STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/16/2024	
	PROVIDER OR SUPPLIE IC CARE OF GOSH			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
F 0000							
Bldg. 00	IN00440328 and IN Complaint IN00440 related to the allegat F677 and F691. Complaint IN00440 the allegations are of Survey dates: Augu Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 16 SNF: 11 NF: 84 Total: 111 Census Payor Type Medicare: 11 Medicaid: 84 Other: 16 Total: 111 These deficiencies accordance with 41 Quality Review con 483.10(e)(3)	20328 - Federal/State deficiencies ations are cited at F558, F656, 20409 - No deficiencies related to cited. 20328 - Federal/State deficiencies are cited at F558, F656, 20409 - No deficiencies related to cited. 20328 - Federal/State deficiencies are cited at F558, F656, 20409 - No deficiencies related to cited. 20328 - Federal/State deficiencies are cited at F558, F656, 20409 - No deficiencies related to cited. 20328 - Federal/State Findings cited in 0 IAC 16.2-3.1. 20329 - IAC 16.2-3.1.	F 00	000	The creation and submission this plan of correction does a constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu a traditional revisit.	not his et ion	
SS=D	Reasonable Acco						
Bldg. 00	Needs/Preference Based on observati	es on, interview, and record	F 05	558	F558 – Reasonable		09/09/2024

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

TITLE

(X6) DATE

Caley Nixon Executive Director 09/09/2024

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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		JLTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		155689	B. W	ING		08/16	/2024	
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	8			OLLEGE AVE			
MA IEST	IC CARE OF GOSH	4EN			EN, IN 46526			
IVIAJEST	IO DANE OF GOSF	ILIN		GUSHE	_IN, IIN 4UJZU			
(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	
	review, the facility failed to ensure resident rights				Accommodations			
		bathing preferences were not			Needs/Preferences			
	accommodated for	1 of 6 residents reviewed for			It is the practice of this facility	to		
	Resident Rights, (R	esidents C)			ensure all resident rights are			
					honored in regard to bathing			
	Finding includes:		1		preferences.			
			1					
	_	vation and interview on 8/15/24			What corrective action(s) wil	I		
	at 9:48 A.M., Resid	lent C was noted to be lying in			be accomplished for those			
	bed, wearing a nigh	t gown with uncombed hair			residents found to have been	า		
	and general unkemp	ot appearance. The resident			affected by the deficient			
	indicated her prefer	rence was to receive showers			practice:			
	every Monday, Thu	rsday, and Saturday on the			Resident C – shower preferen	ces		
	day shift, but the fa	cility changed her shower			reviewed with resident. Care	plan		
	days to Tuesdays ar	nd Thursday. Resident C			and shower schedule updated	l to		
	indicated the facilit	y staff told her if she had	reflect resident shower					
	showers on Thursda	ay, she was not eligible to			preferences.			
	have another showe	er on Saturday. Resident C						
	indicated she did no	ot get her showers per her			How other residents having	the		
	preference and she	did not get all of the showers			potential to be affected by th	e		
	she was scheduled t	to receive. Resident C			same deficient practice will b	ре		
	indicated she liked	to participate in Sunday			identified and what correctiv	е		
	worship services, b	ut did not feel comfortable			action(s) will be taken:			
	attending church if	she had not been showered in			All residents have the potentia	ıl to		
	a number of days.	Resident C indicated the lack	be affected by this deficient					
	of showers impeded	d her social life.			practice. Residents shower			
					preferences and schedules			
	Resident C's clinica	l record was reviewed on			reviewed and updated as			
	8/15/24 at 1:16 P.M	I. Diagnoses included spina			appropriate. All shower sched	dules		
		iratory failure, paraplegia, and			updated to accommodate resi			
	obstructive and refl	ux uropathy.			preferences.			
	.							
		imum Data Set (MDS)			What measures will be put ir	ito		
	· ·	1/30/23, indicated the resident			place or what systemic			
		act, and that it was very			changes will be made to			
	-	make choices about her			ensure that the deficient			
	showering and bath	ing.			practice does not recur:			
					All nursing staff will be in-serv	iced		
		ost recent quarterly MDS			on or before 9/9/2024. This			
1	accecement dated 1	/22/24 indicated Resident C	1		in service will be conducted by	, tho	I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULT.		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155689	B. WI	NG		08/16/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			COLLEGE AVE		
MAJEST	IC CARE OF GOSI	HEN			EN, IN 46526		
							T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	_	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
required substantial to maximal assistance for				Director of Nursing or Designe	e		
showering and bathing needs.				and will include a review of			
					resident rights and		
		n, initiated on 9/24/23 and			accommodating needs and		
		, indicated Resident C required			preferences as it relates to sh	ower	
		ities of daily living related to			preferences.		
		pina bifida, paraplegia,			1141		
		ed on 4/16/24, indicated the			How the corrective action(s)		
		bathed or showered on			will be monitored to ensure t	ne	
		, and Saturday on the first			deficient practice will not recur, i.e., what quality		
	shift and as necessar	•				4	
	Silit and as necessar	ary.			assurance program will be p into place:	uı	
	A review of Recide	ent C's Shower records from			Ongoing compliance with this		
		indicated the resident did not			corrective action will be monite		
	· ·	cheduled showers she was		though the facility Quality			
		e in that time frame. Resident		Assurance and Performance			
		howers on the following dates		Improvement Program. The			
		6, 9,16, 20, 23, 29, 30, 2024 and			Director of Nursing/Designee	will	
		, and 13, 2024. There were no			be responsible for completing		
	_	refusals. Four of the missed			QAPI Audit tools labeled "Sho		
	showers were on S				QAPI" weekly for 4 weeks and		
		,			monthly for at least 6		
	On 8/15/24 at 12:3	5 P.M., the Assistant Director of			months. The Director of		
		Resident Council Minutes from			Nursing/Designee will audit al	ı	
	7/9/24 and 8/12/24	. The 7/9/24 minutes indicated			resident care plans to ensure		
	residents were not	getting their scheduled			shower preferences are		
	showers.	-			appropriately reflected and		
	A Response from t	he Department Manager			maintained. If 100% is not		
	indicated the show	er schedule was reviewed and			achieved an action plan will be	е	
	would be complete	ly revamped to ensure staff			developed. Findings will be		
	were able to compl	ete assigned showers daily.			submitted to the Quality	ļ	
		es indicated concern was voiced			Assurance and Performance		
	again, related to sh	owers and residents had			Improvement Committee for re	eview	
		ere typically getting only one			and follow-up.		
		response from the Department			By what date the systemic		
	_	the revamping of the shower			changes will be		
		be completed by 8/16/24 to			completed: 09/09/2024		
	ensure all showers	could be completed when			Compliance Date = 09/09/202	4	
1	scheduled.						

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

PRINTED: 09/18/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING B. WING	COMPLETED 08/16/2024		
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Nursing provided a Showers," dated 1/2 current facility policis the practice of thi with bathing to main stimulate circulation as per current standa will be provided she facility schedule proresident safety" On 8/15/24 at 1:30 I Nursing provided a Rights," dated 1/202 current facility policisThe resident has existence, self-deter participate in establicoutcomes of care, the and duration of care services and/or item care" On 8/15/24 at 1:45 I provided a form title NON-COMPLIANO signed by the adminindicated and identificated and identificated residents where preference and the standard control of the signed by the admining of the signed by t	P.M., the Assistant Director of policy titled, "Resident 024, indicating it was the ey. The policy indicated, "It is facility to assist resident intain proper hygiene.," In and help prevent skin issues ands of practiceResidents owers as per request or as per process and bass upon P.M., the Assistant Director of policy titled, "Resident 24, and indicated it was the ey. The policy indicated, a right to a dignified minationThe right to ishing the expected goals and he type, amount, frequency,The right to receive the is included in the plan of P.M., the Administrator ed, "FACILITY PAST CE REPORT," dated 8/13/24 and distrator on 8/15/24. The form fied concern that residents showers per preference. That time, the Administrator where not receiving showers the facility was going to correct the lack of showers.			

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Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. WI	NG		08/16/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER	{		2400 C	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	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0656	()()(-)						
SS=D	Develop/Impleme	nt Comprehensive Care Plan					
Bldg. 00							
		view and interview, the facility	F 06	556	F656 –Develop/Implement		09/09/2024
		omprehensive and person			Comprehensive Care Plan	4	
	_	was developed for urostomy			It is the practice of this facility	to	
		ents reviewed for urostomy			ensure that all residents have		
	care, (Resident C).				individualized comprehensive		
	Finding includes:				plans developed related urost care.	ionly	
	1 manig merades.				care.		
	During an observati	ion and interview, on 8/15/24			What corrective action(s) wil	ı	
	1	lent C's urostomy was noted to			be accomplished for those	-	
	· ·	ninal are with a ostomy bag			residents found to have been	1	
	_	ere bag. The catheter bag,			affected by the deficient		
		ide had 600 ccs of urine.			practice:		
		ed staff did not empty her			Resident C – all care plans ha	ve	
	urostomy bag regul	arly			been reviewed and updated to		
					reflect and individualized		
	Resident C's record	was reviewed on 8/15/24 at			comprehensive plan of care.		
	1:16 P.M. Diagnose	es included, but were not					
	_	ida, chronic respiratory failure,			How other residents having	the	
	paraplegia, and obs	tructive and reflux uropathy.			potential to be affected by th		
					same deficient practice will be	е	
		um Data Set (MDS)			identified and what correctiv	е	
		7/30/23, indicated Resident C			action(s) will be taken:		
		act, required substantial to			All residents have the potentia	ıl to	
		for most activities of daily			be affected by this deficient		
		a urostomy for the removal of			practice. All residents with		
	urine from the body	··			urostomy related care were		
	A Dhygigian's Out-	r for Resident C, dated 7/1/24			reviewed to ensure care plans	are	
		idicated, "Urostomy bag empty			accurate and reflect and	nlan	
		directions specified for order"			individualized comprehensive of care. Care plans to be review	•	
		r physician orders related to			and updated in conjunction wi		
		ing of the urostomy.			resident MDS assessments or		
	are care of monitori	and areasons.			needed.	uu	
	A current Care Plan	n, initiated on 9/29/23 and					
		licate Resident C had a			What measures will be put in	ito	
		tomy and was at risk for			place or what systemic	-	

STATEMEN	T OF DEFICIENCIES	F DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) MULTIPLE CONSTRUCTION (X2)			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED		
		155689	B. W	/ING		08/16/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	L			OLLEGE AVE			
MAJEST	IC CARE OF GOSH	IEN			EN, IN 46526			
_			1		,	ı		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		PLETION	
TAG		LISC IDENTIFYING INFORMATION nence of bladder and bowel.	+	TAG			ATE	
					changes will be made to			
		ventions related to urostomy			ensure that the deficient			
	care, management,	or monitoring.			practice does not recur:			
	Dramin a an intanziar	on 9/15/24 at 2:00 D.M. tha			All nursing staff will be in-serv	cea		
	1	y, on 8/15/24 at 2:00 P.M., the ated Resident C's Care Plans			on or before 9/9/2024. This	, the		
		pecific to the resident's needs			in-service will be conducted by			
		are and what was expected			Director of Nursing or Designe	:E		
	from nursing staff.	ne and what was expected			and will include a review of			
	nom nursing staff.				resident comprehensive care			
	On 8/15/24 at 1.20	P.M., the Assistant Director of			planning, urostomy care, and following resident care plans.			
		policy titled, "Comprehensive			lonowing resident care plans.			
		24 and indicated it was the			How the corrective action(s)			
		cy. The policy indicated, "It is			will be monitored to ensure t	ho		
		cility to develop and			deficient practice will not	ile		
		ehensive person-centered care			recur, i.e., what quality			
		nt,that includes measurable			assurance program will be p			
	1 ~	frames to meet a resident's			into place:			
	medical, nursing,				Ongoing compliance with this			
	inedical, naising,	ieeds			corrective action will be monite	ored		
	On 8/16/24 at 1:30	P.M., the Administrator			though the facility Quality	Jiou		
		tled, "Ostomy Care -			Assurance and Performance			
		ny, and Ileostomy, dated 1/24,			Improvement Program. The N	IDS		
	· ·	the current facility policy.			Coordinator/Designee will be	_		
		d, "The frequency of pouch			responsible for completing the			
		ducts required for changing			QAPI Audit tools labeled			
		be noted on the resident's			"Comprehensive Care Plan			
	I -	e planThe surrounding skin			Review" weekly for 4 weeks a	nd		
	of the ostomy will b	be monitored for excoriation,			monthly for at least 6			
	abrasion, and break	downthe comprehensive			months. The MDS			
	care pan will reflect	any special products or			Coordinator/Designee will aud	it all		
	pouching technique	s needed to prevent or			resident care plans with urosto	omy		
	manage any skin br	eakdown surrounding the			care weekly to ensure all care			
	ostomyIntervention	ons to prevent complications			plans are accurate, person			
	or promote dignity	associated with the ostomy			centered, and being followed l	ру		
	will be included in	the person-centered care			direct care staff. If 100% is no	t		
	plan"				achieved an action plan will be	,		
					developed. Findings will be			
	This Federal tag is 1	related to complaint			submitted to the Quality			
	IN00440328.				Assurance and Performance			

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 08/16/2024	
	PROVIDER OR SUPPLIER		2400 (CADDRESS, CITY, STATE, ZIP COD COLLEGE AVE IEN, 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
	3.1-35(a)(b)(1)			Improvement Committee for reand follow-up. By what date the systemic changes will be completed: 09/9/2024 Compliance Date = 09/9/2024	
F 0677 SS=D Bldg. 00	Based on observation review, the facility showers/bathing op	portunities as scheduled for reviewed for Resident Rights,	F 0677	F677- ADL Care Provided for Dependent Residents It is the practice of this facility ensure that all residents receishowers as scheduled and perpreference.	to ve
	Findings include: 1. During an observat 2:43 P.M., the restroom in a wheelchat debris on his shirt. Resident B's clinicated 8/14/24 at 1:00 P.M. stroke, hemiplegiated at An Annual Minimut 6/3/24, indicated Recognitively impaired maximal assistance indicated it was very choices about his shadown at the company of the c	vation of Resident B on 8/14/24 sident was observed in his ir, dressed in a t-shirt with food I record was reviewed on Diagnoses included history of		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B – shower preferent and schedules reviewed and updated. Resident C – shower preferent and schedules reviewed and updated. Resident D – shower preferent and schedules reviewed and updated. Resident J – shower preferent and schedules reviewed and updated. Resident J – shower preferent and schedules reviewed and updated. Resident K – shower preferent and schedules reviewed and updated.	n n n n n n n n n n n n n n n n n n n

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Event ID:

PLCW11 Facility ID: 000091

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155689	B. W	ING		08/16/2	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				OLLEGE AVE		
MAJEST	IC CARE OF GOSH	IEN			EN, IN 46526		
	T				1	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	+	DATE
	assistance for activities of daily living related to				Resident M – shower preferer	nces	
		emiparesis, and muscle			and schedules reviewed and		
		vention indicated the resident			updated.		
		showered on Monday,				41	
	wednesday, and Fri	iday on the second shift.			How other residents having		
	A	at Dis Charres 1 C			potential to be affected by th		
		nt B's Shower records from			same deficient practice will be		
	l '	ndicated the resident did not			identified and what correctiv	e	
		heduled showers he was			action(s) will be taken:		
		ceived in that time frame.			All residents have the potentia	ai to	
		cheduled: July 3, 10, 12, 17, 24,			be affected by this deficient		
	_				practice. All bathing schedule		
26, 29, 2024, and August 2 and 5, 2024, with refusals for showering documented on August 8,				and preferences reviewed and	'		
	9 and 12.	ng documented on August 8,			updated. Bathing schedules		
	9 and 12.				changed to accommodate all	atad	
	2 Dumin a an ahaam	vation and interview on 9/15/24			resident preferences and upda		
	_	vation and interview on 8/15/24 ent C was noted to be lying in			with residents. All staff educat		
		gown with uncombed hair			on updated shower schedules		
		ot appearance. The resident			updated shower program, and	'	
		ence was to receive showers	documentation of showers,				
	_	rsday, and Saturday on the			including any refusal.		
	1 .	icility changed her shower			What measures will be put in	10	
	1 -	nd Thursdays. Resident C			place or what systemic		
	1 .	y staff told her if she had			changes will be made to		
	· ·	y, she was not eligible to			ensure that the deficient		
		r on Saturday. Resident C			practice does not recur:		
		ot get her showers per her			All nursing staff will be in-serv	iced	
		did not get all of the showers			on or before 09/09/2024. This		
	1 -	o receive. Resident C			in-service will be conducted by		
		to participate in Sunday			Director of Nursing or Designe		
		at did not feel comfortable			and will include a review of		
	_	she had not been showered in			resident bathing preferences,		
		Resident C indicated the lack			updated shower schedules,		
	of showers impeded				updated shower program, and	ı	
	·				refusal of care documentation		
	Resident C's record	was reviewed on 8/15/24 at					
	1:16 P.M. Diagnose	es included, but were not			How the corrective action(s)		
	1	ida, chronic respiratory failure,			will be monitored to ensure t		
		ructive and reflux uropathy.			deficient practice will not		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155689	B. W	VING		08/16/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN			EN, IN 46526		
_			-		, 		375
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	An Admission Min	imum Data Set (MDS)			recur, i.e., what quality	4	
		/30/23, indicated the resident			assurance program will be p into place:	ut	
		act and it was very important			Ongoing compliance with this		
		ces about her showering and			corrective action will be monit	orod	
	bathing.	ees about her showering and			though the facility Quality	oreu	
	oathing.				Assurance and Performance		
	A Review of the mo	ost recent comprehensive MDS			Improvement Program. The		
		/22/24 completed for a			Director of Nursing/Designee	will	
		ent, indicated Resident C			be responsible for completing		
		to maximal assistance for her			QAPI Audit tools labeled "Sho		
	showering and bath				QAPI" weekly for 4 weeks and		
	one wering and caus	mg needs:			monthly for at least 6	•	
	A current Care Plar	initiated on 9/24/23 and			months. The Director of		
		indicated Resident C required			Nursing/Designee will audit al	I	
		ties of daily living related to			resident shower schedules da		
		pina bifida, paraplegia,			ensure that all residents are	,	
	-	stomy. An intervention, dated			receiving showers per prefere	nce.	
	-	ed on 4/16/24, indicated the			If 100% is not achieved an ac		
	resident was to be b	pathed or showered on			plan will be developed. Findir	ngs	
	Monday, Thursday,	and Saturday on the first			will be submitted to the Quality	-	
	shift and as necessa	ry.			Assurance and Performance		
					Improvement Committee for re	eview	
	A review of Reside	nt C's Shower records from			and follow-up.		
		ndicated the resident did not			By what date the systemic		
		scheduled showers she was			changes will be		
		in that time frame. Resident			completed: 09/09/2024		
		nowers on the following dates			Compliance Date = 09/9/2024		
	_	6, 9,16, 20, 23, 29, 30, 2024 and					
	-	and 13, 2024. There were no					
	documentations of	refusals of showers.					
	D 11 (D)	1 0/15/04					
		l was reviewed on 8/15/24 at					
		es included, but were not					
	limited to, spina bif	ida, and paraplegia.					
	An Annual Minimu	m Data Set (MDS) assessment,					
		eated Resident D was					
	· ·	equired substantial to maximal					
		ing and bathing, and that it					
	I SSISIMILE TOT BITOW		- 1		l .		I

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	ING		08/16/	/2024
				CTREET	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
NAA JEGTI	0.0405.05.0001	IENI			OLLEGE AVE		
MAJESTI	C CARE OF GOSH	1EN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		to her to make choices about					
	showering and bath	ing, needs.					
	8	6					
	A current Care Plan	, initiated on 7/24/23 and					
		indicated Resident D required					
		ties of daily living related to					
		pina bifida and paraplegia. An					
	•	ed the resident was to be					
		on Wednesday and Saturday					
	on the second shift						
	on the second shift	and as necessary.					
	A review of Pecide	nt D's Shower records from					
		ndicated the resident did not					
	·						
		eduled showers she was					
		in that time frame. Resident					
		nowers on the following dates					
		5, 10,17, 20, 24 and 27, 2024,					
	-	with no refusals for showers					
	documented.						
		ord was reviewed on 8/15/24 at					
	_	es included, but were not					
		gia following a stroke,					
	overactive bladder a	and chronic kidney disease.					
		m Data Set (MDS) assessment,					
	dated 5/13/24, indic	cated Resident J had severe					
	cognitive impairme	nt, required substantial to					
	maximal assistance	for showering and bathing.					
	and that it was very	important to her to make					
	choices about show	ing and bathing.					
	A current Care Plan	n, initiated on 5/26/23,					
		J required assistance for					
		ving related but not limited to					
	•	ervention initiated on 11/15/23,					
		nt was to be bathed or					
		esday, and Saturday on the]
	first shift and as neo	-					
	inst sinit and as nec	coom j.					

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING 00 COMPLET B. WING 08/16/2				
	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	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	O BE	(X5) COMPLETION DATE
TAG	A review of Resider 7/1/24 to 8/13/24, ir receive 4 of the 12 s supposed to have re Resident J did not re following dates as s and August 3 and 10 showers documente 4. Resident K's rec 2:40 P.M. Diagnose limited to, spinal co kidney disease and A Minimum Data S 5/13/24, for a Disch Resident K was cog on staff for showerivery important to hi showing and bathing A current Care Plan revised on 5/30/24, assistance for activity not limited to centra spine, and quadriple on 7/29/24, indicate bathed or showered on the second shift a A review of Resider 7/1/24 to 8/13/24, ir receive 5 of the 14 supposed to have re Resident K did not refollowing dates as s	nt J's Shower records from adicated the resident did not scheduled showers she was ceived in that time frame. Receive showers on the cheduled: July 6 and 20, 2024, 20, 2024, with no refusals for d. Ford was reviewed on 8/15/24 at as included, but were not red dysfunction, heart failure, quadriplegia. Ret (MDS) assessment, dated arge Assessment, indicated nitively intact, was dependent ing/bathing needs and it was meto make choices about g. Initiated on 5/24/24 and indicated Resident J required ties of daily living related but all cord syndrome of cervical regia. An intervention initiated define the resident was to be on Monday and Thursday,	TAG			DATE
	showers documente 5. Resident M's rec	d. cord was reviewed on 8/15/24				

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/16/2024	
	ROVIDER 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 LISC IDENTIFYING INFORMATION DOSES, included but were not	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE	
	limited to, multiple	sses, included but were not sclerosis, overactive bladder, ankles and muscle weakness.				
	3/21/24, completed indicated Resident I dependent on staff the needs and it was very	et (MDS) assessment, dated due to a Significant Change, , M was cognitively intact, was for showering and bathing ry important to her to make ering and bathing needs				
	revised on 12/3/20, assistance for activibut not limited to, nankle contractors. A 6/2/18 and revised cresident required to	in, initiated on 6/2/18 and indicated Resident M required ties of daily living related to, nuscle weakness and bilateral in intervention initiated on on 6/19/23, indicated the tal assistance for bathing on day, on the first shift.				
	7/1/24 to 8/13/24, in receive 5 of the 13 supposed to have re Resident M did not following dates as s	nt M's Shower records from ndicated the resident did not scheduled showers she was ceived in that time frame. receive showers on the cheduled: July 8, 15, 18 and st 1 and 5, 2024, with no st documented.				
	Nursing provided R 7/9/24 and 8/12/24.	P.M., the Assistant Director of esident Council Minutes from The 7/9/24 minutes indicated ained that they were not led showers.				
	indicated the showe would be completel	ne Department Manager r schedule was reviewed and y revamped to ensure staff te assigned showers daily.				

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 08/16/2024		
NAME OF P	ROVIDER OR SUPPLIER	₹		T ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE			
MAJESTIC CARE OF GOSHEN			GOSHEN, IN 46526				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION An 8/12/24 Resident Council minutes note		TAG	DEFICIENCI	DATE		
	An 8/12/24 Resident Council minutes note indicated a concern related to showers was voiced						
		typically getting only one					
	shower weekly.						
	A Response from the Department Manager indicated the revamping of the shower assignment was to be completed by 8/16/24 to ensure all showers would be completed when scheduled.						
	On 8/15/24 at 1:30 P.M., the Assistant Director of Nursing provided a policy titled, "Resident Showers," dated 1/2024, and indicated it was the current facility policy. The policy indicated, "It is the practice of this facility to assist resident with bathing to maintain proper hygiene,, stimulate circulation and help prevent skin issues as per current standards of practiceResidents will be provided showers as per request or as per facility schedule protocols and bass upon resident safety"						
	On 8/15/24 at 1:45 P.M., the Administrator provided a form titled, "FACILITY PAST NON-COMPLIANCE REPORT," dated 8/13/24 and signed by the administrator on 8/15/24. The form indicated and identified concern that residents were not receiving showers per preference.						
	indicated residents	w at that time, the Administrator where not receiving showers and the facility was going to correct the lack of showers.					
	This Federal tag is related to complaint IN00440328.						
	3.1-38(a)(3)						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155689	B. WING			08/16/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	£			OLLEGE AVE			
MAJESTIC CARE OF GOSHEN					EN, IN 46526			
WINDLOTTO OAKE OF GOOTIEN			1		1		T	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	IE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
F 0691	483.25(f)							
SS=D	Colostomy, Urostomy, or Ileostomy Care							
Bldg. 00			FA	CO.1	F004 Onland II 1		00/00/2024	
	Based on interview and record review, the facility failed to ensure urostomy orders, care, and		F 00	91	F691 – Colostomy, Urostomy	, or	09/09/2024	
		-			Ileostomy Care	t o		
	monitoring orders were in place for the c 3 residents reviewed for urostomy care, (It is the practice of this facility	ω		
	C).	a for arostomy care, (Resident			ensure that all residents with	for		
	<i>C)</i> .				urostomy have orders in place care and monitoring.	s in place for		
	Finding includes:				care and monitoring.			
	1 manig moraco.				What corrective action(s) wil	ı		
	During an observation and interview on 8/15/24 at				be accomplished for those	•		
	_	t C was observed in her bed,			residents found to have been			
	dressed in a gown. The resident's urostomy was			affected by the deficient		•		
	-	tht abdominal area with the			practice:			
	-	ted to a catheter bag hanging			Resident C – all orders review	ed .		
	at the bedside, hold	ing 600 CCs of urine. Resident			and updated to reflect appropri	riate		
	C indicated staff did not empty her urostomy regularly. She indicated she often did not get her catheter bag emptied on the day shift.				urostomy care and monitoring			
					How other residents having	the		
					potential to be affected by th	e		
	During an interview on 8/15/24 at 2:00 P.M., the				same deficient practice will be	ре		
		cated the facility hired a new			identified and what correctiv	е		
		ound 7/1/24, and all orders had			action(s) will be taken:			
		the resident's Electronic			All residents have the potentia	ıl to		
	,	MR). The Administrator			be affected by this deficient			
		C's urostomy orders were not			practice. All residents with			
	I	system as they should have			urostomy related care were			
	been.				reviewed to ensure all orders			
	Dasidant Clause	1 yyaa mayiayyad am 9/15/24 -4			in place for appropriate care a	na		
		l was reviewed on 8/15/24 at es included , but were not			monitoring.			
	_	ida, chronic respiratory failure,			What mossures will be not in	ıto.		
	-	tructive and reflux uropathy.			What measures will be put in place or what systemic	ilo		
	parapiegia, and 008	arecuve and remux uropaury.			changes will be made to			
	A Quarterly Minim	um Data Set (MDS)			ensure that the deficient			
		/30/23, indicated Resident C			practice does not recur:			
	· ·	act, required substantial to			All nursing staff will be in-serv	iced		
		for most activities of daily			on or before 9/9/2024. This	1000		
		a urostomy for the removal of			in-service will be conducted by	v the		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155689	B. WING		08/16/2024		
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			OLLEGE AVE		
МД ІЕСТ	IC CARE OF GOSL	4EN					
MAJESTIC CARE OF GOSHEN			GOSHEN, IN 46526				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY 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
	urine from the body	7.			Director of Nursing or Designe	ee	
					and will include a review of		
	-	er, dated 7/1/24 with no end rostomy bag empty q [every]			resident orders and updating		
					orders per physician request.		
		specified for order" There					
		ician orders related to the care			How the corrective action(s)		
	or monitoring of the	e urostomy.		will be monitored to ensure the			
	D ' CD '1	CLM 1'			deficient practice will not		
	Review of Resident				recur, i.e., what quality	4	
		ford (MAR), from 7/1/24 to			assurance program will be p	ut	
		an undated order for "Urostomy and an order, "Urostomy bag			into place:		
				Ongoing compliance with this corrective action will be monitored			
	empty q shift," with a discontinued date of 7/1/24.			though the facility Quality			
	There was no documentation the urostomy bag			Assurance and Performance			
	was emptied at any time from 7/1/24 to 8/14/24.				Improvement Program. The		
	Review an article titled, "Nursing Care for Patients				Director of Nursing		
		ery," dated 8/10/23, by the			Services/Designee will be		
		sociations of America,			responsible for completing the		
	· ·	y pouch should be changed			QAPI Audit tools labeled	•	
	-	than 1/3 full, and the pouch			"Comprehensive Care Plan		
		nanged on an average of 2			Review" weekly for 4 weeks a	nd	
	times weekly.	8			monthly for at least 6		
	,				months. The Director of		
	Review of an article	e titled, "Ostomy basics," dated			Nursing/Designee will review a	all	
	9/9/22, by the American Nurse Association,				resident orders daily. If 100% is		
	indicated the urostomy pouches or bags are			not achieved an action plan will be			
	typically changed 2 times weekly and as needed			developed. Findings will be			
	for leakage, and should be emptied when they are				submitted to the Quality		
	1/3 to 1/2 full.				Assurance and Performance		
					Improvement Committee for re	eview	
	On 8/16/24 at 1:30 P.M., the Administrator			and follow-up.			
	provided a policy titled, "Ostomy			By what date the systemic			
	Care-Colostomy, Urostomy, and Ileostomy,"				changes will be		
	dated 1/24, and indicated it was the current facility				completed: 09/9/2024		
		ndicated, "It is the policy of			Compliance Date = 09/9/2024		
•		re that residents which require					
	colonostomy, urostomy, or ileostomy services						
	receive care consistent with professional						
	standards of practice "		1				I

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

PRINTED: 09/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
	155689 B. WING				08/16/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN			STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID	SUMMARY	MARY STATEMENT OF DEFICIENCIE ID		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	This Federal tag is a IN00440328. 3.1-47(a)(3)	related to complaint					

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