

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 04/16/2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526			
(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 3/2/2024. This visit was in conjunction with the Investigation of Complaints IN00431785, IN00430217, IN00431720 and IN00429892. Complaint IN00431785 - No deficiencies related to the allegations are cited. Complaint IN00430217- No deficiencies related to the allegations are cited. Complaint IN00431720- No deficiencies related to the allegations are cited. Complaint IN00429892- No deficiencies related to the allegation are cited Survey dates: April 15 and 16, 2024 Facility number: 000091 Provider number: 155689 AIM number: 100290080 Census Bed Type: SNF/NF: 122 Total: 122 Census Payor Type: Medicare: 5 Medicaid: 71 Other: 46 Total: 122 Majestic Care of Goshen was found to be in			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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{F 000}	Continued From page 1 compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey. Quality Review Completed on 4/17/2024	{F 000}			