

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>015205</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/27/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN OAKS OF GOSHEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>282 JOHNSTON STREET GOSHEN, IN 46528</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00447923, IN00447082, IN00446764, IN00446756, IN00446759 and IN00446553.</p> <p>Complaint IN00447923 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00447082 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00446764 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00446756 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00446759 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00446553- No deficiencies related to the allegations are cited.</p> <p>Survey date: November 26 &amp; 27, 2024</p> <p>Facility number: 015205</p> <p>Residential Census: 107</p> <p>Green Oaks of Goshen was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00447923, IN00447082, IN00446764, IN00446756, IN00446759 and IN00446553.</p> <p>Quality Review completed on 12/02/2024</p>	R 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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