STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155783	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenleaf Health Campus	1201 E Beardsley Ave Elkhart, IN 46514

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to assessments completed after a change in condition for 1 of 3 residents reviewed for change of condition. (Resident E) Finding includes:The record for Resident E was reviewed on 6/30/26 at 11:35 a.m. Diagnoses included, but were not limited to, anemia (low iron), diabetes, dementia, heart failure, anxiety, delirium, and dysphagia (difficulty swallowing) The 4/17/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making, required partial to moderate assistance for eating, and required substantial to maximum assistance for oral hygiene, personal hygiene, and upper body dressing. For all other Activities of Daily Living (ADLs) Resident E was dependent on staff for care. A Nursing Progress Note, dated 6/26/26 at 8:56 a.m., indicated the resident was in bed prior to breakfast and morning medication was attempted to be given. The resident had pocketed the pills, and they were removed from her mouth. The aides had set the resident up in the common area and tried to feed her breakfast while the nurse had crushed her medication. The medication was successfully given with yogurt and water. The staff had called the daughter and had face-timed her and the daughter was unable to get the resident to speak or smile. The daughter requested her mother be put back to bed indicating that maybe she was just tired and needed to sleep. Around 12:00 p.m., crushed medication was attempted to be give and the resident was not able to swallow. The Nurse Practitioner and texted and an order was received to send the Resident out for evaluation. The daughter was called and arrived shortly after the notification and requested the resident be sent out via 911. The record lacked vitals and an assessment at start of change of condition during breakfast.A Nursing Progress Note, dated 6/26/26 at 12:25 p.m., indicated the resident's vitals had been obtained and were as followed: 101/68, heart rate 70, temperature 97.9, and blood sugar was 169. The resident was diaphoretic (sweating profusely) at the time of the assessment.During an interview on 6/30/26 at 1:23 p.m., CNA1 indicated she had gotten the resident up out bed at about 9:30 a.m., on 6/26/2026, because the resident ate with assistance from the restorative aides. She indicated the resident slept a lot and was assisted out of bed around the same time every day. When she had been gotten up that morning, Resident E kept opening her mouth and had acted differently. She thought it was odd and had informed the nurse. CNA 1 indicated she had attempted to feed the resident a little bit of her cream of wheat with little success. She indicated they had called the resident's daughter and Resident E had been assisted back to bed after her daughter requested she be put back to bed. When the nurse had checked on her again later, she appeared worse and that was when the facility had her sent out (to the emergency room). During an interview on 6/30/26 at 2:14 p.m., RN1 indicated she was waiting for Resident E's daughter to arrive because she had assisted her with feeding her her breakfast and giving her her medications. She had had trouble giving her medication in the past. She indicated the resident was not known to her and she had only cared for her four times previously. RN 1 indicated the aides had gotten the resident up and had taken her to the dining room. RN 1 indicated she had started feeding the resident her food and had given her two capsules of medication and the resident was unable to swallow them. RN 1 indicated this had occurred around 9:30 a.m. As the aides had attempted to feed (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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident E cream of wheat, she noticed several staff surrounding the resident. The staff had indicated the resident was not swallowing her food. RN 1 indicated she had attempted to feed Resident E yogurt and that had been successful. RN 1 indicated the Employee Experience Manager (EXM) had called the resident's daughter and had face-timed with her. RN 1 indicated she had been mad about that because she was the nurse she should have been the staff member that called the resident's daughter. RN 1 indicated she could have had her sent out then, but the daughter told the EXM to lay her mother back down and that her mother was just sleepy and sometimes she just needed a sleep day. RN 1 indicated the resident had had more medications due at noon, and when she had checked on her, she was unresponsive and her vital signs were lower than when she had taken them at breakfast. RN 1 indicated Resident E's vital signs at breakfast were unremarkable. RN 1 indicated she had then called the Nurse Practitioner and had received an order to send the resident out for an evaluation. The resident's daughter was notified of the order and had agreed to send Resident E out to the hospital. The transporter (of the nonemergent ambulance service that had been initially contacted to transport Resident E) had indicated there was a 20-30-minute transfer wait time. As time went on, the resident became more clammy, with wet skin, and could nott close her mouth. The family was at the bedside and requested the resent be sent out via 911. During an interview on 6/30/36 at 3:13 p.m., the Employee Experience Manager (EXM/CNA) indicated she had called Resident E's daughter because the resident was off and she had wanted to get her daughter on the phone because the resident had not responded very well her (EXM). During an interview on 7/1/26 at 11:01 a.m., the Executive Director indicated she understood the vitals/assessment should have been documented by the nurse at the time of the change of condition. This citation relates to Intake 3062903.410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(2)