STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREEN OAKS OF GOSHEN	282 JOHNSTON STREET GOSHEN, IN 46528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
R 0000 Bldg. 00	This visit was for an Initial State Residential Licensure Survey. Survey dates: January 17, 2024 Facility number: 015205 Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/22/24.	R 0000	Please accept this Plan of Correction for Green Oaks of Goshen Initial Survey with a Date Certain of 2/17/24.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian Cook	Executive Director	02/02/2024

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	(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure 2 of 6 employees received orientation to the facility and their department prior to working independently. (Employees 6 and 7) Findings include: 1. During a review of employee personnel files, completed on 1/17/2024 at 3:00 P.M., the following was noted: There was no general and job specific orientation documentation for Employee 7, a Qualified Medication Aide (QMA) with a start dated of 12/26/2023. During an interview with the Business Office Manager (BOM) on 1/17/2024 at 3:40 P.M., she confirmed a few employees had not received general orientation prior to starting to work. The BOM indicated Employee 7's actual first work date was January 5, 2024.2. A record review, completed on 1/17/2024 at 3:30 P.M. for Employee 6, indicated he did not attend a general orientation or begin dementia training upon hire.	R 0119	The General Orientation for Employee #6 and #7 will be completed on or before February 17, 2024. An audit of all employee files will be completed by the Business Office Manager. The employee files found to be out of compliance during the audit will have General Orientation completed and Dementia Training started on or before February 17, 2024. Inservice on General Orientation and Dementia Training timing completion will be conducted by the Regional Director of Operations and/or designee with the Business Office Manager and the Executive Director on or before February 17, 2024. The Business Office Manager will conduct an audit of employee files weekly for 4 weeks and monthly for 3 months. Variances will be corrected at the time of observation and reported to the community's Quality Assurance	02/17/2024

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	During an interview on 1/17/2024 at 3:40 P.M., the Business Office Manager indicated Employee 6 started employment without attending a general orientation or beginning dementia training per protocol. On 1/17/2024 at 3:52 P.M., the Business Office Manager, provided a policy titled, "General Orientation," dated 4/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...All new Employees will receive general orientation within their first 30 days of employment. Employees will be paid at their regular rate of pay for time spent in orientation...." On 1/17/2024 at 3:53 P.M., the Business Office Manager indicated that they did not have a policy for dementia training they just follow the state rule.		program. The Executive Director is responsible for the compliance of this regulation. Compliance by February 17, 2024	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not			

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	had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on record review and interview, the facility failed to ensure health screen documentation was completed for 1 of 6 employee files reviewed. (Employee 7) Finding includes: During a review of personnel files on 1/17/2024 at 3:00 P.M. the following was noted: The personnel file for Employee 7, a Qualified Medication Aide with a start date of 12/26/2023, did not contain any documentation a health screen had been completed prior to the employee working independently. During an interview, on 1/17/2024 at 3:45 P.M.	R 0121	The Health Screen for Employee #7 will be completed on or before February 17, 2024. An audit of all employee files will be completed by the Business Office Manager. The employee files found to be out of compliance during the audit will have a health screen and TB completed on or before February 17, 2024. Inservice on Health Screening and TBs for employees will be completed by the Regional Director of Operations and/or Designee with the Business Office Manager and the Executive Director on or before February 17,	02/17/2024

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	with the Business Office Manager, she confirmed there was no documentation a health screen was completed for Employee 7. The employee's first work date in the facility was 1/5/2024. A policy and procedure, dated effective 4/2021, and titled, "Health Screening" provided by the Business Office Manager on 1/17/2024 at 4:05 P.M. included the following: "Policy: Upon employment and annually thereafter, all employees shall participate in the community's tuberculosis screening program...Responsibility: A. It is the responsibility of the Nursing Supervisor or designee to administer or collect proof of TB skin testing for each new employee within 90 days prior to employment or 7 days after employment..."		2024. The Business Office Manager will conduct an audit of employee files weekly for 4 weeks and monthly for 3 months. Variances will be corrected at the time of observation and reported to the community's Quality Assurance program. The Executive Director is responsible for the compliance of this regulation.	
R 0153 Bldg. 00	410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen. Based on record review, observation, and interview, the facility failed to provide safety precautions for a resident with oxygen in use for 1 of 5 residents reviewed for medical services. (Resident 6) Finding includes: A record review was completed on 1/17/2024 at 10:53 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, generalized anxiety disorder, and acute and chronic respiratory failure with hypoxia.	R 0153	Oxygen signage placed on the outside door of resident #6 apartment on January 18, 2024. All residents with oxygen have potential to be affected by alleged deficient practice. No other residents were found without adequate signage. Director of Nursing inserviced nursing staff on Oxygen policy, including proper safety signage for oxygen on February 1, 2024. Director of Nursing and/or designee will audit new	02/17/2024

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	During an interview on 1/17/2024 at 1:34 P.M., Resident 6 indicated she used oxygen, and was observed to have a nasal cannula attached to an oxygen concentrator. One large oxygen cylinder and two portable oxygen cylinders were observed in the main area of the apartment. Upon leaving Resident 6's apartment, no signage was observed to indicate oxygen was in use. During an interview, on 1/17/2024 at 2:25 P.M., QMA 4 indicated some of the residents have oxygen tags on their doors, and other residents do not have oxygen tags. She indicated she did not know where to find the tags. On 1/17/2024 at 2:26 P.M., LPN 2 indicated a magnet was usually placed outside a room to indicate oxygen use. A policy was provided on 1/17/2024 at 2:40 P.M. by the Executive Director. The policy, titled, "Oxygen Use & Storage Policy and Procedures", did not address the use of signage for oxygen, but did have an attachment of, "Sign: Oxygen in Use".		admissions with oxygen within 24 hours of admission to ensure proper oxygen in use signage is posted on outside of resident apartment. QA committee will review audits x 6 months and make recommendations as necessary. The Executive Director is responsible for the compliance of this regulation. Compliance by February 17, 2024	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to			

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	self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure an admission weight was completed for 1 out of 5 resident records reviewed for evaluations. (Resident 5) Finding includes: A record review was completed for Resident 5 on 1/17/2024 at 1:30 P.M. Diagnoses included, but were not limited to: chronic kidney disease, type 2 diabetes, hypertensive heart failure, and hyperlipidemia. During an interview on 1/17/2024 at 1:42 P.M., the Regional Director of Clinical Services indicated Resident 5 did not have an admission weight recorded and should have. On 1/17/2024 at 1:58 P.M., the Regional Director of Clinical Services provided a policy titled, "Service Plan," dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated "... 3. The resident's weight taken on admission and semiannually thereafter...."	R 0216	Weight was obtained on Resident #5 on January 6, 2024 and documented in EMR. All residents have potential to be affected by alleged deficient practice. No other residents were found with missing weight. Director of Nursing inserviced nursing staff on Service Plan policy on February 1, 2024. Director of Nursing and/or designee will audit new admissions vitals including weights within 24 hours of admission to ensure weights are entered into EMR. QA committee will review audits x 6 months and make recommendations as necessary. The Executive Director is responsible for the compliance of this regulation. Compliance by February 17, 2024	02/17/2024
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to provide sanitary food service from the kitchen, which had the potential to affect 29 of 29 residents observed for food services. (Main Kitchen)	R 0273	Cook noted in 2567 was trained on the community's policy on General Food Handling, including the proper use of gloves, on January 19, 2024.	02/17/2024

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	Finding includes: The service of the afternoon meal was observed on 1/17/2024 from 11:42 A.M. through 12:03 P.M. The meal included hot dog coney island, tator tots, coleslaw, and a substitution of hamburgers. Cook 8 was observed to wear gloves to serve the meal. With her gloved hands, she opened the oven with a temperature food probe in one hand and a hot pad in the other, and again repeated this process. With the same gloved hands, Cook 8 picked up a plate, opened the hamburger buns, removed a bun, and made a hamburger sandwich that was served. Cook 8 using the same gloved hands picked up a plate, removed a hot bun, and hand scooped tator tots on the plate. Cook 8 then hand scooped tator tots into a bowl. Cook 8 was observed rearranging meal tickets with her gloved hands and then rearranging the tator tots in the steam table. Cook 8 then was observed getting tator tots from an under the counter holding freezer, and placing them in the fryer. Cook 8 changed her left gloved hand, and then emptied the cooked tator tots from the fryer into the steam table. Cook 8 then continued to serve, touching the hot dog buns and tator tots. During an interview on 1/17/2024 at 2:16 P.M., the Certified Dietary Manager (CDM) indicated gloves should be changed after touching other objects when serving food. She indicated she observed Cook 8 touch other objects and touch the buns.		All residents have potential to be affected by alleged deficient practice. No other staff were noted to be utilizing gloves inappropriately. Culinary Service Director inserviced culinary staff on proper glove usage on February 2, 2024. Culinary Service Director will observe 4 staff members/week to ensure proper glove usage and counsel staff using gloves inappropriately. QAPI will review audits x 6 months and make recommendations as necessary. The Executive Director is responsible for the compliance of this regulation. Compliance by February 17, 2024	

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	A policy was provided on 1/17/2024 at 2:35 P.M. The policy titled, "General Food Preparation Policy and Procedure", indicated, " ...If gloves are used to handle ready-to-eat food, they shall be single-use gloves, i.e., shall be used for only one task (preparing/handling ready-to-eat food), shall be used for no other purpose and shall be discarded when damaged or soiled or when interruptions occur in operations ...."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review, observation, and interview, the facility failed to have emergency records available for 1 of 5 residents reviewed for Emergency Information Files. (Resident 6) Finding includes:	R 0356	Emergency record for Resident # 6 placed in Emergency Binder. Resident #6 not affected by alleged deficient practice. All residents have potential to be affected by alleged deficient practice. All current residents have	02/17/2024

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	A record review was completed on 1/17/2024 at 10:53 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, generalized anxiety disorder, and acute and chronic respiratory failure with hypoxia. Resident 6 admitted to the facility on 1/13/2024. On 1/17/2024 at 11:09 A.M., the Emergency Information File was provided by LPN 2 in the nursing office. Resident 6 was not observed to be in the file. LPN 2 indicated she was not aware that every resident needed to be placed in the Emergency Information File. During an interview, on 1/17/2024 at 1:17 P.M., the Regional Clinical Service Director indicated the Emergency Information File was not as thorough as the file located at the front desk, but the file should have a good amount of the residents in the file. During an observation on 1/17/2024 at 1:31 P.M., the Emergency Information File was located at the front desk. Resident 6 was not located in the Emergency Information File. A policy was requested for the Emergency Information File on 1/17/2023 at 2:30 P.M. On 1/17/2024 at 3:55 P.M., the Executive Director indicated the facility did not have a policy for Emergency Information Files. He indicated they follow the state regulation.		emergency profile information in the Emergency binder. Nursing staff and receptionist inserviced on Emergency records for all residents, including new admissions on February 1, 2024 by Regional Director of Nursing. The Director of Nursing and/or Executive Director will audit Emergency Binders weekly x 1 month, then monthly x 5 months. QAPI committee to review audits x 6 months and make recommendations as needed. The Executive Director is responsible for the compliance of this regulation.	
R 0378 Bldg. 00	410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) Mental Health Screening- Deficiency (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but			

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	not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual.			
	Based on record review and interview, the facility failed to ensure a mental health screening, including obtaining a two year treatment history, was obtained for 1 of 5 sampled residents. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 1/17/2023 at 10:45 A.M. Resident 2 was admitted to the facility on 1/3/2024 with diagnoses including, but not limited to: major depressive disorder, recurrent. During a review of a list of Medicaid recipients, Resident 2 was noted to have a payor source of medicaid.	R 0378	Two-year treatment history was added to current record of Resident #2 on January 17, 2024. Resident #2 had no adverse effects from alleged deficiency. Residents that have major mental illness have potential to be affected by alleged deficient practice. No residents identified to have been affected. Nursing staff inservice on need to obtain two-year treatment history on all residents with major mental illness on February 1, 2024 by Regional Director of Clinical Services. Director of Nursing will audit resident record with major mental	02/17/2024

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	There was a pre-admission assessment completed for Resident 2 in September 2023 and again in December 2023, but there was no documentation a two year history of mental health treatments was obtained and reviewed prior to the resident's admission to the facility. During an interview with LPN 2 on 1/17/2024 at 1:17 P.M., she indicated she had been instructed to contact Resident 2's mental health provider to request the 2 year mental health history. LPN 2 indicated it appeared the request for release of records had been sent to the mental health provider previously, but the records had never been obtained. During an interview with the Regional Nurse Consultant, on 1/17/2024 at 3:00 P.M., she indicated there was no specific policy and procedure addressing the need for mental health treatment records, services and/or care plan development.		health illness 24 hours after admission to ensure two-year treatment history is included in record. QAPI will review audits x 6 months and make recommendations. The Executive Director is responsible for the compliance of this regulation. Compliance by February 17, 2024.	
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREEN OAKS OF GOSHEN	282 JOHNSTON STREET GOSHEN, IN 46528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
	arrangements. Based on record review and interview, the facility failed to ensure a comprehensive care plan addressing the resident's major mental health diagnosis and needs was developed for 1 of 5 sampled residents. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 1/17/2023 at 10:45 A.M. Resident 2 was admitted to the facility on 1/3/2024 with diagnoses, including but not limited to: major depressive disorder, recurrent. During a review of a list of Medicaid recipients, Resident 2 was noted to have a payor source of medicaid. There was a pre-admission assessment, completed for Resident 2 in September 2023 and again in December 2023, but there was no documentation a two year history of mental health treatments was obtained and reviewed prior to the resident's admission to the facility. The admission "RSP" (Residential Service Plan) for Resident 2 addressed the resident's need for support due to an intellectual disability but there was no care plan to address the resident's major depressive disorder, recurrent diagnosis. During an interview with LPN 2, on 1/17/2024 at 1:17 P.M., she indicated the resident was seen by a local mental health provider. During an interview with the Regional Nurse Consultant, on 1/17/2024 at 3:00 P.M., she confirmed the service plans for Resident 2 did not address his mental health diagnosis. In addition,	R 0383	Resident Service Plan was added to current record of Resident #2 on January 17, 2024. Resident #2 had no adverse effects from alleged deficiency. Residents that have major mental illness have potential to be affected by alleged deficient practice. No residents identified to have been affected. Nursing staff inservice on need to enter a Resident Service Plan on all residents with major mental illness on February 1, 2024 by Regional Director of Clinical Services. Director of Nursing will audit resident records with major mental health illness 24 hours after admission to ensure Resident Service Plan is included in record. QAPI will review audits x 6 months and make recommendations. The Executive Director is responsible for the compliance of this regulation.	02/17/2024

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	she indicated there was no specific policy and procedure addressing the need for mental health services and care plans.			