

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2024
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/24/24 and 06/25/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 08/09/24</p> <p>Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710</p> <p>At this Life Safety Code PSR, Greencroft Healthcare was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.</p> <p>The facility consists of the original one-story building with a partial basement determined to be of Type V (111) and the two-story 2015 addition determined to be of Type II (111). The buildings are separated by a Fire Wall with 2-Hour Fire Resistive Rating.</p> <p>Building #1 (the original building) is fully sprinklered, has a fire alarm system with smoke detection in the corridors, areas open to the corridor, and battery smoke alarms in all resident rooms that are not connected to the fire alarm system but provides a visual and audible signal at the nurses' station. This building is separated from independent living by a Fire Wall with 2-Hour Fire Resistive Rating. The facility has a capacity</p>	{K 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2024
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	Continued From page 1 of 233 and had a census of 144 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. There is a staff only smoking shack separate from the building that was not sprinklered. Quality Review completed on 08/12/24	{K 000}			
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/24/24 and 06/25/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 08/09/24 Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710 At this Life Safety Code PSR survey, Greencroft Healthcare was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. The facility consists of the original one-story building with a partial basement determined to be of Type V (111) and the two-story 2015 addition determined to be of Type II (111). The buildings are separated by a Fire Wall with 2-Hour Fire	{K 000}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2024
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	Continued From page 2 Resistive Rating. Building 02 (the two-story 2015 addition) is fully sprinklered, has a fire alarm system with smoke detection in the corridor, areas open to the corridor, and in all resident rooms. The facility has a capacity of 233 and had a census of 159 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. There is a staff only smoking shack separate from the building that was not sprinklered. Quality Review completed on 08/12/24	{K 000}			
{K 521} SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	{K 521}			
			This tag has an annual waiver requested.		