STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155205	A. BUILDING 00 B. WING	06/13/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00435888 and IN00436194. Complaint IN00435888 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00436194 - Federal/State deficiencies related to the allegations are cited at F689 and F557. Survey dates: June 10, 11,12 & 13, 2024 Facility number: 000112 Provider number: 155205 AIM number: 100288710 Census Bed Type: SNF/NF: 154 Total: 154 Census Payor Type: Medicare: 27 Medicaid: 80 Other: 47 Total: 154 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 6/21/2024	F 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Greencroft at Goshen respectfully requests a desk review.	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:			

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

Terry A Tomasi | Administrator | 07/02/2024

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

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	§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on interview and record review, the facility failed to ensure a resident rights were respected regarding photos taken by a facility staff member posted on social media without the resident's knowledge or permission for 1 of 3 resident's reviewed for resident's rights, (Resident F) Finding Includes: A record review for Resident F was completed on 6/14/24 at 1:00 P.M. Diagnoses included but were not limited to: dementia, breast cancer, heart failure, spinal stenosis, depression, and cerebrovascular disease. An Annual Minimum Data Set (MDS) assessment, dated 5/3/24, indicated Resident F was cognitively intact, required moderate assistance for most Activities of Daily Living (ADLs), and utilized a wheelchair for locomotion. A review of an incident reported to the Indiana State Department of Health Survey Report System, submitted by the facility Administrator indicated on 5/28/24 at 4:35 P.M., Certified Nursing Assistant (CNA) 7 reported Employee (E) 3 posted a picture of Resident F on her social media. The Incident Report indicated immediate action included notification to the Administrator, Director of Nursing, physician, and Resident F's family. The resident was assessed, Employee 3 was suspended, a police report was filed with the local police department and an investigation was initiated. A follow-up report dated 6/3/24 indicated the investigation was completed and	F 0557	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The allegation was reported to IDOH, and Goshen Police Dept. The family and physician were notified, and the incident investigated. The employee no longer works for the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents who reside on the Households units are identified to be at risk. However, no other residents were identified to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff in-service will be conducted on or before 7/5/24. This in-service will include review of the facility policy related to Resident Rights and Abuse. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	07/05/2024

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	included staff and resident interviews. Resident F did not recall any photographs taken and Social Services provided follow-up visits with the resident with no distress noted. Employee 3 received disciplinary action. On 6/12/24 at 9:30 A.M., the Administrator provided a document, Reportable Incident, dated 6/5/24, (no time documented). The Reportable Incident indicated on 5/28/24 (no time documented), Employee 3 took a photo of Resident F in the lounge area with the resident's breast exposed and posted it on social media. On 5/28/24 (no time documented), the Administrator notified the resident's family member/POA. The family member/POA did not want the resident to know about the photo taken. On 5/31/24 (no time documented), Administrator provided police case number to Resident F's family member/POA. Review of an investigation interview conducted by the Administrator and Human Resource Manager with Employee 3, dated 5/28/24, indicated she took a photograph of Resident F, "...her boob was out ..." Employee 3 indicated in the interview that she posted the photo on Snap Chat and then removed it from social media and from her phone cloud. She indicated she did not ask permission to take the photo, the resident probably did not know she took the photo, and she did not think it was respectful to take the photo of the resident's breast. Review of an investigation interview conducted by the Administrator and Human Resource Manager with Employee 8, dated 5/28/24, indicated Employee 8 saw the photo of Resident F on her phone before serving dinner. She indicated Employee 3 posted it and she reported it to the nurse.		**assurance program will be put into place:** The Social Services Director/designee will interview 5 residents and team members per week for 4 weeks, 3 per week for 4 weeks, and then will conduct random interviews of residents, family members, or team members monthly for 3 months or until substantial compliance. Results will be reviewed in QAA and reported in QAPI. **By what date the systemic changes will be completed:** Compliance Date: 7/6/24	

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	Review of an investigation interview conducted by the Administrator and Human Resource Manager with Employee 9, dated 5/28/24, indicated Employee 9 saw the photo of Resident F on the phone before serving dinner and reported it to the nurse. Review of a Team Member Coaching & Counseling Form, dated 6/4/24, indicated, "On Tuesday May 28, 2024 you posted an image of a resident with her exposed breast to Snap Chat. This image was seen by fellow team members, who reported it to Administration and HR [Human Resources]. Your actions to post this image is a violation of the resident's rights, confidentiality, Code of Conduct and our CROFT values. Your decision to post that image resulted in a reportable to state, with outcome of abuse to a resident by you. These are the actions which the employee is expected to take to resolve the issues (s) noted above and the expected timeline. ACTION Termination TARGET DATE Immediately ..." Review of the facility's Human Resources Handbook signed on 10/10/23 by Employee 3, indicated, " ...Our goal is to treat out residents with respect and dignity. This means that we treat confidentially all information (medical, financial, personal) about the residents in all of our facilities. Inappropriate disclosure, including the use of electronic devices or social media sites used to share a personal image through pictures and video or any other designated confidential resident information is strictly prohibited. Violation of the established confidentiality guidelines will result in disciplinary action, up to and including termination of employment ..." On 6/12/24 at 9:30 A.M., the Director of Nursing			

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	provided an all-staff in-service signature sheet, dated 5/28/24, that indicated team members were not allowed to take photos or videos of residents and were not to post photos on social media. The in-service included the employee Human Resources Handbook regarding photographing and posting resident photos During an interview on 6/13/24 at 9:37 A.M., the Administrator indicated Employee 3 had taken a picture of Resident F and posted it to social media. She indicated on 5/28/24 at 4:35 P.M., CNA 7 was in the common area and saw Employee 8 and Employee 9 looking at a phone and giggling. The Administrator indicated CNA 7 asked Employees 8 and 9 what was funny and they showed her a picture that Employee 3 posted on social media of Resident F. The Administrator indicated the resident was sitting in the common area at a chair and her shirt was raised exposing the side of her bare breast. The Administrator indicated she immediately called the Employee 3 to the Director of Nursing's office and they conducted interviews with Employees 3, 8, and 9, and began their investigation. The Administrator indicated the photo was on the social media for less than 1 hour, and she suspended Employee 3 immediately, and terminated her when the investigation was completed. The Administrator indicated Resident F's family was notified immediately as well as the local police and the State Agency, and that staff education was initiated 5/28/24. On 6/12/24 at 9:30 A.M., the Director of Nursing provided a policy titled, Resident Rights, dated 5/8/23, which indicated, " ...The facility will ensure that all direct care and indirect care staff members ...are educated on the rights of residents and the responsibility of the facility to properly care for its			

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	residents ...The resident has the right to a dignified existence ...The resident has a right to be treated with respect and dignity ..." This citation relates to Complaint IN00436194.			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to ensure 1 of 3 residents reviewed for accidents was provided safe transfer assistance utilizing a mechanical stand lift This deficient practice resulted in a significant injury which required a transfer to an acute care center for treatment, hospice admission and death, (Resident B). Finding includes: A record review for Resident B was completed on 6/13/24 at 11:00 A.M. Resident B's diagnoses included dementia, deep venous thrombosis, rheumatoid arthritis, anxiety, and history of hip fracture. The resident was admitted to the facility on 9/15/23, was hospitalized for a fall on 5/30/24, was readmitted to the facility under hospice care on	F 0689	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The resident no longer resides in the facility. The team member was educated regarding the current lift policy. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who are transferred via mechanical lift. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A master list of lifts and the	07/05/2024

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	6/5/24, and expired on 6/7/24. A Quarterly Minimum Data Set (MDS) assessment, dated 5/1/24, indicated the resident had severe cognitive impairment, was dependent on others for transfer assistance from a chair to the bed and to stand from a seated position. The resident required substantial assistance to move from sitting on the side of the bed to laying flat on the bed, and required a wheelchair for mobility. A Physical Therapy Evaluation and Plan of Treatment, dated 3/8/24, indicated the resident was dependent for all transfers, had impaired strength to both the right and left lower extremities and was able to sit unsupported for 30 seconds when her feet were flat on the floor without back support, though she was unable to stand without without support for 10 seconds. The current Care Plans for Resident B included: Assistance for activities of daily living related to impaired function of late loss of activities of daily living due to dementia", dated 10/2/23. One approach, dated 10/2/23, indicated 2 staff were to assist the resident with transfers when using the Parker Lift (a lift-to-stand mechanical device). Resident B had poor safety awareness due to dementia, dated 10/2/23, and included an approach indicating staff were encouraged to call for assist with transfers and toileting. Resident B had a diagnosis of depression and anxiety and was fearful of falling, and included an approach to see the care plan for assistance for daily living, including assistance needed, dated 10/2/23 Resident was at risk for complications from blood thinning medications with an intervention that indicated to prevent fall which could potentially cause high risk of bleeding due to anticoagulant use, dated 11/15/23 Resident had a potential for		recommended staff required to operate was created. The lift policy was updated to reflect manufacturers guidelines. Nursing staff in-service will be conducted on or before 7/5/24. This in-service will include review of the facility updated policy related to mechanical lifts and recommended guidelines for staff to operate. Nursing staff mechanical lift validations. **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 DON/designee will conduct lift observations 3 times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and randomly for 3 months or until substantial compliance. Findings will be submitted to the QAPI Committee for review and follow up. Results will be reviewed in QAA and reported in QAPI. **By what date the systemic changes will be completed:** Compliance Date: 7/6/24	

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	falls related to impaired cognition, new living environment and impaired mobility, and included an approach to see the care plan for assistance for daily living, including assistance needed, dated 10/02/23. A fall risk assessment completed on 2/20/24, indicated Resident B had a fall risk of 20 which indicated a high risk for falls. A physician's order dated 4/5/24, indicated the resident required a mechanical stand lift. Review of an incident reported to Indiana State Department of Health, submitted by the Administrator, indicated on 5/31/24 at 9:21 A.M., Resident B was sitting on the bed after she was transferred and reached to grab the mechanical lift when Certified Nurses Aide (CNA) 2 was moving it away and the resident fell to the floor. The resident sustained lacerations around the left eye and right scalp, and sustained a right subdural hematoma (a condition where blood collects between the skull and the surface of the brain). The resident was sent to a local hospital for evaluation and treatment. An incident follow up dated 6/5/24, indicated and investigation into the fall was completed, and indicated the resident had fallen from the bed and was observed on the floor between the bed and the nightstand. The resident required sutures and staples for the lacerations, and treatment for the hematoma. The resident returned to the facility from the hospital Review of Resident B's Incident Report, dated 5/30/24 at 7:00 P.M., indicated CNA 2 approached Licensed Practical Nurse (LPN) 6, and stated he had a resident fall. LPN 6 entered the room to find Resident B laying on her left side between the bed and the nightstand. The resident was noted to			

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	have blood on her face. LPN 6 assisted the resident to a partial sitting position. A large open laceration was noted above the resident's left eyebrow, a laceration to her scalp, and a skin tear on her left shoulder extending from her shoulder to her left elbow. LPN immediately applied pressure to the lacerations and instructed another staff member to call 911. The resident remained alert and oriented and was able to engage in conversation with LPN 6 in an effort to keep her awake. The resident was unable to explain how she fell. A review of an investigation/follow-up documented by LPN 6, dated 5/31/24 at 1:16 A.M., indicated, "CNA [CNA 2] reports that he had transferred resident to her bed via mechanical lift, once resident was sitting on bed he attempted to remove lift and resident reached out causing her to fall. [CNA 2] approached writer and stated he had a resident fall. Writer entered room to find resident laying on her left side between the bed and the nightstand. Resident noted to have blood on her face. Writer assisted resident to partial sitting position. Large open laceration above left eyebrow, laceration to scalp, skin tear on left shoulder extending to left elbow.. Writer immediately applied pressure to lacerations and instructed another staff member to call 911. Resident remained alert and oriented was able to engage in conversation. Vitals obtained by paramedics in rout to hospital..." A review of an interview statement by the Administrator from CNA 2, dated 5/31/24 (no time documented) indicated the following: " Resident B was in her recliner with her feet up and the CNA was getting her ready for bed. CNA removed the resident's shirt and placed a gown on her. He indicated he used the stand lift, attached the sling			

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	and stood the resident up. He cleaned her bottom area and changed her brief. CNA then wheeled her over to the bed in the stand lift, sitting her on the bed at an angled position with her bottom on the bed and body leaning back after he removed the sling. CNA 2 quickly glanced behind him to move the lift back and that is when Resident B fell off the bed. He was confused and did not know if the resident grabbed the lift. CNA 2 indicated he did not have assistance with the lift and no other staff were in the room at the time of the fall. He indicated the resident's feet were still on the platform of the lift and she tubi grips on her feet. CNA indicated he assumed the resident grabbed the stand lift, but did not feel her grab it. CNA 2 indicated he knew the transfer status of the resident was on the care sheets and through CNA report." Review of Resident B's Emergency Room (ER) note dated 5/30/24 at 8:31 P.M., the ER physicians indicated Resident B presented the ER with complaints of a ground level fall. He indicated the resident sustained a large left supraorbital laceration of about 4 cm that was gaping and into the muscle layer which required 9 sutures to repair, a right frontotemporal hematoma, a right scalp laceration of about 9 cm which was repaired with unspecified number of staples, and a significant skin tear covering most of the deltoid region at the left shoulder. Review of Resident B's Emergency Room (ER) note, dated 5/30/24 at 8:31 P.M., indicated the ER physicians documented Resident B presented to the ER with complaints of a ground level fall. He indicated the resident sustained a large left supraorbital laceration of about 4 cm that was gaping and into the muscle layer which required 9 sutures to repair, a right frontotemporal			

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	hematoma, a right scalp laceration of about 9 cm which was repaired with unspecified number of staples, and a significant skin tear covering most of the deltoid region at the left shoulder. A radiology report for Resident B, dated 5/30/24 at 8:27 P.M., indicated a subdural hematoma with a thickness of 2 to 3 mm. An ER note dated 5/31/24 at 4:00 A.M., indicated, "Critical Care Attestation: Upon my evaluation, this patient had a high probability of imminent or life-threatening deterioration..." A Hospital Discharge Summary, dated 6/5/24 at 11:00 A.M., indicated the following: "hemoglobin was noted to be low likely related to acute subdural hematoma. Patient was evaluated by hospice, plan was for the patient to be discharged back to the facility where the hospice team will evaluate her and admit her over there" A physician's order dated 6/6/24, indicated to admit to local hospice for hospice diagnosis. A review of hospice Certification of Terminal Illness Statement, dated 6/5/24, indicated Resident B's Terminal Diagnosis was, "Traumatic subdural hemorrhage..." On 6/14/24 at 12:10 P.M., the Director of Nursing provided Resident B's Indiana State Department of Health Certificate of Death, dated 6/7/24. The certificate indicated the, "Immediate cause (Final Disease Or Condition Resulting in Death) A. Complications From a Fall Striking Her Head..." A review of the Validation Checklist with sit to stand to wheelchair using a stand up mechanical lift, was provided on 6/12/24 by the Director of Nursing indicating this was the current validation			

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education tool for mechanical lifts. The checklist indicated, "...Second assist flush to resident while instructing the resident to pull with their arms and straighten their legs if able...Operator to lift resident by pressing 'up' on controller. Unlock the wheels of the stand lift. Second assist to remain beside resident during standing..."

During an interview, on 6/11/23 at 11:05 A.M., the Administrator indicated CNA 2 transferred Resident B from her recliner to the bed using the stand up mechanical lift. The Administrator indicated the facility staff know they are to use 2 staff for all mechanical lift transfers.

During an interview on 6/11/24 at 11:45 A.M., CNA 2 indicated he transferred Resident B from her recliner to the bed using the mechanical stand lift. He indicated he did not ask for assistance and he transferred the resident alone. CNA 2 indicated the bed had to be raised a few inches to fit the legs of the stand lift under the bed and placed it at a slight angle. CNA 2 indicated he transferred the resident to the bed and had her sitting at an angle because it was easier to swing the resident's legs in the bed when higher up in the bed and at an angle. CNA 2 indicated he removed the sling, placed it over the lift and went to pull the lift back. CNA 2 indicated he glanced behind him to ensure the area was clear and pulled the stand up lift back away from the bed. He indicated the resident's feet were on the foot rest after she was placed in the bed and when he went to move the stand lift back, he indicated the resident must have grabbed the handle of the lift causing her to fall. He said he did not feel resistance as if she was holding on because the stand lift was heavy and required effort to move it.

On 6/12/24 at 9:30 A.M., the Director of Nursing

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GREENCROFT HEALTHCARE	1225 GREENCROFT DR GOSHEN, IN 46527

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided a policy titled, "Mechanical Lift Use Policy," dated 7/22/21, and indicated it was the current mechanical lift policy. The policy indicated, "...Mechanical lift transfers will be conducted by 2 team members at all times..." This citation relates to Complaints IN00436194 and IN00435888.			