

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

PRINTED: 08/08/2024
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/06/2024
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	
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00439527, IN00439223 and IN00437374. This visit was in conjunction with a PSR to the Investigation of Complaint IN00435888 and IN00436194 completed on June 15, 2024. Complaint IN00439527 - No deficiencies related to the allegations are cited. Complaint IN00439223 - No deficiencies related to the allegations are cited. Complaint IN00437374 - No deficiencies related to the allegations are cited. Survey dates: July 31, August 1, 5, & 6, 2024. Facility number: 000112 Provider number: 155205 AIM number: 100288710 Census Bed Type: SNF/NF: 144 Total: 144 Census Payor Type: Medicare: 12 Medicaid: 84 Other: 46 Total: 144 Greencroft Healthcare was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00439527, IN00439223 and IN00437374.	F 000			

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

TITLE

(X6) DATE

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

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F 000	Continued From page 1 Quality Review completed on 8/7/2024.	F 000			