	This finding was r	eviewed with the Administrator,			updated the "Healthcare Fire			
	Maintenance Lead	1, Maintenance Lead 2, and			Safety Plan" to identify smoke	or		
	Clinical Superviso	ors at the exit conference.			fire barrier doors.			
					Administrator/designee will			
	3.1-19(b)				educate all staff of the updated	ł		
					"Healthcare Fire Safety Plan" t	0		
					identify smoke and fire barrier			
					doors throughout the facility or	n or		
					before 7/21/2024.			
					Administrator/designee will aud			
					the "Healthcare Fire Safety Pla			
					to validate staff understand ho	w 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 monito	orea		
			1		through the facility Quality		1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

Assurance and Performance

If continuation sheet Page 41 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205			A. BUILDING B. WING	02	COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE		1225 G	ADDRESS, CITY, STATE, ZIP COD REENCROFT DR EN, IN 46527		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 02	shall include not lead provisions: (1) Smoking shall I ward, or compartmaliquids, combustible used or stored and location, and such signs that read NC posted with the interest smoking. (2) In health care of smoking is prohibited prominently placed secondary signs we smoking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the pasupervision.	ons ons shall be adopted and less than the following be prohibited in any room, ment where flammable le gases, or oxygen is at in any other hazardous area shall be posted with o SMOKING or shall be renational symbol for no occupancies where ted and signs are at all major entrances, with language that prohibits be required. tients classified as not		Improvement Program (QAPI) Maintenance Director/designe will be responsible for complet the QAPI Audit tool "Fire Safe Plan" weekly for 4 weeks, and monthly thereafter for at least months. If threshold of 90% is met, an action plan will be developed. Findings will be submitted to the QAPI Commi for review and follow up. 5. By what date the systemic changes for each deficiency where the completed: July 22, 2024	e ting ty 5 not ttee

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet

Page 42 of 46

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		N IDENTIFICATION NUMBER A. BUILDING <u>02</u> COMPLETED		A. BUILDING <u>02</u> COM		LETED	
	155205		B. W	NG		06/25	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				REENCROFT DR			
GREEN	CROFT HEALTHCA	RE			EN, IN 46527		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		be provided in all areas					
	where smoking is	•					
		ers with self-closing cover					
		n ashtrays can be emptied					
		vailable to all areas where					
	smoking is permit	ted.					
	18.7.4, 19.7.4		,, ,	- 4 1			07/01/2021
		view, observation and	K 0	/41	K741 - 2		07/21/2024
		ty failed to provide ashtrays			What corrective action will I		
		rs with self-closing cover			accomplished for those reside		
		ashtrays can be emptied of			found to have been affected b	-	
	noncombustible material and safe design in 1 of 1				deficient practice; Maintenand		
	areas where smoking is permitted. This deficient				Tech cleaned cigarette butts f		
	-	et staff in the "smoke shack" of			staff smoking area disposing i		
	the facility.				metal container with a secure	d	
					metal lid with 2" opening and		
	Findings include:				relocated the non-metal trash		
	D11	oi Cali Co-iliant-			receptable.	. 41	
		view of the facility's			2. How other residents having		
	_	-Free Environment" written			potential to be affected by the		
		intenance Lead 2 during record .m. to 12:10 p.m. on 06/24/24,			same deficient practice will be		
		oing is not permitted in the			identified and what corrective		
		-			action(s) will be taken; No		
		the policy states "Smoking or nitted in personal vehicles or			residents were affected. 3. What measures will be put	into	
		cated in personal vehicles or			place and what systemic char		
		he Maintenance Lead 2 during			will be made to ensure that th	•	
		from 12:43 p.m. to 3:30 p.m. on			deficient practice does not red		
		tenance Lead 2 stated the			Maintenance manager validat		
		king in the "smoke shack"			metal container with a secure		
		to staff only. He also stated			metal lid with 2" opening in sn		
		own to smoke outside of the			shack for staff to dispose of	IONO	
		poses of his cigarette butts on			cigarette butts and the trash		
		venty cigarette butts were			receptable was relocated.		
	-	nd outside the "smoke shack".			Administrator/designee will		
	_	shack" open non-covered			educate staff on smoking area	a	
		over 10 cigarette butts, a metal			disposal of cigarette butts and		
		sing of cigarette butts was			trash receptable relocation wi		
	_	, it did not have a self-closing			type of materials allowed for		
		an open non-metal trash			disposal on or before 7/21/20	24.	

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED	
		155205	B. WING 06/25/2024			2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					REENCROFT DR		
GREENCROFT HEALTHCARE					:N, IN 46527		
OKELINO	TOT THE RETTION			OCCITE	114, 114 40027		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	•	d over 20 cigarette butts with			Maintenance Manager/designe		
	other combustible material. Based on interview at				will conduct random audits the		
		ion, the Maintenance Director			"Smoke Shack".		
		closing metal containers were			4. How the corrective action(s)	will	
		garette butts were not			be monitored to ensure the		
		f where staff smoking was			deficient practice will not recur	,	
	taking place.				i.e., what quality assurance		
	This finding was	vioused with the Administrator			program will be put into place;		
	_	viewed with the Administrator, , Maintenance Lead 2, and			Ongoing compliance with this		
		s at the exit conference.			corrective action will be monitor through the facility Quality	nea	
	Chinical Supervisors	s at the exit conference.			Assurance and Performance		
	3.1-19(b)				Improvement Program (QAPI)	Tho	
	3.1-19(0)				Maintenance Director/designe		
					will be responsible for complet		
					the QAPI Audit tool "Smoking	····9	
					Area" weekly for 4 weeks, and		
					monthly thereafter for at least		
					months. If threshold of 90% is		
					met, an action plan will be		
					developed. Findings will be		
					submitted to the QAPI Commit	tee	
					for review and follow up.		
					5. By what date the systemic		
					changes for each deficiency w	ill	
					be completed: July 22, 2024		
K 0920	NFPA 101						
SS=D	· · ·	ent - Power Cords and					
Bldg. 02	Extens						
		ent - Power Cords and					
	Extension Cords						
		patient care vicinity are only					
	used for compone						
		d electrical equipment					
	(PCREE) assemble						
		lified personnel and meet					
		0.2.3.6. Power strips in					
	-	cinity may not be used for					
	non-PCREE (e.g.,	personal electronics),					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IDH21

Facility ID: 000112

If continuation sheet Page 44 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 06/25/2024 155205 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1225 GREENCROFT DR **GREENCROFT HEALTHCARE** GOSHEN, IN 46527 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0920 K920 - 2 07/21/2024 failed to ensure power strips in 1 of 24 resident 1. What corrective action will be rooms used outside the patient care vicinity met accomplished for those residents UL 1363. Patient care vicinity is defined as a found to have been affected by the space, within a location intended for the deficient practice; Non-medical examination and treatment of patients, extending 6 grade power-strip was removed feet beyond the normal location of the bed, chair, from resident room 621. table, treadmill, or other device that supports the 2. How other residents having the patient during examination and treatment. A potential to be affected by the patient care vicinity extends vertically to 7 feet 6 same deficient practice will be identified and what corrective inches above the floor. This deficient practice affects 2 resident who reside in resident room 621. action(s) will be taken: 1 resident and staff have the potential to be Findings include: affected 3. What measures will be put into Based on observation during tour of the facility place and what systemic changes from 12:43 p.m. to 3:30 p.m. on 06/24/24 with the will be made to ensure that the Maintenance Lead 2 and Maintenance Lead 1, in deficient practice does not recur: resident room 621 on the "Haven" unit, a power Maintenance Tech's conducted an strip outside the patient care vicinity was used for audit to validate no extension a resident's personal electrical equipment items cords or non-medical grade power that lacked a UL 1363 label on the power strip. strips in resident care areas. This was verified and acknowledged by the Administrator/designee will

FORM CMS-2567(02-99) Previous Versions Obsolete

Maintenance Lead 1 at the time of observations.

Event ID:

Faci

7IDH21

Facility ID: 000112

If continuation sheet

educate staff on allowed usage of UL rating medical grade power

Page 45 of 46

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	02	COMPL	ETED
	155205		B. WI	NG		06/25/	2024
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			REENCROFT DR		
GREENC	ROFT HEALTHCA	RE			EN, IN 46527		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	viewed with the Administrator,			strips in resident rooms on or		
		1, Maintenance Lead 2 and			before 7/21/2024. Maintenand	e	
	Clinical Supervisor	s at the exit conference.			Manager/designee will conduc		
					random audits of resident roo		
	3.1-19(b)				to validate no extension cords		
					non-medical grade power strip	os in	
					use.		
					4. How the corrective action(s) will	
					be monitored to ensure the		
					deficient practice will not recu	r,	
					i.e., what quality assurance		
					program will be put into place;		
					Ongoing compliance with this		
					corrective action will be monit	ored	
					through the facility Quality		
					Assurance and Performance		
					Improvement Program (QAPI)		
					Maintenance Director/designe		
					will be responsible for comple	ting	
					the QAPI Audit tool "Power		
					Strip/Extesion Cord" weekly for		
					weeks, and monthly thereafte		
					at least 5 months. If threshold		
					90% is not met, an action plar		
					be developed. Findings will be		
					submitted to the QAPI Commi	ttee	
					for review and follow up.		
					5. By what date the systemic		
					changes for each deficiency w	/ill	
					be completed: July 22, 2024		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7IDH21 Facility ID: 000112 If continuation sheet Page 46 of 46