STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2025			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
E 0000	REGULATORT OF	R ESC IDENTIFY TING INFORMATION	IAG		DATE		
Bldg	conducted by the In accordance with 42 Survey Date: 02/25 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency Care of Goshen was Emergency Prepare Medicare and Med and Suppliers, 42 C The facility has 186 the survey, the cens	00091 155689 290080 Preparedness survey, Majestic is found not in compliance with edness Requirements for icaid Participating Providers CFR 483.73 6 certified beds. At the time of	E 0000	Majestic Care of Goshen pleaccept the following as the facility's credible allegation compliance. This plan of correction does not constitu an admission of guilt or liable by the facility and is submitted only in response to the regulatory requirement. Majestic Care of Goshen respectfully asks for consideration of a desk review.	of ite ility red		
E 0007 SS=F Bldg	Based on record re failed to ensure the addressed resident limited to, persons	view and interview, the facility emergency preparedness plan population, including, but not at-risk; in accordance with 42 This deficient practice could	E 0007	E007 EP Program Patient Population What corrective action will b accomplished for those residents found to have beer affected by the deficient practice? Resident population added	n to		
	Maintenance Direction 02/25/25, no do	view and interview with the tor from 9:33 a.m. to 1:04 p.m. cumentation was provided tency preparedness plan		the EP binder. No ill effect due alleged deficient practice. How will you identify other residents having the potentia to be affected by the same			

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

TITLE

(X6) DATE

Tiffany Shepperd Executive Director 03/18/2025

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED			<u>`</u>	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED
		155689	B. WI	NG		02/25/2025
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NEAR OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		population, including, but not			deficient practice and what	
		at-risk. Based on interview at			corrective action will be take	n?
		eview, the Maintenance			·All current residents in the	
		w updated emergency			facility have the potential to be	
		s currently being worked on,			affected by the alleged deficie	
		e has not been in his position			practice. A full house audit wa	S
	very long and has n	ot reviewed the current plan.			completed to ensure all EP	
					binders include resident	
		viewed with the Maintenance			population.	
	Director at the exit	conference.			What measures will be put in	ito
					place or what systematic	
					changes will you make to	
					ensure that the deficient	
					practices do not recur?	
					·All staff educated on the ne	
					to ensure that EP binders inclu	ade
					resident population.	
					Maintenance/designee wi	
					audit all EP binders 1x weekly months to ensure EP binders	XO
					include resident population.	
					How will corrective actions(s	
					be monitored to ensure the	"
					deficient practice will not	
					occur, l.e., what quality	
					assurance program will be p	ut
					into place?	
					·Maintenance/designee will	
					complete audit tool to reflect	
					resident population included ir	n the
					EP binder.	
					·Maintenance/Designee will	
					present the summaries of the	
					audits to the Quality Assuranc	е
					committee monthly for 6 mont	hs,
					thereafter, if it is determined b	у
					the Quality Assurance commit	tee
					that further monitoring is need	ed,
					audit will continue.	
						l

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	l í	JILDING	NSTRUCTION		SURVEY LETED 5/2025
	PROVIDER OR SUPPLIER		-	2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
E 0015 SS=F Bldg		3.113(b)(6)(iii), 441.1 Is for Staff and Patients					
Bldg	failed to ensure emer and procedures inch provision of subsistives residents, whether the place, include, but a (i) Food, water, mer supplies. (ii) Alternation and (a) Temphealth and safety and storage of provision Fire detection, extinuand (b) Sewage and with 42 CFR 483.73 could affect all resident findings include: Based on record revelocity Maintenance Direct on 02/25/25, no polyprovided regarding pharmaceutical suppharmaceutical suppha	riew and interview with the or from 9:33 a.m. to 1:04 p.m. icy, plan or procedure was food, medical, and plies. Based on interview, the or stated a new updated dness plan is currently being stated that he has not been in ng and has not reviewed the viewed with the Maintenance	E 0	015	Majestic Care of Goshen accept the following as the facility's credible allegatic compliance. This plan of correction does not constant admission of guilt or liby the facility and is submonly in response to the regulatory requirement. E015 Subsistence Needs Staff and Patients What corrective action with accomplished for those residents found to have be affected by the deficient practice? Emergency evacuation padded to the EP binder incomplarmacy process and procedures, emergency for process, as well as emerged water. No ill effect due to a deficient practice. How will you identify other residents having the pote to be affected by the same deficient practice and what corrective action will be tareful to a fected by the alleged definition of the practice. A full house audit completed to ensure all EP binders include the policies emergency evacuation include emergency pharmacy, food	titute cability nitted for II be een colicy luding cod ency llleged er ntial e at aken? ne co be ccient was c for uding	03/14/2025
					water policies.		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2025		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MAJESTI	IC CARE OF GOSH	HEN	2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					What measures will be put i	nto	
					place or what systematic		
					changes will you make to ensure that the deficient		
					practices do not recur?		
					·All staff educated on the ne	eed	
					to ensure that EP binders inc		
					emergency evacuation policie		
				encompassing emergent			
					pharmacy, food, and water		
					supplies.		
					Maintenance/designee w		
					audit all EP binders 1x weekl	•	
					months to ensure EP binders		
					include updated emergency		
					evacuation policies, including		
					pharmacy, food, and water		
					supplies. How will corrective actions(۵)	
					be monitored to ensure the	3)	
					deficient practice will not		
					occur, I.e., what quality		
					assurance program will be	out	
					into place?		
					·Maintenance/designee will		
					complete audit tool to reflect		
					emergency evacuation policie		
					included in the EP binder tha		
					include emergent pharmacy,	food,	
					and water supplies.		
					·Maintenance/Designee wil		
					present the summaries of the		
					audits to the Quality Assuran committee monthly for 6 mon		
					thereafter, if it is determined I		
					the Quality Assurance comm	-	
					that further monitoring is need		
					audit will continue.	 ,	

Event ID: H1T021 Facility ID: 000091 If continuation sheet Page 4 of 45

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED	
		155689	B. W	ING		02/25/	2025
	ROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		NIE.	DATE	
E 0018	403.748(b)(2), 416	6.54(b)(1), 418.113(b)(
SS=F	, , , ,	acking of Staff and Patients					
Bldg		· ·					
	Based on record rev	view and interview, the facility	E 0	018	Majestic Care of Goshen ple	ase	03/14/2025
	failed to ensure eme	ergency preparedness policies			accept the following as the		
	and procedures incl	uded a system to track the			facility's credible allegation of compliance. This plan of		
	_	staff and sheltered residents					
in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all residents and				correction does not constitu			
				an admission of guilt or liab	-		
				by the facility and is submitt	ted		
				only in response to the			
				regulatory requirement.			
				E018 Procedures for Trackin	g		
				Staff and Patients			
	staff.				What corrective action will b	е	
	Findings in 1.4.				accomplished for those	_	
	Findings include:				residents found to have been	n	
	Dagad an reased ray	view and interview with the			affected by the deficient		
		for from 9:33 a.m. to 1:04 p.m.			practice? ·Emergency evacuation poli	01/	
		icies or procedures that			added to the EP binder that	Су	
	_	o track the location of on-duty			included tools for tracking both	h	
	-	residents in the LTC facility's			staff and resident population.		
		er an emergency was available			effect due to alleged deficient		
	_	n interview at the time of			practice.		
		Maintenance Director referred			How will you identify other		
		cuation plan; however, the plan			residents having the potential	al	
		uation and relocation and did			to be affected by the same		
	not refer to a trackir	ng system in place.			deficient practice and what		
					corrective action will be take	n?	
		viewed with the Maintenance			·All current residents in the		
	Director at the exit	conference.			facility have the potential to be		
					affected by the alleged deficie		
					practice. A full house audit wa	ıs	
					completed to ensure all EP		
					binders include the policies fo		
					emergency evacuation includi	-	
					resident and staff population a	and	
					tracking tools.	.4	
					What measures will be put ir	ito	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING		COMPI	COMPLETED	
		155689	B. W	ING		02/25/2025		
				_				
NAME OF F	PROVIDER OR SUPPLIE	2			ADDRESS, CITY, STATE, ZIP COD			
		15.1			OLLEGE AVE			
MAJEST	IC CARE OF GOSI	HEN		GOSHE	EN, IN 46526			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					place or what systematic			
					changes will you make to			
					ensure that the deficient			
					practices do not recur?			
					·All staff educated on the ne	ed		
					to ensure that EP binders incl	ude		
					emergency evacuation policie	S		
					encompassing staff and reside	ent		
					tracking.			
					Maintenance/designee wi	II		
					audit all EP binders 1x weekly	x6		
					months to ensure EP binders			
					include updated emergency			
					evacuation policies, including	staff		
					and resident tracking tools.			
					How will corrective actions(s	;)		
					be monitored to ensure the			
					deficient practice will not			
					occur, I.e., what quality			
					assurance program will be p	ut		
					into place?			
					·Maintenance/designee will			
					complete audit tool to reflect			
					emergency evacuation policie			
					included in the EP binder that			
					include staff and resident			
					population.			
					·Maintenance/Designee will			
					present the summaries of the	_		
					audits to the Quality Assurance			
					committee monthly for 6 mont			
					thereafter, if it is determined b	-		
					the Quality Assurance commit that further monitoring is need			
					audit will continue.	c u,		
					audit will continue.			
E 0030	403 748(c)(1) 41(6.54(c)(1), 418.113(c)(
SS=F	Names and Conta							
Bldg	a.mee and conte							
J.	Based on record re-	view and interview, the facility	E 00	030	Majestic Care of Goshen ple	ase	03/14/2025	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u></u>	COMPLETED
		155689	B. W	ING		02/25/2025
				OTD FET	A DODDEGG CHTM CTATE THE COD	
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD	
NAA IEGE	10 04 DE 0E 0001	IENI			OLLEGE AVE	
MAJEST	IC CARE OF GOSI	HEIN		GOSHE	EN, IN 46526	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	failed to ensure the	emergency preparedness			accept the following as the	
	communication pla	n includes (1) Names and			facility's credible allegation	of
	contact information	for the following: (i) Staff (ii)			compliance. This plan of	
	Entities providing s	services under arrangement (iii)			correction does not constitu	ıte
		ns (iv) Other LTC facilities (v)			an admission of guilt or liab	ility
	Volunteers in accor	dance with 42 CFR 483.73(c)			by the facility and is submitt	ted
	(1). This deficient p	practice could affect all			only in response to the	
	occupants.				regulatory requirement.	
					E030 Names and Contact	
	Findings include:				Information	
					What corrective action will b	е
		view and interview with the			accomplished for those	
		tor from 9:33 a.m. to 1:04 p.m.			residents found to have been	n
	·	cumentation was provided			affected by the deficient	
		communication plan included			practice?	
		information for staff, residents'			·Names and contact informa	ation
		TC facilities or volunteers. The			for staff, entities providing	
	_	n did include a list of vendors			services, resident physicians,	
	_	roviding services. This			LTC facilities added to the EP	
	_	ould affect all residents and			binder. No ill effect due to alle	ged
	staff.				deficient practice.	
		t deal area.			How will you identify other	
		viewed with the Maintenance			residents having the potentia	al
	Director at the exit	conference.			to be affected by the same	
					deficient practice and what	
					corrective action will be take	nr
					·All current residents in the	
					facility have the potential to be affected by the alleged deficie	
					practice. A full house audit wa	
					completed to ensure all EP	ان
					binders include the contact	
					information for staff, entities	
					providing services, resident	
					physicians, and LTC facilities	in
					the county.	""
					What measures will be put in	nto
					place or what systematic	
					changes will you make to	
					ensure that the deficient	
	I		1		Silvare that the delicient	l

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

PRINTED: 03/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	JPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		COMPLETED	
		155689	B. WING		02/2	5/2025
	PROVIDER OR SUPPLIE		1	STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUSC INFORMATION	PR	ID PROVIDER'S PLAN OF CORRECT EFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION
E 0031 SS=F Bldg	403.748(c)(2), 41 Emergency Offici	6.54(c)(2), 418.113(c)(als Contact Information		practices do not recur? ·All staff educated on the toensure that EP binders names and contact informationstaff, entities providing seresident physicians and Lacilities in the county. Maintenance/designer audit all EP binders 1x were months to ensure EP bindinclude updated contact information of above entite How will corrective actions to ensure deficient practice will not occur, I.e., what quality assurance program will into place? ·Maintenance/designer complete audit tool to reflicent audit tool to reflicent contact information is incomplete audit tool to reflicent act information of all entities above. ·Maintenance/Designer present the summaries of audits to the Quality Assurance complete monthly for 6 thereafter, if it is determine the Quality Assurance countant further monitoring is audit will continue.	s include nation for ervices, TC ee will eekly x6 ders ies. ons(s) the ot will ect all uded in e contact listed e will f the urance months, ied by mmittee needed,	DATE
	failed to ensure the communication pla	view and interview, the facility emergency preparedness n includes (2) Contact following: (i) Federal, State,	E 003	Majestic Care of Goshel accept the following as facility's credible allega compliance. This plan o	the tion of	03/14/2025

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u></u>	COMPLETED
		155689	B. W	'ING		02/25/2025
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD	
MA IECT		IENI			OLLEGE AVE	
WAJEST	IC CARE OF GOSH	1EN		GUSHE	EN, IN 46526	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	tribal, regional, or l	ocal emergency preparedness			correction does not constitu	ıte
	staff (ii) The State I	Licensing and Certification			an admission of guilt or liab	ility
	Agency (iii) The Of	ffice of the State Long-Term			by the facility and is submitt	ted
	Care Ombudsman (iv) Other sources of assistance			only in response to the	
	in accordance with	42 CFR 483.73(c) (2). This			regulatory requirement.	
	deficient practice co	ould affect all residents, staff			E031 Emergency Officials	
	and visitors.				Contact Information	
					What corrective action will b	e
	Findings include:				accomplished for those	
					residents found to have been	n
	Based on record review and interview with the				affected by the deficient	
	Maintenance Director from 9:33 a.m. to 1:04 p.m.				practice?	
	on 02/25/25, the emergency preparedness				Emergency officials' contact	it
	communication plan included "911" as the contact				information for Federal, State,	,
	phone number for local police, fire and emergency				tribal, regional, ISDH, and the	
	medical services, bu	ut failed to include contact			Ombudsman added to the EP	
	information for Fed	leral, State, tribal, or regional,			binder. No ill effect due to alle	ged
	the State Licensing	and Certification Agency, the			deficient practice.	
	Office of the State l	Long-Term Care Ombudsman			How will you identify other	
	or other sources of	assistance.			residents having the potential	al
					to be affected by the same	
	This finding was re	viewed with the Maintenance			deficient practice and what	
	Director at the exit	conference.			corrective action will be take	n?
					·All current residents in the	
					facility have the potential to be	e
					affected by the alleged deficie	₁nt
					practice. A full house audit wa	is
					completed to ensure all EP	
					binders include the contact	
					information for Emergency	
					personnel.	
					What measures will be put ir	nto
					place or what systematic	
					changes will you make to	
					ensure that the deficient	
					practices do not recur?	
					·All staff educated on the ne	
					to ensure that EP binders incl	ude
					and contact information for	
					emergency personnel.	

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

PRINTED: 03/21/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155689	A. BUILDING B. WING	onstruction 	COMPLETED 02/25/2025		
	PROVIDER OR SUPPLIEI		2400 C	STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Maintenance/designee will audit all EP binders 1x weekly months to ensure EP binders include updated contact information of above entities. How will corrective actions(some monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be pointo place? Maintenance/designee will complete audit tool to reflect a contact information is included the EP binder that include continformation of all entities listed above. Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 montions the program of the public program of the audity Assurance committee monthly for 6 montions that further monitoring is need audit will continue.	y x6 s) but all d in ntact d ce ths, by ttee		
E 0037 SS=F Bldg	403.748(d)(1), 41 EP Training Progr	6.54(d)(1), 418.113(d)(ram					
	failed to conduct ar Emergency Prepare facility must do all (i) Initial training in policies and proced staff, individuals pr arrangement, and v expected roles;	view and interview, the facility inual training for the edness Program (EPP). The LTC of the following: In emergency preparedness ures to all new and existing evolding services under colunteers, consistent with their ency preparedness training at	E 0037	Majestic Care of Goshen ple accept the following as the facility's credible allegation compliance. This plan of correction does not constitu an admission of guilt or liab by the facility and is submitt only in response to the regulatory requirement. E037 EP Training Program What corrective action will be	of ite ility ted		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	LETED
		155689	B. W	ING		02/25	/2025
		<u> </u>	1	OTT DET	ADDRESS CITY STATE TO SOF		
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE		
MAJEST		IENI					
MAJEST	IC CARE OF GOSH	1EN		GUSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` ′	mentation of all emergency			accomplished for those		
	preparedness training	_			residents found to have been	n	
		aff knowledge of emergency			affected by the deficient		
	-	dance with 42 CFR 483.73(d)			practice?		
	(1).				·Annual EPP training provid		
	_	ice could affect all residents,			all staff. No ill effect due to alle	eged	
	staff and visitors.				deficient practice.		
	F				How will you identify other		
	Findings include:				residents having the potential	al	
					to be affected by the same		
	Based on record review and interview with the Maintenance Director from 9:33 a.m. to 1:04 p.m.				deficient practice and what		
		•			corrective action will be take	n?	
	·	cumentation of annual EPP			·All current residents in the		
	training and no documentation to show staff				facility have the potential to be		
		knowledge of the EPP was			affected by the alleged deficie		
		v. Based on record review and			practice. A full house audit wa		
	_	copy of training conducted			completed to ensure EPP train	ning	
		based Relias system was			took place for all staff.		
	_	no emergency preparedness			What measures will be put in	nto	
		in the completed training. No			place or what systematic		
		ntation to show evidence of			changes will you make to		
		rovided to show initial or			ensure that the deficient		
	_	taff knowledge of emergency			practices do not recur?	a	
	procedures.				·All staff educated on EPP.		
		the state of the state of			further educated on the need		
		viewed with the Maintenance			ensure that annual training tal	Kes	
	Director at the exit	conference.			place for EPP.	:11	
					Maintenance/designee wi		
					audit all EPP training 1x week	-	
					x6 months to ensure EP traini	ng	
					is taking place upon hire and		
					annually.		
					How will corrective actions(s	5)	
					be monitored to ensure the		
					deficient practice will not		
					occur, l.e., what quality	4	
					assurance program will be p	ut	
					into place?		
					·Maintenance/designee will		
	I		1		complete audit tool to reflect a	all	1

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NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2025
		2400 C	COLLEGE AVE	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
			EP training is completed upon and annually. Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 monthereafter, if it is determined the Quality Assurance committee that further monitoring is need audit will continue.	e nce nths, by nittee
Based on record reversities failed to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based function in the LTC facility or man-made emergency plants from engaging its not community-based of full-scale functional the onset of the acture (ii) Conduct an additional exercise. b. A mock disaster of the conduct of functional exercise. b. A mock disaster of the conduct of the conduct of the community-based of functional exercise.	rements riew and interview, the facility ercises to test the emergency er year, including drills using the emergency C facility must do the annual full-scale exercise that distributed in the content of the content	E 0039	E039 EP Testing Requirement What corrective action will accomplished for those residents found to have be affected by the deficient practice? Emergency drill conduct for "Active Shooter" and a to drill for 2025. No ill effect duralleged deficient practice. How will you identify other residents having the potent 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 laffected by the alleged deficient practice. A full house audit we completed to ensure all EP binders include emergency conducted within 12 months. What measures will be put place or what systematic changes will you make to	be en cted rnado e to tial cken? e be ient vas drills
	PROVIDER OR SUPPLIER IC CARE OF GOSH SUMMARY: (EACH DEFICIEN REGULATORY OR Based on record reversed failed to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community accessible, conduct facility-based functions. If the LTC facilit or man-made emerge of the emergency pleased from the emergency pleased functional the onset of the actu (ii) Conduct an additinclude, but is not lia. A second full-scal community-based of functional exercise. b. A mock disaster of c. A tabletop exercise.	DENTIFICATION NUMBER 155689 PROVIDER OR SUPPLIER IC CARE OF GOSHEN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a	DENTIFICATION NUMBER 155689 ROVIDER OR SUPPLIER IC CARE OF GOSHEN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that is community-based or an individual, facility-based functional exercise that is community-based or an individual, facility-based functional exercise that is community-based or an individual, facility-based functional exercise that is community-based or an individual, facility-based functional exercise that is community-based or an individual, facility-based functional exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or	PROVIDER OR SUPPLIER IC CARE OF GOSHEN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION By WING EP training is completed up and annually. Maintenance/Designee will present the summaries of the audits to the Quality Assurance comm that further monitoring is near audit will continue. 403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based functional exercise for 1 year following: (ii) Conduct an additional exercise that is community-based or an individual, facility-based functional exercise that is community-based or an individual, facility-based functional exercise that is community-based or individual, facilit

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	r í	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	a narrated, clinically and a set of problem messages, or prepar challenge an emerge (iii) Analyze the LT maintain documenta exercises, and emer LTC facility's emer accordance with 42 This deficient pract staff and visitors. Findings include: Based on record rev Maintenance Direct on 02/25/25, the fact documentation of arconducted in the last interview, the Main active shooter exercince in the last 12 metrics.	TC facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). ice could affect all residents, riew and interview with the for from 9:33 a.m. to 1:04 p.m. callity failed to provide my emergency exercises at 12 months. Based on tenance Director stated an rise was conducted but was bonths.		ID PREFIX TAG	providers Plan of correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) practices do not recur? All staff educated on the net to ensure that EP binders include updated emergency drills. Maintenance/designee with audit all EP binders 1x monthly months to ensure EP binders include updated emergency drills. How will corrective actions (so be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be printo place? Maintenance/designee will complete audit tool to reflect a emergency drills are conducted least annually. Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 month thereafter, if it is determined by the Quality Assurance committed audit will continue.	eed ude II y x6 rills. s) ut ed at	(X5) COMPLETION DATE
K 0000							
Bldg. 01	Licensure Survey w		K 0	000	Majestic Care of Goshen pleaccept the following as the facility's credible allegation of compliance. This plan of correction does not constituan admission of guilt or liability the facility and is submitted only in response to the	of ite ility	

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Provider Number: 155689

AIM Number: 100290080

Event ID:

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Facility ID: 000091

regulatory requirement.

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155689	B. WING	-	02/25/		
		.0000			52,20		
NAME OF D	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	NO VIDER OR SUPPLIER	X.	2400 C	COLLEGE AVE			
MAJEST	IC CARE OF GOSH	IEN	GOSH	EN, IN 46526			
07.0 TD	ovn n s	OT LITERATE OF DESCRIPTION				OV.5°	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
			Majestic Care of Goshen respectfully asks for				
	Requirements for Pa	-		consideration of a desk revi	iow.		
	-	-		Consideration of a desk revi	ew		
		, 42 CFR Subpart 483.90(a),					
	-	re and the 2012 edition of the					
		ction Association (NFPA) 101,					
	,	SC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	This one-story facil	ity was determined to be of					
	· ·	ruction and was fully					
		cility has a fire alarm system					
	_	-					
		on in the corridors and in areas					
	-	rs. The resident rooms are					
	-	e station, hard wired smoke					
		ding is partially protected by					
		l gas-powered emergency					
	generators. The fac	eility has a capacity of 186 and					
	had a census of 110	at the time of this survey.					
	All areas where resi	idents have customary access					
		The facility had a storage shed					
	_	s sprinklered, and two					
		eds that were not sprinklered.					
	astachea storage sir	The mare not sprinklered.					
	Quality Review con	npleted on 02/28/25					
K 0291	NFPA 101						
SS=F	Emergency Lightir	ng					
Bldg. 01		-					
_	Based on observation	on, record review and	K 0291	Majestic Care of Goshen ple	ease	03/14/2025	
		ty failed to ensure 1 of 1	12 0271	accept the following as the		03/11/2023	
		t was tested monthly and		facility's credible allegation	of		
		utes over the past year to		compliance. This plan of	J.		
	-	ald provide lighting during		correction does not constitu	ıto		
	_	itages and a written record of					
	•			an admission of guilt or liab	-		
	-	nd tests was provided.		by the facility and is submit	tea		
	Section /.9.3.1.1 (1) requires functional testing		only in response to the			

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shall be conducted monthly, with a minimum of 3

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regulatory requirement.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	weeks and a maxim for not less than 30 testing shall be cond of 1 1/2 hours if the battery powered and inspections and test for inspection by the jurisdiction. This desidents, staff and Findings include: Based on record reve Maintenance Direct on 02/25/25, docum was provided; howe testing for an emerginary review. Based on ol Maintenance Direct on 02/25/25, a batter was located in the moutside to the generobservation the Maintenance Maintenance Direct on 02/25/25, a batter was located in the moutside to the generobservation the Maintenance Direct observation the Maintenance Direct on 02/25/25, a batter was located in the moutside to the generobservation the Maintenance Direct observation the Maintenance Di	um of 5 weeks between tests, seconds, (3) Functional ducted annually for a minimum emergency lighting system is d (5) Written records of visual is shall be kept by the owner e authority having efficient practice could affect all efficient practice could affect all evisitors. The wand interview with the for from 9:33 a.m. to 1:04 p.m. tentation of testing of exit signs ever, no documentation of testing of exit signs ever, no documentation of testing of exit signs ever, no documentation of testing of exit signs every light was available for the proposer of the proposer	TAG	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Battery powered emerged light that was located in the mechanical room leading out to the generator area was test annually for at least 90 minut. Additionally, the battery back light is tested monthly for at least 90 seconds. No ill effect due alleged deficient practice. How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be tak. All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit we completed to ensure all batter powered emergency lights we tested annually for at least 90 minutes. Additionally, the batter backup light was tested mont for at least 30 seconds. What measures will be put it place or what systematic changes will you make to ensure that the deficient practices do not recur? All staff educated on the net to ensure that all battery power emergency lights were tested annually for at least 90 minutes. Additionally, the battery power emergency lights were tested annually for at least 90 minutes. All staff educated on the net to ensure that all battery power emergency lights were tested annually for at least 90 minutes. And backup light tested monted to ensure that all battery power emergency lights were tested annually for at least 90 minutes. And backup light tested monted to ensure that the deficient practices do not recur?	pe pency side sted es. up peast to bial en? e eent es ry ere o terry hily ento eed ered les.

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

PRINTED: 03/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155689	B. WI	NG		02/25/	/2025
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					for at least 30 seconds. Maintenance/designee wi audit all documentation for bat powered emergency lights 1x monthly x6 months to ensure battery powered emergency ligwere tested. How will corrective actions(s be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be pinto place? Maintenance/designee will complete audit tool to reflect ensure that all battery powered emergency lights were tested. Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 month thereafter, if it is determined by the Quality Assurance committed audit will continue.	ghts b) ut d e hs, y tee	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities						
	interview; the facili documentation of 1 annual or semiannu NFPA 96, 2011 Ed Control and Fire Pr Cooking Operation exhaust system sha buildup by a proper certified person(s) a	review, observation and ity failed to provide of 1 kitchen exhaust system hally cleaning and inspection. ition, Standard for Ventilation otection of Commercial s, Section 11.4 states the entire hall be inspected for grease rly trained, qualified, and acceptable to the authority and in accordance with Table	K 03	324	Majestic Care of Goshen plea accept the following as the facility's credible allegation of compliance. This plan of correction does not constitu an admission of guilt or liabil by the facility and is submitt only in response to the regulatory requirement. K 324 Cooking Facilities What corrective action will be	of te ility ed	03/14/2025

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02/21/2025

	T OF HEALTH AND HU					FOI	RM APPROVED B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED	
		155689	B. W	/ING		02/25/2025		
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526			
(V4) ID	CLIMANA DAY	CTATEMENT OF DEPOSITACIE			, T		(7/5)	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION Schedule for Inspection for	+	TAG	accomplished for those		DATE	
		quires systems serving			residents found to have been	1		
	-	ooking operations shall be			affected by the deficient	•		
		ally. NFPA 96, 11.6.1 states,			practice?			
	-	the exhaust system is found to			Documentation obtained	to		
		ith deposits from grease laden			show that inspection/cleaning			
		inated portions of the exhaust			the kitchen hood exhaust syste			
	_	aned by a properly trained,		completed. No ill effect due to				
		fied person(s) acceptable to the		alleged deficient practice.				
		risdiction. Hoods, grease			Kitchen staff needed train	ied		
	removal devices, fa	ans, ducts, and other			on the proper use of portable f	ire		
	appurtenances shall	l be cleaned to remove			extinguishers and the manual			
	combustible contan	ninants prior to surfaces			activation of fire-extinguishing			
	becoming heavily of	contaminated with grease or			equipment.			
	oily sludge. After t	the exhaust system is cleaned,			Facility marked designate	ed		
	it shall not be coate	ed with powder or other			areas for returning cooking			
	substance. When a	n exhaust cleaning service is			appliances to where they were	!		
	used, a certificate s	howing the name of the			under the kitchen hood			
	servicing company,	, the name of the person			extinguishing equipment when	the		
	performing the wor	k, and the date of inspection or			cooking appliances are moved	for		
	cleaning shall be m	aintained on the premises.			the purposes of maintenance a	and		
	This deficient pract	ice could affect kitchen staff.			cleaning.			
					How will you identify other			
	Findings include:				residents having the potentia	ıl		
					to be affected by the same			
		view and interview with the			deficient practice and what			
		tor from 9:33 a.m. to 1:04 p.m.			corrective action will be take	n?		
		cumentation was provided to			All current residents in the			
	•	or cleaning of the kitchen			facility have the potential to be			
l .	l 1	1 11 1 4 1 10 1			1 66 () () () () () ()		1	

hood exhaust system had been conducted. Based on interview, the Maintenance Director stated the kitchen hood exhaust cleaning had been completed; however, no documentation was provided at the time of survey.

2.) Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial

affected by the alleged deficient practice. A full house audit was completed to ensure all inspections/cleanings is on file for the kitchen hood exhaust systems and that there was a clearly marked area to return cooking appliances to where they were under the kitchen hood extinguishing equipment when the cooking appliances are moved for

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	01	COMPL	ETED
		155689	B. W	ING		02/25/	/2025
		L		CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
MAIEST	IC CARE OF GOSI	JEN			OLLEGE AVE EN, IN 46526		
IVIAJEST	OANE OF GOS	ILIN		GUSHE	_IN, IIN 40JZU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s, Section 10.5.7 states			the purposes of maintenance	and	
	instruction shall be provided to employees				cleaning.		
		er use of portable fire			All current kitchen staff i		
	_	he manual activation of			the facility have the potential		
		equipment. Section 11.1.4 states			affected by the alleged deficie		
		nually operating the fire			practice. A full house audit wa		
	extinguishing syste	-			completed to ensure all kitche		
		ne kitchen and shall be			staff were trained on the prop		
		loyees by management. This			use of portable fire extinguish	ers	
	deficient practice c	ould affect kitchen staff.			and the manual activation of		
	Findings include:				fire-extinguishing equipment.		
					What measures will be put in	nto	
					place or what systematic		
		on and interview with the			changes will you make to		
		tor from 1:07 p.m. to 3:20 p.m.			ensure that the deficient		
		tchen was provided with a UL			practices do not recur?		
		ression system. Based on			All staff educated on the		
	_	our of the kitchen, Cook #1 was			need to ensure that all		
		uld do if there was a grease fire			inspections/cleanings is on file	e for	
		d. She stated she would use a			the kitchen hood exhaust sys		
		The surveyor asked Cook #1			and on the approved method	for	
		e would take, and she stated			returning cooking appliances		
	_	fire alarm. Cook #2 was asked			where they were under the kit		
		at the same time; however, she			hood extinguishing equipmen		
		erent answer. Based on			when the cooking appliances	are	
		Maintenance Director, he			moved for the purposes of		
		kitchen staff needed training			maintenance and cleaning.		
		er use of portable fire			·		
		he manual activation of			·All kitchen staff were educa		
	fire-extinguishing	equipment.			on the proper use of portable		
					extinguishers and the manual		
		vation and interview, the			activation of fire-extinguishing	l	
		ovide an approved method for			equipment.		
		appliances to where they were			Maintenance/designee v		
		ood extinguishing equipment			audit all kitchen hood inspecti		
		nstalled for 1 of 1 kitchen hood			1x monthly x6 months to ensu		
		ems. NFPA 96 Standard for			all inspections/cleanings is or	file	
		l and Fire Protection of			for the kitchen hood exhaust		
		ng Operations Section 2011			systems and that kitchen staf	f are	
	Edition Section 12.	1.2.2*Cooking appliances			properly educated on the prop	oer	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	l í	JILDING	01	COMPL	
		155689	B. W			02/25/	
		<u> </u>		CERTER :	ADDRESS SITE OF THE SITE OF	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
NAA IEGE		JENI			OLLEGE AVE		
IVIAJEST	IC CARE OF GOSI	TEIN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n shall not be moved, modified,			use of portable fire extinguish	ers	
	_	out prior re-evaluation of the			and the manual activation of		
		system by the system installer			fire-extinguishing equipment.		
	or servicing agent, unless otherwise allowed by the design of the fire extinguishing system.				How will corrective actions(s)	
					be monitored to ensure the		
		ne fire-extinguishing system			deficient practice will not		
	_	evaluation where the cooking			occur, l.e., what quality		
	* *	red for the purposes of			assurance program will be p	out	
		leaning, provided the			into place?		
	* *	rned to approved design			Maintenance/designee v		
	_	oking operations, and any			complete audit tool to reflect a		
	disconnected fire-extinguishing system nozzles			inspections/cleanings is on file for			
		liances are reconnected in			the kitchen hood exhaust sys		
		e manufacturer's listed design			and that kitchen staff are prop	•	
		.1.2.3.1 An approved method			educated on the proper use of		
	_	nat will ensure that the		portable fire extinguishers and the			
		ed to an approved design			manual activation of		
		eient practice could affect			fire-extinguishing equipment	and	
	kitchen staff.				that an approved method for		
	F: 1:				returning cooking appliances		
	Findings include:				where they were under the kit		
		in a sala			hood extinguishing equipmen		
		on and interview with the			when the cooking appliances	are	
		tor from 1:07 p.m. to 3:20 p.m.			moved for the purposes of		
	•	ng appliances including a gas			maintenance and cleaning is		
		ven, located under the hood in			maintained.		
		not provided with an approved			·Maintenance/Designee will		
		ensure that the appliances			present the summaries of the		
		approved design location			audits to the Quality Assurance		
		moved for maintenance and			committee monthly for 6 mon		
		interview with the			thereafter, if it is determined to	-	
		tor, he was not aware of any			the Quality Assurance commi		
	method or procedu	те пі ріасе.			that further monitoring is need audit will continue	iea,	
	1) Resed on record	I review and interview; the			audit will continue		
		sure 1 of 1 kitchen fire					
	_						
		was inspected semiannually.					
		ition, Standard for Ventilation					
		rotection of Commercial					
	Cooking Operation	s, Section 11.2.1 states			1		I

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

PRINTED: 03/21/2025 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689		ILDING	nstruction 01	(X3) DATE : COMPL 02/25/	ETED
	ROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	and listed exhaust he fire-activated water extinguish a fire in thood exhaust plenume shall be made by procertified person(s) a having jurisdiction a deficient practice constraints. Based on record review Maintenance Direct on 02/25/25, no door show a semi-annual suppression system annual inspection of system was conduct no documentation of months after the anrifor review. Based or record review, the Mass not aware of an if an inspection had	-					
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System	ı - Out of Service					
	failed to provide a c for the protection of procedures to be fol alarm system has to	iew and interview, the facility omplete 1 of 1 written policy residents indicating lowed in the event the fire be placed out of service for n a twenty-four-hour period in	K 03	346	K 346 Fire Alarm System - Ou of Service What corrective action will be accomplished for those residents found to have been affected by the deficient	e	03/14/2025

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Event ID:

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155689	B. W	ING		02/25	2025
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	NOTHER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		C, Section 9.6.1.6. This			practice?		
	-	ffects all residents, staff and			Fire Watch plan includes		
	visitors.				contacting the Indiana Depart		
	F' 1' ' 1 1				of Health via the IDOH Gatew	-	
	Findings include:				link at https://gateway.isdh.in.	gov	
	D11	.: 1 :-4 41 - 41 -			as the primary method and		
		view and interview with the			includes the secondary metho	a	
		for from 9:33 a.m. to 1:04 p.m.			when the IDOH Gateway is	tha	
		e watch plan failed to: ng the Indiana Department of			nonoperational by completing	uie	
	Health via the IDO				Incident Reporting form and		
					e-mailing it to		
		n.in.gov as the primary method method when the IDOH			incidents@isdh.in.gov. and		
		rational by completing the			includes that the person assig		
		form and e-mailing it to			to fire watch has no other duti	es	
					assigned. No ill effect due to		
	incidents@isdh.in.g	on assigned to fire watch can			alleged deficient practice. How will you identify other		
	have no other duties	_			-	=	
	nave no other duties	s assigned.			residents having the potentia	aı	
	Rosed on interview	during the record review, the			to be affected by the same deficient practice and what		
		for stated he had not reviewed			corrective action will be take	n2	
		revision of the plan was in			·All current residents in the	111	
	progress.	revision of the plan was in			facility have the potential to be	<u>, </u>	
	progress.				affected by the alleged deficie		
	3.1-19(b)				practice. A full house audit wa		
	3.1 17(0)				completed to ensure our polic		
					and procedures include conta	•	
					the Indiana Department of He	-	
					via the IDOH Gateway link at	w. 11 1	
					https://gateway.isdh.in.gov as	the	
					primary method or by the		
					secondary method when the I	DOH	
					Gateway is nonoperational by		
					completing the Incident Repor		
					form and e-mailing it to		
					incidents@isdh.in.gov. and		
					includes that the person assig	ned	
					to fire watch has no other duti		
					assigned	=	
					What measures will be put in	nto	

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMP	E SURVEY PLETED 5/2025		
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE		
				place or what systemat changes will you make ensure that the deficier practices do not recur? All staff educated on to ensure that our fire waincludes contacting the IDepartment of Health via Gateway link at https://gateway.isdh.in.gprimary method or by the secondary method where Gateway is nonoperation completing the Incident form and e-mailing it to incidents@isdh.in.gov. a includes that the person to fire watch has no other assigned Maintenance/designed audit our policies 1x more months to ensure contact Indiana Department of Inthe IDOH Gateway link a https://gateway.isdh.in.gprimary method or by the secondary method where Gateway is nonoperation completing the Incident form and e-mailing it to incidents@isdh.in.gov. a includes that the person to fire watch has no other assigned How will corrective active monitored to ensure deficient practice will in occur, I.e., what quality assurance program will into place?	the need atch Indiana a the IDOH as the IDOH as the IDOH as the IDOH as the IDOH and by Reporting and a sasigned er duties at gov is the IDOH and by Reporting and as the IDOH and by Reporting and as the IDOH and by Reporting and assigned er duties at gov is the the IDOH and by Reporting and assigned er duties the IDOH and by Reporting and assigned er duties the IDOH and by Reporting and assigned er duties the IDOH and by Reporting and assigned er duties the IDOH as the IDOH and by Reporting and assigned er duties the IDOH as the			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	<u>01</u>	COMPL	
		155689	B. WI	NG _		02/25/	/2025
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
NA IFOT		LIENI			OLLEGE AVE		
MAJEST	IC CARE OF GOS	HEIN		GUSHI	EN, IN 46526		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		·ΤΕ	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	·Maintenance/designee will		DATE
					complete audit tool to reflect		
					ensure that contacting the Ind	iana	
					Department of Health via the		
					Gateway link at		
					https://gateway.isdh.in.gov is	the	
					primary method or by the		
					secondary method when the I		
					Gateway is nonoperational by		
					completing the Incident Report form and e-mailing it to	ung	
					incidents@isdh.in.gov. and		
					includes that the person assig	ned	
					to fire watch has no other duti		
					assigned		
					·Maintenance/Designee will		
					present the summaries of the		
					audits to the Quality Assurance		
					committee monthly for 6 mont		
					thereafter, if it is determined be the Quality Assurance commit	-	
					that further monitoring is need		
					audit will continue.	ou,	
			1				
K 0353	NFPA 101						
SS=F Bldg. 01	Sprinkler System	- Maintenance and Testing					
		view and interview, the facility	K 0	353	Majestic Care of Goshen ple	ase	03/14/2025
		sprinkler system inspections in			accept the following as the		
		FPA 25. NFPA 25, Standard for			facility's credible allegation	of	
	-	ting, and Maintenance of			compliance. This plan of	-4-	
		Protection Systems, 2011 1.2 states valves and fire			correction does not constitu		
	· ·	tions shall be inspected,			an admission of guilt or liable by the facility and is submitted.		
	_	ned in accordance with Chapter			only in response to the		
		2 states Table 13.1.1.2 shall be			regulatory requirement.		
		ion, testing and maintenance of			K 353 Sprinkler System -		
		ponents and trim. Section 4.3.1			Maintenance and Testing		
		be made for all inspections,			What corrective action will b	е	
	tests, and maintena	ince of the system and its			accomplished for those		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
IAU	components and sha authority having jur deficient practice co and visitors. Findings include: Based on record rev Maintenance Direct on 02/25/25, month for all sprinkler syst months was not ava interview at the tim Maintenance Direct sprinkler system co	all be made available to the isdiction upon request. This buld affect all residents, staff, where we are incompleted in the interview with the core from 9:33 a.m. to 1:04 p.m. by inspection documentation tem control valves for 12 of 12 illable for review. Based on the of record review, the core acknowledged monthly introl valve inspection not available for review.	IAG	residents found to have bee affected by the deficient practice? Monthly inspection documentation for all sprinkle system control valves for 12 months are available for reviill effect due to alleged deficipractice. How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be take. All current residents in the facility have the potential to affected by the alleged deficipractice. A full house audit we completed to ensure monthly inspection documentation for sprinkler system control valves 12 of 12 months are available review What measures will be put place or what systematic changes will you make to ensure that the deficient practices do not recur? Maintenance educated on need to ensure that all month inspection documentation for sprinkler system control valves 12 of 12 months available for review Maintenance/designee was audit inspection documentation for sprinkler system control valves 12 of 12 months available for review Maintenance/designee was audit inspection documentation for sprinkler system control valves 13 prinkler system control valves 14 prinkler system control valves 15 prinkler system control valves 16 prinkler system control valves 17 prinkler system control valves 18 prinkler system control valves 19 prinkler system	er of 12 ew. No ent tial ten? coe ident //as // r all es for e for into the hly r all es for r will ion for alves sure

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 02/25/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE		
K 0354 SS=F	NFPA 101 Sprinkler System	Out of Service		How will corrective actions be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be pinto place? ·Maintenance/designee will complete audit tool to reflect completed monthly inspection documentation for all sprinkle system control valves. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurancommittee monthly for 6 mon thereafter, if it is determined the Quality Assurance committed the Quality Assurance committed in the	put I n er II e ce oths, by ittee		
Bldg. 01	Based on record reversal failed to provide 1 of the event the autom placed out-of-service 24-hour period in acceptance of the Standard for the Maintenance of Was Systems. NFPA 25 procedures that the follow. A.15.5.2 (4) consist of trained perpatrol the affected a extinguishers and the fire department.	iew and interview, the facility of 1 correct written policies in atic sprinkler system has to be e for 10 hours or more in a ecordance with LSC, Section quires sprinkler impairment with NFPA 25, 2011 Edition, Inspection, Testing and ter-Based Fire Protection , 15.5.2 requires nine impairment coordinator shall (b) states a fire watch should ersonnel who continuously rea. Ready access to fire the ability to promptly notify are important items to expatrol of the area, the person	K 0354	K 354 Sprinkler System - Ou Service What corrective action will I accomplished for those residents found to have bee affected by the deficient practice? Firewatch plan includes contacting the Indiana Depart of Health via the IDOH Gatew link at https://gateway.isdh.in as the primary method or by secondary method when the Gateway is nonoperational by completing the Incident Report form and e-mailing it to incidents@isdh.in.gov. and	tment vay .gov the IDOH		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155689	B. W	'ING		02/25/2025	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8					
MA IEST	IC CARE OF GOSH	IEN	2400 COLLEGE AVE GOSHEN, IN 46526				
MAJEST	IC CARE OF GOSF	1EIN		GUSHE	EN, IN 40320		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	should not only be	looking for fire, but making			includes the person assigned	to	
	sure that the other f	ire protection features of the			fire watch can have no other o	luties	
		ress routes and alarm systems			assigned. No ill effect due to		
	are available and fu	nctioning properly. This			alleged deficient practice.		
	deficient practice co	ould affect all residents, staff			How will you identify other		
	and visitors.				residents having the potentia	al	
					to be affected by the same		
	Findings include:				deficient practice and what		
					corrective action will be take	n?	
		view and interview with the			·All current residents in the		
	Maintenance Director from 9:33 a.m. to 1:04 p.m.				facility have the potential to be	;	
	on 02/25/25, the fire watch plan failed to:				affected by the alleged deficie	nt	
	1.) include contacting the Indiana Department of				practice. A full house audit wa	s	
	Health via the IDO	H Gateway link at			completed to ensure our Firev	vatch	
	https://gateway.isdl	n.in.gov as the primary method			plan includes contacting the		
	or by the secondary	method when the IDOH			Indiana Department of Health	via	
	Gateway is nonoper	rational by completing the			the IDOH Gateway link at		
	Incident Reporting	form and e-mailing it to			https://gateway.isdh.in.gov as	the	
	incidents@isdh.in.g				primary method or by the		
		on assigned to fire watch can	secondary method when the IDOH				
	have no other duties	s assigned.	Gateway is nonoperational by				
					completing the Incident Repor	ting	
		during the record review, the		form and e-mailing it to			
		for stated he had not reviewed			incidents@isdh.in.gov. and		
	•	revision of the plan was in	includes the person assigned to				
	progress.				fire watch can have no other o	luties	
					assigned		
	3.1-19(b)				What measures will be put in	ıto	
					place or what systematic		
					changes will you make to		
					ensure that the deficient		
					practices do not recur?		
					·All staff educated on the ne		
					to ensure that our Firewatch p		
					includes contacting the Indian		
					Department of Health via the I	DOH	
					Gateway link at		
					https://gateway.isdh.in.gov as	the	
					primary method or by the		
					secondary method when the I	DOH	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2025	
	ROVIDER OR SUPPLIE		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
				Gateway is nonoperational by completing the Incident Reported form and e-mailing it to incidents@isdh.in.gov. and includes the person assigned fire watch can have no other assigned Maintenance/designee waudit all documentation for our Firewatch plan; that includes contacting the Indiana Depart of Health via the IDOH Gatew link at https://gateway.isdh.in as the primary method or by secondary method when the Gateway is nonoperational by completing the Incident Report form and e-mailing it to incidents@isdh.in.gov. and includes the person assigned fire watch can have no other assigned. How will corrective actions(be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be printo place? Maintenance/designee will complete audit tool to reflect ensure that our Firewatch platincludes contacting the Indian Department of Health via the Gateway link at https://gateway.isdh.in.gov as primary method or by the secondary method when the Gateway is nonoperational by completing the Incident Report form and e-mailing it to	y pring I to duties will ur tment vay .gov the IDOH y pring I to duties st in na IDOH .s the IDOH .y	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	ЛLDING	01	COMPLETED		
		155689	B. W	ING		02/25/	02/25/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI OF CORRECTION	1	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					incidents@isdh.in.gov. and includes the person assigned fire watch can have no other dassigned ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 mont thereafter, if it is determined be the Quality Assurance committent further monitoring is need audit will continue.	duties ee hs, y ttee		
K 0355 SS=F Bldg. 01	failed to ensure port given maintenance a year apart. NFPA 1 Fire Extinguishers, that fire extinguishers at the time of hydro indicated by an inspnotification. Section maintenance as a the extinguisher that is assurance that a fire effectively and safe damage or condition any repair or replace hydrostatic testing or required. Section 7. shall have a tag or laindicates the month performed, identifies work, and identifies	riew and interview, the facility rable fire extinguishers were at periods not more than one 0, the Standard for Portable at Section 7.3.1.1.1 requires are shall be subjected to revals of not more than 1 year, static test, or when specifically section or electronic an 3.3.15 defines extinguisher corough examination of the fire intended to give maximum extinguisher will operate by and to determine if physical an will prevent its operation, if the ement is necessary, and if or internal maintenance is 3.3 states each fire extinguisher abel securely attached that and year the maintenance was as the person performing the the name of the agency at the restricted of the security of the agency at the state of the agency at the security of the security of the agency at the security of the se	K 0	355	K 355 Portable Fire Extinguishers What corrective action will b accomplished for those residents found to have beer affected by the deficient practice? Annual fire extinguisher inspection documentation in place. Annual inspections that were conducted in the last yea available for review. No ill effe due to alleged deficient practic How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be take All current residents in the facility have the potential to be affected by the alleged deficie practice. A full house audit wa completed to ensure all	taris ect ce.	03/14/2025	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	01	COMPLETED	
		155689	B. W	ING		02/25/2025	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8	2400 COLLEGE AVE				
MAJEST	IC CARE OF GOSH	HEN	GOSHEN, IN 46526				
	Т		1		,	T	
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH TAG DEFICIENCY)		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG		DATE	
	F' 1' ' 1 1				documentation for annual fire		
	Findings include:				extinguisher inspections are in	١	
	Dagad on magand nor	view and interview with the			place. Annual inspections		
		tor from 9:33 a.m. to 1:04 p.m.			conducted in the last year is available for review.		
		aintenance director provided an					
		sher inspection document that			What measures will be put in	110	
	_	of 2024. No documentation of			place or what systematic		
		n conducted in the last year			changes will you make to ensure that the deficient		
	_	-			practices do not recur?		
was available for review. Based on interview with the Maintenance Director, he stated the fire				• Maintenance educated on t	the		
extinguishers received an annual inspection but				need to ensure that all annual			
		vide documentation to show			extinguisher inspection	ille	
	_	ection had been completed in			documentation is in place, and	۱	
	the last year.	ection had been completed in			1	'	
	tile last year.				that annual inspections were		
	This finding was ro	viewed with the Maintenance			conducted in the last year is available for review.		
	Director at the exit					au	
	Director at the exit	conference.			Maintenance/designee wi	III	
	3.1-19(b)				audit annual fire inspection		
	3.1-19(0)				documentation 1x monthly x6 months to ensure that all annu	ıal	
					fire extinguisher inspection	ıaı	
						۱	
					documentation is in place, and	1	
			that annual inspections are conducted. All documentation for			for	
				last year is available for review. How will corrective actions(s)			
					be monitored to ensure the	<i>''</i>	
					deficient practice will not		
					occur, I.e., what quality		
					assurance program will be p	ut	
					into place?		
					·Maintenance/designee will		
					complete audit tool to reflect		
					completed annual fire inspecti	ion	
					documentation in place.	.=	
					·Maintenance/Designee will		
					present the summaries of the		
					audits to the Quality Assurance	ce	
					committee monthly for 6 mont		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155689	B. W.	JILDING	01	COMPLETED 02/25/2025		
		133009	B. W.			02/23/	02/23/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					thereafter, if it is determined by the Quality Assurance commit that further monitoring is need audit will continue.	tee		
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors							
Blag. UT	failed to ensure 2 of maintained in accor 19.3.6.3. Section 19 doors shall be provi the door closed. Sec doors shall not be h than those that relea or pulled. This defic residents, staff, and compartments. Findings include: Based on observation Maintenance Direct on 02/25/25, the cor 202 and resident roc several attempts to one of the provided maintained by the core of the provided maintenance Direct on 02/25/25, the core several attempts to one of the provided maintained by the provided by the provided maintained by the provided maintained by the provided maintained by the provided by the provide	on and interview, the facility (110 resident room doors were dance with LSC Section 12.6.3.5 states that corridor ded with a means for keeping stion 19.3.6.3.10 states that eld open by devices other use when the door is pushed stient practice could affect all visitors in 1 of 4 smoke on and interview with the cor from 1:07 p.m. to 3:20 p.m. cridor doors to resident rooms om 211 failed to latch after close and latch the doors by rector at the time of	K 0	363	K 363 Corridor - Doors What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The corridor doors to resident rooms 202 and resident rooms 202 and resident room 211 latch. No ill effect did to alleged deficient practice. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All current residents in the facility have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all corridor doors to resident rooms latch. What measures will be put in place or what systematic changes will you make to ensure that the deficient practices do not recur? Maintenance educated on the need to ensure that all corridor doors to resident rooms latch. Maintenance/designee will audit 5 resident corridor doors weekly x6 months to ensure the	ent ue al n? ent s or uto	03/14/2025	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
				all corridor doors to resident rooms latch. How will corrective actions(be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be pinto place? ·Maintenance/designee will complete audit tool to reflect corridor doors to resident roo are latching. ·Maintenance/Designee will present the summaries of the audits to the Quality Assurancemmittee monthly for 6 mon thereafter, if it is determined if the Quality Assurance committee that further monitoring is need audit will continue.	all ms I ce ths, by dittee	
K 0500 SS=F Bldg. 01	interview, the facili fired water boilers he ensure the water her condition. NFPA 1 all health facilities to maintained and ope possibility of a fire evacuation of occup could affect all residuals. Findings include: Based on observation Maintenance Direct	on, record review and ty failed to ensure 2 of 4 fuel and current certificates to aters were in safe operating 01, Section 19.1.1.3.1 requires to be designed constructed, rated to minimize the emergency requiring the bants. This deficient practice dents, staff, and visitors. On and interview with the cor from 1:07 p.m. to 3:20 p.m. as fired boilers with a BTU	K 0500	K 500 Building Services - On What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Boiler certificate of inspection documentation is in place from the State of Indian review. No ill effect due to all deficient practice. How will you identify other residents having the potentiato be affected by the same deficient practice and what corrective action will be taken.	n na for leged	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155689	B. W	ING		02/25/2025	
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
			2400 COLLEGE AVE				
MAJEST	IC CARE OF GOSH	HEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		DDEELY (EACH CORRECTIVE ACTION SHO		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	-	ere in use located in the bolier			·All current residents in the		
		ff of the employee service hall,			facility have the potential to be		
		hot water to the facility but			affected by the alleged deficie		
		f Inspection documentation			practice. A full house audit wa	S	
		diana for review. Based on			completed to ensure all		
		nterview with the Maintenance			documentation is in place for t	he	
		a.m. to 1:04 p.m. on 02/25/25,			boiler inspection.		
		om the Indiana Department of			What measures will be put in	ito	
		for the two water boilers were			place or what systematic		
	not provided.				changes will you make to		
	This finding was ro	viewed with the Maintenance			ensure that the deficient		
	Director at the exit				practices do not recur? ·Maintenance educated on t	ho	
	Director at the exit	comerence.			need to ensure that all	HE	
	3.1-19(b)				documentation is in place and		
	3.1 17(0)				available for review for the boi		
					inspections.	ici	
					Maintenance/designee wi	II	
					audit boiler inspection		
					documentation 1x monthly x6		
					months to ensure that all		
					documentation remains up-to-	date	
					and available for review.		
					How will corrective actions(s	s)	
				be monitored to ensure the			
					deficient practice will not		
					occur, l.e., what quality		
					assurance program will be p	ut	
					into place?		
					·Maintenance/designee will		
					complete audit tool to reflect b	oiler	
					certificate of inspection		
					documentation is in place.		
					·Maintenance/Designee will		
					present the summaries of the		
					audits to the Quality Assurance		
					committee monthly for 6 mont		
					thereafter, if it is determined b	-	
					the Quality Assurance commit		
					that further monitoring is need	ea,	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPL	E CON	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		a. building <u>01</u>		01	COMPLETED		
		155689	B. WI	NG			02/25/	02/25/2025	
NAME OF D	PROVIDER OR SUPPLIER		•	STRE	EET Al	DDRESS, CITY, STATE, ZIP COD			
						DLLEGE AVE			
MAJESTI	IC CARE OF GOSH	IEN		GOS	SHE	N, IN 46526			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	T	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	\dashv	DEFICIENCY)		DATE	
						audit will continue.			
K 0511	NFPA 101								
SS=F	Utilities - Gas and	Flectric							
Bldg. 01	Junues - Gas and	LICOUIC							
Diag. 01	1.) Based on record	review and interview, the	K 0:	511		K 511 Utilities - Gas and Elec	tric	03/14/2025	
		ure that the emergency	1 1 0	J 1 1		What corrective action will be		03/17/2023	
		able source of fuel in				accomplished for those	-		
	-	requirements of NFPA 101 -				residents found to have been	1		
		on 19.5.1.1, 9.1, 9.1.3.1 and				affected by the deficient			
		lition, 5.1. LSC Section 9.1.3.1				practice?			
		enerators shall be installed,				Letter of reliability from			
		ed in accordance with NFPA				NIPSCO, the utility providing the	he		
		mergency and Standby Power				natural gas on file. GFCI repla			
		on. Section 5.1.1 states the				in beauty shop and performing			
		urces shall be permitted to be				appropriately. No ill effect due			
	used for the emerge	ncy power supply (EPS):				alleged deficient practice.			
	(1) Liquid petroleun	n products at atmospheric				How will you identify other			
	pressure					residents having the potentia	al		
		eum gas (liquid or vapor				to be affected by the same			
	withdrawal)					deficient practice and what			
	(3) Natural or synth	-				corrective action will be take	n?		
	•	el 1 installations in locations				·All current residents in the			
	_	y of interruption of off-site				facility have the potential to be			
		, on-site storage of an				affected by the alleged deficien			
		arce sufficient to allow full				practice. A full house audit was			
	-	to be delivered for the class				completed to ensure the letter			
	_	quired, with the provision for				reliability is on file and available			
		rom the primary energy source				upon request as well as GFCl'	S		
		gy source. This deficient t all residents, staff and				performing appropriately.	to		
	visitors.	i an residents, stari and				What measures will be put in place or what systematic	ilo		
	v 1311013.					changes will you make to			
	Findings include:					ensure that the deficient			
	i manigo meiade.					practices do not recur?			
	Based on record rev	iew and interview with the				·Maintenance educated on the	he		
		or from 9:33 a.m. to 1:04 p.m.				need to ensure that the letter of			
		ility's emergency generators				reliability from NIPSCO is on fi			
		el source. The facility failed to				and that the GFCI's in the build			
	_	eliability from NIPSCO, the				are functioning appropriately	9		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SU COMPLET 02/25/20	TED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE	
IAU	utility providing the observation and into Director from 1:07 two 200 kW natura the rear of the facility failed to ensure the facility failed the	e natural gas. Based on erview with the Maintenance p.m. to 3:20 p.m. on 02/25/25, I gas generators were located in ty. Pation and interview, the sure 1 of 1 wet location in the rovided with ground fault GFCI) protection against 19.5.1.1 requires utilities in 9.1. LSC 9.1.2 requires in 9.1. LSC 9.1.2 requires in equipment to comply with Electrical Code. NFPA 70, at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for provided as required in C). The ground-fault in a readily relling Units. All 125-volt, and 20-ampere receptacles tions specified in 210.8(B)(1) we ground-fault rotection for personnel. (3) and (4): Receptacles that are le and are supplied by a rated to electric snow-melting, and vessel heating equipment to be installed in accordance	IAU	Maintenance/designed audit documentation 10 x6 months to ensure the of reliability remains on that the updated documentation available for result of that GFCI's are working appropriately. How will corrective active and the monitored to ensure deficient practice will occur, I.e., what qualify assurance program winto place? Maintenance/designed complete audit tool to refeliability documentate place and functioning of the monitoring of the monitoring audits to the Quality Assurance that further monitoring audit will continue.	gnee will k monthly hat the letter in file and mentation eview and g ctions(s) re the not ty fill be put hee will reflect letter ation is in GFCI's. hee will s of the ssurance 6 months, hined by committee	DATE	

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	OF CORRECTION OF CORRECTION 155689	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/25/2025
	PROVIDER OR SUPPLIER	2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION
	conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 6 ft. of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of			
	the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect residents, staff and visitors in the Beauty Salon.			
	Findings include:			
	Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, there was one electric receptacle			

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	NT OF DEFICIENCIES OF CORRECTION	ES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIER		24	REET ADDRESS, CITY, STATE, ZIP COD 00 COLLEGE AVE DSHEN, IN 46526	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
K 0711 SS=F Bldg. 01	ground fault circuit electrical receptacle when tested with a covering of the GFG be physically damage time of observation acknowledged the packnowledged the recorrectly when tested. This finding was reported by the properties of the exit of the	viewed with the Maintenance conference. elocation Plan view and interview, the facility of 1 written emergency fire orporated all items listed in 19.7.2.2. alarms to fire department. e call to fire department ms. mediate area. tooke compartment.	K 0711	K 711 Evacuation and Relocation Plan What corrective action will accomplished for those residents found to have to affected by the deficient practice? Facility's fire safety produced addresses the following ite Emergency phone call to find department by Isolation of Preparation of floors and by for evacuation. d) Extinguish 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 who corrective action will be to All current residents in the same deficients in the same deficients of the same deficient practice and who corrective action will be to All current residents in the same deficients of the same deficients of the same deficient practice and who corrective action will be the same deficient practice and who corrective action will be the same deficient practice and who corrective action will be the same deficient practice and who corrective action will be the same deficient practice and who corrective action will be the same deficient practice and who corrective action will be the same deficient practice and who corrective action will be the same deficient practice and who corrective action will be the same deficient practice.	peen plan pms: a) pire fire. c) puilding shing. per pential pe at aken?

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIE		2400 (ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE IEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	on 02/25/25, the fa address the follow: a) Emergency phos b) Isolation of fire. c) Preparation of fi evacuation. d) Extinguishment Based on interview the Maintenance D and stated the afor the provided plan.	cility's fire safety plan did not ing items: ne call to fire department oors and building for of fire v at the time of record review, birector looked through the plan ementioned items were not in		facility have the potential to be affected by the alleged deficie practice. A full house audit was completed to ensure the facilitifire safety plan addresses the following items: a) Emergency phone call to fire department I Isolation of fire. c) Preparation floors and building for evacua d) Extinguishing What measures will be put in place or what systematic changes will you make to ensure that the deficient practices do not recur? ·Maintenance educated on the need to ensure that the Facilitifire safety plan addresses the following items: a) Emergency phone call to fire department I Isolation of fire. c) Preparation floors and building for evacua d) Extinguish Maintenance/designee will audit documentation 1x month x6 months to ensure that the facility's fire safety plan addresses the following items: a) Emergency phone call to fire department I Isolation of fire. c) Preparation floors and building for evacua d) Extinguish How will corrective actions (s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be pinto place? ·Maintenance/designee will complete audit tool to reflect to reflect to the place?	ent sty's (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING 01 B. WING		COMPLETED 02/25/2025	
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills			facility's fire safety plan addre the following items: a) Emerge phone call to fire department I Isolation of fire. c) Preparation floors and building for evacuar d) Extinguishing process ·Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 mont thereafter, if it is determined by the Quality Assurance commit that further monitoring is need audit will continue.	ency b) o of tion. ee ths, by ttee
	failed to conduct queshifts. LSC 19.7.1.6 quarterly on each shear This deficient practice and visitors. Findings include: Based on record revelocity Maintenance Director on 02/25/25, there versus following: 1. Third shift fire driven and the shift fire driven driven and the shift fire driven and the	iew and interview, the facility arterly fire drills for 4 of 12 requires drills to be conducted ifft under varied conditions. ce affects all residents, staff iew and interview with the or from 9:33 a.m. to 1:04 p.m. was no documentation for the ill in the first quarter of 2024 or ll in the second quarter of 2024 ill in the fourth quarter of 2024 dreview, the Maintenance ecords documented in the was not able to locate the	K 0712	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility fire drills conduct as required and are current. Neffect due to alleged deficient practice. How will you identify other residents having the potentiate 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 the alleged deficient practice. A full house audit was completed to ensure the facility fire drills have been completed to ensure the facility required.	n ted lo ill al en? ent is ty's

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		f '	,		NSTRUCTION	(X3) DATE SURVEY	
		A. BUILDING <u>01</u>			COMPLETED		
155689			B. WING 02/25/2025				
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN				2400 C	NDDRESS, CITY, STATE, ZIP COD DLLEGE AVE EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	I E	DATE	
	missing fire drill do This finding was re	viewed with the Maintenance			What measures will be put in place or what systematic changes will you make to ensure that the deficient	to	
	2 1 10/4)				practices do not recur?	L _	
	3.1-19(b) 3.1-51(c)				·Maintenance educated on t		
	3.1-31(c)				need to ensure that the Facility fire drills are completed as	ys	
					required by ISDH.		
					Maintenance/designee wi	II	
					audit documentation 1x month		
					x6 months to ensure that the		
					facility's fire drills are happenir	ng	
					on schedule as required.		
					How will corrective actions(s)	
					be monitored to ensure the		
					deficient practice will not occur, l.e., what quality		
					assurance program will be p	ut	
					into place?	a.	
					·Maintenance/designee will		
					complete audit tool to reflect the	ne	
					facility's compliance with fire d		
					being completed as required b	y	
					ISDH.		
					·Maintenance/Designee will present the summaries of the		
					audits to the Quality Assurance	e	
					committee monthly for 6 month		
					thereafter, if it is determined b		
					the Quality Assurance commit	tee	
					that further monitoring is need	ed,	
					audit will continue.		
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Insp	pection & Testing - Doors					
	failed to ensure ann	view, and interview, the facility ual inspection and testing of 3 and transfilling room fire door	K 07	761	K 761 Maintenance, Inspection & Testing - Doors What corrective action will be		03/14/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2025					
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN			2400 0	STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E E RIATE COMPLETION DATE				
PREFIX	REGULATORY OR assemblies was commedical gas storage be in accordance with provisions of NFPA Code, applicable to and testing. 8.7.1.1 having a degree of the general occup structure shall be profollowing means: (1) Enclosing the arwindows that has a accordance with See 8.3.3.1 states opening protection rating by protected by approve assemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire Deprotectives, except accordance with the Standard for	cy Must be preceded by full LSC IDENTIFYING INFORMATION upleted. LSC 19.3.2.4 states and administration areas shall th Section 8.7 and the 1.99, Health Care Facilities administration, maintenance, states protection from any area mazard greater than that normal bancy of the building or ovided by one of the 1.4 and 1.4 and 1.4 and 1.4 and 1.4 and 1.5	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	completion DATE cen ual grage endoor eview. tial t ken? endoor eview. into on the dility's grage endoor endo				
	NFPA 80, 5.2.4.2 st following items sha (1) No open holes o either the door or fr	r breaks exist in surfaces of		Maintenance/designee audit documentation 1x mor x6 months to ensure that the facility's documentation of a inspection of the oxygen sto	nthly e nnual				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPLETED			ETED		
155689		B. WING 02/25/2025			2025		
			<u> </u>	CEDELET	ADDRESS COMMA STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		ely fastened in place, if so			and transfilling room and fire d	oor	
	equipped.	J ,			assemblies is completed.		
		e, hinges, hardware, and			How will corrective actions(s	, l	
	, ,	eshold are secured, aligned,			be monitored to ensure the	'	
		er with no visible signs of			deficient practice will not		
	damage.	or what he wasters engine er			occur, l.e., what quality		
	(4) No parts are mis	ssing or broken			assurance program will be p	_{ut}	
		do not exceed clearances			into place?	· ·	
	listed in 4.8.4 and 6				·Maintenance/designee will		
		device is operational; that is,			complete audit tool to reflect the	ne	
	\ \ /	apletely closes when operated			facility's compliance of	·~	
	from the full open p				documentation of annual		
	(7) If a coordinator is installed, the inactive leaf				inspection of the oxygen stora	م ا	
	closes before the ac				and transfilling room and fire d	_	
		are operates and secures the			assemblies completed.		
	door when it is in the	-			·Maintenance/Designee will		
		vare items that interfere or			present the summaries of the		
		are not installed on the door or			audits to the Quality Assurance	_	
	frame.	ire not instance on the door of			committee monthly for 6 month		
		ications to the door assembly			thereafter, if it is determined by		
		ed that void the label.			the Quality Assurance commit		
	_	edge seals, where required, are			that further monitoring is need		
		their presence and integrity.			audit will continue.	eu,	
		ice could affect all residents,			audit will continue.		
	staff and visitors.	ice could affect all residents,					
	starr and visitors.						
	Eindings in abids.						
	Findings include:						
	Događ on rogard roj	view and interview with the					
		tor from 9:33 a.m. to 1:04 p.m.					
		cumentation of annual					
		tygen storage and transfilling					
		mblies was available for					
		nterview at the time of record					
		nance Director provided a map					
		the doors that were inspected.					
		ighted locations showed					
	•	t doors in the corridors of the					
	-	enance Director also stated an					
	annual inspection was not conducted for the						

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		X1) PROVIDER/SUPPLIER/CLIA	, ,	IULTIPLE CONSTRUCTION UILDING 01		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER 155689	A. BUILDING <u>01</u> B. WING			COMPLETED	
133009			B. WING 02/25/2025				
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN			STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	oxygen storage and assemblies.	transfilling room fire door					
	This finding was rev Director at the exit of	viewed with the Maintenance conference.					
	3.1-19(b)						
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipme Extens	ent - Power Cords and					
	Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure flexible cords and adapters were not used as a substitute for fixed wiring in 2 of 4 smoke compartments. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 staff members working in the social services office. Findings include: Based on observation and interview with the Maintenance Director from 1:07 p.m. to 3:20 p.m. on 02/25/25, an extension cord was found powering a computer in the Social Services office. The Maintenance Director acknowledged the improper use of the extension cord at the time of observation. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		K 092	20	K 920 Electrical Equipment - Power Cords and Extens What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Extension cord removed from Social Service office. No effect due to alleged deficient practice. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All current residents in the facility have the potential to be affected by the alleged deficie practice. A full house audit wa completed to ensure the facilit was free from extension cords What measures will be put in place or what systematic changes will you make to ensure that the deficient practices do not recur? All staff educated on the ne	e ill ill al n? e nt s y into	03/14/2025

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

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER		ILDING	<u>01</u>	COMPLETED		
155689			B. WING 02/25/2025					
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN				STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	(X		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
					from extension cords Maintenance/designee wi audit 5 areas of the building 1 weekly x6 months to ensure the the facility is free from extensi cords How will corrective actions(s) be monitored to ensure the deficient practice will not occur, I.e., what quality assurance program will be p into place? ·Maintenance/designee will complete audit tool to reflect the facility's compliance with being free of extension cords. Maintenance/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 mont thereafter, if it is determined be the Quality Assurance commit that further monitoring is need audit will continue.	ut he g hs, y ttee		
K 0923 SS=F Bldg. 01	Storag Based on observation failed to ensure full were separated in 3 transfilling rooms. The affect all residents at Findings include: Based on observation Maintenance Direct on 02/25/25, the oxides.	Organization of the container on and interview, the facility and empty oxygen cylinders of 3 oxygen storage and This deficient practice could and staff. On and interview with the or from 1:07 p.m. to 3:20 p.m. tygen storage and transfilling and D-wings contained full and	K 09	223	K 923 Gas Equipment - Cylin and Container Storage What corrective action will b accomplished for those residents found to have been affected by the deficient practice? Oxygen cylinders were separated and marked as full and/or empty. No ill effect due alleged deficient practice. How will you identify other	e 1	03/14/2025	

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BU	ILDING	01	COMPLETED 02/25/2025		
		B. WI	NG				
			_	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			COLLEGE AVE		
MAJEST	IC CARE OF GOSI	HEN			EN, IN 46526		
WAGEOT		ILIN		00011			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		nders, but the cylinders were			residents having the potential	al	
		I not marked as full or empty.			to be affected by the same		
		at the time of observation, the			deficient practice and what		
		tor acknowledged the cylinders			corrective action will be take	n?	
	were not marked as	s full and empty.			·All current residents in the		
					facility have the potential to be		
	_	eviewed with the Maintenance			affected by the alleged deficie		
	Director at the exit	conference.			practice. A full house audit wa		
	21.10(1)				completed to ensure the facilit	-	
	3.1-19(b)				separated oxygen cylinders ar	nd	
					marked them as full/empty.		
					What measures will be put in	ito	
					place or what systematic		
					changes will you make to		
					ensure that the deficient		
					practices do not recur?		
					·All staff educated on the ne		
					to ensure that oxygen cylinder		
					aren't mixed together and that		
					they are marked as full or emp Maintenance/designee wi	-	
					audit all oxygen rooms in the	"	
					building 5x weekly x6 months	to	
					ensure that the facility is	10	
					separating oxygen cylinders a	nd	
					marking them as full/empty.	nu l	
					How will corrective actions(s	4)	
					be monitored to ensure the	'	
					deficient practice will not		
					occur, I.e., what quality		
					assurance program will be p	ut	
					into place?		
					·Maintenance/designee will		
					complete audit tool to reflect the	ne	
					facility's compliance with oxyg		
					cylinders.		
					·Maintenance/Designee will		
					present the summaries of the		
					audits to the Quality Assuranc	e	
				committee monthly for 6 mont			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2025	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN			STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
					thereafter, if it is determined by the Quality Assurance committ that further monitoring is neede audit will continue.	ee	

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