STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greencroft Healthcare	1225 Greencroft Dr Goshen, IN 46527

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to provide wound care as directed by the physician for 1 of 3 residents reviewed for wounds.(Resident D).Finding includes:The clinical record for Resident D was reviewed on 8/6/25 at 2:14 P.M. Diagnoses included, but were not limited to, peripheral neuropathy, type 2 diabetes, anxiety, chronic kidney disease, and history of stroke.Resident D's physician's orders included an current order for weekly skin checks. The order was dated 3/4/25 to begin on 3/11/25 and had no stop date. The order indicated the facility was to complete a head to toe assessment of the resident's skin and to re-evaluate and update any existing skin concerns every week on Monday evenings.A Skin Evaluation Record dated 4/9/25 at 2:22 P.M., indicated Resident D had a partial thickness skin tear to the right buttock, described as a scrape measuring 0.2 cm wide x 0.2 cm long x 0.1 cm depth. The wound was treated with zinc oxide.Review on Resident D's Treatment Administration Record indicated Resident D's order for a re-evaluation of the skin concern was signed off, but there were no associated re-evaluations documented on 4/21/25, 4/28/25, 5/5/25, 5/19/25 or 5/26/25.Resident B's Skin Evaluations, from 6/2/25 to 7/7/25, indicated there had been no change in the resident's wound size or condition, with the wound measuring on 7/7/25 at 9:50 P.M.- 0.1 cm wide x 0.1 cm long x 0.1 cm deep. The form indicated the wound continued to be treated with zinc oxide.Review of Resident B's Progress Note dated 7/10/25 at 4:15 P.M., indicated Resident B had requested a skin assessment of his right buttock and the nurse had examined the area per his request. The note indicated the Nurse Practitioner was notified of the wound condition and new orders had been received to begin Nystatin and Triamcinolone (topical creams to treat fungal and yeast infections) topically 2 times daily for 7 days. There was no documentation that a skin assessment had been completed on 7/10/25.A Skin Evaluation Record, dated 7/14/25, indicated a partial thickness skin tear to the right buttock that was described as dark pink and measured - 7.8 cm wide x 5.3 cm long x no depth.A new order had been received on 7/17/25 to extend the treatment of Nystatin and Triamcinolone topically 2 times daily for an additional 7 days.On 8/11/25 at 8:30 A.M., during an interview with the Assistant Director of Nursing, she confirmed there had been a lack of documentation regarding Resident D's Weekly Skin Check re-evaluations related to the wound to the right buttock and that the resident's wounds should have been assessed and documented as ordered.On 8/11/25 at 9:40 A.M., the Administrator provided a copy of the facility policy titled, Skin Assessment, dated 8/19/24, and deemed it to be the current facility policy. The policy indicated, .[A] skin assessment will be conducted by a licensed or registered nurse upon admission and weekly thereafter.Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations [e.g. skin conditions, how the resident tolerated the procedure, etc.]. c. Document type of wound. d. Describe the wound[measurements, color type of tissue in wound bed, drainage, odor, pain]. e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate.On 8/11/25 at 9:40 A.M., the Administrator provided a copy of the facility policy titled, Wound Documentation, dated 2/26/24, and indicated it was the current policy used by the facility. The policy indicated that wound assessments were to be documented upon weekly and as needed if the resident or wound condition deteriorated.This Citation relates to Complaint 2571559.3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for medication administration was free from significant medication errors. (Resident B) This deficient practice resulted in the resident experiencing nausea and vomiting and requiring the administration of an additional medication to treat the adverse side effect of the medication errors.Finding Includes:Resident B's clinical record was reviewed on 8/7/25 at 9:11 A.M., diagnoses included but were not limited to a history of stroke with hemiplegia, heart disease, constipation, gastroenteritis, colitis.Resident B was admitted to the facility for respite care from home and under hospice care on 6/3/25. Hospice Physician's orders dated 6/3/25, on admission, included but were not limited to; Morphine concentrate 100 mg/5mL (20 mg/mL), 0.25 mL, orally for shortness of breath or severe pain every 4 hours as needed, Lomotil 2.5 mg- 0.025 mg, 1 tablet orally, every 8 hours as needed for diarrhea, Tums 200 mg chewable tablet, 2 tablets orally, (no time frame given), as needed for gastroenteritis. On 6/4/25 hospice added an order for Zofran 4 mg, 1 tablet every 6 hours as needed for nausea and vomiting.Review of Resident B's Medication Administration Record, dated 6/3/25, indicated the resident was to receive; Morphine concentrate 10 mg/0.5 mL, 0.25 mL, orally for shortness of breath or severe pain every 4 hours at 6:00 P.M., 8:00 P.M., 6:00 A.M., 10:00 A.M., and at 2:00 P.M., Lomotil 2.5 mg- 0.025 mg, 1 tablet orally, every 8 hours for diarrhea, at 2:00 P.M., 10:00 P.M., and at 6:00 A.M., Tums 200 mg chewable tablet, 2 tablets orally every night at bedtime for gastroenteritis. Resident B's Medication Administration Record indicated the resident received the following; Morphine on 6/3/25 at 6:00 P.M. and 10:00 P.M., and on 6/4/25 at 2:00 A.M. and 6:00 A.M., Lomotil on 6/3/25 at 10:00 P.M. and on 6/4/25 at 6:00 A.M., Tums on 6/3/25 at 8:00 P.M., Zofran on 6/4/25 at 2:39 P.M., and on 6/5/25 at 5:29 A.M.The resident's Medication Administration Record on 6/3/25 and 6/4/25 indicated the resident was not experiencing any shortness of breath, pain, or diarrhea. There was no complaint of gastroenteritis documented on 6/3/25.Resident B's Review Assessment/Pain Interview, dated 6/3/25 at 8:56 P.M., indicated the resident was able to express herself to other and able to understand others, in the past 5 days, the resident had not experienced any pain or shortness of breath, and diarrhea was not listed as a current problem or condition.The resident's Interdisciplinary Notes included but were not limited to the following: 6/4/25 at 7:11 A.M., a physician's note indicated the resident took morphine for shortness of breath and pain and was not experiencing any diarrhea. 6/4/25 at 3:54 P.M., .Resident nauseous and vomiting this afternoon. 6/4/25 at 3:30 P.M., Medications clarified with [hospice]. Zofran 4 mg every 6 hours as needed for nausea and vomiting. 6/4/25 at 8:53 P.M., Resident alert, verbal and oriented.Had 2 episodes of vomiting this shift. PRN Zofran given. No complaint of pain. On 8/8/25 at 12:58 P.M. during an interview, the Admissions Coordinator, indicated when Resident B was admitted for respite care, the facility received medication orders from the resident's hospice service and then sent the facility physician who would check and sign the orders and then sent to the unit where the admitting nurse entered the orders in the Electronic Medical system. During an interview on 8/8/25 at 1:05 P.M., the Assistant Director of Nursing indicated Registered Nurse 4 was Resident B's the admitting nurse and entered the resident's orders in the computer incorrectly. She indicated Morphine, Lomotil, and Tums were incorrectly entered into the system as routine medications when they had been ordered as needed.On 8/8/25 at 2:29 A.M., during an interview the hospice nurse indicated, on 6/4/25 at an unknown time, she received a report from the facility that the resident was having nausea and vomiting and that the nurse had withheld her morphine. The hospice nurse indicated she went to the facility at that time and noted Resident B's Morphine, Lomotil, and Tums had been entered in the system to be administered as routine rather than PRN as ordered. The hospice nurse indicated on arrival, the resident was nauseated, so ordered Zofran in response, and then notified the resident's responsible party of the medication error.A policy titled Medication Error Policy, dated 4/19, was provided by the Administrator on 8/11/25 at 8:40 A.M., and deemed as current. The policy indicated, .'Medication error' means the observed or identified.administration of medications.not in accordance with: the prescriber's order.The facility shall ensure medications will be administered as follows: a. According to the physician's orders.This citation relates to Complaint 1699537.3.1-48(c)(2)