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	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00442353 and IN00443554.. Complaint IN00442353 - Federal/State deficiencies related to the allegations are cited at F804. Complaint IN00443554 - Federal/State deficiencies related to the allegations are cited at F580. Survey dates: September 16, 17, 19, & 20, 2024. Facility number: 000112 Provider number: 155205 AIM number: 100288710 Census Bed Type: SNF/NF: 155 Total: 155 Census Payor Type: Medicare: 25 Medicaid: 85 Other: 45 Total: 155 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 9/26/2024	F 0000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Greencroft Goshen does not admit that the deficiencies listed on this report exist, nor does the Facility admit to any statements, findings, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions that form the basis for the deficiencies. Greencroft Goshen respectfully requests a desk review.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to ensure a resident's responsible party was notified in a timely manner after a fall for 1 of 3 residents reviewed for falls, (Resident C).	F 0580	F580 **The facility was found to be out of compliance by failing to ensure a resident's responsible**	10/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna Jones	VP System Coordination/HFA	10/10/2024

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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	Finding includes: During an interview on 9/17/24 at 2:40 P.M., Resident C's Responsible Party indicated she heard from an unnamed Certified Nursing Assistant (CNA) that Resident C had fallen over a recent weekend. Resident C's responsible party indicated the facility had not notified her of the fall. During an interview, on 9/20/24 at 9:00 A.M., the Director of Nursing indicated Resident C had a fall on 8/23/24 without injuries. The Director of Nursing indicated the physician was notified at the time, but the family was not notified though they should have been notified. The Director of Nursing indicated the Nurse called the family on 9/19/24 to apologize for the oversite. A record review for Resident C was completed on 9/20/24 at 9:42 A.M. Diagnoses included, but were not limited to: repeated falls, congestive heart failure, restlessness and agitation, chronic obstructive pulmonary disease, hypertension, restless leg syndrome and macular degeneration. Resident C's Admission Fall Risk assessment, dated 4/29/24, indicated the resident was at high risk for falls having had three or more falls in the past three months. A facility Incident form, dated 8/23/24 at 12:15 A.M., indicated the CNA had went to check on Resident C and found the resident on the floor in front of her recliner. There were no injuries observed and no pain or discomfort was voiced from the resident. The Incident form indicated the physician was notified on 8/23/24 at 12:20 A.M. There was no documentation regarding		**party was notified in a timely manner for a fall for 1 of 3 residents.** **The resident's responsibility party has been notified.** **An audit was completed of falls for the past 30 days. Any residents identified as being affected were addressed. All responsible parties were notified.** **Nursing staff were educated to notified responsible parties of resident falls.** **An audit will be conducted by the DON/designed of responsible party notification of falls 3x/ for 4 weeks, 2x week for 4 weeks, weekly for 4 weeks, until substantial compliance. Results will be reviewed in QAA and reported in QAPI.**	

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	notification of Resident C's family. A policy titled "Notification of Changes," dated 1/23/24 was provided by the Director of Nursing on 9/19/24 at 1:03 P.M., indicating it was the current policy. The policy indicated, "...The purpose of the policy is to ensure the campus promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification...The campus must inform the...resident's family member or legal representative..." This Federal tag relates to complaint IN00443554. 3.1-5(a)(1)(3)			
F 0804 SS=F Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on interviews and record review, the facility failed to ensure hot food temperatures were assessed and logged consistently in the main kitchen to ensure food was served at palatable temperatures. This deficient practice had the potential to affect 155 of 155 residents in nursing care who were served from the main kitchen. Finding includes: During an interview, on 9/16/24 at 12:28 P.M., the Dietary Team Lead staff member indicated food was prepared in the main kitchen and then delivered to the unit servery kitchens, where it was held in steam tables. She indicated she had heard some concerns the food was not always as warm as it should be when served. She indicated hot foods should be held and served at at least	F 0804	F804 The facility was found to be out of compliance by failing to ensure hot food temps were assessed and logged consistently in the main kitchen to ensure food was served at palatable temperatures. **Dietary staff were immediately educated on food temps.** **All residents have the potential to be affected** **Dietary staff were educated on food temps.** **An audit will be conducted by the Dietary Manager/designee 3x/week for 4 weeks, 2x week for 4 weeks, weekly for 4 weeks until substantial compliance. Results will be**	10/25/2024

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	140 degrees Fahrenheit. During an interview, on 9/17/24 at 10:20 A.M., Resident B indicated he/she had been served cold food many times. Resident B indicated when food that was supposed to be served hot was served cold, he/she lost their appetite. Residen Bt indicated he/she had refused to eat cold food and planned to throw their tray across the dining room if food was ever served cold to them again. During a Resident Council meeting, conducted on 9/17/24 at 10:45 A.M., 3 of 12 alert and oriented residents indicated the hot food on the Knolls and Vista units was sometimes served cold. During an interview on 9/20/24 at 10:37 A.M., the Interim Dietary Manager indicated all hot and cold foods should be checked for adequate temperatures as indicated in the facility policy. The Interim Dietary Manager indicated the kitchen had not been consistently documenting food temperatures in the kitchen before serving food to the nursing units. The Kitchen Food Temp Log sheets were reviewed for 8/11/24 to 9/15/25 and indicated no recorded food temperatures were logged for the following days: 8/11,12,13,14, 16, 17, 18, 21, 22, 23, 25, 26, 27, 28, 29, 2024 and 9/1, 2, 4, 5, 6, 11, 2024. On 9/19/24 at 1:03 P.M., the Executive Director provided a policy titled, Record of Food Temp Policy, dated 3/1/22 indicating it was the current facility policy. The policy indicated, "...It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving		**reviewed in QAA and reported in QAPI.**	

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	temperature(s) before trays are assembled...Hot foods will be held at 135 degrees Fahrenheit or greater...cold food temperatures will be kept at or below 41 degrees Fahrenheit...Measure and record the temperatures for each food product and milk at all meals. Record temperature on temperature log..." This citation relates to Complaint IN00442353. 3.1-21(a)(2)			