PRINTED: 07/01/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039			
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155205		JILDING	ONSTRUCTION	(X3) DATE COMPI 06/13	LETED
	PROVIDER OR SUPPLIE		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, IN 46527			
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R 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
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 06/12/2025-06/13/2025 Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710 At this Emergency Preparedness survey, Greencroft HealthCare was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 231 certified beds. At the time of the survey, the census was 146.		E 00	000	This Plan of Correction is preand submitted as required by By submitting this Plan of Correction, Greencroft Gosh does not admit that the deficiencies listed on this repexist, nor does the Facility actor any statements, findings, conclusions that form the bathe alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies statements, and conclusions form the basis for the deficiencies	on is prepared uired by law. un of ft Goshen ue this report ucility admit dings, or the basis for es. The ight to d/or trative iencies,	
E 0039 SS=F Bldg	Based on record re failed to conduct explan at least twice punannounced staff procedures. The Lafollowing: (i) Participate in an is community-base a. When a community	view and interview, the facility sercises to test the emergency per year, including drills using the emergency TC facility must do the	E 00)39	E039 – EP Testing Requirent Facility conducted a community-based full-scale exercise on 6/26/25. Documentation of the exercisincluded as an attachment to Plan of Correction. The requirements of E039 has been reviewed by the campute Emergency Preparedness	se is o this ave	06/27/2025

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

b. If the LTC facility experiences an actual natural

TITLE (X6) DATE

other requirements of E039 are

Brian Cook Administrator 06/27/2025

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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		A. BUILDING B. WING	E CONSTRUCTION	COMPLETED 06/13/2025	
	PROVIDER OR SUPPLIER		1225	ET ADDRESS, CITY, STATE, ZIP COD 5 GREENCROFT DR 6HEN, IN 46527	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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 the emergency properties of the emergency properties of the acture (ii) Conduct an addinclude, but is not lie. A second full-scale community-based of functional exercise. b. A mock disaster c. A tabletop exercifacilitator that inclure a narrated, clinically and a set of problem messages, or preparchallenge an emerg (iii) Analyze the LT maintain documents exercises, and emer LTC facility's emeraccordance with 42. This deficient pract Findings include: Based on record reverties Maintenance and Machinistrator at 12 facility failed to programme and full-scale exercise when a conface sible, or an accessible, or an accessible, or an accemergency. Based of Healthcare Maintenance and Maintenance Maintenance Maintenance and Machinistrator at 12 facility failed to programme accessible, or an accessible, or an accessible, or an accessible, or an accessible and ministrators.	itional exercise that may imited to the following: ale exercise that is a ran individual, facility-based drill; or se or workshop that is led by a des a group discussion, using a relevant emergency scenario, a statements, directed red questions designed to ency plan. To facility's response to and action of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). The discrete discrete all occupants. The discrete discrete all occupants is designed to ency plan, as needed in compared to the discrete discrete all occupants.		being met. The Emergency Preparedness Committee has been educate the need for a full-scale exerc every 12 months as opposed every calendar year. Timing and dates of exercise are required under E039 will incorporated into the minutes the campus' Emergency Preparedness Meeting minut along with due dates for the r such exercise. The minutes of Emergency Preparedness Committee will be reviewed b facility's QAPI Committee as double-check to ensure compliance.	ed on cise to sthat be of es next of the oy the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205			JILDING	ONSTRUCTION	(X3) DATE COMPL 06/13/	ETED	
	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)	ATE	(X5) COMPLETION DATE
K 0000 Bldg. 01	calendar year to corprovided documents functional exercise of 2024; however, if more than 12 month. This finding was rethealthcare Mainten Systems Administrated and the Licensure Survey was Department of Healthcare Survey was Department of Healthcare Survey was Department of Healthcare Proceedings of 13/2025. Survey Dates: 06/12 Facility Number: 1002 At this Life Safety Chealthcare was four Requirements for Pamedicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) The facility consists of 2002 to 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The safety Code (Life Safety Code) The facility consists of 2002 the safety Code (Life Safety Code) The safety C	viewed with the Administrator, ance and Maintenance ator at the exit conference. Recertification and State as conducted by the Indiana th in accordance with 42 CFR Injunction with the Life Safety by Survey that exited on 2/2025-06/13/2025 2/2025-06/13/2025 Code survey, Greencroft and not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the cition Association (NFPA) 101, SC), Chapter 19, Existing	K 0	000	This Plan of Correction is prey and submitted as required by By submitting this Plan of Correction, Greencroft Goshe does not admit that the deficiencies listed on this report exist, nor does the Facility and to any statements, findings, or conclusions that form the base the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions to form the basis for the deficient	law. n ort mit r is for	

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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 06/13/2025	
	ROVIDER OR SUPPLIER		1225 G	ADDRESS, CITY, STATE, ZIP COD REENCROFT DR EN, IN 46527	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE	
	determined to be of	d the two-story 2015 addition Type II (111). The buildings Fire Wall with 2-Hour Fire			
	sprinklered, has a fi detection in the corr corridor, and batter rooms that are not c system but provides the nurses' station. I from independent li 2-Hour Fire Resistir	ginal building) is fully re alarm system with smoke ridors, areas open to the y smoke alarms in all resident connected to the fire alarm a visual and audible signal at This building is separated ving by a Fire Wall with we Rating. The facility has a had a census of 146 at the			
	access were sprinkle facility services were staff-only smoking building that was no				
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other	npleted on 06/18/25			
	interview, the facili documentation for to for the facility of battery-operated rooms in 2 of 15 sm in 4.6.12.3 states explained and tests. Fire-warmaintained and tests manufacturer's publication of the facility of the fac	on, record review and ty failed to ensure he preventative maintenance smoke alarms in 38 resident toke compartments. NFPA 101 isting life safety features c, if not required by the Code, NFPA 72, 29.10 Maintenance ning equipment shall be ed in accordance with the ished instructions and per the apter 14. NFPA 72, 14.2.1.1.1	K 0300	K300 – Protection—Other Facility tested all 38 battery-operated smoke alarm 6/20/25. Documentation of the tests is included in facility's Preventive Maintenance progr The 38 battery-operated smok alarms are the only fire-warnir equipment that was not compl with K300. Maintenance staff have been trained on the manufacturer's	ram. ke

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155205	B. Wl	ING		06/13/	2025
	ROVIDER OR SUPPLIER		•	1225 G	ADDRESS, CITY, STATE, ZIP COD REENCROFT DR EN, IN 46527		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI OF 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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		and maintenance programs			guidance that the battery-oper	ated	
		uirements of this Code and			some alarms should be tested		
	-	pment manufacturer's			weekly. Evidence of that train	•	
	published instructio				is included as an attachment t	0	
	_	ice could affect occupants in 2			this Plan of Correction.		
	of 15 smoke compa	rtments.			Maintenance staff will supply t		
	E. 1				Administrator with a copy of the		
	Findings include:				Preventive Maintenance recor showing the weekly testing of		
	Based on record review with the Healthcare Maintenance at 10:53 a.m. on 06/12/2025, documentation of battery-operated smoke detector testing was available for review; however, documentation provided indicated				battery-operated smoke alarm		
					every week for the next four w	eeks	
					and then monthly for the next	6	
					months unless and until the		
					battery-operated smoke alarm	S	
		ere last tested on 05/16/2025.			are no longer in use. Those		
		on with the Healthcare			records will then be given to the	ne	
	Maintenance 9:15 a				QAPI Committee for review.		
		oke detectors were located in					
		n the Gables and Knoll wings					
		manufacturer's label on the					
		oke detectors indicated they					
	were to be tested we	eekly.					
	This finding was re-	viewed with the Administrator,					
	_	ance and Maintenance					
	Systems Administra	ator at the exit conference.					
	3.1-19(b)						
K 0324	NFPA 101						
SS=E Bldg. 01	Cooking Facilities						
Diag. 01	Rased on observation	on and interview, the facility	K 0	224	K324 – Coking Facilities		06/27/2025
		approved method for	KU	324	Devices have been obtained a	nd	00/2//2023
	-	ppliances to where they were			installed that will ensure that the		
		ood extinguishing equipment			cooking appliances noted are	10	
		nstalled for 3 of 3 kitchen			returned to where they were w	hen	
	•	system. NFPA 96 Standard			the kitchen hood extinguishing		
		trol and Fire Protection of			equipment was designed and	1	
		ng Operations Section 2011			installed. Pictures of the device	ces	

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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 06/13/2025	
	PROVIDER OR SUPPLIEF		1225 (ADDRESS, CITY, STATE, ZIP CO GREENCROFT DR EN, IN 46527	DD
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION (X5) OULD BE PPROPRIATE COMPLETION DATE
TAG	Edition Section 12. requiring protection or rearranged without fire-extinguishing so or servicing agent, the design of the fir Section 12.1.2.3 The shall not require recappliances are move maintenance and clappliances are return location prior to condisconnected fire-exattached to the appliance with the manual. Section 12 shall be provided the appliance is returned location. This defick it chen staff only. Findings include: Based on observation Maintenance at 8:40 appliances including oven under one hood with 2 ovens and a a second hood was Based on observation Maintenance at 9:00 appliances including oven and flat-top glocated in the Vista cooking appliances approved method the appliances were retained in the plant of th	1.2.2* Cooking appliances a shall not be moved, modified, but prior re-evaluation of the ystem by the system installer unless otherwise allowed by the extinguishing system. The fire-extinguishing system evaluation where the cooking the fire-extinguishing system evaluation where the cooking the fire-extinguishing system evaluation where the cooking the fire-extinguishing system nozzles are reconnected in the manufacturer's listed design extinguishing system nozzles iances are reconnected in the manufacturer's listed design extinguishing system nozzles iances are reconnected in the manufacturer's listed design extinguishing system nozzles iances are reconnected in the manufacturer that the dot on approved design extent practice could affect the system of the manufacturer stove with an odd, and a gas 4-burner stove flat-top grill was located under located in the main kitchen. On with the Healthcare and a model of the wind on the work of the were provided with an interest of the system of the were provided with an interest of the system of the work o	TAG	is included as an attach this Plan of Correction. No other equipment wa be out of compliance w Maintenance and Culin have been educated or to return cooking applia where they were when hood extinguishing equipment designed and installed need to have positionin installed for any new compliances going forward Visual inspections will be the three cooking appliances effective. The inspection documented and given facility Administrator we four weeks and monthly another 3 months. That documentation will be set the QAPI Committee at meetings for the next 4	is found to ith K324. ary staff in the need inces to the kitchen ipment was and the ig devices poking rd. be made of ances to are in swill be ito the eekly for y for it shared with its

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155205	B. W	ING		06/13/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				REENCROFT DR		
GREENC	ROFT HEALTHCA	RE			EN, IN 46527		
(X4) ID	SUMMARY S	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)	ſΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	-	n 06/13/2025, he acknowledged					
	he had heard of the	-					
	_	acility did not have an					
	approved method to return the cooking appliances to the proper location. This finding was reviewed with the Administrator,						
Healthcare Maintenance and Maintenance							
	Systems Administra	ator at the exit conference.					
	3.1-19(b)						
K 0761	NFPA 101						
SS=F		pection & Testing - Doors					
Bldg. 01		200.0. d. 100g 200.0					
	Based on record rev	view and interview, the facility	K 0	761	K761 – Maintenance, Inspectio	on &	06/27/2025
		ual inspection and testing of		, 01	Testing – Doors		00/27/2025
		oor assemblies was were			Facility has conducted its annu	ıal	
		lance with LSC 19.1.1.4.1.1.			inspection and testing of its fire		
	Communicating ope	enings in dividing fire barriers			door assemblies. Documentat		
	required by 19.1.1.4	1.1 shall be permitted only in			of those inspections is include		
	corridors and shall b	pe protected by approved			an attachment to this Plan of		
	self-closing fire doo	or assemblies. LSC 8.3.3.1			Correction.		
	states openings requ	ired to have a fire protection			An audit was done to determin	e	
	rating by Table 8.3.4	4.2 shall be protected by			whether there were other fire of	loor	
	approved, listed, lab	peled fire door assemblies and			assemblies than the 20 noted.	The	
	fire window assemb	olies and their accompanying			additional doors were added to	the	
	hardware, including	all frames, closing devices,			Preventive Maintenance Progr	am.	
	anchorage, and sills	in accordance with the			Healthcare maintenance staff	were	
	requirements of NF	PA 80, Standard for Fire Doors			trained on fire door inspections	3.	
		Protectives, except as			Documentation of that training	is	
	otherwise specified	in this Code.			inlcuded as an attachment to t	his	
		es fire door assemblies shall be			Plan of Correction.	ļ	
	-	I not less than annually, and a			Maintenance staff will supply t		
		e inspection shall be signed			Administrator with a copy of th	е	
		ion by the AHJ. NFPA 80,			fire door assembly checks to		
		onal testing of fire door and			ensure compliance. Those che	cks	
		shall be performed by			will then be given to the QAPI		
		owledge and understanding of			Committee for review.		
	the operating compo	onents of the type of door					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155205	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COM	TE SURVEY TPLETED 13/2025
	PROVIDER OR SUPPLIER CROFT HEALTHCA		1225 0	ADDRESS, CITY, STATE, ZIP (GREENCROFT DR EN, IN 46527	COD	
(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 COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	being subject to test fire door assemblie from both sides to a door assembly. NFPA 80, 5.2.4.2 step following items shat (1) No open holes of either the door or for (2) Glazing, vision are intact and secur equipped. (3) The door, frame noncombustible through and in working order damage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and (6) The self-closing the active door comfrom the full open process before the active door when it is in the self-closing through a considerable for the active door when it is in the self-closing through a considerable for the active door when it is in the self-closing through the active door when it is in the self-closing through through through the self-closing through the self-closing thro	ting. NFPA 80, 5.2.4.1 states is shall be visually inspected assess the overall condition of tates as a minimum, the all be verified: or breaks exist in surfaces of tame. It is a state of the state of	TAG	DEFICIENCY	AFROTNITE	DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205			LDING	nstruction 01	(X3) DATE S COMPL 06/13/	ETED	
	ROVIDER OR SUPPLIER			1225 GF	DDRESS, CITY, STATE, ZIP COD REENCROFT DR N, IN 46527		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0921 SS=F Bldg. 01	assemblies were ins with the Healthcare 06/12/2025, he state doors by a number beach door was locat the Healthcare Main 06/13/2025, when a room door assembly they weren't." This finding was reveleathcare Mainten Systems Administration of the Mainten Systems Administration of the Mainten Systems Administration of the Maintenanc Based on record reveleathcare for Patient Care Rel (PCREE). NFPA 9010.5 states the physical leakage current, and and portable PCREI 10.3. Testing interveleathcare rooms is tested 10.3.6 before being repair or modification several electrical apcompliance with NF Service manuals, improvided by the maintain required by 10.5. development of a principle of the state of the maintain compliance with NF Service manuals, improvided by the maintain required by 10.5. development of a principle of the state of the	ot indicate if all the door pected. Based on interview Maintenance at 9:39 a.m. on did the documentation identified out could not identify where ed. Based on interview with itenance at 9:19 a.m. on sked if the oxygen storage was inspected, he stated "No viewed with the Administrator, ance and Maintenance iter at the exit conference. Testing and iew and interview, the facility required maintenance and documentation of inspections ated Electrical Equipment 9 2012 edition, sections 10.3 and ical integrity, resistance, touch current tests for fixed E is performed as required in als are established with als. All PCREE used in patient in accordance with 10.3.5.4 or put into service and after any on. Any system consisting of pliances demonstrates PA 99 as a complete system. Structions, and procedures infacturer include information 3.1.1 and are considered in the ogram for electrical equipment rical equipment instructions	K 09	21	K921 – Electrical Equipment – Testing and Maintenance Facility has completed PCREE testing, including the testing of physical integrity, resistance, leakage current, and touch current, on all equipment used patient care rooms. The form used for the PCREE testing is included as an attachment to the Plan of Correction. An inventory was taken of all patient-care related electrical equipment, including equipmentstorage and not currently in use All items included in the inventivate been PCREE tested. Maintenance, Admissions, Soc Services, and Central Supply shave been educated on PCREE.	f the I in this nt in se. tory cial staff	06/27/2025

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STATEMEN	T 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		06/13/	2025
	ROFT HEALTHCA		•	1225 GI	ADDRESS, CITY, STATE, ZIP COD REENCROFT DR EN, IN 46527		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S BLANGE 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 APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	and maintenance ma	anuals are readily available,			testing and the need to have		
	-	d condensed operating			patient-care related electrical		
		appliance are legible. A record			equipment tested before being	put	
		of electrical equipment tests, repairs, and modifications is maintained for a period of time to			into service and after any repa	ir or	
					modification.		
	_	lemonstrate compliance in accordance with the			Audits will be conducted to		
		acility's policy. Personnel responsible for the			determine if the equipment in		
	_	e and use of electrical			those rooms has been PCREE	-	
	appliances receive of	continuous training. ice could affect all occupants.			tested. These audits will be		
	inis delicient practi	ice could affect all occupants.			conducted on 10 resident roon weekly for 4 weeks and month		
	Findings include:				for 4 months. Results of the au	•	
					will be reviewed by the facility'		
	Based on record review with the Healthcare				QAPI Committee to ensure	3	
	Maintenance at 11:08 a.m. on 06/12/2025, the				compliance and to direct action	ns if	
		ovide documentation of testing			concerns are noted.		
		ated Electrical Equipment			0011001110 010 11010 01		
		the facility as required by					
	, ,	NFPA 99, Health Care Facilities					
	Code. Based on int	erview with the Healthcare					
	Maintenance at 11:0	08 a.m. on 06/12/2025, he stated					
	he was just informe	d about PCREE testing but has					
	not performed any I	PCREE testing.					
	_	viewed with the Administrator,					
		ance and Maintenance					
	Systems Administra	ator at the exit conference.					
	3.1-19(b)						
K 0000							
Bldg. 02							
Diag. 02	A Life Safety Code	Recertification and State	K 0	000	This Plan of Correction is prep	ared	
	_	as conducted by the Indiana	100	000	and submitted as required by I		
	-	th in accordance with 42 CFR			By submitting this Plan of	~···	
	483.90(a).				Correction, Greencroft Gosher	۱ ا	
					does not admit that the		
	This visit was in con	njunction with the Life Safety			deficiencies listed on this repo	rt	
		by Survey that exited on			exist, nor does the Facility adn		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155205	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE COMPL 06/13/	ETED
	ROFT HEALTHCA		1225 G	ADDRESS, CITY, STATE, ZIP COD BREENCROFT DR EN, 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 APPROPRIA	λΤΕ	(X5) COMPLETION
PREFIX TAG	REGULATORY OF 06/13/2025. Survey Dates: 06/12 Facility Number: 06 Provider Number: 10 2 At this Life Safety of Healthcare was four Requirements for Provider Medicare/Medicaid Life Safety from Fin National Fire Protectife Safety Code (In Health Care Occupation of Type V (111) and determined to be of are separated by a Franch Resistive Rating. Building #2 (the two sprinklered, has a find detection in the concorridor, and in all a capacity of 231 at time of this survey. All areas where the access were sprinklered facility services we only smoking shack that was not sprinklered.	2/2025-06/13/2025 2/2025-06/13/	PREFIX TAG	to any statements, findings, or conclusions that form the basi the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions to form the basis for the deficiencien.	r is for hat	DATE
			I	1		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155205	B. W	NG		06/13/	2025
					_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					REENCROFT DR		
GREENC	ROFT HEALTHCA	RE		GOSH	EN, IN 46527		
(X4) ID	SUMMARY S	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)	_	DATE
K 0761	NFPA 101						
SS=F	Maintenance, Insp	ection & Testing - Doors					
Bldg. 02							
Ŭ	Based on record rev	view and interview, the facility	K 0	761	K761 – Maintenance, Inspection	on &	06/27/2025
		ual inspection and testing of		701	Testing – Doors		00/27/2025
		oor assemblies was were			Facility has conducted its annu	ıal	
		lance with LSC 19.1.1.4.1.1.			inspection and testing of its fire		
	•	enings in dividing fire barriers			door assemblies. Documenta		
		1.1 shall be permitted only in			of those inspections is include		
		pe protected by approved			an attachment to this Plan of	_ 40	
		or assemblies. LSC 8.3.3.1			Correction.		
	•				An audit was done to determin	ie l	
	states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by				whether there were other fire of		
	approved, listed, labeled fire door assemblies and				assemblies than the 20 noted.		
	fire window assemblies and their accompanying				additional doors were added to		
		all frames, closing devices,			Preventive Maintenance Progr		
	_	in accordance with the			Healthcare maintenance staff		
	_	PA 80, Standard for Fire Doors			trained on fire door inspections		
	-	Protectives, except as			Documentation of that training		
	otherwise specified	-			inlouded as an attachment to t		
	_	es fire door assemblies shall be			Plan of Correction.	1110	
		I not less than annually, and a			Maintenance staff will supply t	he	
	-	e inspection shall be signed			Administrator with a copy of th		
		ion by the AHJ. NFPA 80,			fire door assembly checks to		
		onal testing of fire door and			ensure compliance. Those che	erks	
		shall be performed by			will then be given to the QAPI	,one	
		owledge and understanding of			Committee for review.		
		onents of the type of door			Committee for review.		
		ing. NFPA 80, 5.2.4.1 states					
		s shall be visually inspected					
		ssess the overall condition of					
	door assembly.	55 - 55 411- 5 (5141) 					
	-	rates as a minimum, the					
	following items sha						
	_	r breaks exist in surfaces of					
	either the door or fra						
		light frames, and glazing beads					
		ely fastened in place, if so					
	equipped.	in place, it so					
		, hinges, hardware, and					
	(3) The door, frame	, minges, maruware, amu					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155205		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/13/2025	
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 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		P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	BE COMPLETION		
TAG	SUMMARY STATEMENT OF DEFICIENCIE			TAG	DEFICIENCY)		DATE	

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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. WING				06/13/2025		
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			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	· ·			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG				TAG			DATE	
	3.1-19(b)							
K 0920	NFPA 101							
SS=E		ent - Power Cords and						
Bldg. 02	Extens							
	Based on observation and interview, the facility		K 0	920	K920 – Electrical Equipment –		06/27/2025	
	_	ver strips with appropriate UL			Power Cords and Extens			
	-	n 1 of 16 resident rooms in the			The power strips, extension co	•		
	Cove wing and 1 of 16 resident rooms in the				and relocatable power taps no			
	Haven wing. Power strips used for PCREE are				during the survey were remov	ed.		
	required to meet UL 1363A or UL 60601-1. Power				An audit was completed to			
	strips for non-PCREE in the patient care rooms (outside of vicinity) are required to meet UL 1363.				determine if there were any of			
		ice could affect residents in 2			power strips, extension cords,			
	resident rooms.	ice could affect residents in 2			and/or relocatable power taps patient care vicinities. Those t			
	resident rooms.				were found were removed.	ııaı		
	Based on observation with the Healthcare				Maintenance, Admissions, and	4		
	Maintenance at 1:46 p.m. on 06/12/2025, a				Social Services staff, Unit	•		
	relocatable power tap with an UL listing of				Managers and Unit Secretarie	s		
	E192912 was located in resident room 606 on the Cove wing. The relocatable power tap was				were trained on the need to ke			
					patient care vicinities free of p	ower		
	plugged directly into a wall receptacle and				strips, extension cords, and			
		a chair, lamp, and telephone.			relocatable power taps.			
	-	ver tap was located on the			Documentation of that training			
		ident's chair. The Healthcare			included as an attachment to	his		
		red the relocatable power tap			Plan of Correction.			
		Vation. Based on interview			Facility staff will complete and			
		Maintenance at 1:46 p.m. on nowledged the relocatable			document a visual inspection resident rooms to determine	DI IU		
		UL 1363, 1363A or 60601-1.			whether the room remains free	- ∩f		
	For the mas not a				power strips, extension cords,			
	This finding was rev	viewed with the Administrator,			relocatable power taps. This a			
	_	ance and Maintenance			will be completed once/week f			
	Systems Administra	ator at the exit conference.			four weeks and then monthly			
					three months. The audits will be			
3.1-19(b)					reviewed by the facility's QAP	I		
				Committee for the next four				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155205	A. BUILDING <u>02</u> B. WING		02	06/13/2025			
133203									
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD				
GREENCROFT HEALTHCARE				1225 GREENCROFT DR GOSHEN, IN 46527					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	-	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE		
					months.				
K 0921	NFPA 101								
SS=F	Electrical Equipme	ent - Testing and							
Bldg. 02	Maintenanc								
		view and interview, the facility	K 0	K 0921 K921 – Electrical Equipment		-	06/27/2025		
		e required maintenance and			Testing and Maintenance				
	•	locumentation of inspections			Facility has completed PCREE				
		ated Electrical Equipment			testing, including the testing of the				
		9 2012 edition, sections 10.3 and ical integrity, resistance,			physical integrity, resistance,				
		I touch current tests for fixed			leakage current, and touch	lin			
		E is performed as required in			current, on all equipment used patient care rooms. The form				
	_	als are established with			used for the PCREE testing is				
	-	ols. All PCREE used in patient			included as an attachment to				
		in accordance with 10.3.5.4 or			Plan of Correction.				
		put into service and after any			An inventory was taken of all				
	_	on. Any system consisting of			patient-care related electrical				
	several electrical ap	pliances demonstrates			equipment, including equipme	nt in			
	compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures				storage and not currently in us	se.			
					All items included in the inven	tory			
	provided by the manufacturer include information				have been PCREE tested.				
		3.1.1 and are considered in the			Maintenance, Admissions, So				
		ogram for electrical equipment			Services, and Central Supply				
		rical equipment instructions			have been educated on PCRE	E			
		anuals are readily available,			testing and the need to have				
	-	d condensed operating			patient-care related electrical	4			
		appliance are legible. A record lent tests, repairs, and			equipment tested before being				
		intained for a period of time to			into service and after any repairmodification.	iii Oi			
		ance in accordance with the			Audits will be conducted to				
	-	rsonnel responsible for the			determine if the equipment in				
		e and use of electrical			those rooms has been PCREE	<u> </u>			
	appliances receive c				tested. These audits will be				
		ice could affect all occupants.			conducted on 10 resident rooms				
	·	-			weekly for 4 weeks and month	nly			
	Findings include:				for 4 months. Results of the a	•			
					will be reviewed by the facility's				
	Based on record review with the Healthcare				QAPI Committee to ensure				

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

PRINTED: 07/01/2025 FORM APPROVED OMB NO. 0938-039

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 06/13/2025			
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Maintenance at 11:08 a.m. on 06/12/2025, the facility failed to provide documentation of testing of Patient Care Related Electrical Equipment (PCREE) in use in the facility as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Based on interview with the Healthcare Maintenance at 11:08 a.m. on 06/12/2025, he stated he was just informed about PCREE testing but has not performed any PCREE testing. This finding was reviewed with the Administrator, Healthcare Maintenance and Maintenance Systems Administrator at the exit conference.				compliance and to direct actio concerns are noted.	ns if		

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