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notified in a timely manner after a fall for 1 of 3 of compliance by failing to				F 0580	F580		10/25/2024	
notified in a timely manner after a fall for 1 of 3 of compliance by failing to		failed to ensure a resident's responsible party was			The facility was found to be out			
	I		manner after a fall for 1 of 3		-			
			-		<u> </u>			

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

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WPZL11 Facility ID: 000112 If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED		
		155205	B. WING				/20/2024	
				OTREET	ADDRESS CITY STATE ZID OCT			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
GREENCROFT HEALTHCARE					REENCROFT DR			
GREEN				GOSH	EN, IN 46527			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					party was notified in a time	ly		
	Finding includes:				manner for a fall for 1 of 3			
					residents.			
	_	v on 9/17/24 at 2:40 P.M.,			The resident's responsibili	ty		
	_	nsible Party indicated she			party has been notified.			
		med Certified Nursing			An audit was completed of	falls		
	` /	at Resident C had fallen over a			for the past 30 days. Any			
		esident C's responsible party			residents identified as being	•		
		y had not notified her of the			affected were addressed. A	AII .		
	fall.				responsible parties were			
	During an interview, on 9/20/24 at 9:00 A.M., the				notified.	al 4 a		
	_	y, on 9/20/24 at 9:00 A.M., the gindicated Resident C had a fall			Nursing staff were educate			
	_				notified responsible parties	S OT		
		injuries. The Director of			resident falls.	h		
	Nursing indicated the physician was notified at				An audit will be conducted	ру		
	the time, but the family was not notified though				the DON/designed of responsible party notificati	on of		
	they should have been notified. The Director of Nursing indicated the Nurse called the family on				falls 3x/ for 4 weeks, 2x we			
	9/19/24 to apologiz	_			for 4 weeks, weekly for 4	er.		
	7/17/21 to upologiz	e for the oversite.			weeks, until substantial			
	A record review for	Resident C was completed on			compliance. Results will be	<u>.</u>		
		M. Diagnoses included, but were			reviewed in QAA and repor			
		eated falls, congestive heart			in QAPI.			
	_	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								

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCT		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER					COMPLETED	
155205		B. WI	NG		09/20/	2024		
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 1225 GREENCROFT DR GOSHEN, 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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0804 SS=F Bldg. 00	1/23/24 was provide on 9/19/24 at 1:03 F current policy. The purpose of the policy promptly informs the resident's physician, his or her authority, when there is a charcampus must inform or legal representation. This Federal tag relations are supposed to the suppose of the policy promptly informs or legal representation. This Federal tag relations are supposed to the suppose of the suppose of the policy promptly information and interviews failed to ensure hot assessed and logged kitchen to ensure for temperatures. This potential to affect 1 care who were served Finding includes: During an interview Dietary Team Lead was prepared in the delivered to the unit was held in steam to heard some concern warm as it should be	iffication of Changes," dated ed by the Director of Nursing P.M., indicating it was the policy indicated, "The ey is to ensure the campus he resident, consults the and notifies, consistent with the resident's representative has requiring notificationThe in theresident's family member	F 08	304	F804 The facility was found to be out compliance by failing to ensure hot food temps were assessed and logged consistently in the main kitchen to ensure food with served at palatable temperature Dietary staff were immediate educated on food temps. All residents have the potent to be affected Dietary staff were educated of food temps. An audit will be conducted by the Dietary Manager/designed 3x/week for 4 weeks, 2x week for 4 weeks, weekly for 4 weeks until substantial compliance. Results will be	e d as res. ly ial on	10/25/2024	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WPZL11 Facility ID: 000112

If continuation sheet Page 3 of 5

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		PLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
155205		B. W	ING		09/20/	2024		
		<u> </u>	1	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					REENCROFT DR			
GREENCROFT HEALTHCARE					N, IN 46527			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		SHOULD BE COMPLETION EAPPROPRIATE		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE	
	140 degrees Fahren	heit.			reviewed in QAA and reporte	ed		
	During an interview	y, on 9/17/24 at 10:20 A.M.,			in QAPI.			
	_	d he/she had been served cold						
		Resident B indicated when food						
	I -	o be served hot was served						
		ir appetite. Residen Bt						
		d refused to eat cold food and						
		neir tray across the dining						
	_	ver served cold to them again.						
		Č						
	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						
	_	nager indicated all hot and cold						
	foods should be che	_						
		icated in the facility policy.						
	The Interim	reaced in the facility poney.						
	Dietary Manager in	dicated the kitchen had not						
	been consistently do	ocumenting food temperatures						
	in the kitchen befor	e serving food to the nursing						
	units.							
	T IZ'. 1 T 17	г т 1 <i>г</i>						
	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							
		2 indicating it was the current						
	1	policy indicated, "It is the						
policy of this facility to record food temperatures								
	daily to ensure food	is at the proper serving						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WPZL11 Facility ID: 000112

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

PRINTED: 10/17/2024 FORM APPROVED OMB NO. 0938-039

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 09/20/2024	
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	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)				DATE
	temperature(s) before trays are assembledHot foods will be held at 135 degrees Fahrenheit or greatercold food temperatures will be kept at or below 41 degrees FahrenheitMeasure 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)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WPZL11 Facility ID: 000112 If continuation sheet Page 5 of 5