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	12/23/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to provide showers timely for a dependent resident for 1 of 4 residents who were reviewed for showers. (Resident D)During an interview on 12/16/2025 at 2:40 P.M., Resident D could not recall the last time he had had a shower. Resident D's record review was completed on 12/18/2025 at 2:45 P.M. Diagnoses included, but were not limited to: displaced fracture of cervical vertebra, Lewy Bodies dementia, Parkinson's disease and right foot drop. An admission Minimum Data Set (MDS) assessment, dated 9/19/2025, indicated Resident D had intact cognition and was dependent on staff for showering. Resident D's record lacked the documentation that he had been given a shower on 11/17, 11/20, 11/27, 12/1 and 12/15/2025 as scheduled. There was no documentation to indicate the resident had been showered on different dates or he had refused a shower on his scheduled dates. A current Care Plan, initiated on 9/16/2025, indicated Resident B had self-care deficit related to bathing. An intervention, initiated 9/16/2025, indicated staff was to help the resident with activities of daily living. During an interview on 12/18/2025 at 3:30 P.M., the Director of Nursing (DON) indicated there was not any more shower sheets or documentation indicating Resident D had received two showers a week. The DON indicated all residents should have been offered two showers or bed baths per week and if the resident refused, the refusal should have been documented in the resident's record. On 12/18/2025 at 3:330 P.M., the DON provided a policy, dated 11/15/2025 and titled, Activities of Daily Living. The DON identified the policy as the one currently used by the facility. The policy indicated, .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care This citation relates to Intake 2643464.3.1-38(a)(3)

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	Based on record review and interview, the facility failed to follow the plan of care for a resident with a history of falls. This deficient practice resulted in a resident falling and sustaining multiple injuries, including bilateral (affecting both sides) small acute subarachnoid hemorrhage along the temporal lobes, a small acute intraventricular hemorrhage in occipital horns, a 0.7 centimeter subdural hematoma and an acute right occipital bone fracture extending into the forearm magnum. (Resident B) Finding includes:Resident B's record review was completed on 12/17/2025 at 11:30 A.M. Diagnoses included, but were not limited to: right side fracture of the base of skull, dementia, traumatic subarachnoid hemorrhage, conversion disorder with seizures or convulsions, senile degeneration of brain, depression, generalized anxiety disorder and obstructive and reflux uropathy. An Annual Minimum Data Set (MDS) assessment, dated 9/11/2025, indicated Resident B had minimal difficulty hearing, had clear speech, had been able to make himself understood and been able to understand others and had adequate vision without glasses. In addition, Resident B had moderate cognitive impairment, had not had any behaviors towards himself, staff or other residents and had not wandered or rejected any care, required moderate assistance of one staff member to move from the seated to standing position, utilized a walker to ambulate and required the assistance of one staff member for supervision or touch assistance while ambulating. A Fall Risk Evaluation, dated 10/3/2025, indicated Resident B required an assistance device while walking (walker) and was a high risk for fall. A current Care Plan, initiated on 8/15/2025, indicated Resident B had a high risk of falls. The interventions included on the plan were staff was to keep walker within reach of resident (initiated on 10/16/2025) and staff were to apply non-skid socks at bedtime (initiated on 10/16/2025).An Incident note, dated 10/10/2025 at 3:55 P.M., indicated Resident B had been found on the bathroom floor in his room. Resident B had not been using his walker at the time of the fall. The care plan for Resident B was not updated after the 10/10/2025 fall with any new preventative interventions until 10/16/2025. An Incident Note, dated 10/16/2025 at 1:48 A.M., indicated Resident B had been found sitting on the floor of his room, near the door. The resident had not been using his walker and had been wearing regular socks and not non skid socks. Resident B's record lacked the documentation he had refused to wear non skid socks. There were no new care plan interventions implemented related to the 10/10 and 10/16/2025 falls.An Incident Note, dated 11/14/2025, indicated Resident B was in the dining room and had gotten up without assistance and without his walker when he fell and hit his head and immediately started to have a seizure. The resident's family declined to have the resident sent to the Emergency Department (ED) to be evaluated. A Nursing Note, dated 11/19/2025 2:42 P. M., indicated staff had called Resident B's POA and requested the resident be sent to the ED for an evaluation from the fall on 11/14/2025 due to increased falls. The note indicated the resident had a witnessed fall on 11/18/2025 and an unwitnessed fall on 11/19/2025, both without injury. Resident B's POA was agreeable to transfer the resident to the ED. A Radiology Report from a local ED, dated 11/19/2025 at 5:52 P.M., indicated Resident B's Computed Tomography (CT) scan had identified a bilateral small acute subarachnoid hemorrhage along the temporal lobes, a small acute intraventricular hemorrhage in occipital horns, a 0.7 centimeter subdural hematoma and an acute right occipital bone fracture extending into the forearm magnum. During an interview on 12/17/2025 at 2:30 P.M., the Assistant Director of Nursing (ADON) indicated she had been the staff member responsible for reviewing falls. The ADON indicated the IDT staff reviewed all falls and after each fall, the Care Plan should have been updated with a new intervention. The ADON indicated Resident B's Care Plan already had an intervention to keep his walker within reach at the time of the fall on 11/14/2025, but staff believed it might have been a tripping hazard for other residents and moved the walker across the room, against the wall, out of Resident B's reach. The ADON indicated she believed the intervention to keep the walker within reach had not applied to the dining room and had only applied to the resident's room. No information had been provided to establish if the intervention should not have been utilized in the dining room or other common areas of the facility before the end of the survey on 12/18/2025 at 4:10 P.M. During an interview on 12/18/2025 at 1:40 P.M., the ADON indicated she had not been aware Resident B's Care Plan regarding fall risk had not been updated with any new intervention or why the IDT had not reviewed the fall from 10/10/2025. The ADON indicated if a resident refused an intervention, the refusal should have been documented in the Electronic Medical Record. During an interview on 12/18/2025 at 1:45 P.M., the Director of Nursing (DON) indicated the facility did not have a policy for following the Care Plan interventions On 12/18/2025 at 3:00 P.M. the ADON provided a policy, dated