STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING **01** B. WING _____	R **04/10/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments A Post Survey Revisit (PSR) to the Emergency Preparedness Survey that exited on 02/25/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/10/2025 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 At this PSR, Majestic Care of Goshen was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 186 certified beds. At the time of the survey, the census was 106. Quality Review completed on 04/14/25	{E 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey that exited on 02/25/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR Subpart 483.90(a). Survey Date: 04/10/2025 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 At this PSR, Majestic Care of Goshen was found in compliance with Requirements for Participation	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING **01** B. WING _____	R **04/10/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1 in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The resident rooms are provided with single station, hard wired smoke detectors. The building is partially protected by two 200 kW natural gas-powered emergency generators. The facility has a capacity of 186 and had a census of 106 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a storage shed on the roof that was sprinklered, and two detached storage sheds that were not sprinklered. Quality Review completed on 04/14/25	{K 000}		