05/16/2024

	T OF HEALTH AND HI R MEDICARE & MEDI						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689		JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/26/2024	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL 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
Bldg	conducted by the accordance with 4 Survey Date: 03/2 Facility Number: Provider Number: AIM Number: 10 At this Emergency Care of Goshen w Emergency Prepart Medicare and Medicare and Medicare and Medicare and Suppliers, 42 The facility has 18 the survey, the cere	26/24  000091 155689 0290080  y Preparedness survey, Majestic as found in compliance with redness Requirements for dicaid Participating Providers CFR 483.73  86 certified beds. At the time of	E 00	000	The creation and submission this plan of correction does constitute an admission by the provider of any conclusion structure for the statement of deficiencies, or of any violate of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu a traditional revisit.	not :his set ion	
Bldg. 01	Licensure Survey	le Recertification and State was conducted by the Indiana alth in accordance with 42 CFR	K 0	000	The creation and submission this plan of correction does constitute an admission by the state of the constitute and the constitute and the constitute and the constitute and the constitute of the constitute and the constitute of the constitute o	not	

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

At this Life Safety Code survey, Majestic Care of Goshen was found not in compliance with

483.90(a).

Survey Dates: 03/26/24

Facility Number: 000091

Provider Number: 155689

AIM Number: 100290080

provider of any conclusion set forth in the statement of

deficiencies, or of any violation of regulation. Due to the low

request a desk review in lieu of

scope and severity of these

findings we respectfully

TITLE

a traditional revisit.

Caley Nixon **Executive Director** 05/14/2024

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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(X6) DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		 JILDING	nstruction 01	(X3) DATE COMPL 03/26/	ETED	
	ROVIDER OR SUPPLIER		2400 C	NDDRESS, CITY, STATE, ZIP COD OLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0161 SS=E Bldg. 01	Life Safety from Fir National Fire Protect Life Safety Code (L. This one story facility Type V (111) construction open to the corridor provided with single detectors. The build two 200 kW natural generators. The fachad a census of 120 All areas where resist were sprinklered. Ton the roof that was detached storage she Quality Review con NFPA 101 Building Construct Building Construct 2012 EXISTING Building construction Table 19.1.6.1, un 19.1.6.2 through 1 19.1.6.4, 19.1.6.5	42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101, SC) and 410 IAC 16.2.  Ty was determined to be of ruction and was fully illity has a fire alarm system in the corridors and in areas s. The resident rooms are estation, hard wired smoke ling is partially protected by gas powered emergency illity has a capacity of 186 and at the time of this survey.  The facility had a storage shed sprinklered, and two eds that were not sprinklered.  Type and Height ion Type and Height on type and stories meets less otherwise permitted by 9.1.6.7				
	2 II (111)	One story				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155689	B. W	NG		03/26	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN			EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	non-sprinklered	Maximum 2 atomics					
	sprinklered	Maximum 3 stories					
	Sprinklered						
	3 II (000)	Not allowed					
	non-sprinklered	riot allowed					
	4 ' III (211)	Maximum 2 stories					
	sprinklered \ '						
	5 IV (2HH)						
	6 V (111)						
	7 III (200)	Not allowed					
	non-sprinklered						
	8 V (000)	Maximum 1 story					
	sprinklered						
	l •	s must be sprinklered					
		approved, supervised					
	1	in accordance with section					
	9.7. (See 19.3.5)						
		iption, in REMARKS, of the					
		number of stories, including					
		on which patients are of smoke or fire barriers and					
	·	Complete sketch or attach					
		the building as appropriate.					
	•	on and interview, the facility	K 0	161	K161 – Building Construction	n	04/26/2024
		ne building type of V(111) by			Type and Height		0 1,20,202 1
		enetrations in 1 of 1 one-hour			It is the practice of this facility	to	
		assemblies were maintained to			ensure through penetrations in		
	ensure the fire resis	tance of the two-hour barrier.			1 one-hour fire ceiling barrier		
	LSC 8.3.5.1 require	es penetrations for cables, cable			assemblies were maintained t	О	
		es, tubes, combustion vents			ensure the fire resistance of the	ne	
		wires, and similar items to			two-hour barrier.		
		rical, mechanical, plumbing,					
		s systems that pass through a			What corrective action(s) wil	I	
		ceiling assembly constructed			be accomplished for those		
		ll be protected by a firestop			residents found to have been	n	
	1 -	he firestop system or device			affected by the deficient		
		cordance with ASTM E 814,			practice:		
1	L Standard Test Meth	od for Fire Tests of Through			1 The two inch uncealed		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155689	B. W	NG		03/26/2024
				CTREET	ADDRESS SITU STATE ZID SOD	
NAME OF F	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD	
NAA IEGE	10 04 DE 0E 0001	IENI			OLLEGE AVE	
MAJEST	IC CARE OF GOSI	TEN		GUSHI	EN, IN 46526	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	Penetration Fire Sto	ops, or ANSI/UL 1479,			penetration around wires in th	е
	Standard for Fire T	ests of Through-Penetration			one-hour ceiling fire barrier in	
	Fire Stops. This de	ficient practice affects 30			Cedar electrical room had foal	m
	residents in one sm	oke compartment.			cleaned out and replaced with	fire
					caulk.	
	Findings include:					
					How other residents having	the
	Based on observation	ons Maintenance Director on			potential to be affected by th	e
	03/26/24 at 11: 30 a	a.m. in the Cedar electrical room			same deficient practice will be	ре
	there was an unseal	led two-inch penetration			identified and what correctiv	e
	around wires in the	one-hour ceiling fire barrier.			action(s) will be taken:	
		at the time of observation, the			All residents on Cedar wing ha	ave
	Maintenance Direc	tor agreed the ceiling fire			the potential to be affected by	this
	barrier was not mai	ntained as a one-hour barrier			deficient practice. The	
	due to the unsealed	hole through ceiling fire			Maintenance Director/Designe	e e
	barrier.				will be responsible for complet	ting
					QAPI audit tool "Life Safety	
	_	viewed with the Maintenance			Rounds" 3x/week for the first	
		lministrator at the exit			month, 2x/week for the second	
	conference.				month, and weekly for at least	: 6
					months.	
	3.1-19(b)					
					What measures will be put in	ito
					place or what systemic	
					changes will be made to	
					ensure that the deficient	
					practice does not recur:	
					The Environmental team will be	e
					in-serviced on or before	115-
					4/17/2024. This in-service wil	De
					conducted by the Executive	
					Director or Designee and will include a review of fire barriers	a and
					penetrations. The Maintenand	Je
					Director/Designee will be	עט
					responsible for completing QA	
					audit tool "Life Safety Rounds"	
					3x/week for the first month,	
					2x/week for the second month	
I	I		I		and weekly for at least 6 mont	ns.

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>0</u> 1	COMP	E SURVEY LETED 6/2024
	ROVIDER OR SUPPLIEF		2400 C	ADDRESS, CITY, STATE, ZIP C COLLEGE AVE EN, IN 46526	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
				How the corrective ac will be monitored to e deficient practice will recur, i.e., what qualit assurance program winto place: Ongoing compliance will be though the facility Quale Assurance and Perform Improvement Program Maintenance Director/I will be responsible for QAPI audit tool "Life Schounds" 3x/week for the month, and weekly for months. If 100% compont achieved an action developed. Findings with submitted to the Qualit Assurance and Perform Improvement Committed and follow-up.  By what date the systichanges will be completed: 04/26/2024 Compliance Date =	nsure the not y iill be put iith this e monitored lity mance. The Designee completing afety he first e second at least 6 oliance is plan will be yill be y mance he for review emic	
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unles special locking and	d means of egress shall not a latch or a lock that if a tool or key from the s using one of the following rangements: S OR SECURITY THREAT				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED  B. WING 03/26/2024			ETED		
	F PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	clinical security no used, only one look permitted on each be made for the raby: remote controlocks or keys carrother such reliable staff at all times.  18.2.2.2.5.1, 18.2.  19.2.2.2.6  SPECIAL NEEDS ARRANGEMENT Where special looks afety needs of the Clinical or Secare being met. In electrical locks the release upon loss building is protect automatic sprinkle space is protected detection system at an attended lookspace); and both systems are arrarupon activation.  18.2.2.2.5.2, 19.2.  DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, supdetection system automatic sprinkles 18.2.2.2.4, 19.2.2.	king arrangements for the e patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised er system and the locked d by a complete smoke (or is constantly monitored cation within the locked the sprinkler and detection aged to unlock the doors  2.2.5.2, TIA 12-4 SS LOCKING S lelayed-egress locking in accordance with permitted on door ag low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155689	B. W	ING	_	03/26/2024
NAME OF B	DROWIDED OF CUIDNITE			STREET .	ADDRESS, CITY, STATE, ZIP COD	
	PROVIDER OR SUPPLIER				OLLEGE AVE	
MAJEST	IC CARE OF GOSH	HEN		GOSH	EN, IN 46526	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEPOLENCY)	DATE
	LOCKING ARRAN					
		Egress Door assemblies				
	be permitted.	lance with 7.2.1.6.2 shall				
	18.2.2.2.4, 19.2.2.	2.4				
	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS					
		t access door locking in				
	I	7.2.1.6.3 shall be permitted				
		es in buildings protected				
		approved, supervised				
automatic fire detection system and an						
	approved, supervised automatic sprinkler					
	system.	·				
	18.2.2.2.4, 19.2.2.	.2.4				
	Based on observation	on and interview, the facility	K 0	222	K222 – Egress Doors	04/17/2024
	failed to ensure the	means of egress through 2 of			It is the practice of this facility	to
	12 delayed egress lo	ocks was readily accessible for			ensure all delayed egress lock	king
		and visitors. LSC 7.2.1.6.1.(3)			arrangements are installed an	d
		visible, durable sign in letters			functioning properly.	
		25mm) high and not less than				
		stroke width on a contrasting			What corrective action(s) wil	II
	_	ds as follows shall be located			be accomplished for those	
		acent to the release device in			residents found to have been	n
	_	ess: "PUSH UNTIL ALARM			affected by the deficient	
		CAN BE OPENED IN 15			practice:	
		deficient practice could affect 60			1 B wing exit doors have be	en
	residents on D and	C wings.			supplied with the appropriate	
	Findings include:				signage to indicate the doors	Can
	rmanigs include:				be opened in 15 seconds by pushing on the doors	
	Rased on observation	ons with the Maintenance			2 Garden Room exit doors h	12/0
		nistrator on 03/26/24 between			been supplied with the approp	
		p.m., the exit doors located on			signage to indicate the doors	
		den Room were provided with			be opened in 15 seconds by	oui!
	_	s but lacked the proper			pushing on the doors	
		he doors can be opened in 15			pasining of the doors	
		on the doors. Based on			How other residents having	the
		e of observation, the			potential to be affected by th	
		for agreed the doors were			same deficient practice will l	l l

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	OF CORRECTION	DENTIFICATION NUMBER  155689  A. BUILDING  01  B. WING			COMPLETED 03/26/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	equipped with a delaproper signage.  This finding was rev	ayed egresses and lacked the viewed with the Maintenance ministrator during the exit		identified and what corrective action(s) will be taken: All residents on D and C wing have the potential to be affect by this deficient practice. The Maintenance Director/Designwill be responsible for comple QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on before 4/17/2023. This in-ser will be conducted by the Maintenance Director or Desi and will include a review of equivalent doors and proper signage. The Maintenance Director/Designwill be responsible for comple QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place:	d t 6  or vice gnee gress ihe ee ting d t 6  the			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMP	E SURVEY LETED 5/2024
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COLLEGE AVE EN, IN 46526	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extinaccordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door.  Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.		though the facility Qu Assurance and Perfo Improvement Prograr Maintenance Director will be responsible fo QAPI audit tool "Life: Rounds" 3x/week for month, 2x/week for th month, and weekly fo months. If 100% con not achieved an actio developed. Findings submitted to the Qual Assurance and Perfo Improvement Commit and follow-up. By what date the sys changes will be completed: 04/17/20 Compliance Date = 0	rmance m. The r/Designee r completing Safety the first ne second or at least 6 npliance is on plan will be will be lity rmance ttee for review stemic	

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Event ID:

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Facility ID: 000091

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155689	B. W	NG	<del>_</del>	03/26/	/2024
				_			
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
NAA 1505	10 04 DE 05 0001	IEN!			OLLEGE AVE		
MAJEST	IC CARE OF GOSI	HEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	,						
	Area Automatic Sprinkler Separation N/A						
	•	-Fired Heater Rooms					
		er than 100 square feet)					
	, -	nance, and Paint Shops					
	-	ooms (exceeding 64					
	gallons)						
	e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)						
		classified as Severe					
	Hazard - see K32						
		vation and interview, the	K 0	321	K321- Hazardous Areas		04/26/2024
		sure 2 of 10 hazardous rooms	K o	It is the practice of this facility to		to	04/20/2024
	-	fired equipment were			ensure all hazardous rooms th		
		er spaces by smoke resistant			contain fuel fired equipment a		
	_	ficient practice could affect 40			separated from other spaces b		
	residents in two sm	-			some resistant partitions.	<i>,</i> ,	
	residents in two sin	one comparaments.			Some resistant partitions.		
	Findings include:				What corrective action(s) wil	ı	
	i mamga meraac.				be accomplished for those	•	
	Based on observation	ons with the Maintenance			residents found to have been	1	
		nistrator on 03/26/24 between			affected by the deficient	•	
		p.m., in the laundry room			practice:		
		nd in the boiler room both			1 Laundry room behind the		
	ceilings contained l				dryers and in the boiler room h	noles	
		inch to 5 inches in size. Based			in ceiling foam removed and	10100	
	_	he time of the observation, the			replaced with drywall and muc	ł	
		tor agreed there were unsealed			2 Room used for storage on		
		two rooms which contained			wing has been cleaned out an		
	fuel fired equipmer				hinges replaced with automati		
	1.001 Inou equipmen				closing devices.	-	
					How other residents having t	the	
	2) Based on observ	vation and interview, the			potential to be affected by th		
		sure 1 of 1 rooms greater than			same deficient practice will be		
		being used for storage of large			identified and what correctiv		
	30 square reet and	ochig used for storage of farge	1		I identified and what correctly	<b>C</b>	I

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155689	B. Wl	ING		03/26/	2024
				CTREET	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
MA IFOT	10 04 DE 05 000I	IEN			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	1EN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	amounts of combus	tibles was protected as a			action(s) will be taken:		
hazardous area. This deficient practice could				All residents have the potentia	ıl to		
	affect 40 residents i	-			be affected by this deficient		
					practice. The Maintenance		
	Findings include:				Director/Designee will be		
	8				responsible for completing QA	ا اPI	
	Based on observation	ons with the Maintenance			audit tool "Life Safety Rounds"		
		nistrator on 03/26/24 at 11:55			3x/week for the first month,		
		ge room on B-wing contained			2x/week for the second month	<u> </u>	
		upplies, was greater than 50			and weekly for at least 6 mont	-	
		re making the room a			and wookly for at loads o mone	110.	
		e PPE room was not protected			What measures will be put in	nto	
		because the corridor door to			place or what systemic		
		elf-closing or automatic			changes will be made to		
		nterview at the time of			ensure that the deficient		
	-	intenance Director agreed the			practice does not recur:		
		d large amount of combustible			All staff will be in-serviced on or		
		than 50 square feet, and the			before 4/17/2024. This in-serv		
	-	room was not self-closing.			will be conducted by the	7100	
	Connuor door to the	reem was never treemg.			Maintenance Director or Desig	nnee	
	The findings were r	eviewed with the Maintenance			and will include a review of eg	-	
	_	Iministrator during the exit			doors. The Maintenance	1000	
	conference.				Director/Designee will be		
					responsible for completing QA	ا اعا	
	3.1-19(b)				audit tool "Life Safety Rounds"		
	(-)				3x/week for the first month,		
					2x/week for the second month	ļ 1	
					and weekly for at least 6 mont	•	
					and woonly for at loads of mont		
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality	ļ	
					assurance program will be p	ut	
					into place:		
					Ongoing compliance with this	ļ	
					corrective action will be monitor	ored	
					though the facility Quality	J. Cu	
					Assurance and Performance	ļ	
					Improvement Program. The	ļ	
			1		improvement Program. The	ļ	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/16/2024 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155689	B. WING		03/26/2024
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526	•
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accordant 19.3.2.5.2 * cooking facilities smoke compartment patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer pacconditions under 1	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ing equipment (i.e., small s microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under		Maintenance Director/Designed will be responsible for complete QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance in not achieved an action plan will developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow-up.  By what date the systemic changes will be completed: 04/26/2024  Compliance Date = 04/26/2026	ting d t 6 is ill be eview

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NFPA 96 per 9.2.3 are not required to be

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		r í	ILDING	onstruction 01	(X3) DATE COMPI 03/26	LETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE	
IAU	enclosed as haza be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observation failed to properly in protected by 1 of 1 systems. LSC 9.2.3 be in accordance where 12.1.2.2 states cook protection shall not rearranged without fire-extinguishing so reservicing agent, the design of the firsuch installations, which continued in service method that would were returned to an after they had been cleaning. Section 10 that produces greas be a source of igniting grease removal development by fire-extinguishing practice affects staff residents in the main. The findings included Based on observation birector and Adming p.m., the cooking ecovered by the suppression of	ridous areas, but shall not ridor.  1. 18.3.2.5.4, 19.3.2.5.1  2. 9.2.3, TIA 12-2  2. 2. 3 and interview, the facility install and maintain equipment kitchen hood extinguishing states cooking equipment shall ith NFPA 96. NFPA 96 section sing appliances requiring be moved, modified, or prior re-evaluation of the system by the system installer unless otherwise allowed by the extinguishing system, unless the approved existing shall be permitted to be the extinguishing system, unless approved design location moved for maintenance and 20.1.2 states cooking equipment the eladen vapors and that might it ion of grease in the hood, ince, or duct shall be protected and greater than the deficient of in the kitchen and 50 and dining room.  The deficient of the wheeled the elader was not properly pression due to the wheeled the elader was not provided with the dithat would ensure that the the turned to an approved design	K 03		K324 – Cooking Facilities It is the practice of this facilitiensure all equipment is propinstalled and maintained.  What corrective action(s) who is accomplished for those residents found to have be affected by the deficient practice: The gas six-fire burner rang properly placed under the firsuppression system.  How other residents having potential to be affected by same deficient practice will identified and what correct action(s) will be taken: All residents and staff in kitch have the potential to be affected by this deficient practice. The Maintenance Director/Desig will be responsible for compound QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second months.  What measures will be put place or what systemic changes will be made to ensure that the deficient practice does not recur:	vill een e was re g the the li be tive chen cted lie nee leting	04/17/2024	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01		SURVEY LETED 5/2024		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE PROPRIATE	(X5) COMPLETION DATE		
	during observation, agreed the cook top position for comple the kitchen was not method that would were returned to an after they had been cleaning.  The finding was rev	eaning. Based on interview the Maintenance Director was not in the correct ete fire suppression and stated provided with an approved ensure that the appliances approved design location moved for maintenance and  viewed with the Administrator effector during the exit		All kitchen will be in-serve before 4/17/2024. This is will be conducted by the Maintenance Director or and will include a review equipment placement ar suppression systems. The Maintenance Director/Dewill be responsible for congapility of the month, 2x/week for the month, 2x/week for the month, and weekly for a months.  How the corrective activalled by the month of	Designee of od fire the esignee ompleting ety e first second t least 6  I be put th this monitored y ance The esignee ompleting ety ety ance the ot  I be put th this monitored y ance the esignee ompleting ety ety ety ety ety ance the esignee ompleting ety			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155689	B. WI	B. WING 03/2		03/26/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				OLLEGE AVE		
MAJESTI	C CARE OF GOSH	EN			EN, IN 46526		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					changes will be		
					completed: 04/17/2024		
					Compliance Date = 04/17/202	4	
V 0252	NIEDA 404						
K 0353 SS=F	NFPA 101	Maintanance and Tastina					
Bldg. 01		Maintenance and Testing  Maintenance and Testing					
Diag. 01		r and standpipe systems					
	-	ted, and maintained in					
	·	IFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					
	_	ting are maintained in a					
	-	d readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
		RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8,						0.5/0.4/0.004
		review and interview, the	K 0	353	K353 – Sprinkler Systems –		05/21/2024
	-	intain 1 of 1 automatic sprinkler			Maintenance and Testing	4	
	•	requires all sprinkler systems			It is the practice of this facility		
	_	ested, and maintained in PA 25, Standard for the			maintain sprinkler systems and ensure all automatic sprinkler	J	
		and Maintenance of			systems shall be inspected an	d	
		rotection Systems. NFPA 25,			maintained.	u	
		on 5.3.4.1.2 states the			mantanica.		
		ifreeze solution shall be			What corrective action(s) wil	ı	
		num necessary for the			be accomplished for those	•	
anticipated minimum temperature. NFPA 25, 4.3.1 requires records shall be made for all inspections,				residents found to have beer	1		
				affected by the deficient			
	•	ace of the system components			practice:		
		vailable to the authority			1 All sprinklers have been		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPL	ETED
		155689	B. W	NG		03/26	/2024
				CTD PPT	ADDRESS CITY STATE ZIR COP		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
NAA JEGT	10 04 DE 0E 0001	IENI			OLLEGE AVE		
IVIAJEST	IC CARE OF GOSH	1EIN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	having jurisdiction	upon request. This deficient			placed on a monthly inspection	n	
	practice could affec	et all residents, staff, and			and documentation schedule i	in	
	visitors.				TELS.		
					2 All sprinkler heads have be	een	
	Findings include:				inspected and sprinkler vendo	r	
					scheduled replacement on		
	Based on review of	the facility's annual sprinkler			05/21/24.		
	system inspection r	eport with the Maintenance			3 All testing has been reviev	ved	
	Director and Admir	nistrator on 03/26/24 at 10:28			with vendor and additional		
	a.m., the annual spr	inkler report dated 02/08/24			inspection and correction		
	showed the low test	ting point for the antifreeze			scheduled for 05/21/2024.		
	was -1 degrees Fahr	renheit. The reference section					
	in NFPA Annex Fig	gure A.5.3.4.1 Isothermal Lines -			How other residents having t	the	
	Lowest One-Day Mean Temperature (Fahrenheit.)				potential to be affected by th	ie	
	showed the mean lo	owest temperature for the			same deficient practice will b	ре	
	facility was at -10 F	Fahrenheit. Based on an			identified and what correctiv	e	
	interview at the tim	e of record review, the			action(s) will be taken:		
	Maintenance Direct	tor agreed the antifreeze was			All residents have the potentia	al to	
	tested at -1 degrees	and stated their area can get			be affected by this deficient		
	below -1 degrees in	the winter.			practice. The Maintenance		
					Director/Designee will be		
					responsible for completing QA	ŀΡΙ	
	2.) Based on observ	vation and interview, the			audit tool "Life Safety Rounds'	,,	
	facility failed to rep	place 2 of 2 sprinkler heads in			3x/week for the first month,		
		and 2 of 6 sprinkler heads in	2x/week for the second month,			١,	
	-	accordance with LSC 9.7.5.			and weekly for at least 6 mont	ths.	
		tion, at 5.2.1.1.1 sprinklers shall					
	_	eakage; shall be free of			What measures will be put in	nto	
	_	naterials, paint, and physical			place or what systemic		
	-	be installed in the correct			changes will be made to		
	,	-right, pendent, or sidewall).			ensure that the deficient		
		.1.1.2 any sprinkler that shows			practice does not recur:		
		following shall be replaced: (1)			All staff will be in-serviced on		
		ion (3) Physical Damage (4)			before 4/17/2024. This in-serv	vice	
		glass bulb heat responsive			will be conducted by the		
		g (6) Painting unless painted by			Maintenance Director or Desig	-	
	-	acturer. This deficient practice			and will include a review of eg	ress	
		the service hall and 50			doors. The Maintenance		
	residents in the dini	ng room.			Director/Designee will be		
					responsible for completing QA	ŀΡΙ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/26/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Findings include:  Based on observation Director and Admir 11:00 a.m. and 1:00 heads showed signs a) Two sprinklers in signs of corrosion. b) Two sprinkler hedryers were loaded Based on interview Maintenance Direct aforementioned spriloading and corrosion.  The findings were resulted.	at the time of observation, the or confirmed the inkler heads showed signs of on.	PR	EFIX PAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  audit tool "Life Safety Rounds 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month and weekly for at least 6 month deficient practice will not recur, i.e., what quality assurance program will be pinto place:  Ongoing compliance with this corrective action will be monit though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designe will be responsible for comple QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the secon month, and weekly for at least months. If 100% compliance not achieved an action plan we developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow-up.  By what date the systemic changes will be completed: 05/21/24.	the  ut  ored  d t 6 is ill be eview	(X5) COMPLETION DATE	
K 0511 SS=E Bldg. 01	complies with NFF				Compliance Date = 05/21/24.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/26/2024 155689 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2400 COLLEGE AVE MAJESTIC CARE OF GOSHEN GOSHEN, IN 46526 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 K 0511 1.) Based on observation and interview, the K511 - Utilities - Gas and 04/17/2024 facility failed to ensure 2 of 2 receptacles within 6 **Electric** feet from a sink were provided with ground fault It is the practice of this facility to circuit interrupter (GFCI) protection against ensure all receptacles within 6 feet electric shock. LSC 19.5.1.1 requires utilities from a sink are provided with GFCI comply with Section 9.1. LSC 9.1.2 requires protection against electrical electrical wiring and equipment to comply with shock. NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault What corrective action(s) will Circuit-Interrupter Protection for Personnel, be accomplished for those states, ground-fault circuit-interruption for residents found to have been personnel shall be provided as required in affected by the deficient 210.8(A) through (C). The ground-fault practice: circuit-interrupter shall be installed in a readily 1 The B-wing spa and accessible location. shower/storage room receptacles (B) Other Than Dwelling Units. All 125-volt, have been replaced with GFCI single-phase, 15- and 20-ampere receptacles protected receptacles and tested. installed in the locations specified in 210.8(B)(1) 2 The electrical wires and through (8) shall have ground-fault splices were removed and hole circuit-interrupter protection for personnel. filled. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) 3 The electrical outlet in dining Outdoors, storage room has been replaced (5) Sinks - where receptacles are installed within with a cover. 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with How other residents having the associated showering facilities, (8) Garages, potential to be affected by the service bays, and similar areas where electrical same deficient practice will be diagnostic equipment, electrical hand tools. identified and what corrective NFPA 70, 517-20 Wet Locations, requires all action(s) will be taken: receptacles and fixed equipment within the area of All residents have the potential to the wet location to have GFCI protection. Note: be affected by this deficient Moisture can reduce the contact resistance of the practice. The Maintenance body, and electrical insulation is more subject to Director/Designee will be failure. This deficient practice could affect 30 responsible for completing QAPI residents on B-wing. audit tool "Life Safety Rounds" 3x/week for the first month,

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/26/2024	
	ROVIDER OR SUPPLIER		2400	EET ADDRESS, CITY, STATE, ZIP COD 0 COLLEGE AVE SHEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	N (X5) BE COMPLETION DATE
	Findings include:			2x/week for the second mor	nth,
	Director and Admir 11:00 a.m. and 1:00 shower/storage roor receptacles about 29 electric receptacles was confirmed whe Based on interview Maintenance stated not GFCI protected  2.) Based on observ facility failed to ensure the boiler room were	ation and interview, the ture 1 of 1 electrical splices in e made in a junction box. LSC		What measures will be put place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced of before 4/17/2024. This in-serviced before 4/17/2024. This in-serviced before distributed by the Maintenance Director or Definition and will include a review of Electrical Outlets. The Maintenance Director/Designing will be responsible for compact QAPI audit tool "Life Safety"	on or ervice esignee gnee pleting
	comply with NFPA Article 322.56 (A) s	ical wiring and equipment to 70, National Electrical Code. states splices shall be made in s. This deficient practice dents in one smoke		Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months.  How the corrective action will be monitored to ensur deficient practice will not	ond ast 6
	Director and Admir p.m., in the boiler re from the ceiling wit wires were not cont Based on interview observations, the M	aintenance Director were bare electrical wires that		recur, i.e., what quality assurance program will be into place: Ongoing compliance with the corrective action will be more though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designed will be responsible for compliance QAPI audit tool "Life Safety Rounds" 3x/week for the first	nis nitored e e gnee gnee oleting
	facility failed to ens	vation and interview, the cure 1 of 1 electrical outlets in n contained a cover plate and		month, 2x/week for the second month, and weekly for at least months. If 100% compliance	ond ast 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155689		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/26/2024		
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(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 APPROPRIA DEFICIENCY)	5.112		
	was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 55 residents in the main dining room.  Findings include:  Based on observations with the Maintenance Director and Administrator on 03/26/24 12:40 p.m.,		not achieved an action plan w developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow-up.  By what date the systemic changes will be completed: 04/17/2024  Compliance Date = 04/17/204	eview		
	in the dining storeroom had an electrical outlet with missing cover plates and exposing metal terminals. Based on an interview at the time of observation, the Maintenance Director agreed an outlet was missing the cover plate and there were electrical contacts visible.  The findings were reviewed with the Administrator and Maintenance Director during the exit conference.					
K 0521 SS=F Bldg. 01	3.1-19(b)  NFPA 101  HVAC  HVAC  Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.  18.5.2.1, 19.5.2.1, 9.2					
	Based on record review, observation, and interview; the facility failed to ensure 1 of 1 fire damper systems were inspected and provided necessary maintenance after the first year after	K 0521	K521 - HVAC It is the practice of this facility ensure the fire dampers in the facility are inspected and prov			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE A. BUILDING B. WING	e construction  5	(X3) DATE SURVEY COMPLETED 03/26/2024			
NAME OF F	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COL	)			
MAJEST	IC CARE OF GOSH	HEN	2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5)  JLD BE COMPLETION PROPRIATE DATE			
1710		east every four years in	Ind	necessary maintenance.				
		FPA 90A. LSC 9.2.1 requires and air conditioning (HVAC)		What corrective action(	lliw (2			
		ed equipment shall be in		be accomplished for the	•			
	accordance with NI	FPA 90A, Standard for the		residents found to have				
		Conditioning and Ventilating		affected by the deficien	t			
	-	OA, 2012 Edition, Section 5.4.8.1		practice:				
	_	shall be maintained in		Vendor was contacted for				
		FPA 80, Standard for Fire pening Protectives. NFPA 80,		additional fire damper ins				
		on 19.4.1 states each damper		previous fire damper insp				
		inspected 1 year after		provided.	occions			
	installation. Section 19.4.1.1 states the test and			provided.				
	inspection frequency shall be every 4 years except			How other residents ha	ving the			
	for hospitals where	the frequency is every 6 years.		potential to be affected	_			
	If the damper is equ	sipped with a fusible link, the		same deficient practice	will be			
		ed for testing to ensure full		identified and what corr	rective			
		-place if so equipped. The		action(s) will be taken:				
	-	e blocked from closure in any		All residents have the po				
		ns and testing shall be		be affected by this deficie				
		iting the location of the fire		practice. The Maintenand				
		pection, name of inspector and		Director/Designee will be				
		ered. The documentation shall		responsible for ensuring	damper			
		icate when and how the orrected. This deficient		inspections are properly	4-1			
	practice could affect			scheduled and documen	iled			
		et an residents.		through TELS.				
	Findings include:			What measures will be				
	D1 1	iidl dl - NG-'		place or what systemic				
		eview with the Maintenance		changes will be made to				
		nistrator on 03/26/24 at 10:10		ensure that the deficien				
		ation was provided to show if the steel the steel that the steel the steel that t		practice does not recur The Maintenance	•			
	_	n observation with the		Director/Designee will be	_			
	-	tor between 11:00 a.m. and 2:00		responsible for completing				
		noke/fire dampers in the duct		audit tool "Life Safety Ro	_			
	-	and fire barriers. Based on an		3x/week for the first mon				
		ne of records review and		2x/week for the second r				
		In a record fevil wanta		and weekly for at least 6				
	· ·	could not be found and did not		to include TELS review.				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  03/26/2024	
	PROVIDER OR SUPPLIER		2400 (	FADDRESS, CITY, STATE, ZIP COD COLLEGE AVE IEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) COMPLETION DATE
	The finding was rev	s were ever inspected.  viewed with the Administrator irector during the exit		How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place:  Ongoing compliance with thi corrective action will be mon though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Design will be responsible for compl QAPI audit tool "Life Safety Rounds" 3x/week for the firs month, 2x/week for the secomonth, and weekly for at lea months. If 100% compliance not achieved an action plant developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for and follow-up.  By what date the systemic changes will be completed: 04/17/2024  Compliance Date = 04/17/2024	put s itored e nee eeting t nd st 6 e is will be
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro-	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable be within 10 seconds. If the n is not met during the becess shall be provided to his capability for the life			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				ETED
		155689	B. WING 03/26/2024				/2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OLLEGE AVE		
MAILCE		IENI					
MAJESTIC CARE OF GOSHEN				GUSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	safety and critical	branches. Maintenance					
	and testing of the	generator and transfer					
		ormed in accordance with					
	NFPA 110.						
	Generator sets are	e inspected weekly,					
	exercised under lo	oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	onths for 4 continuous hours.					
	Scheduled test un	nder load conditions include					
	a complete simula	ated cold start and					
	automatic or man	ual transfer of all EES					
	loads, and are cor	nducted by competent					
	personnel. Maintenance and testing of stored						
	energy power sou	rces (Type 3 EES) are in					
	accordance with N	NFPA 111. Main and feeder					
	circuit breakers ar	re inspected annually, and a					
	program for period	dically exercising the					
	components is es	tablished according to					
	manufacturer requ	uirements. Written records					
	of maintenance ar	nd testing are maintained					
	and readily availal	ble. EES electrical panels					
	and circuits are m	arked, readily identifiable,					
	and separate from	n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for r	new installations.					
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		view and interview the facility	K 0	918	K918 – Electrical Systems –		04/17/2024
		f 2 emergency generators had a			Essential Electric Systems		
		iel in accordance with the			It is the practice of this facility		
	_	PA 101 - 2012 edition, Section			ensure emergency generators		
		1 and NFPA 110, 2010 Edition,			have a reliable source of fuel.		
		1.3.1 states emergency					
	_	installed, tested and			What corrective action(s) will	i	
		rdance with NFPA 110,			be accomplished for those		
	_	gency and Standby Power			residents found to have beer	1	
	-	ion. Section 5.1.1 states the			affected by the deficient		
		ources shall be permitted to be			practice:		
	used for the emerge	ency power supply (EPS):			The emergency generator ven	dor	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155689	B. W	ING		03/26/2	2024
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
NAA IEGE	10 04 DE 0E 0001	IENI			OLLEGE AVE		
MAJESTIC CARE OF GOSHEN			GOSHE	EN, IN 46526			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
	(1) Liquid petroleur	m products at atmospheric			was contacted and provided a	ı	
	pressure	•			letter of liability for the facilitie	1	
	(2) Liquefied petrol	leum gas (liquid or vapor			two nature gas generators.		
	withdrawal)						
	(3) Natural or synth	netic gas			How other residents having	the	
	1 ' '	el 1 installations in locations			potential to be affected by th		
	_	ty of interruption of off-site			same deficient practice will I		
	_	n, on-site storage of an			identified and what corrective	1	
		arce sufficient to allow full			action(s) will be taken:		
		to be delivered for the class			All residents have the potentia	al to	
	_	equired, with the provision for			be affected by this deficient		
	_	from the primary energy source			practice. The Maintenance		
	to the alternate ener				Director/Designee will be		
		ples of probability of			responsible for reviewing TEL	s	
		nclude the following:			monthly to ensure that the lett	1	
	_	amage, or a demonstrated	liability is current for the				
	_	This deficient practice had the			emergency generators.		
	potential to affect a	-					
	•				What measures will be put in	nto	
	Findings include:				place or what systemic		
					changes will be made to		
	Based on records re	eview with the Maintenance	ensure that the deficient				
	Director and Admir	nistrator on 03/26/24 at 10:45			practice does not recur:		
		liability for the facility's two			The Maintenance		
	i i	ors was provided for review.			Director/Designee will be		
		ew during records review, the			responsible for reviewing TEL	s	
		tor stated the natural gas		monthly to ensure that a lett			
	reliability letter cou				liability is current for the		
					emergency generators.		
	The finding was rev	viewed with the Administrator					
	and Maintenance D	irector during the exit			How the corrective action(s)		
	conference.	-			will be monitored to ensure	1	
					deficient practice will not		
	3.1-19(b)				recur, i.e., what quality		
					assurance program will be p	ut	
					into place:		
					Ongoing compliance with this		
					corrective action will be monit		
					though the facility Quality		
					Assurance and Performance		
	I		1		1		

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	OF CORRECTION	IDENTIFICATION NUMBER  155689	ATION NUMBER A. BUILDING <u>01</u>		COMPLETED 03/26/2024	
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care r other UL standard used with general cords are not use	ent - Power Cords and ent - Power Cords and catient care vicinity are only ents of movable ed electrical equipment les that have been alified personnel and meet 10.2.3.6. Power strips in cinity may not be used for personal electronics), m care resident rooms that E. Power strips for PCREE r UL 60601-1. Power strips the patient care rooms ) meet UL 1363. In ooms, power strips meet ls. All power strips are precautions. Extension d as a substitute for fixed		Improvement Program. The Maintenance Director/Desig will be responsible for comp QAPI audit tool "TELS" wee 4 weeks and monthly for at months. If 100% compliance not achieved an action pland developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for and follow-up.  By what date the systemic changes will be completed: 04/17/2024  Compliance Date = 04/17/20	gnee pleting ekly for least 6 ee is will be e	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		<u>01</u>	COMPLETED	
		155689	B. WING			03/26/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			COLLEGE AVE		
MAJEST	IC CARE OF GOSI	HEN	GOSHEN, IN 46526				
	1						Γ
(X4) ID		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	' '	emoved immediately upon					
		purpose for which it was					
	installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8						
		(D) (NFPA 70), TIA 12-5	17.0	220			04/17/0004
		on and interview, the facility	K 09	920	K920 – Electrical Equipment		04/17/2024
		f 1 extension cords and 1 of 1			Power Cords and Extensions It is the practice of this facility to ensure extension cords and power strips are not used as a substitute		
		not used as a substitute for					
		vide power equipment with a					
	_	or met the UL rating of 1363A or					
	_	care locations according to			for fixed wiring to provide pow	er to	
	_	19 and NFPA-70/2011, 400.8.			equipment.		
	I his deficient pract	tice could affect 4 residents.					
	F: 1: : 1 1				What corrective action(s) wil	II	
	Findings include:				be accomplished for those		
	D41	idl dl - Maintanana			residents found to have been	n	
		ons with the Maintenance			affected by the deficient		
		nistrator on 03/26/24 between			practice:	\ <del>7</del>	
		0 p.m., the following areas had			1 Extension cord in room 20		
	improper use of power strips and extension cords: A.) In room 207 an extension cord was used to				was removed and replaced with		
	1	's computer equipment.			appropriate power source.		
	_	ower-strip that did not meet			2 Power strip in room 228 w	as	
		_			removed and replaced with appropriate power source.		
	1363A or 60601-1 was used to power s electronics.				How other residents having	tho	
	Based on interview at the time of observation, the Maintenance Director Agreed an extension cord				potential to be affected by th		
					same deficient practice will be		
	and a power-strip not meeting 1363A or 60601-1				identified and what corrective		
	was used in a patient care area.				action(s) will be taken:	-	
	as used in a patie.				All residents have the potentia	al to	
	This finding was re	eviewed with the Maintenance			be affected by this deficient		
	_	dministrator during the exit			practice. The Maintenance		
	conference.	9			Director/Designee will be		
					responsible for completing QA	ΛPI	
	3.1-19(b)				audit tool "Life Safety Rounds		
					3x/week for the first month,		
					2x/week for the second month	١,	
					and weekly for at least 6 month	•	
					which will include checks for		
					various rooms and office to er	sure	

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155689		A. BUILDING <u>01</u> B. WING		COMPLETED 03/26/2024	
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				compliance with extension cor and power strips.	rds	
				What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:  All staff will be in-serviced on a before 4/17/2024. This in-serviced in will be conducted by the Maintenance Director or Designad will include a review of extension cords and power strusage. The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month and weekly for at least 6 mont.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  Ongoing compliance with this corrective action will be monitored to ensure the program will be printo place.	or vice gnee rip API API Abs. Abe ut Dred Dred Dred Dred Dred Dred Dred Dred	
				month, and weekly for at least	6	

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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 03/26/2024		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF GOSHEN			STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	EFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	T	ΆG			DATE
					not achieved an action plan wi developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for re and follow-up. By what date the systemic changes will be completed: 04/17/2024 Compliance Date = 04/17/2024	eview	

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