

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>05/20/2024</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 IN00433381, IN00433141, IN00433161 and IN00432375.</p> <p>Complaint IN00433381 - No deficiencies related to the allegation are cited.</p> <p>Complaint IN00433141 - No deficiencies related to the allegation are cited.</p> <p>Complaint IN00433161 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00432375 - No deficiencies related to the allegations are cited.</p> <p>Survey date: 5/20/24</p> <p>Facility number: 015205</p> <p>Residential Census: 69</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 IN00433381, IN00433141, IN00433161 and IN00432375.</p> <p>Quality Review completed on 5/21/2024</p>	R 000		

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