STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00450693, IN00451117 and IN00451678. Complaint IN00451117 - No deficiencies related to the allegations are cited. Complaint IN00450693 - No deficiencies related to the allegations are cited. Complaint IN00451678 - Federal/State deficiencie related to the allegations are cited at F880. Survey dates: January 15, 16, 17, 21, 22 and 23, 2025 Facility number: 000091 Provider number: 155689 AIM number: 100290080 Census Bed Type: SNF/NF: 23 SNF: 5 NF: 73 Total: 101 Census Payor Type: Medicare: 6 Medicaid: 73 Other: 22 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 2/3/2025	F 0000	***Majestic Care of Goshen please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.*** ***Majestic Care of Goshen Respectfully requests consideration of a desk review.***	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Shepperd	Executive Director	02/19/2025

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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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on observation, interview and record review, the facility failed to ensure the physician was notified of abnormal blood sugar levels and insulin refusals for 2 of 2 residents reviewed for insulin (Resident 4 & 96) and of new skin issues for 1 of 6 residents reviewed for skin (Resident 5). Findings include: 1. The record for Resident 4 was reviewed on 1/17/2025 at 9:30 A.M. Diagnosis included, but were not limited to: Type 2 diabetes. A Physicians' order, dated 7/1/2024, indicated the physician was to be notified if Resident 4's blood glucose levels were above 400. - On 9/3/2024 at 4:26 P.M., Resident 4's blood glucose level was 403 mg/dl. - On 10/12/2024 at 5:26 P.M., the residents blood glucose level was 411 mg/dl. - On 10/29/2024 at 8:37 P.M., the residents blood glucose level was 479 mg/dl. During an interview, on 1/21/2025 at 9:39 A.M., RN 15 indicated a nursing progress note should have been in Resident 4's chart for the days the physician had been notified of an elevated blood glucose level. A review of Resident 4's nursing progress notes indicated the record lacked documentation the physician was notified of elevated blood glucose levels above 400 mg/dl. During an interview, on 1/21/2025 at 2:46 P.M., the Administrator confirmed there were no nursing	F 0580	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Physician notified of abnormal blood glucose levels for resident 4, no ill effect due to alleged deficient practice. ·Physician notified of abnormal skin findings for resident 5, no ill effect due to alleged deficient practice. ·Physician notified of refusal of medications for resident 96, no ill effect due to alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility that receive glucose checks, have abnormal skin findings, and who refuse medications have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure physician notification of abnormal glucose levels, abnormal skin findings, and refusal of medications is completed. **What measures will be put into place or what systematic changes will you make to**	02/12/2025

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	progress notes associated with the elevated blood glucose levels. 2. During an interview on 1/15/2025 at 2:07 P/M., the family of Resident 5 indicated they had noticed a discoloration on the resident's right lower arm and were never given an explanation on how it happened. During an observation and interview on 1/17/2025 at 11:11 A.M., with LPN 14, Resident 5 was noted to have two discolored/ecchymotic areas to her proximal right forearm and distal right forearm. LPN 14 indicated she was unaware of the areas and she did not know where they had come from. On 1/17/2025 at 9:20 A.M., a record review was completed for Resident 5. Diagnosis included, but were not limited to: muscle weakness. An Annual Minimum Data Set (MDS), dated 12/26/2024 indicated Resident 5's cognition was severely impaired. A Care Plan, initiated on 7/15/2023 indicated Resident 5 was at risk for skin breakdown. Interventions included, but were not limited to: skin inspection weekly and as needed, document and notify MD of abnormal findings. A review of Resident 5's weekly skin evaluations indicated there were no new skin findings on the following dates: - 12/2/2024 - 12/9/2024 - 12/16/2024 - 12/30/2024 - 1/6/2024 - 1/15/2024 - 1/20/2024		**ensure that the deficient practices do not recur?** ·Nursing educated on the need to notify physician of change in condition for all residents (IE: blood glucose levels, abnormal skin findings, and refusal of medications). DON/designee will audit 5x a week, 5 random residents x6 months to ensure physician notification takes place for glucose levels, medication refusals, and abnormal skin findings. ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The DON/designee will complete audit tool to reflect timely physician notification for abnormal glucose levels, abnormal skin findings, and refusals of medications. ·The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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A review of Resident 5's Nursing Progress Notes and weekly skin evaluations lacked documentation LPN 14 identified the residents abnormal skin findings on 1/17/2025 at 11:11 A.M. and reported the findings to the MD.

During an interview on 1/22/2025 at 10:26 A.M., the DON indicated a new skin evaluation should have been completed on Resident 5 after the skin abnormality was discovered by LPN 14. She indicated the Nurse Practitioner, MD, and family should have been notified of the resident's abnormal skin findings and they were not.3. A record review for Resident 96 was completed on 1/21/2025 at 10:09 A.M. Diagnosis included but were not limited to: diabetes mellitus type 2 (DM) with chronic kidney disease, iron deficiency anemia, legal blindness, hypertensive heart disease without heart failure, and vitamin D deficiency.

Resident 96's Physician Orders included, the following orders regarding insulin and blood glucose assessments:
Insulin Lispro (a rapid acting) insulin- inject subcutaneous before meals per sliding scale of blood sugar results- if 200 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units, subcutaneously before meals and at bedtime for hyperglycemia if less than 60 notify MD.
Insulin Glargine (long acting)- inject 20 units subcutaneously daily in the morning.
Insulin Glargine (long acting)- inject 10 units subcutaneously daily at night.

A current Care Plan, initiated on 6/26/2024 and updated 1/16/25, indicated Resident 96 is at risk for complications and symptoms of hypoglycemia

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	or hyperglycemia due to diagnosis of diabetes, with interventions including but not limited to: diabetes medication as ordered by Medical Doctor (MD), observe for side effects and effectiveness, diet as ordered, educate and remind resident importance of medications and compliance with dietary restrictions, observe for signs or symptoms of hyperglycemia, observe for signs or symptoms of hypoglycemia, blood sugars as ordered by doctor, labs as ordered, document abnormal findings and notify MD A current Care Plan, initiated on 6/26/2024 and updated 1/16/25, indicated Resident 96 refused medications, treatments, glucometer checks, supplements, VS, insulin, and meals. Interventions included, but not limited to: explain to resident what you are doing before initiating task, MD will be notified prn of resident refusals, re-approach when refuses medications, refer to Nurse Practitioner (NP) as needed to do a med review, staff to provide education regarding refusal of medications ,treatments and blood sugar testing, staff will approach at another time if resident refusals The Medication Administration Record (MAR) indicated Resident 96 refused insulin medication for the following dates in: September 2024 156 times out of 178 doses, October 2024 175 times out of 186 doses, November 2024 182 times out of 182 doses, December 2024 186 times out of 186, and January 2025 90 times out of 91 doses. An Interdisciplinary Team (IDT) note dated 10/25/2024 at 12:36 P.M. indicated Resident 96 refused medications regularly, including blood sugar checks and diabetic med's. There was no indication MD and or NP was notified of refusals.			

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	A NP visit note, dated 11/15/2024 indicated Resident 96 had Diabetes Mellitus and staff were to continue insulin as ordered. She also indicated that per nursing staff resident often refused insulin. A Nursing progress note dated 1/5/2025 at 10:17 A.M. indicated resident refused blood sugar checks and insulin before breakfast and lunch. There was no indication the MD or NP were notified. The chart lacked documentation to show the MD and/or NP had been notified of resident's refusal of insulin for 789 of the 823 potential doses ordered. During an interview conducted on 1/23/2025 at 9:54 A.M., RN 10 indicated that the facility staff documented resident refusals in the NP communication book for them to review during their visits. She indicated that she could not locate any information for Resident 96's refusals in the communication book. RN 10 also indicated that facility nurses would also call the NP regarding refusals of care, but there was no documentation of any calls with the NP regarding the resident's refusal of insulin. She indicated a conversation with the MD and/or NP should have been conducted earlier due to the resident's excessive refusals. During an interview on 1/23/2025 at 9:22 A.M., the Director of Nursing (DON) indicated that staff were to encourage and educated the resident when he refused insulin, attempt to administer the medication three times, and then chart the refusals. She indicated, usually if a resident refused medications or a treatment for thirty days or more, the facility nursing staff would have a			

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	conversation with the MD and/or NP about discontinuing the order. She indicated that they had not had that conversation with the MD or NP. On 1/21/2025 at 9:22 A.M., the Administrator provided the policy titled, "Blood Glucose Monitoring,' dated 12/12/2023 and indicated it was the policy currently being used by the facility. The policy indicated, "It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders. 20. Report critical test results to physician timely....." On 1/22/2025 at 9"10 A.M., the Administrator provided the policy titled, "Wound Management Policy," dated 5/30/2024 and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy of this facility to ensure residents who do not have skin integrity impairments do not develop a new condition affecting the skin. It is the policy of this facility that those residents with impaired skin integrity are recognized by our care team, treated timely, and interventions to heal are not exhausted until the skin is healed...." On 1/22/2204 at 9:10 A.M., the administrator provided the policy titled, "Change in Condition/Physician Notification", and indicated it was the policy currently being used by the facility. The policy indicated "The nurse will notify the physician/NP and the resident/resident representative when: Excessive refusal of treatment or medications (typically more than 2-3 times), Notification will be attempted within 24 hours, The nurse will document timely regarding the change in resident's condition, interventions and notifications ..."			

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F 0585 SS=D Bldg. 00	3.1-5(a)(3) 483.10(j)(1)-(4) Grievances Based on interview and record review, the facility failed to ensure corrective action adequately addressed a response to resident council grievances of call light and shower concerns and readily provided grievance forms for residents to utilize anonymously. This practice had the potential to affect 101 of 101 residents. Findings include: 1. During a resident/surveyor meeting, on 1/17/2025 at 1:00 P.M., the residents in attendance, 10 of 12, indicated their grievances brought forward during the monthly meetings were addressed , but the grievances went unchanged . The residents who regularly attended resident council meetings indicated they usually shared their grievances at the monthly meetings. During the resident council meeting with the surveyors, conducted on 1/17/2025 at 1:08 P.M., grievances were voiced about routine showers not being completed and call lights not illuminating outside of their rooms. They indicated they were given bells and whistles to alert staff when assistance was needed. They indicated a laptop was placed at the nurse's station that indicated when a call light was activated, but the CNAs did not have time to go to the nurse's station to see who had activated their call light. Resident 86 indicated the best way to receive help was to go to the resident's room doorway and find a staff member. She also indicated she had been left on the toilet for 30-45 minutes because her call light had not been answered timely. Resident 102	F 0585	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident Council Grievances resolved with regard to call light times and shower concerns, no ill effect due to alleged deficient practice. ·Grievance forms placed in common areas so that residents can utilize them anonymously. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility that file grievances and attend resident council have the potential to be affected by the alleged deficient practices. A full house audit was completed to ensure all residents are satisfied with resident council grievance solutions, A full house audit to ensure blank grievance forms are located in common areas of the facility completed. **What measures will be put into place or what systematic changes will you make to**	02/12/2025

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	indicated he had been left on the toilet for at least an hour because his call light had not been answered timely.. Review of the Resident Council Meeting Notes, from 2/6/2024-12/10/2024, included, but were not limited to the following concerns with written responses: -2/6/2024 Old Business: Long call light times. New Business: Call light times too long. Response: 2/23/2024 Call light-received concerns from special residents and will review all call light response times for those individuals. -3/12/2024 Old Business: Long call light times. New Business: Call light times, showers. Response: 4/1/2024 Will be addressed again in the next staff meeting of call light times. Boiler issues have been resolved, and showers should be given on scheduled shower days. -4/9/2024 Old Business: Showers and call lights. New Business: Showers and long call light times. Response: 5/8/2024 Created and hired a position for a shower aide and the shower aide was available, from 10:00 A.M.-6:00 P.M. Tuesday through Saturday, to help with the shower situation. Call light reports were reviewed to ensure call lights were answered timely. -5/14/2024 Old Business: Long call light times and showers not being completed. New Business: Ongoing complaints were heard by the council. Unfortunately, according to those residents, the issues were not getting better.		**ensure that the deficient practices do not recur?** ·All staff educated on the need to ensure grievances are readily available in common areas for our residents to file grievances anonymously. Staff also educated on ensuring adequate resolutions are in place for resident council concerns. SW/designee will audit 5x a week, 5 resident council attendees x6 mos. to ensure adequate resolutions are in place for resident council concerns IE: call lights are being answered timely and showers given as requested. SW/designee will audit all common areas 5x weekly x6 months to ensure grievances are available to file an anonymous complaint in common areas of the facility ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The SW/designee will complete audit tool to reflect grievance availability and adequate resolutions to resident council concerns. ·The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee	

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	However, some residents claim the issues were better for them, but they were not consistent with all wings. Response: None provided. -6/11/2024 Old Business: Call light times. New Business: Not provided. Response: Undated. The resident council would like to know how the issue of long call light times should be resolved. Met with the CNAs and nurses and discussed the importance of everyone helping to answer call lights in a timely manner. -7/9/2024 Old Business: Call lights and showers on their regularly scheduled shower days. New Business: Not provided Response: Undated. CNAs were instructed not to turn the call light off if the requested task had not been completed. The shower schedule had been reviewed and would be completely revamped to ensure staff were able to complete assigned showers daily. -8/13/2024 Old Business: Please see nursing concern form. New Business: Not provided. Response: 8/15/2024 Revamped shower assignments to be completed by 8/16/2024 to ensure all showers can be completed when scheduled. -9/10/2024 Old Business: Completed grievance reports that addressed individual resident concerns as well as issues with the nursing department. New Business: Questions about the call light system and concerns about showers for a couple of residents.		monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	Response: 9/11/2024 Showers would be adapted to resident preference. Interventions with the call light concerns included providing alternative methods (bells and whistles) to all residents to alert staff of needs. Staff were to complete frequent rounding to check on residents. -10/8/2024 Old Business: Residents thanked the Administrator for making the changes needed to get through the call light situation until the call light system could be fixed. New Business: None. Response: 10/9/2024 Laptops had been placed at the nursing stations to alert of call light activation. Bells and whistles were provided to all residents. Staff had increased rounding to ensure laptops were functioning and all residents had a backup method for the call lights, such as the bells and whistles. Daily audits were performed to help ensure timeliness of assisting residents. The shower schedule had been previously revamped and adjusted. Will discuss with residents what their preferences were for showers and adjust accordingly. -11/12/2024 Old Business: Showers and length of time to answer call lights. New Business: Not provided. Response: 11/12/2024 A call to the corporate office was completed and the corporate office would lead the facility to upgrade the call light system. Shower and call light times were monitored to better care for the residents. -12/10/2024 Old Business: Call light concerns and some shower concerns. New Business: Call light times and showers.			

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	Response: 12/10/2024 Reassured residents that call lights were signaled at the laptop at the nurse's station. Encouraged residents to point out staff members by name who were not completing showers so discussions could be made with those staff members. Unit managers audited shower sheets the morning after the scheduled shower and added the missed showers to the shower schedule the next day. The call light reports were reviewed. The average call light response time was 17 minutes. During an interview, on 1/23/2025 at 12:56 P.M., the Activity Director indicated concerns reported in the resident council meeting were sent to the respective department for a reply and resolution. She indicated the staff should have been informed of repeated complaints and the Customer Service Representative should have visited residents with reoccurring complaints. 2. During the surveyor/resident council meeting, on 1/17/2025 at 1:08 P.M., the residents indicated they usually shared their grievances at the monthly resident council meetings. The residents indicated they did not know where to find a grievance form to report a grievance independently and anonymously. The residents council indicated they would have to have the assistance of a staff member to file a grievance. During an interview, on 1/23/2025 at 9:04 A.M., Social Service Director 1 indicated the Customer Service Representative, who rounded all day, had grievance forms for residents to complete if needed. She indicated some grievance forms may be at the front desk. She indicated the grievance forms were not in a place a resident could anonymously take a form.			

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	During an interview, on 1/23/2025 at 9:15 A.M., the Executive Director indicated grievance forms should have been available for residents to complete During an interview, on 1/23/2025 at 9:13 A.M., the Activity Director indicated she kept grievance forms in a cabinet for her staff to complete if a resident had a grievance to file. She indicated grievance forms were at the nurse's station and the front desk. She indicated she never thought about having the grievance forms available for a resident to anonymously submit a grievance. During an interview, on 1/23/2025 at 9:34 A.M., the Social Service Director 2 indicated grievances were available at the front desk in a folder. However, the forms could not be visualized amongst the other file folders and were not available to a wheelchair bound resident due to the height at which the forms were stored on the wall. A policy was provided, on 1/17/2024 at 10:56 A.M., by the Executive Director. The policy titled, "Grievances", indicated, " ...1. Purpose To support each resident's/patient's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal ...Policy B. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident/patient; and coordinating with state and federal agencies as necessary in light of specific allegations ... I. A grievance may be filed anonymously ...Procedure D. The Grievance			

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	155689	A. BUILDING 00 B. WING	01/23/2025

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	Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. a. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. b. All Care Team Members involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. "Prompt efforts" include acknowledgement of complaint/grievances and actively working toward a resolution of that complaint/grievance ...E. The Grievance Official, or designee, will keep the resident/patient appropriately apprised of progress towards resolution of the grievances ...J. The facility will make prompt efforts to resolve grievances ...." Although the facility had documented responses to facility grievances from the Resident Council, the facility failed to ensure the interventions to address the concerns were effective and resolved the repeated grievances. 3.1-7(a)(2) 3.1-3(l)			
F 0640 SS=A Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record review and interview, the facility failed to submit a discharge minimum data set (MDS) assessment for 1 of 1 resident reviewed for resident assessment. (Resident 104) Finding includes: A record review for Resident 104 was completed on 1/23/2025 at 8:33 A.M. Diagnoses included, but were not limited to: wedge compression fracture of	F 0640	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident discharged from facility. No ill effect noted due to the alleged deficient practice. **How will you identify other**	02/12/2025

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	3rd lumbar vertebra, quadriplegia, fracture of the orbit and displacement of cervical disc at C5-C6. An Admission MDS assessment was completed on 8/20/2024. A Discharge MDS could not be located in the medical record. A Nursing Progress Note, on 9/14/2024 at 5:55 P.M., indicated Resident 104's sister spoke with the nurse on duty regarding being the resident discharging home. A new order was obtained to discharge Resident 104 home with her sister. During an interview, on 1/23/2025 at 8:49 P.M., the Executive Director indicated a discharge MDS assessment should be completed within 14 days of the discharge from the facility. She indicated the MDS discharge assessment should have been completed. A policy for discharge MDS assessments was requested, on 1/23/2025 at 11:42 A.M. The Executive Director indicated there was not a policy for discharge MDS assessment, but the facility follows the RAI (Resident Assessment Instrument) manual for assessment schedules. The Centers for Medicare & Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2023, included the following. " ...RAI OBRA-required [Omnibus Budget Reconciliation Act] Assessment Summary: The Discharge Assessment with return not anticipated should be completed within 14 days of the discharge date ...."		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents ready to discharge from the facility have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents discharged from the facility had a discharge MDS in place. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·MDS/Nursing educated on the need to ensure that residents discharging from facility have a discharge MDS in their record. MDS/designee will audit all residents' that are discharged each week to ensure discharge MDS is completed for discharged residents. ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** The MDS/designee will complete audit tool to reflect all residents' that are discharged each week will have a discharge MDS is completed for residents. ·The Director of Nursing /	

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			Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0646 SS=D Bldg. 00	483.20(k)(4) MD/ID Significant Change Notification Based on record review and interview, the facility failed to ensure 1 of 2 resident's Level One PASARR (Preadmission Screening and Resident Review) assessment was completed accurately and failed to ensure an updated Level 1 review was completed for 1 of 27 residents reviewed for MDS assessments . (Resident 18) Finding includes: The record for Resident 18 was reviewed on 1/21/2025 at 3:28 P.M. Diagnoses included, but were not limited to: depression, anxiety, post traumatic stress disorder, dementia and on 9/14/2024 a new diagnoses of psychotic disorder with delusions. Resident 18's current medications include: trazadone (antidepressant) 150 mg (milligram) 1 tablet at bed time; Fluoxetine (antidepressant) 20 mg 1 tablet daily; Haloperidol (antipsychotic) 10 mg 1 tablet two times a day and Haloperidol 5 mg 1 tablet once a day. A Preadmission Screening and Resident Review form, dated 4/14/2020, indicated Resident 18's diagnoses included adjustment disorder with mixed anxiety and depressed mood, post traumatic	F 0646	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** · New level I completed for resident 18 with updated dx included. No change in level I outcome from what was already in record. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility that require updated level I's related to a significant change have the potential to be affected by this alleged deficient practice. . A full house audit was completed to ensure all residents with significant changes in dx have an updated PASARR. **What measures will be put into place or what systematic changes will you make to**	02/12/2025

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	stress disorder, and insomnia. The form indicated there were no known mental health behaviors... and no known or suspected ...diagnosis... Under the medications including antidepressants, mood stabilizers, antipsychotics and other mental health medications - only Ativan and Trazadone were documented. A Notice of PASARR Level 1 Screen Outcome form, dated 4/24/2020, indicated Resident 18's Level 1 PASARR showed no Level II was required to be completed. The rationale included the following: The Level 1 screen indicates that a PASRR disability is not present because of the following reason: "There is no evidence of a PASARR condition of an intellectual /developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be completed." During an interview, on 1/23/2025 at 1:02 P.M., Social Service Staff indicated another Level 1 should have been completed for Resident 18 when a mental health diagnosis was added and after antipsychotic medications were ordered. On 1/23/2025 at 1:35 P.M., the Administrator provided the policy titled, "Preadmission Screening And Resident Review (PASARR), dated 12/12/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a Level II resident review. Examples include: ...b. A resident whose intellectual disability or related condition was not previously identified and evaluated		**ensure that the deficient practices do not recur?** ·Nursing/SW educated on the need to ensure residents with a change in their MD/ID dx have an updated level I completed timely. DON/designee will audit 5x a week, 5 random residents x6 months to ensure residents' PASARR is accurate and up to date with any changes. ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The SW/designee will complete audit tool to reflect PASARR documentation is input timely and accurately. ·The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	through PASARR...." 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview, and record review, the facility failed to ensure preventative measures were implemented timely to prevent pressure ulcer development for 1 of 3 residents reviewed for facility-acquired pressure ulcers (Resident 96). Finding includes: The record for Resident 96 was reviewed on 1/21/2025 at 10:09 A.M. Diagnosis included, but were not limited to: diabetes mellitus type 2 (DM) with chronic kidney disease, iron deficiency anemia, legal blindness, hypertensive heart disease without heart failure, and vitamin D deficiency. Review of the most recent MDS (Minimum Data Set) assessment for Resident 96, completed on 12/2/2024 for a Significant Change in Condition indicated Resident 96 was alert and oriented, required substantial/maximal staff assistance for dressing, transferring and bathing needs and had one unstageable pressure ulcer. . A Braden Scale for Predicting Pressure assessment, completed 6/14/2024, indicated Resident 96 was at risk for developing pressure sores. Resident 96's chart lacked documentation of any further Braden risk assessments having been completed after 6/14/2024.			
F 0686 SS=D Bldg. 00		F 0686	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident # 96's care plan was reviewed and updated as needed with Additional interventions/preventative measures implemented for resident 96 (IE: heels floated, and prevalon boot in place) to prevent pressure ulcer development. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility that are at risk for skin breakdown have the potential to be affected by this alleged deficient practice. . A full house audit was completed to ensure all residents that are at risk with skin integrity have preventative interventions in place. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All nursing educated on the	02/12/2025

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	A current Care Plan, initiated on 6/26/2024 and updated on 1/16/2025, indicated Resident 96 was at risk for skin breakdown related to her diagnoses of: DM 2, anemia, hypertension, CKD 2, mixed hyperlipidemia, Vit D deficiency, Legal blindness, Edema, and Weakness. Interventions included but are not limited to: Assist with bed mobility to turn and reposition routinely, prevalon boot to left foot when in bed as tolerated, preventative skin care as ordered/indicated, and skin inspection weekly and as needed, document and notify MD of abnormal findings. A current Care Plan, initiated on 6/26/2024 and updated on 1/16/2025, indicated Resident 96 had impaired skin integrity stage 3, Pressure Ulcer to the right heel- goes to (name of local town) wound clinic. Interventions included, but were not limited to: assess and document skin condition, notify MD of signs of infection, assess for pain and treat as indicated, assist with bed mobility to turn and reposition routinely, pressure reducing/redistributing cushion in chair, pressure reducing/redistributing mattress on bed, prevalon boot to the right foot at all times as tolerated, supplements as ordered, and wound treatment as ordered. A current Care Plan, initiated on 6/26/2024 and updated on 1/16/2025, indicated Resident 96 needed assistance with activities of daily living related to DM 2, anemia, HTN, CKD 2, mixed hyperlipidemia, Vit D def, legal blindness, edema, and weakness. Interventions included ,but were not limited to: Continence - assist with incontinent care, bed mobility: extensive staff assistance, personal hygiene: extensive staff assistance, and transfers: extensive staff assistance. Current Physician Orders included: weekly		need to ensure residents that are at risk for skin breakdown have proper interventions in place and that those interventions are followed. DON/designee will audit 5x a week, 5 residents at risk for skin breakdown x6 months to ensure proper preventative measures are in place to avoid pressure ulcers. ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The DON/designee will complete audit tool to reflect proper interventions are in place for residents at risk for skin breakdown, and to ensure prevention of pressure ulcer development. ·The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	nursing summary every Tuesday, house barrier cream, pressure reducing cushion to wheelchair, pressure reducing mattress, and prevalon boot to right foot at all times and left foot while in bed. A Progress Note, dated 10/25/2024, by the Wound Nurse Practitioner (NP) indicated Resident 96 had no open wounds. Recommendations by the wound NP were to apply barrier cream as necessary and avoid pressure on bony prominences by adhering to turning protocols and floating the resident's heels. There was no documentation in the record that Resident 96's heels had been floated. A resident skin evaluation assessment, completed on 10/25/2024, indicated Resident 96 had no new skin areas. There were no other resident skin evaluation assessments completed for Resident 96 during the three weeks after 10/25/2024. A resident skin evaluation assessment for Resident 96, completed on 11/192024, indicated the resident had no new skin areas. A resident skin evaluation assessment for Resident 96, completed on 11/23/2024, indicated Resident 96's right heel was sore and the skin was peeling. There was no documentation in Resident 96's record of any new intervention being put in place when the area was identified. A wound NP progress note, dated 11/25/2024, indicated Resident 96 had an unstageable pressure sore to her right heel measuring 4.5 centimeters (cm) length, 4 cm width and a depth of 0.1 cm with a moderate amount of exudate.			

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	Recommendations of ongoing pressure reduction and turning and repositioning, including pressure reduction to heels and bony prominence's and follow with the wound clinic. A wound center note, dated 12/5/2024, indicated Resident 96 had a facility acquired stage 3 pressure ulcer to the right heel measuring 1.5 cm in length 1.6 cm in width, depth of 0.2 cm and a medium amount of exudate (drainage) with exposed fat layer. A recommendation was made for a prevalon boot on the right foot at all times and to the left foot while in bed. A resident care team (RCT) note, dated 12/06/2024, indicated the care team was to provide resident education on how to off-load. There was no mention of the prevalon boot ordered by wound center MD. A wound center note dated 12/12/2024, indicated Resident 96's facility acquired stage 3 pressure ulcer to the right heel measured 2.7 cm in length, 2.6 cm in width, depth of 0.2 cm and a medium amount of exudate was noted with an exposed fat layer. The recommendations continued to include the use a prevalon boot on the right foot at all times and to the left foot while in bed. A document provided by facility, from a website timestamped as being printed on 12/12/24 and was handwritten on stating "this is the type of boot (Resident's Name) needs". During an interview with the ADON, on 01/22/25 at 2:50 P.M., she indicated that the facility usually knew of wound clinic recommendations with 24-48 hrs and the nurse on the unit was responsible for transcribing any new treatments or orders. It was not clear how long it had taken for the facility to			

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	obtain the Prevelon boot for Resident 96 that had been ordered on 12/5/2025. During an interview, on 1/23/2024 at 12:15 P.M., CNA 13 indicated that Resident 96 has had the current prevalon boots for about three weeks and did not have any type of boot previously. A current policy was provided by the Administrator on 1/22/2204 at 9:10 A.M. titled, "Wound Management Policy", indicated "policy of facility to ensure residents who do not have skin integrity impairments do not develop a new condition affecting the skin". The policy also indicated the facility will have a system in place to monitor for early symptoms of the development of new skin impairments, and RCT continues to discover each resident's skin integrity impairment risks through individual treatment preferences that resident with impaired skin are recognized, treated timely, and interventions implemented until healed 3.1-40			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review and interview, the facility failed to provide nephrostomy dressing changes for 1 of 4 residents reviewed for catheter care. (Resident G) Finding includes: During an interview with Resident G, on 1/15/2025 at 10:30 A.M., she indicated her nephrostomy dressings had not been changed in some time and a new dressing had just been applied.. She indicated the staff did not know how to apply the	F 0690	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Nephrostomy dressing change, orders are in place and completed for resident G. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same**	02/12/2025

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	dressings. During an interview on 1/21/2025 at 9:46 A.M., Resident G indicated a certified nursing assistant (CNA) had changed her nephrostomy tube dressings yesterday because the dressings had fallen off. A record review for Resident G was completed on 1/17/2025 at 9:18 A.M. Diagnoses included, but were not limited to: nephrostomy, obstructive and reflexive uropathy, overactive bladder and carcinoma of the bladder. A Quarterly Minimum Data Set (MDS) assessment, dated 12/23/2024, indicated Resident G was cognitively intact and had an indwelling catheter. Physician Order's, dated 8/14/2024, indicated to monitor the left and right nephrostomy tube site every shift. However, there were no orders in the medical record for routine dressing changes to the nephrostomy sites or the stopcock (operational valve regulating the flow of a liquid) dressings. A Care Plan, initiated 8/16/2024 and revised on 12/17/2025, indicated Resident G was at risk for infection/complications related to her nephrostomy tubes. However, the interventions did not include care of the nephrostomy tubes. A professional reference, https://my.clevelandclinic.org/health/treatments/25141-nephrostomy-tube, indicated the nephrostomy tube dressings needed replaced/changed at least twice a week, anytime a shower was completed and if the area became wet		**deficient practice and what corrective action will be taken?** ·All current residents in the facility that have a nephrostomy have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents with nephrostomies have orders in place for dressing changes for their nephrostomy site. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All nursing educated on the need to ensure that residents with nephrostomies have dressing changes ordered and completed. DON/designee will audit all residents with nephrostomies to ensure residents' nephrostomy site is clean without drainage and that there is a dressing in place 5x weekly x6 mos. ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The DON/designee will complete audit tool to reflect proper dressing changes in place for residents with nephrostomies. ·The Director of Nursing / Designee will present the	

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	or dirty. During an observation, on 1/21/2025 at 10:38 A.M., Resident G's nephrostomy tube sites were observed. The bilateral sites had an undated padded dressing over the tube insertion site. Dirty padded dressings, with excessive zinc oxide ointment and darkened dressing edges, were observed over the stopcocks of the bilateral nephrostomy tubes. CNA 12 indicated the dressings were placed due to the stopcocks causing indentations in Resident 12's skin. During an interview, on 1/21/2025 at 11:02 A.M., RN 15 indicated nephrostomy tube dressings should be changed daily and there should have been a physician's order. She indicated the dressings over the stopcocks should be changed as the order indicated and there should be a physician's order regarding when to change the stopcock/nephrostomy tube dressings. A policy was provided, on 1/21/2025 at 1:18 P.M., by the Executive Director. The policy titled, "Nephrostomy/Cystostomy Care", indicated, " ...Residents with nephrostomy or cystostomy tubes will receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goal and preferences ...2. The care and maintenance of nephrostomy/cystostomy tubes shall be in accordance with physician orders. The orders shall specify the and frequency of dressing changes and emptying of collection bags along with any special instructions ...." 3.1-41(a)		summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0745 SS=D	483.40(d) Provision of Medically Related Social Service			

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	155689	A. BUILDING 00 B. WING	01/23/2025

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Bldg. 00	Based on interview, observation and record review, the facility failed to ensure follow up speciality appointments and referrals (gynecological/oncology/hematology/vascular surgeon/nephrology) were made for 2 of 2 residents reviewed for physician orders. (Residents G & 64) Findings include: 1. During an interview on 1/15/2025 at 10:32 A.M., Resident G cried while talking about a need for a gynecological oncology appointment as her uterine cancer had returned, according to the most recent hospital testing. She indicated it had been eleven weeks since she had a follow up ultrasound and an appointment had not been secured. She indicated a mass had been found, during the ultrasound. She was concerned about the possible growth of the cancer cells. A record review for Resident G was completed on 1/17/2025 at 9:18 A.M. Diagnoses included, but were not limited to: cancer and carcinoma of the bladder. A Quarterly Minimum Data Set (MDS) assessment, dated 12/23/2024, indicated Resident G was cognitively intact and had moderate depression. A pelvic transvaginal ultrasound, dated 11/18/2024, indicated a roughly 3-centimeter mass within the endometrium had been noted. A Patient Transfer Assessment from the hospital, dated 11/21/2024, indicated a new, possibly solid, 3-centimeter mass noted in the endometrium and to follow up with gynecological oncology in the	F 0745	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Follow-up appointment scheduled for resident G for gynecological oncology appointment. No ill effect due to alleged deficient practice. ·Follow-up appointments scheduled for resident 64 for hematology, vascular surgeon, and nephrology. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility that have a need to see a specialist has the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents requiring appointments with specialists, have orders in place and the appointments scheduled. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All nursing educated on the need to ensure residents requiring specialist visits have appointments scheduled in a timely manner. DON/designee will audit 5x a	02/12/2025

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	outpatient setting. A Physician's Order, dated 11/22/2024, indicated an order to schedule an appointment with gynecological oncology as soon as possible. A Nurse Practitioner Note, dated 11/22/2024, indicated during Resident G's hospital stay, a transvaginal ultrasound was performed and a new mass was found on her uterus. Resident G had a history of cervical cancer and was to follow up with gynecological oncology. The facility was to schedule Resident G's follow-up appointment with gynecology and an oncology appointment was to be made as soon as possible. A Nurse Practitioner Note, dated 12/10/2024, indicated Resident G was only concerned about her follow-up appointment with gynecological oncology appointment due to the presence of a uterine mass. The Nurse Practitioner verified with the Unit Manger who indicated she was still working to schedule the appointment and had been in contact with the oncology office. During an interview, on 1/17/2024, RN 10 indicated Resident G's referral was made at an office closer in proximity to the facility, but Resident G did not want that office. She indicated the referrals request had been faxed to the office the resident preferred on 1/13/2024. A copy of a faxed referral was observed, dated 12/6/2024 to a gynecology oncology office. RN 10 indicated the office could not meet Resident G's needs and referred her to a different gynecology office. Two other faxed referral was observed for gynecology oncology offices, dated 1/9/2025 and 1/16/2025.		week, 5 random residents x6 months to ensure residents' specialty appointments and referrals are made. ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The DON/designee will complete audit tool to reflect specialty appointments are scheduled, and referrals are made timely. ·The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	A Nursing Progress Note Dated 1/20/2025 at 12:09 P.M., indicated a gynecology oncology appointment had been set for 2/6/2025 at 10:30 A.M. During an interview, on 1/23/2025 at 12:59 P.M., RN 10 indicated Resident G would not give them the name of her gynecological doctor from December to January. 2. A record review for Resident 64 was completed on 1/17/2025 at 11:39 A.M. Diagnoses included, but were not limited to: chronic kidney disease, iron deficiency anemia, congestive heart failure and atrial fibrillation. A Physician's Order, dated 10/22/2024, indicated to refer Resident 64 to hematology for progressively low platelets and anemia. A Nursing Progress Note, on 10/22/2024 at 10:21 A.M., indicated an order was placed for a hematology consultation for Resident 64. A Physician's Order, dated 11/26/2024, indicated to refer Resident 64 to a vascular surgeon related to right leg pain. A Physician's Order, dated 12/16/2024, indicated to refer Resident 64 to nephrology for chronic kidney disease. A Patient Information Check Out Sheet, dated 9/4/2024, from the Heart and Vascular Center indicated to schedule a follow-up appointment within 6 weeks to 3 months. Nursing Progress Notes could not be found in the medical record related to scheduling any of the specialty referrals.			

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	During an interview, on 1/23/2025 at 10:51 A.M., RN 10 indicated she did not have information on the nephrology appointment. She believed she had set the appointment up, but Resident 64 refused to go. She indicated the referral to the vascular surgeon was still being worked on as the facility needed documentation from the Angio-Seal (a small device that closes a puncture in an artery in the leg after an angiography procedure) surgery to make the referral. She indicated Resident 64 had seen the vascular surgeon in September and was to follow up in 6 months. She did not address the referral to hematology referral. A policy was provided, on 1/23/2025 at 9:59 A.M., by the Director of Nursing. The policy titled, "Change in Condition/Physician Notification", indicated, " ...It is the policy of this facility to promptly identify, respond to, and report changes in resident conditions to the resident's physician/NP [nurse practitioner]/PA [physician assistant]/ resident representative. A significant change is a major decline or improvement pf the resident's status ...2. When a change in condition is discovered, the nurse will evaluate the resident and notify the resident's physician/NP/PA with pertinent information to discuss care for the resident. 3. The nurse will notify the physicians/NP/PA and the resident/resident representative when: medication omissions/errors ...excessive refusal of treatment or medications [typically more than 2-3 time] ...abnormal labs, weights, or vital signs ...." 3.1-37(a)			
F 0758 SS=D	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN			

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Bldg. 00	Use Based on record review and interview, the facility failed to ensure the physician documented a clinical contraindication when a gradual dose reduction (GDR) was declined for 2 of 5 residents reviewed for unnecessary medications (Residents 18 & 101). Findings include: 1. The record for Resident 18 was reviewed on 1/21/2025 at 3:28 P.M. Diagnoses included but were not limited to: renal insufficiency, diabetes, depression, anxiety, dementia and Post Traumatic Stress Disorder (PTSD). A Pharmacy Recommendation, dated 2/3/2024, indicated Resident 18 had been receiving Haloperidol (antipsychotic) 1 mg (milligram) four times a day since 7/12/2023. The recommendation was to decrease from 1 mg four times a day to 1 mg three times a day. The form indicated: " if a gradual dose reduction was contraindicated, please review the following and check if appropriate. 1. The residents target symptoms returned or worsened after the most recent attempt at a tapering dose. 2. Past reduction attempts have resulted in problematic behavior and/or staff inability to provide care. 3. Past reduction attempts have resulted in psychiatric instability by exacerbating and underlying medical or psychiatric disorder. 4. Past reduction attempts have caused the resident to post danger to self or others. Please provide below a CMS required patient specific rationale describing why a Gradual Dosing Reduction attempt is clinically contraindicated."	F 0758	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident 18 has documentation in place to support the contraindication noted by NP, for GDR of her psychotropic medications. No ill effect due to alleged deficient practice. ·Resident 101 has documentation in place to support the contraindication noted for GDR of her psychotropic medication, medicine was scheduled and PRN order discontinued. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility that have PRN psychotropic medications and/or psychotropic medications that require a GDR, have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all residents that are on psychotropic medications, have proper GDR's in place, d/c dates for PRN psychotropic medications, and/or documentation in place to support rationale behind contraindications of discontinuation of meds. **What measures will be put into**	02/12/2025

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	The form had the documentation of "addressed with NP-GDR contraindicated". There was no documentation of a clinical rational to show why the recommendation was contraindicated. A Pharmacy Recommendation, dated 7/4/2024, indicated Resident 18 had an order for PRN (as needed) Haloperidol with no stop date. The form indicated the following: "...if a gradual dose reduction was contraindicated, please review the following and check if appropriate. 1. The residents target symptoms returned or worsened after the most recent attempt at a tapering dose. 2. Past reduction attempts have resulted in problematic behavior and/or staff inability to provide care. 3. Past reduction attempts have resulted in psychiatric instability by exacerbating and underlying medical or psychiatric disorder. 4. Past reduction attempts have caused the resident to post danger to self or others. Please provide below a CMS required patient specific rationale describing why a Gradual Dosing Reduction attempt is clinically contraindicated." The documentation indicated "address with NP-GDR contraindicated--hospice." There was no documentation of a clinical rational to show why the recommendation was contraindicated. A Pharmacy Recommendation, dated 11/13/2024, indicated Resident 18 had received trazadone (antidepressant) 150 mg at bedtime since 8/25/2023. The recommendation was to decrease the trazadone to 125 mg. The form indicated: "... if a gradual dose reduction is contraindicated, please review the following and check if		**place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All nursing/SW educated on the need to ensure residents that are on psychotropic medications have GDR's completed with documented rationale behind any contraindications identified, and/or d/c orders for PRN medications within 14 days of the PRN order. DON/designee will audit 5x a week, 5 different residents x6 months to ensure PRN psychotropic medications are discontinued and/or proper documentation is in place to support the need for the PRN medicine. ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The DON/designee will complete audit tool to reflect residents on psychotropic medications have GDR's completed with documented rationale behind contraindications and/or d/c orders for PRN medications within14 days of the PRN order. ·The Director of Nursing / Designee will present the summaries of the audits to the	

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	appropriate. 1. The residents target symptoms returned or worsened after the most recent attempt at a tapering dose. 2. Past reduction attempts have resulted in problematic behavior and/or staff inability to provide care. 3. Past reduction attempts have resulted in psychiatric instability by exacerbating and underlying medical or psychiatric disorder. 4. Past reduction attempts have caused the resident to post danger to self or others. Please provide below a CMS required patient specific rationale describing why a Gradual Dosing Reduction attempt was clinically contraindicated." The response documented was " Hospice - contraindicated to dc (discontinue) or change at this time." There was no documentation of a clinical rational to show why the recommendation was contraindicated. 2. A record review for Resident 101 was completed on 1/17/2025 at 2:17 P.M. Diagnoses included, but were not limited to anxiety and depression. A Pharmacy Recommendation, dated 12/11/2024, for Resident 101 indicated the recommendation was to evaluate the continued need for Alprazolam 0.5 mg every 8 hours PRN (as needed). The form indicated the following: "Please consider: Discontinuing the medication. Add stop date to the medication for short-term use (MAX 14 days) and evaluate use. If current order is necessary, then please reevaluate resident and document risk/benefit to continue up to an additional 14 days to assist facility with regulatory requirements."		Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	The response to the recommendation, dated 1/22/2025, six weeks later was to "continue with the PRN." There was no documentation of a clinical rational to show why the recommendation was contraindicated. A Pharmacy Recommendation, dated 1/13/2025, for Resident 101 indicated the recommendation was to evaluate the continued need for Alprazolam 0.5 mg every 8 hours PRN (as needed). The form indicated the following: "Please consider: Discontinuing the medication. Add stop date to the medication for short-term use (MAX 14 days) and evaluate use. If current order is necessary, then please reevaluate resident and document risk/benefit to continue up to an additional 14 days to assist facility with regulatory requirements." The response to the recommendation, dated 1/22/2025, indicated to continue the Alprazolam 0.5 mg every 8 hours PRN for anxiety. There was no documentation of a clinical rational to show why the recommendation was contraindicated. During an interview, on 1/23/2025 at 9:20 A.M. the Director of Nursing indicated the Gradual Dose Recommendations did not have the documentation to support a medical contraindication to the recommendation. On 1/23/2025 at 11:14 A.M., the Administrator provided the policy titled, "Unnecessary Drugs", dated 12/12/2023, and indicated the policy was the one currently used by the facility. The policy indicated..."It is the facility's policy that each resident's drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs... Each			

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	resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements: a. Dose (including duplicate therapy) b. Duration of use. c. Indications and clinical need for medication... 8. Periodic re-evaluation of the medication regimen will be conducted as necessary to determine whether prolonged or indefinite use of the medication in indicated...." 3.1-48(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medications were kept in a locked cart when unattended, were dated and labeled, medication carts were without loose pills and failed to store treatment creams separate from oral medications during medication storage review for 2 of 3 storage units. (200 hall middle medication cart and 100 hall medication cart) Findings include: 1. During a medication storage observation of the 100 hall medication cart, on 1/22/2025 at 1:24 P.M., with QMA 16 the following was observed: - a bottle of Latanoprost eye drops with no resident identifier. - an opened and unlabeled bottle of Timolol eye drops. - an opened bottle of Lactulose with no opened date. - four loose pills in 2 drawers. During an interview, on 1/22/2025 at 1:51 P.M., QMA 16 indicated the medications should have	F 0761	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Medication Carts all locked when unattended, and free from loose pills and debris. no ill effect due to alleged deficient practice. ·Medications labeled and dated, tx creams removed from proximity of oral medications. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility that require medication pass, have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all Med carts are locked and free from debris/loose medications and that	02/12/2025

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	an opened date, the eye drops should have been labeled and the loose pills should not have been in the cart. 2. During a medication storage observation of the 200 hall middle cart, on 1/22/2025 at 2:24 P.M., with RN 2 the following was observed: - four tubes of diclofenac sodium 1% (a topical cream medication) stored with oral medications. - a tube of triad wound paste (a topical cream medication) - three tubes on Mupirocin ointment (a topical cream medication) - a tube of of nystatin ointment. - a tube of polygrip denture adhesive with no resident identifier. - an opened bottle of eye drops with a label over the drug name with no resident identifiers. During an interview, on 1/22/2025 at 2:46 P.M., LPN 17 indicated the treatments and topical cream medication should not have been stored in the the medication cart. On 1/23/2025 at 11:14 A.M., the Administrator provided the policy titled, "Medication Storage", dated 1/1/2025, and indicated the policy was the one currently used by the facility. The policy indicated, "4. Internal Products: Medications to be administered by mouth are stored separately from other formulations (i.e., eye drops, ear drops, injectable's). A policy was requested regarding labeling medications but one was not provided prior to the end of the survey. 3.1-25(j)		all meds are labeled and dated. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All nursing educated on the need to ensure that med carts are locked and free from loose meds/debris. Additionally, education provided to ensure creams and tx are separated from one another. DON/designee will audit 5x a week, to ensure all med carts are locked and free from loose meds/debris, medications are labeled/dated, and that oral medications are stored separate from tx creams ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The DON/designee will complete audit tool to reflect all med carts are locked when unattended, loose meds/debris removed from cart, oral meds are not mixed with tx creams. ·The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality	

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			Assurance committee that further monitoring is needed, audit will continue.	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on interview and record review, the facility failed to complete laboratory testing as ordered by the physician for 1 of 1 residents reviewed for laboratory services. (96) Finding includes: The record for Resident 96 was reviewed on 1/21/2025 at 10:09 A.M. Diagnosis included but were not limited to: diabetes mellitus type 2 (DM) with chronic kidney disease, iron deficiency anemia, legal blindness, hypertensive heart disease without heart failure and vitamin D deficiency. A current Care Plan, initiated on 6/26/2024 and updated 1/16/2025, indicated Resident 96 was risk for complications and symptoms of hypoglycemia or hyperglycemia due to a diagnosis of diabetes. Interventions, included but not limited to: diabetes medication as ordered by Medical Doctor (MD). observe for side effects and effectiveness, diet as ordered, educate and remind resident importance of medications and compliance with dietary restrictions, observe for signs or symptoms of hyperglycemia, observe for signs or symptoms of hypoglycemia, blood sugars as ordered by doctor, labs as ordered, document abnormal findings and notify MD. A current Care Plan, initiated on 6/26/2024 and updated 1/16/2025, indicated Resident 96 had impaired skin integrity stage 3 Pressure Ulcer to	F 0770	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident 96 labs completed as ordered. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility that require labs to be drawn, have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all labs are completed as ordered. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All nursing educated on the need to ensure that labs are completed as ordered. DON/designee will audit 5x a week, 5 random residents x6 months to ensure resident's laboratory testing is completed as ordered by the physician	02/12/2025

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MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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	the right heel- goes to Goshen wound clinic. Interventions, included but not limited to: assess and document skin condition, notify MD of signs of infection, assess for pain and treat as indicated, assist with bed mobility to turn and reposition routinely, pressure reducing/redistributing cushion in chair, pressure reducing/redistributing mattress on bed, prevalon boot to right foot at all times as tolerated, supplements as ordered, and wound treatment as ordered. A Physician's Order dated 11/11/2024, with a start date of 11/18/2024, included an order for a Hemoglobin A1c (a blood test to measure average blood glucose levels over a three month time span) every three months, starting on November 18, 2024. Resident 96's record lacked documentation the lab due on 11/18/2024 was completed. A Physician Order, dated 12/5/2024 from (local town name) Wound Center indicated laboratory work for a C-reactive protein and erythrocyte sedimentation rate (ESR), a blood test to used to detect inflammation in the body, was to be completed. A Nurse Progress Note, dated 12/6/2024 at 12:58 P.M. indicated the facility had received orders from Goshen wound center for labs and had entered into the electronic system utilized by the laboratory the facility used. A wound center report dated 12/12/2024 at 12:28 P.M., indicated that Resident 96 lab work had not been completed yet. A lab report dated 12/16/2024 indicated the CRP lab had been collected on 12/16/2024 at 3:20 A.M.,		·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The DON/designee will complete audit tool to reflect all labs are completed as ordered. ·The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	and results were reported to the facility on 12/16/2024 at 9:51 P.M. However, a wound center report dated 12/19/2024 at 10:00 A.M., indicated not all of the previously ordered tests were completed. A lab report dated 12/24/2024 indicated the ESR lab test had been collected on 12/20/2024 at 4:05 A.M., and the results were reported to the facility on 12/24/2024 at 9:03 A.M. During an interview conducted on 1/22/2025 at 2:50 P.M. The ADON indicated the facility was notified of wound center recommendations within 24-48 hours, the nurse on the unit was responsible for transcribing the new orders and placing the order into the electronic system for the laboratory. She stated the lab came three times per week, so she did not know why the labs had not been completed timely. During an interview, conducted on 1/23/2025 at 9:22 A.M., the Director of Nursing (DON) indicated Resident 96's A1c blood test should have been drawn on 11/18/2024 per the physician order. During an interview, conducted on 1/23/2025 at 9:54 A.M., RN 10 indicated Resident 96 should have had an A1C blood test on 11/18/2024, but it was not completed as ordered. She indicated Resident 96 had not had any A1C blood tests completed since the original order was placed on 11/11/2024. A policy was provided, on 1/23/2025 at 9:59 A.M., by the Director of Nursing. The policy titled, "Change in Condition/Physician Notification", indicated, " ...It is the policy of this facility to			

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	promptly identify, respond to, and report changes in resident conditions to the resident's physician/NP [nurse practitioner]/PA [physician assistant]/ resident representative. A significant change is a major decline or improvement pf the resident's status ...2. When a change in condition is discovered, the nurse will evaluate the resident and notify the resident's physician/NP/PA with pertinent information to discuss care for the resident. 3. The nurse will notify the physicians/NP/PA and the resident/resident representative when: medication omissions/errors ...excessive refusal of treatment or medications [typically more than 2-3 time] ...abnormal labs, weights, or vital signs ...." 3.1-49(a)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review and interview, the facility failed to store and prepare food under sanitary conditions related to foods not sealed appropriately, outdated foods, and dirty kitchen equipment for 1 of 1 kitchen observed. This issue had the potential to affect all 101 residents who resided in the facility and received food from this kitchen. Findings include: On 1/15/2025 at 9:45 A.M., a kitchen tour was conducted with the Dietician. The following was observed in the walk-in freezer: - A opened bag of green beans not sealed appropriately. - A opened bag of corn not sealed appropriately. - A opened bag of sausage patties not sealed appropriately.	F 0812	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·All food in kitchen sealed appropriately, outdated food discarded, food labeled/dated, and dirty kitchen equipment cleaned. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility receiving meals from our kitchen, have the potential to be affected by this alleged deficient practice. A full house audit was	02/12/2025

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	- A opened bag of eggs not sealed appropriately. The following was observed in the dry storage area: - a opened bag of cream soup base with no open date. During an interview on 1/15/2024 at 9:50 A.M., the Dietician indicated the items in the walk-in freezer should have been sealed appropriately and the bag of cream soup base should have had an open date. During a follow-up tour of the kitchen, on 1/16/2025 at 8:50 A.M. with the Dietary Manager (DM), the following was observed: - a can opener with dried food on it. - a spatula stored in the drawer as clean with dried food on it. - a measuring cup stored as clean with dried food and grease on it. - a knife stored as clean with dried food on it. - a measuring spoon stored as clean with dried food on it. - the utensils drawer had dried food on the bottom of it. During an interview on 1/16/2024 at 8:57 A.M., the DM indicated the kitchen utensils and the drawer should have been cleaned. On 1/16/2025 at 10:42 A.M., the DON provided a policy titled, "Kitchen Sanitation," dated 12/12/2023 and indicated it was the policy currently being used by the facility, The policy indicated, " Policy: The Dietary Manager will be responsible for overseeing the provision of safe food to all residents. Good sanitary food handling practices with sanitary conditions maintained in the storage, preparation and serving areas will be		completed to ensure all kitchen equipment is clean, food sealed properly, outdated food discarded, and all food labeled/dated. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All staff educated on the need to ensure that food is labeled/dated, utensils clean, outdated food discarded, and food sealed appropriately. Dietary Manager/designee will audit the kitchen 5x a week x6 months to ensure that all food is covered, kitchen utensils are clean, and food is dated. ·Audits will include all shifts, units, and weekends. **How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The Dietary Manager/designee will complete audit tool to reflect kitchen sanitation is maintained IE: food labeled/dated, utensils clean, outdated food discarded, and food sealed appropriately. ·The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further	

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	carried out at all times. The Dietary Manager, Consultant RD and/or designee will make regular inspections. On 1/16/2025 at 10:42 A.M., the DON provided a policy titled, "Labeling and Dating Guidelines," dated 12/12/2023 and indicated it was the policy currently being used by the facility. The policy indicated, "All opened and leftover items will be labeled with the date of opening/date stored and a discard/use-by date....." 3.1-21(i)(3)		monitoring is needed, audit will continue.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure infection control practices were followed related to glove use and handwashing for 3 of 3 residents reviewed for perineal/catheter care and for 1 of 1 residents reviewed for nephrostomy care and during 1 of 3 medication administration passes. In addition, the facility failed to follow their policy regarding Enhanced Barrier Precautions (EBP) to ensure residents with wounds and catheters were placed in isolation for 3 of 5 residents reviewed for EBP isolation. Finally, the facility failed to report an illness outbreak to the State Department of Health. These deficient practices potentially affected 101 of 101 residents in the facility. (Residents 18, E, 98, G, 96, 314 & H) Findings include: 1. During an observation, on 1/17/2025 at 9:56 A.M., Certified Nursing Assistant 11 was observed to provide perineal care to Resident 18. CNA 11 obtained a basin with warm water and	F 0880	Resident 314 Gloves donned/doffed appropriately during resident care. No ill effect due to alleged deficient practice. CNA 11, 3, and 18 was educated during survey on proper handwashing and glove use with resident care. Handwashing/Glove use completed appropriately during resident care. No ill effect due to alleged deficient practice. RN 19 was educated during survey on proper PPE when providing care and when scoring medications, not to touch with hands. Proper PPE worn and medications passed without touching meds with bare hands. Resident 96, EBP was put in place for. Resident 314 discharged from facility. Illness reported to Gateway for infection outbreak	02/12/2025

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	washcloths. She then applied gloves and washed the Resident's front and inner groin area. CNA 11 rolled the resident over and cleaned the resident's buttocks. Without washing her hands or changing her gloves, CNA 11 applied a clean brief, while touching the residents' legs and the clean brief. She then applied the resident's pants and placed a hoyer sling underneath the resident without removing her soiled gloves and/or washing her hands. During an interview, on 1/17/2025 at 10:00 A.M., CNA 11 indicated she should have washed her hands and changed gloves. 2. The record for Resident E was reviewed on 1/17/2025 at 11:25 A.M. Diagnoses included, but were not limited to: depression, cancer and obstructive uropathy. An Admission Minimum Data Set (MDS) assessment, dated 11/18/2024, indicated the resident required the use of a catheter and needed substantial to maximum assist for toileting. During an observation, on 1/21/2025 at 2:45 P.M., Certified Nursing Assistant (CNA) 18 was observed to provide incontinence/catheter care to Resident E. She placed a paper towel on the floor underneath the urinary drainage bag and emptied the urine into a urinal. She then used a washcloth and cleaned the urinary catheter and tubing. Without changing her gloves or washing her hands, CNA 18 applied barrier cream to the resident's buttocks. Next she rearranged the brief and attached the catheter drainage tubing to the adhesive strip on the residents upper leg. CNA 18 pulled the resident's shorts off and placed them in the closet. Finally CNA 18, with the same gloves still on, applied blankets over the resident and		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All current residents in the facility have the potential to be affected by this alleged deficient practice. A full house audit was completed to ensure all infection control is followed related to proper glove use, hand washing, EBP, touching medications with bare hands, additionally an audit was completed to ensure all outbreaks related to infection is reported to gateway. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur?** ·All nursing educated on handwashing, donning/doffing gloves, med pass infection control processes, EBP, and reporting guidelines for infections. DON/designee will audit 5x a week, 5 different staff x6 months to ensure that handwashing is taking place regularly, gloves donned/doffed correctly, EBP are in place, Proper Infection Control measures taken (related to medications being touched with bare hands), and infection outbreak reported to ISDH ·Audits will include all shifts, units, and weekends. **How will corrective actions(s)**	

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	grabbed a computer cord and handed it to the resident. She then removed her gloves and gown and placed them in the trash bag. During an interview, on 1/21/2025 at 3:02 P.M., CNA 18 indicated she should have changed her gloves and washed her hands. 3. During an observation, on 1/22/2025 at 9:27 A.M., RN 19 was observed to complete a pressure ulcer treatment with assistance from CNA 11 for Resident 98. RN 19 placed a barrier on the bed side table. CNA 11 and RN 19 washed their hands and applied gloves. RN 19 cleaned the coccyx area, removed his gloves and applied new gloves. RN 19 applied triad paste (wound dressing) on the coccyx area. RN 19 removed his gloves and then washed his hands. RN 19 was not wearing a gown while completing the pressure area treatment. There was no Personal Protective Equipment (PPE) or a sign indicating the resident was in Enhanced Barrier Precautions (EBP) available on the door or outside of the room. During an interview, on 1/22/2025 at 9:41 A.M., RN 19 indicated he would change his gloves only if he was contaminated and there should have been Personal Protective Equipment (PPE) available and he should have worn a gown. 4. During a medication administration observation, on 1/17/2025 at 12:06 P.M., RN 19 obtained a Lamictal tablet from the medication cart. RN 19 indicated the tablet had to be cut in 1/2 because it was a 200 mg (milligram) dose, and the resident was to receive 100 mg dose. RN 19 indicated the other half will be discarded.		**be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be put into place?** ·The DON/designee will complete audit tool to reflect handwashing is taking place regularly, gloves donned/doffed correctly, EBP are in place, Proper Infection Control measures taken with med pass, and infection outbreak reported to ISDH ·The Director of Nursing / Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months, thereafter, if it is determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	RN 19 placed the tablet in a pill cutter and then with an un-gloved hand, touched the pill to move it to the center. During an interview, on 1/17/25 at 12:07PM the RN indicated he should have worn gloves when touching the pill.5. A record review for Resident G was completed on 1/17/2025 at 9:18 A.M. Diagnoses included, but were not limited to: nephrostomy, obstructive and reflexive uropathy, overactive bladder and carcinoma of the bladder. A Quarterly Minimum Data Set (MDS) assessment, dated 12/23/2024, indicated Resident G was cognitively intact and had an indwelling catheter. A Physician's Order, dated 1/15/2025, indicated to monitor the nephrostomy output every shift. A Care Plan, dated 8/16/2024 and revised 12/17/2024, indicated Resident G was at risk for infection/complications related to the use of nephrostomy tubes. Interventions included, but were not limited to: catheter/peri-care at least every shift and as needed. During an observation, 1/21/2025 at 10:38 A.M., CNA 11 and 12 were providing incontinence care and nephrostomy tube/drainage bag care. CNA 12 brought in a step-by-step instruction guide on nephrostomy tube and drainage bag care provided by the Assistant Director of Nursing, who was also present in the room. CNA 12 indicated she would not have known how to care for a nephrostomy tube if she had not been given the instruction guide. CNA 11 emptied the nephrostomy drainage bag while using a soapy washcloth to release and seal the urinary drainage bag spout. CNA 11 asked, after completing the			

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	procedure, if a nephrostomy drainage bag used the same procedure as emptying a Foley urinary drainage bag and using an alcohol prep pad for cleansing the spout. 6. The record for Resident 96 was completed on 1/21/2025 at 10:09 A.M. Diagnosis included but were not limited to: diabetes mellitus type 2 (DM) with chronic kidney disease, iron deficiency anemia, legal blindness, hypertensive heart disease without heart failure, and vitamin D deficiency. A current Care Plan, initiated 6/26/2024 and updated 1/16/2025, indicated Resident 96 had impaired skin integrity stage 3 pressure ulcer to the right heel- goes to Goshen wound clinic. Interventions included but not limited to, assess and document skin condition, notify MD of signs of infection, assess for pain and treat as indicated, assist with bed mobility to turn and reposition routinely, pressure reducing/redistributing cushion in chair, pressure reducing/redistributing mattress on bed, prevalon boot to right foot at all times as tolerated, supplements as ordered, and wound treatment as ordered. During an observation of the room of resident 96 on 11/22/2025 at 11:55 A.M., there was no sign or personal protective equipment to identify that resident was on enhanced barrier precautions. During an interview conducted on 1/22/2025 at 11:53 A.M., RN 10 indicated that resident 96 had a stage three pressure ulcer to her right heel. She indicated that because of the pressure ulcer, the resident should have been on enhanced barrier precautions. 7. A record review for Resident 314 was completed on 1/22/2025 at 10:09 A.M. Diagnosis			

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	included but were not limited to lymphedema, hypertension, and COPD. A current care plan dated 1/15/2025 indicated that Resident 314 has impaired skin integrity: pressure ulcer on left buttocks stage 2, Venous ulcer - right great toe, right 2nd toe, left great toe, left 2nd toe, and left 3rd toe. Interventions included but were not limited to: assess and document skin condition, notify MD of signs of infection (redness, drainage, pain, fever), assess for pain and treat as indicated, assist with bed mobility to turn and reposition routinely, notify MD of worsening or not improvement in wound, pressure reducing/redistributing mattress on bed, wound treatment as ordered. During an interview on 1/22/2025 at 2:18 P.M., LPN 16 indicated that Resident 314 has wounds that were treated by the wound center and also had wounds on his toes that were treated by the facility. She indicated that with the wounds the resident should have been on enhanced barrier precautions. During an observation on 11/22/2025 at 2:20 P.M., Resident 314 was sitting in his wheelchair with wraps on his bilateral lower extremities. There was no sign or personal protective equipment to identify that resident was on enhanced barrier precautions.8. The record for Resident H was reviewed on 1/17/2025 at 10:04 A.M. Diagnoses included, but were not limited to: malignant neoplasm of prostate and colon and obstructive and reflex uropathy. During an observation of catheter care on 1/21/2025 at 3:29 P.M., CNA 3 put on a gown and a pair of gloves prior to entering Resident H's room. CNA 3 removed the resident's pants and			

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	brief. CNA 3 then changed her gloves began cleaning the resident's catheter tubing. CNA 3 grabbed a clean brief from the bedside table and removed the resident's soiled brief, proceeded to provide perineal care with a soapy rag, placed the clean brief on the resident with the same gloves that had been used to provide perineal care. CNA 3 then pulled the residents pants up and covered the resident with his blankets. CNA 3 removed her gloves and performed hand hygiene. During an interview on 1/21/2025 at 3:43 P.M., CNA 3 indicated she had not changed her gloves after providing perineal care and should have. During an interview on 1/16/2025 at 11:44 A.M., the DON indicated when she was notified of nausea, vomiting and diarrhea in multiple residents on the 200 unit, she notified the Nurse Practitioner and the local Health Department. A review of the facilities monthly infection surveillance report for the month of January indicated 20 residents experienced nausea, vomiting and diarrhea that began on 1/3/2025. A record review was completed for all residents that resided on the 200 hall and indicated an additional six residents, who were not documented on the monthly infection surveillance report for the month of January also experienced nausea, vomiting and diarrhea on 1/3/2025. During an interview on 1/16/2025 at 2:16 P.M., the ADON indicated the cases were not reported to the state and should have been. A policy was provided, on 1/23/2025 at 12:16 P.M., by the Director of Nursing. The policy titled, "Nephrostomy-Cystostomy Care", indicated, "			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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	...Residents with nephrostomy or cystostomy tubes will receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences ...2. The care and maintenance of nephrostomy/cystostomy tubes shall be in accordance with physician orders. The orders shall specify the type and frequency of dressing changes and emptying of collection bags along with special instructions. 3. Nephrostomy/cystostomy tubes shall be managed by licensed nurses. Nurse aides may handle the collection bags in accordance with facility procedures for handling urinary drainage bags ...." A policy for urinary drainage bags was requested, on 11/23/2025 at 11:42A.M. The Executive Director indicated a policy was not available for maintenance of a urinary drainage bag. On 1/16/2025 at 2:33 P.M., the ADON provided the policy titled, "Reportable Infections," dated 1/2/2024 and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy of this facility to report possible incidents of communicable disease or infections to appropriate personnel or authorities. 9. The Infection Preventionist will review lab reports. Any infection or communicable disease that is a reportable disease will be reported to public health authorities...." On 1/21/2025 at 9:22 A.M., the Administrator provided the policy titled, "Medication Administration", dated 12/12/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...13, Remove medication from source, taking care not to touch medication with bare hand...."			

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	A current policy was provided by the ADON on 1/22/2025 at 10:23 A.M., titled, "Enhanced Barrier Precautions", indicated an order for enhanced barrier precautions would be obtained for residents with the following: "Wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers ....and/or indwelling medical devices even if the resident is not know to be infected or colonized with a MDRO...." A policy was requested regarding catheter care but one was not provided prior to the survey exit. This citation relates to complaint IN00451678. 3.1-18(a) 3.1-18(b)(2)			