	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED		
		155689	B. WI	NG		01/18/	2023
	PROVIDER OR SUPPLIE			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	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	This visit was for a Licensure Survey. Investigation of Co IN00398585, IN00 IN00393698, IN00 and IN00397833. Complaint IN00399 Federal/State deficiallegations are cited Complaint IN00399 lack of evidence. Complaint IN00399 lack of evidence. Complaint IN00399 lack of evidence. Complaint IN00399 Federal/State deficiallegations are cited Complaint IN00399 lack of evidence. Complaint IN00399 lack of evidence. Complaint IN00399 lack of evidence.	R LSC IDENTIFYING INFORMATION R Recertification and State This visit included the Implaint IN00399080, IN00394527, IN00394315, IN00390411, IN00389130, IN00389130, IN00390411, IN00389130, IN00390411, IN00389130, IN00389130	F 00			n of not his et on	DATE
	lack of evidence. Complaint IN0039 lack of evidence.	0411 - Unsubstantiated due to 9130 - Unsubstantiated due to					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIGN	 NATURE		TITLE		(X6) DATE

(X6) DATE

Caley Nixon **Executive Director** 02/17/2023

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

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

PRINTED: 03/15/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		JILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/18/	ETED	
	PROVIDER OR SUPPLIER		2400 CC	DDRESS, CITY, STATE, ZIP COD DLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	deficiencies related Unrelated deficienc	833 - Substantiated. No to the allegations are cited. ies are cited.				
	Facility number: 00 Provider number: 1 AIM number: 1002	55689				
	Census Bed Type: SNF/NF: 132 Total: 132					
	Census Payor Type Medicare: 11 Medicaid: 70 Other: 51 Total: 132					
	These deficiencies accordance with 410	eflect State Findings cited in O IAC 16.2-3.1.				
	Quality review com	pleted 2/2/23.				
F 0578 SS=D Bldg. 00	Dir §483.10(c)(6) The and/or discontinue or refuse to partici	right to request, refuse, treatment, to participate in experimental prmulate an advance				
	should be constru- resident to receive	ning in this paragraph ed as the right of the the provision of medical cal services deemed				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WPUV11 Facility ID: 000091

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			SURVEY ETED
ANDILAN	OI CORRECTION	155689	B. W		<u></u>	01/18/	
		100009	D. W		_	01/10/	2023
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
		15.1			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	1EN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	medically unneces	ssary or inappropriate.					
	- ,-,, ,	e facility must comply with					
	· ·	specified in 42 CFR part					
		vance Directives).					
		nents include provisions to					
	· ·	e written information to all					
		ncerning the right to accept					
		or surgical treatment and,					
		ption, formulate an advance					
	directive.						
	, ,	written description of the					
	• .	implement advance					
	directives and app						
		permitted to contract with					
		rnish this information but					
		ponsible for ensuring that					
	•	of this section are met.					
	` '	vidual is incapacitated at					
		sion and is unable to					
		n or articulate whether or					
		executed an advance					
		ty may give advance					
		on to the individual's					
		tative in accordance with					
	State law.						
	` '	not relieved of its obligation					
	-	ormation to the individual					
		able to receive such					
		w-up procedures must be in					
		ne information to the					
		at the appropriate time. view and interview, the facility	EO	570	EE70		02/10/2022
		correct physician order for the	F 03	0/8	F578 –		02/10/2023
	-	ion wishes for 1 of 2 residents			Request/Refuse/Discontinue	00	
		ced directives. (Resident 69)			Treatment; Formulate Advan	ce	
	10 rewed for advalle	ced directives. (Resident 09)			Dir A. It is the practice of this fac	ility	
	Finding includes:				to ensure that all residents have	•	
	i manig merades.					ı c a	
	An initial record res	view on 1/10/2023 at 3:06 P.M			correct physician order for the		

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Event ID:

WPUV11 Facility ID: 000091

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	NG		01/18/	2023
		l	<u> </u>	CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
NAA IEGE	10 04 DE 0E 0001	IENI			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	1EIN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	indicated Resident 69 had a physician's order for a				regarding advanced directives	5.	
	resuscitation choice of a full code on 10/31/2023.				What corrective action(s) wil	I	
	A POST (Physician Orders for Scope of				be accomplished for those		
		11/1/2022, indicated Resident			residents found to have been	1	
	69's wish was to ha	ve a do not resuscitate			affected by the deficient		
	physician's order.				practice:		
					Resident 69- Code status was		
		Resident 69 on 1/11/2023 at 9:35			reviewed with resident, physic		
	1	sident 69's wish was to have an			orders and care plan updated		
	order for do not res	uscitate.			reflect resident advanced dire	ctive	
					wishes.		
		34 A.M., a record review was			How other residents having		
		ses included, but were not			potential to be affected by th		
		d fracture of the second and			same deficient practice will b		
		ora, fracture of the forearm,			identified and what correctiv	е	
	osteoporosis, and h	ypertension.			action(s) will be taken:		
					All residents have the potentia	ıl to	
		S (Minimum Data Set)			be affected by this deficient		
		1/2022, indicated Resident 69			practice. All residents advanc		
	was cognitively inta	act.			directives/code statuses were		
					reviewed for accuracy and upo	dated	
		31/2022, indicated Resident 69			to reflect any changes.		
		advanced directive and wished			What measures will be put		
		terventions included to refer to			into place or what systemic		
	I -	rs for Scope of Treatment			changes will be made to		
	, , , , , , , , , , , , , , , , , , ,	ation of Patient's Preferences			ensure that the deficient		
	l	on regarding healthcare			practice does not recur:		
	choices.				All nursing staff will be in-serv	iced	
	<u> </u>	1/12/2022 - 1 12 725			on or before 1/31/2023. This		
	_	y on 1/13/2023 at 1:40 P.M.,			in-service will be conducted by		
	_	a code was called for Resident			Director of Nursing or Designe	ee	
		he code Resident 69, perform			and will include a review of		
		crash cart available. LPN 26			resident code status, physicial		
		form and indicated the POST			orders, and advanced directive		
		the physician's order. She			The Director or Nursing/Desig	nee	
	indicated the issue needed to be fixed. LPN 26				will audit all resident code		
	indicated in the case of the POST form, she would				statuses weekly for long-term		
	1 -	re and allow natural death and			residents and daily, Monday		
	would not apply CF	PR.			through Friday, for any new		
			1		admissions to ensure all physi	ician	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/18/2023	
	PROVIDER OR SUPPLIER		2400 0	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR On 1/18/2023 at 10s of Nursing indicated physician's order for form indicated a do the Medical Record form prior to a physical provided a policy to the policy indicated Services or designed Physician of advance appropriate orders of the control of the policy indicated services or designed physician of advance appropriate orders of the control of the policy indicated services or designed physician of advance appropriate orders of the control of the policy indicated services or designed physician of advance appropriate orders of the policy indicated services or designed physician of advance appropriate orders of the policy indicated services or designed physician of advance appropriate orders of the policy indicated services or designed physician of advance appropriate orders of the policy indicated services or designed physician of advance appropriate orders or designed physician orders or designed physician of advance appropriate orders or designed physician orders or designed p	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 56 A.M., the Assistant Director I that Resident 69 had a r a full code, and her POST not resituate. She indicated s Coordinator uploaded the ician's order being completed. 2 P.M., the Executive Director fled, "Advanced Directives". I, " The Director of Nursing will notify the Attending fled directives so that an be documented in the ecord and plan of care"	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPRIED TO TH	COMPLETION DATE Check (s) e the put dis nitored e e e will ng the OST - of eks nieved oped. to the	
F 0580 SS=D Bldg. 00	§483.10(g)(14) No (i) A facility must in resident; consult v physician; and not	(Injury/Decline/Room, etc.) tification of Changes. mmediately inform the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	
		155689	B. W	ING		01/18	/2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJEST	IC CARE OF GOSH	IEN		GOSHE	N, IN 46526		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION volving the resident which		TAG	DETOLE (CT)		DATE
	1 ' '	id has the potential for					
	requiring physicial	· · · · · · · · · · · · · · · · · · ·					
		hange in the resident's					
	. , -	or psychosocial status					
	(that is, a deterior	ation in health, mental, or					
	1 ' '	ıs in either life-threatening					
		cal complications);					
	l ' '	r treatment significantly					
		discontinue an existing					
	form of treatment						
	of treatment); or	to commence a new form					
		ransfer or discharge the					
	1 ' '	facility as specified in					
	§483.15(c)(1)(ii).	, ,					
		notification under paragraph					
	(g)(14)(i) of this se	ection, the facility must					
		tinent information specified					
		available and provided					
	upon request to th						
	1 ' '	ist also promptly notify the					
	any, when there is	esident representative, if					
	(A) A change in ro						
	1 ' '	ecified in §483.10(e)(6); or					
		esident rights under Federal					
		gulations as specified in					
	paragraph (e)(10)						
	l ` '	st record and periodically					
		s (mailing and email) and					
	phone number of	the resident					
	representative(s).						
	§483.10(g)(15)						
	_ ,_,,	mposite distinct part. A					
	facility that is a composite distinct part (as						
	,	must disclose in its					
	admission agreem	· ·					
	configuration, incli	uding the various locations					

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Event ID:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	ľ	JILDING	ONSTRUCTION 00	(X3) DATE SI COMPLE 01/18/2	TED
	PROVIDER OR SUPPLIE		•	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	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	ATF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and must specify room changes be under §483.15(c) Based on record re failed to ensure that party was notified aboratory tests and that another resider	composite distinct part, the policies that apply to tween its different locations (9). view and interview, the facility t one resident's responsible in advance of obtaining it X-rays, (Resident D), and it's physician and responsible of significant weight loss.	F 05	580	F580 – Notify of Changes (Injury/Decline/Room, etc.) A. It is the practice of this farto ensure that all residents ar responsible parties are notifie any new physician orders, treatments, or changes in condition. What corrective action(s) wi	cility nd ed of	02/10/2023
	1. On 1/10/2022 at	2:10 P.M., Resident D's clinical			be accomplished for those		
	records were review	wed. The resident's Admission			residents found to have bee	n	
	Record indicated as	n admission date of 3/05/2019			affected by the deficient		
	with diagnoses that	included, but were not limited			practice:		
	to: macular degene	ration, type 2 diabetes, and			Resident D – residents		
	osteoarthritis.				responsible party has been updated.		
	Resident D's most	recent comprehensive			Resident G – residents		
	Minimum Data Set	(MDS) Assessment, was a			responsible party and physici	an	
	Quarterly assessme	ent dated 9/06/2022 and			has been updated.		
		ent had a Brief Interview for					
		indicating the resident was			How other residents having	the	
	severely cognitivel	y impaired.			potential to be affected by the		
					same deficient practice will		
		BC with Diff (Complete Blood			identified and what corrective	ve	
		ntial), discontinue when			action(s) will be taken:		
	completed 10/24/20	022.			All posidonts boys the potenti	-14-	
	Review of Residen	t D's progress note dated			All residents have the potential	ai lO	
		P.M., indicated that labs were			be affected by this deficient practice. All residents noted	to	
		ocal hospital. There was no			have new orders and/or chan		
		onsible party was notified.			condition have been reviewed	-	
	l lie respe	FJ do nomed.			ensure responsible parties ha		
	On 1/19/2023 at 9:	30 A.M., an interview with the			been updated as appropriate.		
		of Nursing indicated the			,		
	resident's responsible party was always notified				What measures will be put i	nto	

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155689		l í	JILDING	onstruction 00	(X3) DATE : COMPL 01/18/	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	of notification of the 10/25/2022 and sho	res, but there was not evidence e lab work completed on ould have been documented.			place or what systemic changes will be made to ensure that the deficient practice does not recur:		
	Resident G indicate weight loss since ac indicated she has no one from nursing, ce talked to her about regarding her weight she had not been of for her weight loss. On 1/13/2023 at 11 Resident G's resport was not a plan nor of weight, and that no informed her that the weight loss. 1/13/2023 at 11:34 Assistant Director of Interdisciplinary Technology.	11:00 A.M., an interview with ad she has had unplanned dmission. The resident of had an appetite and that no lietary, nor the physician have concerns they may have not loss. The resident indicated fered any form of supplements are 1:00 A.M., an interview with asible party, indicated there desire for the resident to lose one at the facility had he resident had a significant a.M., an interview with the of Nursing indicated the earn was discussing Resident was going to start the resident			All nursing staff will be in-serv on or before 1/31/2023. This in-service will be conducted by Director of Nursing or Designed and will include a review of resident change of condition; including new physician order and notification of changes. To Director or Nursing/Designee audit all resident orders and changes in condition daily to ensure that physicians and responsible parties have been notified. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be possible parties.	y the ee s he will	
	on a dietary suppler On 1/13/0323 at 1: record was reviewe The resident's Adm admission date of 1 comprehensive Mir 12/12/2022 for Ad Resident G had a B (BIMS) score of 12 impairment. The re setup help for eatin were not limited to	ment. 30 P.M., Resident G's clinical			into place: Ongoing compliance with this corrective action will be monit though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee be responsible for completing QAPI Audit tools labeled "Cha of Condition" weekly for 4 wee and monthly for at least 6 months. If 100% is not achie an action plan will be develop Findings will be submitted to the	ored will the ange eks ved ed.	

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

PRINTED: 03/15/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING B. WING	00	COMPLETED 01/18/2023	
	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
PREFIX	REGULATORY OR failure, stroke, heming femoral fracture report Review of Resident dated 12/05/2022, in carbohydrate diet reconsistency. Orders be given one time a Ensure Plus to given appetite were both of Review of Resident were not limited to: to diabetes type 2, hollowing a stroke, Interventions included diet as ordered, and to notified weight changes. At symptoms of hypogoto diagnosis of diabeted but were not limited intake. Both Initiate for nutritional risk rehealing process second chronic kidney disease. Interventions included document food/fluic on 12/12/2022. Review of the Resident percentage record from the Resident percenta	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION iplegia, and surgical wound for air. G's physician's dietary orders ndicated a reduced	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION DATE
	on the following dat 12/17/2022 breakfas				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	ING		01/18/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER						
NAA IEGTI		IENI			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	IEIN		GUSHE	N, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	12/19/2022 breakfa	st and lunch					
	12/20/2022 breakfa	st and lunch					
	12/21/2022 breakfa	st lunch and dinner					
	12/22/2022 breakfa	st and lunch					
	12/23/2022 dinner						
	12/24/2022 breakfa	st lunch and dinner					
	12/25/2022 breakfa						
	12/26/2022 breakfa						
	12/29/2022 breakfa	st and lunch					
	12/30/2022 breakfa	st and lunch					
	12/31/2022 breakfa						
	1/1/2j023 breakfast						
	1/3/2023 breakfast a	and lunch					
	1/4/2033 breakfast						
		ent's progress notes indicated					
		to the physician that the					
	_	ficant weigh loss between					
	12/06/2022 and 1/04	4/0223.					
		00 P.M., the policy titled,					
	_	Monitoring", dated 10/2018,					
		Executive Director indicating					
		cility policy. The policy					
		ght report will be generated					
	-	red by the DM [Dietary					
		ristered Dietician], DNS					
	-	g Services], and MDS					
	_						
	-	hange is defined as 5% in 30					
	-	ys, and 10% in 180 days. The					
		and family/guardian will be fied significant weight					
		ned significant weight					
	change"						
	On 1/18/2022 at 2-1	2 P.M., a policy titled,					
		ange", dated 2022, was					
		ecutive Director and reviewed					
		icy indicated, "The purpose					
	-	ensure the facility promptly					
	or this policy is to e	nsure me raemty promptty					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	ETED
		155689	B. WINC	j		01/18/	2023
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			OLLEGE AVE		
MAIESTI	IC CARE OF GOSH	JENI			:N, IN 46526		
MAJESTI	IC CARE OF GOSF	1EIN		GUSHE	IN, IN 40520		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	5	TAG	DEFICIENCY)		DATE
	informs the resident	t, consults the resident's					
	physician;the resi	dent's representative when					
	there is a change re-	quiring notification[to]					
	commence a new fo	orm of treatment to deal with a					
	problem"						
	This Federal tag rel	ates to complaint IN00393698.					
	3.1-5(a)(2)(3)						
				ļ			
F 0600	483.12(a)(1)						
SS=D	Free from Abuse a	•					
Bldg. 00	§483.12 Freedom	from Abuse, Neglect, and					
	Exploitation						
	The resident has t	the right to be free from					
	abuse, neglect, m	isappropriation of resident					
	property, and expl	loitation as defined in this					
	subpart. This incl	udes but is not limited to					
	freedom from corp	ooral punishment,					
	involuntary seclus	ion and any physical or					
	chemical restraint	not required to treat the					
	resident's medical	symptoms.					
	§483.12(a) The fa	cility must-					
	§483.12(a)(1) Not	use verbal, mental, sexual,					
	or physical abuse,	, corporal punishment, or					
	involuntary seclus						
		view and interview, the facility	F 060	0	F600 - Free from Abuse and		02/10/2023
	failed to prevent me	ental anguish to 1 of 3			Neglect		
	residents reviewed	for abuse. (Resident 16)					
					It is the practice of this facility	to	
	Finding includes:				ensure that all residents are fr	ee	
					from abuse, neglect,		
	A clinical record re	view was completed, on			misappropriation of resident		
		M. Resident 16 diagnoses			property, and exploitation		
		no limited to: hypertension,			including mental anguish.		
	hemiplegia, anxiety, depression, diabetes and						
	seizures.				What corrective action(s) wil	I	
					be accomplished for those		
				ı			I

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLET	
		155689	B. WI	NG		01/18/20)23
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	NOT THE OF STATE		<u> </u>	STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	IEN		GOSH	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 DEFICIENCY)	TE C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		Assessment, dated 12/12/2022,			residents found to have been	n	
	indicated the residents' BIMS (Brief Interview for Mental Status) score was 15, cognition intact.				affected by the deficient		
	Required extensive assist of 2 staff for bed				practice:		
	_	toilet use, total assist of 2 staff			Decident 16 was immediate	lu l	
		thing and limited assist for			Resident 16 – was immediate assessed and resident safety	iy	
	eating	uning and minited assist for			ensured. ISDH reportable ser		
	Cathig				1	"	
	During an interview	y, on 1/9/2023 at 4:06 P.M.,			and investigation completed.		
		ed a staff member came to the			How other residents having	the	
		at! The resident indicated she			potential to be affected by th		
		eeded the bedpan, the			same deficient practice will I		
		ide stomped in the room and			identified and what corrective		
		stated "you didn't have to			action(s) will be taken:	~	
		ore you needed to go."					
		, .			All residents have the potentia	al to	
	During an interview	y, on 1/10/2023 at 10:07 A.M.,			be affected by this deficient		
	1	ndicated she had reported the			practice. Multiple residents		
		te and had started an			interviewed during investigation	on	
	investigation.				related to potential abuse with		
					further concerns indicated from		
	A Progress Note, da	ated 1/9/2023 at 5:40 P.M.,			any other residents. Weekly		
	indicated: Resident	informed staff that she had			resident abuse interviews to		
	concern with one er	nployee and her attitude when			continue to be completed by s	staff	
	she puts her call lig	ht on for care. ED			with all residents.		
	1 '	ormed and interviewed					
	resident, nurse com	-			What measures will be put in	nto	
		findings. The resident			place or what systemic		
		e in facility at this time. ED			changes will be made to		
		nat investigation would begin,			ensure that the deficient		
		d not be working with her,			practice does not recur:		
		P (Nurse Practitioner) updated					
		dent own responsible party.			All staff will be in-serviced on		
	_	ated and will continue follow			before 1/31/2023. This in-ser		
	up with resident.				will be conducted by the Exec	utive	
					Director or Designee and will		
	_	dated 1/9/2023, indicated: Brief			include a review of abuse		
	_	lent: resident reported that			prevention and reporting. The		
		de while providing care to			Executive Director/Designee \	will	
	resident. Resident v	vas interviewed, head to toe			audit all resident interviews we	eekly	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/18/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR assessment complet concerns of any nev identified and suspe investigation. Other interviewed. Social continue to monitor On 1/9/2023 at 12:1 provided the policy Program",dated Ma policy was the one of The policy indicated right to be free from misappropriation of exploitation, corpor seclusion and any p not required to treat Abuse- The willful unreasonable confir punishment with res mental anguishE treatment or use of a selfish or unfair adv	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ed with no injuries or v injuries. Employee was ended pending further like residents and staff to be Service updated and will resident. 1 P.M., the Administrator titled,"Abuse Prevention rch 2022, and indicated the currently used by the facility. d"Our residents have the a abuse, neglect, resident property, al punishment and involuntary hysical or chemical restraint the resident's symptom infliction of injury, mement, intimidation, or sulting physical harm, pain or exploitation. Means the unfair a resident or the taking of a rantage of a resident for gh manipulation, intimidation,			n free re the the will g the use thly % is vill be review	
F 0609 SS=D	483.12(b)(5)(i)(A)(Reporting of Alleg					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED	
		155689	B. WING 01/18/2023		
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER			OLLEGE AVE	
ΜΔ ΙΕςΤΙ	IC CARE OF GOSH	IEN		EN, IN 46526	
MAJESTIC CARE OF GOSTIEN			00011	-14, 114 40020	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DATE	
Bldg. 00	§483.12(c) In resp	onse to allegations of			
	abuse, neglect, ex	ploitation, or mistreatment,			
	the facility must:				
	§483.12(c)(1) Ensure that all alleged				
	violations involvino	_			
	•	treatment, including			
	injuries of unknow				
		of resident property, are			
		ely, but not later than 2			
		egation is made, if the			
	events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the				
	-	nvolve abuse and do not			
	result in serious bo				
		e facility and to other			
	, -	to the State Survey			
		protective services where			
		for jurisdiction in long-term			
		ccordance with State law			
	through establishe	ed procedures.			
	- ,,,,	ort the results of all			
	-	ne administrator or his or			
		presentative and to other			
		ance with State law,			
	_	ate Survey Agency, within			
		the incident, and if the			
	_	verified appropriate			
	corrective action n		F.0600		00/10/2022
		iew and interview, the facility	F 0609	F609- Reporting of Alleged	02/10/2023
	-	follow-up to a reportable timely		Violations	:::
		whose reportable's were		A. It is the practice of this fac	· I
	reviewed. (Residen	110)		to ensure that all alleged violate	
	Finding includes:			are reported in a timely manne	4.
	i maing menaes:			What corrective action(s) will	,
	On 1/17/2023 at 3:0	3 P.M., a facility reportable was		be accomplished for those	•
		ent 18. The reportable, dated		residents found to have been	,
	TO TO WOO TOT NESSUE	in 10. The reportable, dated		residents found to nave been	J

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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 00 COMPI				
		155689	B. W	ING		01/18/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8	2400 COLLEGE AVE				
MAJEST	IC CARE OF GOSH	HEN			EN, 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		LISC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		d the resident had reported she			affected by the deficient		
		of \$80.00. An investigation			practice:		
	· ·	nable to determine who took			Resident 18 – follow up report	able	
	the resident's money	y.			was submitted.		
	A follow-up report	was sent to the State			How other residents having	the	
		th on 3/29/2022, 11 days after			potential to be affected by th		
	the initial incident h	nad been reported.			same deficient practice will b		
					identified and what correctiv	е	
	_	y, on 1/17/2023 at 3:09 P.M., the			action(s) will be taken:		
		ated she was unsure of why					
	the follow-up report had been sent in late.				All residents have the potentia	ıl to	
					be affected by this deficient		
	On 1/9/2023 at 12:11 P.M., the Administrator				practice. All reportable incide		
		titled, "Abuse Prevention			reviewed to ensure that timely	,	
	-	arch 2022, and indicated the			follow-up reporting has been		
		currently used by the facility.			completed.		
		d" The Administrator will			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	.4	
	-	port of the results of all abuse			What measures will be put in	ito	
	-	appropriate action taken to the tification agency, and if	place or what systemic				
	-	local laws the local police	changes will be made to				
		budsman, and others as may	ensure that the deficient practice does not recur:				
	_	or local laws, within five (5)			practice accentict recar.		
	-	e reported incident"			All staff will be in-serviced on	or	
	<i>Gy</i> • • • • • • • • • • • • • • • •				before 1/31/2023. This in-service		
	3.1-28(e)				will be conducted by the Exec		
					Director or Designee and will		
					include a review of abuse		
					prevention and reporting. The)	
					Executive Director/Designee v		
					audit all reportables weekly to		
					ensure all have been reported		
					followed up in a timely manne	r.	
					How the corrective action(s)		
					will be monitored to ensure t		
					deficient practice will not	-	
					recur, i.e., what quality		
					assurance program will be p	ut	
					l 'J'		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/15/2023 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			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	00	COMPLETED	
		155689	B. WING	·	01/18/2023	
	ROVIDER OR SUPPLIER C CARE OF GOSH		2400 (CADDRESS, CITY, STATE, ZIP COD COLLEGE AVE HEN, IN 46526	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
IAU	REGULATORT OF	CESC IDENTIFTING INFORMATION	TAG	into place.	DATE	
				into place: Ongoing compliance with this corrective action will be monithough the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee be responsible for completing QAPI Audit tools labeled "Ab Prohibition and Investigation" weekly for 4 weeks and monifor at least 6 months. If 100 not achieved an action plant developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for and follow-up. By what date the systemic changes will be completed: 02/10/2023 Compliance Date = 02/10/20	will g the use " thly % is will be review	
F 0636 SS=D Bldg. 00	§483.20 Resident The facility must of periodically a com- standardized represent resident's fur- each resident's fur- §483.20(b) Composition §483.20(b)(1) Re- Instrument. A fac	Assessments & Timing Assessment Conduct initially and Aprehensive, accurate, Oducible assessment of Anctional capacity. The rehensive Assessments Sident Assessment				

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needs, strengths, goals, life history and preferences, using the resident assessment

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CENTERS FOR MEDICARE & MEDICAID SERVICES						0	MB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155689	B. W	'ING		01/1	3/2023
				CED FEET	ADDRESS CVEN SELECT TIP COD		
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
MA IFOTIO GARE OF GOOLIEN				OLLEGE AVE			
MAJEST	IC CARE OF GOSI	HEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	instrument (RAI) s	specified by CMS. The					
	1 '	include at least the					
	following:						
	1 -	nd demographic information					
	(ii) Customary rou	- · · · · · · · · · · · · · · · · · · ·					
	(iii) Cognitive patt						
	(iv) Communication						
	(v) Vision.	511.					
	(vi) Mood and bel	naviar nattarna					
	` '	•					
	(vii) Psychological well-being.						
	(viii) Physical functioning and structural problems.						
	(ix) Continence.						
		osis and health conditions.					
	(xi) Dental and nu						
	(xii) Skin Conditio						
	(xiii) Activity pursu						
	(xiv) Medications.						
	` ' '	ments and procedures.					
	(xvi) Discharge pl	_					
		ion of summary information					
		litional assessment					
	performed on the	care areas triggered by the					
	completion of the	Minimum Data Set (MDS).					
	(xviii) Documenta	tion of participation in					
	assessment. The	assessment process must					
	include direct obs	ervation and communication					
	with the resident,	as well as communication					
	with licensed and	nonlicensed direct care					
	staff members on	all shifts.					
	§483.20(b)(2) Wh	en required. Subject to the	1				
	- ' ' ' '	ribed in §413.343(b) of this					
	chapter, a facility	- , ,					
		ssessment of a resident in					
	-	the timeframes specified in					
		(i) through (iii) of this					
		eframes prescribed in					
		is chapter do not apply to					
	1 3 1 10.0 (0/0) 01 111	is sinaptor as not apply to	1		l		1

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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 00	(X3) DATE SURVEY COMPLETED 01/18/2023	
	PROVIDER OR SUPPLIER		2400 (CADDRESS, CITY, STATE, ZIP COD COLLEGE AVE HEN, 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
	excluding readmiss significant change or mental condition section, "readmiss facility following a hospitalization or to (iii) Not less than on Based on observation interview, the facility comprehensive assessments. (Resident 280 and 11 and 12 and 12 and 12 and 12 and 13 and 14 and 15 and 16 and	erview on 1/10/2023 at 11:51 indicated she stayed in her ling meals, and would like to cies. 239 A.M., Resident 280 was ed in a facility gown watching interview on 1/12/2023 at 1:42 was observed lying in bed with She indicated during an	F 0636	F636- Comprehensive Assessments & Timing It is the practice of this facility ensure that all residents rece an initial and periodic comprehensive, accurate, standardized reproducible assessment of function capar assessment; including activity assessment. What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice: Resident 280- new activity assessment reviewed and completed. How other residents having potential to be affected by t same deficient practice will identified and what correcti action(s) will be taken: All residents have the potenti be affected by this deficient practice. All residents review and up to date with current ac assessments in place.	city y ill the he be ve

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE STATEMENT OF DEFICIENCIES	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLE	ETED
155689 B. WING 01/18/	2023
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER 2400 COLLEGE AVE	
MAJESTIC CARE OF GOSHEN GOSHEN, IN 46526	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION OF A CHARGE PROVIDER'S PLAN OF CORRECTION SHOULD BE	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG: PEGILI A TORY OR LSC IDENTIFYING INFORMATION TAG: PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG REGULATOR OR ESCIDENTIFIED INFORMATION TAG	DATE
were not limited to: displaced trimalleolar fracture What measures will be put into	
of left lower leg, hemiplegia and hemiparesis place or what systemic	
following a cerebral infarction affecting changes will be made to	
non-dominant side, anxiety disorder, and ensure that the deficient	
osteoarthritis. practice does not recur:	
An Admission MDS (Minimum Data Set) All IDT staff will be in-serviced on	
An Admission MDS (Minimum Data Set) All IDT staff will be in-serviced on or before 1/31/2023. This	
l	
moderate cognitive impairment. She required Executive Director or Designee extensive assistance with one staff member for and will include a review of	
locomotion off her unit. The Interview for Daily resident MDS assessments. The	
and Activity Preferences was not assessed. Executive Director/Designee will	
During an interview on 1/18/2023 at 11:17 A.M., assessments weekly to ensure all	
the Activity Director indicated that she interviews resident assessments in review	
the questions for Section F of the MDS Assessment, Interview for Daily and Activity policy.	
Preferences. She indicated she keeps the interview sheets of each resident. When asked to see How the corrective action(s) will be monitored to ensure the	
Resident 280's interview sheet, the Activity deficient practice will not	
Director indicated she did not have an interview recur, i.e., what quality	
for Resident 280. The Activity Director indicated assurance program will be put	
she did not complete a comprehensive into place:	
assessment for Resident 280.	
Ongoing compliance with this	
On 11/17/2023 at 3:22 P.M., a policy was provided corrective action will be monitored	
by the Activity Director titled, "Activity though the facility Quality	
Assessment". The policy indicated, "1. Within Assurance and Performance	
14 days of a resident's admission to the facility, an Improvement Program. The	
Activity Assessment will be conducted to help Executive Director/Designee will	
develop an activity plan that reflects the choices be responsible for completing the	
and interests of the resident2. The resident's QAPI Audit tools labeled "MDS"	
Activity Assessment is to be conducted by Assessment" weekly for 4 weeks	
Activity Department personnel, in conjunction and monthly for at least 6	
with other staff who will assess related factors months. If 100% is not achieved	
such as functional level, cognition, and medical an action plan will be developed.	
conditions that may affect activities participation. Findings will be submitted to the	

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

PRINTED: 03/15/2023 FORM APPROVED OMB NO. 0938-039

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 01/18/2023	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
	1				1		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
		hs, needs and activity pursuit ences will be included in the			Performance Improvement Committee for review and follow-up.		
	3.1-31(d)(1)				By what date the systemic changes will be completed: 02/10/2023 Compliance Date = 02/10/20	23	
F 0656 SS=E Bldg. 00	§483.21(b) Comp §483.21(b)(1) The implement a comp care plan for each the resident rights and §483.10(c)(3) objectives and time resident's medical psychosocial need comprehensive as comprehensive as following - (i) The services the attain or maintain practicable physic psychosocial well- §483.24, §483.25 (ii) Any services the required under §4 but are not provide exercise of rights the right to refuse (6). (iii) Any specialized rehabilitative serv provide as a result	are plan must describe the at are to be furnished to the resident's highest cal, mental, and c-being as required under or §483.40; and nat would otherwise be 83.24, §483.25 or §483.40 ed due to the resident's under §483.10, including treatment under §483.10(c) ed services or specialized ices the nursing facility will t of PASARR					
	(iii) Any specialize rehabilitative serv provide as a resul recommendations	ices the nursing facility will					

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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>00</u> COMPLETED			ETED	
		155689	B. W	B. WING 01/18/2023			/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	t			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	IEN			EN, IN 46526		
					111, 111 10020		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		resident's medical record.					
	` '	with the resident and the					
	resident's represe	* *					
	' '	goals for admission and					
	desired outcomes						
	' '	preference and potential for Facilities must document					
		ent's desire to return to the					
	community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.						
	(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with						
		set forth in paragraph (c) of					
	this section.	,					
	§483.21(b)(3) The	services provided or					
	arranged by the fa	acility, as outlined by the					
	comprehensive ca	are plan, must-					
	(iii) Be culturally-c	ompetent and					
	trauma-informed.						
		on, interview, and record	F 00	656	F656 –Develop/Implement		02/10/2023
	review, the facility				Comprehensive Care Plan		
		son centered, care plans were			It is the practice of this facility	to	
	_	te for 4 of 4 residents review			ensure that all residents have		
	for care plans. (Res	idents G, H, 72, 280).			comprehensive, person center		
	Findings in ded.				care plans in place and accura	ate.	
	Findings include:				\A/hat agreeative action(a) will	i	
	1 On 1/13/2023 at	1:30 P.M., Resident G's clinical			What corrective action(s) will be accomplished for those	ı	
	record was reviewe				residents found to have beer		
	lecord was reviewe	u.			affected by the deficient		
	The resident's Adm	ission Record indicated an			practice:		
	admission date of 1				practice.		
					Resident G – all residents care	9	
	The residents' most	recent comprehensive			plans reviewed and updated a	_	
		dated 12/12/2022 for			appropriate.		
	Admission Assessn	nent indicated Resident G had			Resident H – all residents care	•	
	a Brief Interview fo	or Mental Status (BIMS) score			plans reviewed and updated a		
		oderate cognitive impairment.			appropriate.		
		ed supervision with set-up			Resident 72 – all residents car	re	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		155689	B. WI	ING		01/18/	
							-
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJESTIC CARE OF GOSHEN			GOSHE	EN, IN 46526			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY 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)	16	DATE
	help for eating. Diagnoses included, but were not				plans reviewed and updated a	s	
	limited to: diabetes.	, acquired absence of parts of			appropriate.		
	digestive tract, fem	oral fracture, kidney failure,			Resident 280 – all residents ca	are	
	stroke, hemiplegia, and surgical wound for femoral				plans reviewed and updated a	s	
	fracture repair.				appropriate.		
	Review of Resident G's physician dietary orders				How other residents having t	the	
	dated 12/05/2022, is	ndicated a reduced			potential to be affected by th		
	carbohydrate diet re	egular texture, thin			same deficient practice will b	е	
	consistency.				identified and what correctiv	е	
	·				action(s) will be taken:		
	Review of Resident	t G's Care Plans included but					
	were not limited to:				All residents have the potentia	ıl to	
	At risk for fluid imbalance due to to diabetes type				be affected by this deficient		
	2, hemiplegia and hemiparesis following a stroke,				practice. All residents care pla	ans	
	kidney disease, ede	ma. Interventions included but			to be completely reviewed and	d	
	were not limited to,	diet as ordered, document			updated in conjunction with		
	intake, weights as o	ordered/indicated, notify			resident MDS assessments.		
	physician of signific	cant weight changes. Initiated					
	12/07/2022.				What measures will be put in	ito	
					place or what systemic		
	At risk for complica	ations and symptoms of			changes will be made to		
	hypoglycemia or hy	perglycemia due to diagnosis			ensure that the deficient		
	of diabetes. Interve	ntions included but were not			practice does not recur:		
	limited to documen	t meal/snack intake. Initiated					
	12/07/2022.				All IDT staff will be in-serviced	on	
					or before 1/31/2023. This		
	Potential for nutrition	onal risk related to potential for			in-service will be conducted by	the the	
	delayed healing pro	cess secondary to diabetes			MDS Coordinator or Designee	and	
	type 2, chronic kidr	ney disease, and left femur			will include a review of resider	nt	
	fracture. Intervention	ons included but were not			comprehensive care planning.	The	
	limited to, documer	nt food/fluid intakes. Initiated			MDS Coordinator/Designee w	ill	
	12/12/2022.				audit all resident care plans in		
					assessment window weekly to)	
		G's documented meal intake			ensure all care plans are accu	rate,	
	percentage record f	from 12/16/22 to 1/13/23,			person-centered, and up to da	ıte.	
	indicated there was	no meal intake documentation					
	on the following da	tes:			How the corrective action(s)		
	12/17/2022 breakfa	st and lunch			will be monitored to ensure t	he	
	12/19/2022 breakfast and lunch		1		deficient practice will not		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	NG		01/18/	2023
				_	_		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJESTIC CARE OF GOSHEN			GOSHE	EN, IN 46526			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS DI ANI DE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	12/20/2022 breakfa				recur, i.e., what quality		
	12/21/2022 breakfa	st lunch and dinner			assurance program will be p	ut	
	12/22/2022 breakfa				into place:		
	12/23/2022 dinner				into piaco.		
	12/24/2022 breakfa	st lunch and dinner			Ongoing compliance with this		
	12/25/2022 breakfa				corrective action will be monitor	ored	
	12/26/2022 breakfa				though the facility Quality		
	12/29/2022 breakfa				Assurance and Performance		
	12/30/2022 breakfa				Improvement Program. The M	/DS	
	12/31/2022 breakfa				Coordinator/Designee will be		
	1/1/2023 breakfast and lunch				responsible for completing the		
	1/3/2023 breakfast and lunch				QAPI Audit tools labeled		
	1/4/2023 breakfast				"Comprehensive Care Plan		
	1/5/2023 breakfast and lunch				Review" weekly for 4 weeks a	nd	
	1/6/2023 breakfast and lunch				monthly for at least 6 months.		
	1/8/2023 dinner				100% is not achieved an actio		
	1/9/2023 breakfast	and lunch			plan will be developed. Finding		
	1,9,2025 610411450				will be submitted to the Quality	_	
	2. On 1/10/2022 at	3:30 P.M., Resident H's clinical			Assurance and Performance	,	
		ved. The resident's Admission			Improvement Committee for re	eview	
		e resident was most recently			and follow-up.	341044	
		lity on date of 9/20/2021, with			and renew up.		
		ided, but were not limited to:			By what date the systemic		
	_	pulmonary disease, heart			changes will be		
		I for assistance with personal			completed: 02/10/2023		
	care.				Compliance Date = 02/10/202	3	
					Compliance Bate C2, 10, 202	·	
	Resident H's most r	recent comprehensive					
		(MDS), was a quarterly					
		27/2022 and indicated the					
		Interview for Mental Status of					
		ate cognitive impaired.					
		d extensive assistance of 2					
	•	l hygiene, bed mobility,					
		toilet use, and was totally					
	_	for bathing. The resident had					
	•	eter, was always incontinent of					
	_	ly anticoagulants and					
		s indicated there were no family					
		entatives who participated in					
	inclination of represe	man. 25 mile participated in	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	a. building <u>00</u>			COMPLETED	
		155689	B. W	B. WING 01/18/			/2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	2			OLLEGE AVE			
MAJEST	IC CARE OF GOSH	HEN			EN, IN 46526			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Resident H's Care P	Planning and goal setting.						
	Daviery of the model	ent Physician's Orders						
		ot limited to Oxygen to run at						
		via nasal cannula, dated						
	1/09/2023.	via nasai cannuia, dated						
		bstructive uropathy, dated						
	1/09/2023.	1 3,						
		nage bag every shift every 8						
	hours, dated 1/09/20							
	Foley catheter care every shift document out put,							
	dated 1/09/2023.							
		N . 1 1 11						
		Plans included but were not						
	-	gas exchange related to						
	-	lure, respiratory failure, sleep breath, morbid obesity with						
	-	ation. Interventions included						
		to, oxygen at 4 liter per minute						
		ontinuous or per facility						
		plan was initiated on 9/04/21						
	and not revised.	p.m.: (, m.)						
	There was not a car	e plan initiated for catheter						
		observation, on 1/10/2023 at						
	· ·	nt 72's legs were wrapped with						
	-	e resident indicated she did						
		ds, but they change the						
	dressings about eve	ry 2 days.						
	A clinical record re	view was completed on						
		A.M. Resident 72's diagnoses					1	
		not limited to: chronic						
	· ·	ary disease with acute						
	-	lar dementia without						
	· ·	nce, and type 2 diabetes						
	mellitus.	, J1						
	A Quarterly MDS (Minimum Data Set)						
	Assessment, dated	10/17/2022, indicated Resident						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/18/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTENTION		
TAG	REGULATORY OF 72 had a BIMS (Br score of 12, which i impairment. The results of the score of 12, which i impairment. The results of the score of 12, which i impairment. The results of the score of 12, which is impairment. The results of the score of 12, which is impairment of the score of 12, which is impairment of the score of 12, which is impairment of 13, which is impairment of 14, which is impairment. The results of 14, which is impairment of 14, which is impairment. The results of 14, which is impairment of 14, which is imp	rief Interview for Mental Status) indicated moderate cognitive sident required limited assist of lity, transfers, dressing, and total assist of 1staff for dated 3/19/2019, the resident hired skin integrity related to liabetes mellitus with insuling ce. Interventions included, but report any discoloration or to Nurse/Wound Nurse, and ordered and PRN. 7, on 1/18/2023 at 1:28 P.M., the ted Resident 72 did not wounds on her legs, but she as so lotion is applied, and her protect the skin. She also not, but should be, on the care nitial interview on 1/10/2023 at not 280 indicated, she stays in cluding meals, and would like invities. 239 A.M., Resident 280 was the ed in a facility gown watching interview on 1/12/2023 at 1:42 was observed lying in bed with She indicated during an	TAG		DATE DATE		
	and 2:58 P.M., Resi	ident 280 was observed lying in gown on and the television					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155689	B. W	ING		01/18/	/2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1		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 CORRE		BROWINED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	playing.						
	1 7 6						
	A clinical record re	view was completed on					
		A.M. Diagnoses included, but					
		displaced trimalleolar fracture					
		miplegia and hemiparesis					
	_	l infarction affecting					
		anxiety disorder, and					
	osteoarthritis.	and a second control of the second control o					
	osteourinitis.						
	An Admission MDS	S (Minimum Data Set)					
		mpleted on 1/3/2023. The					
		d that Resident 280 had					
		impairment. She required					
		e with one staff member for					
		unit. The Interview for Daily					
	and Activity Prefere	ences was not assessed.					
	A Cara Dlan on 1/1/	2/2023, indicated, Resident is					
		a activity during the day, but					
		m the activity staff. An					
		ed, to provide materials that					
	•	280 to be successful in her own					
	activities during the	e day.					
	Dumin a are internet	r on 1/19/2022 at 11:17 A M					
	_	on 1/18/2023 at 11:17 A.M.,					
	-	or indicated that she interviews					
		their interests and includes					
	the questions for Se						
		ew for Daily and Activity					
		dicated she keeps the interview					
		ent. When asked to see					
		view sheet, the Activity					
		the did not have an interview					
		he Activity Director indicated					
	she did not complet	-					
		dent 280. She indicated the					
	care plans are basic	and not person centered.					
	On 1/18/2022 at 9:0	00 A.M., a policy titled, "Care					

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN SUMMARY STATEMENT OF DEFICIENCE (PACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Planning-Interdisciplinary Team", dated 9/28/2017 was provided by the Executive Director who indicated it was the current policy. The policy was reviewed at that time and indicated, " A comprehensive care plan for each resident is developed within 7 days of the completion of the resident Minimum Data Set. Absacline care plan for each resident and person-centered care that meets professional standards of quality of care" This Federal tag relates to complaint IN00394527. 3.1.35(a)(b)(1) F 0857 483.21(b)(2)(1)(iii) Care Plan Timing and Revision 8483.21(b)(2)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and their resident representative is determined not practicable for the development of the resident representative is determined not practicable for the development of the resident and their resident representative is determined not practicable for the development of the resident and their resident representative is determined not practicable for the development of the resident and their resident representative is determined not practicable for the development of the resident and their	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		ľ í	JILDING	onstruction 00	(X3) DATE COMPL 01/18/	ETED	
MAJESTIC CARE OF GOSHEN (XX) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRICEDED BY FULL TAG Planning-Interdisciplinary Team", dated 928/2017 was provided by the Executive Director who indicated it was the current policy. The policy was reviewed at that time and indicated, "A comprehensive care plan for each resident is developed within 7 days of the completion of the resident Minimum Data SE.L. Abseline care plan for each resident minimum Data SE.L. Abseline care plan for each resident minimum Data SE.L. Abseline care plan for each resident minimum Data SE.L. Abseline care plan for each resident minimum Data SE.L. Abseline care plan for each resident minimum Data SE.L. Abseline care plan for each resident minimum Data SE.L. Abseline care plan for each resident minimum Data SE.L. Abseline care plan for each resident. Which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality of cure" This Federal tag relates to complaint IN00394527. 3.1-35(a)(b)(1) F 0657 SS=E Bldg. 00 Care Plan Timing and Revision §48.3.21(b)(2) (Comprehensive care plan must be (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (E) To the extent practicable, the participation of the resident and their resident representative (s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative (s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative (s). An explanation must be included in a resident's needed to practicable	NAME OF P	ROVIDER OR SUPPLIER						
PRETIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION REGULATORY OR ISC IDENTIFYING INFORMATION Planning-Interdisciplinary Team", dated 9/28/2017 was provided by the Executive Director who indicated it was the current policy. The policy was reviewed at that time and indicated, "A comprehensive care plan for each resident is developed within 7 days of the completion of the resident Minimum Data SetA baseline care plan for each residentwhich includes the instructions needed to provide effective and person-centered care that meets professional standards of quality of care" This Federal tag relates to complaint IN00394527. 3.1-35(a)(b)(1) F 0857 483.21(b)(2)(i)-(iii) Care Plan Tirning and Revision §483.21(b)(2)(i) Carpenensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aided with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident a reparticipation of the resident and their resident representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative(s).	MAJESTI	C CARE OF GOSH	EN					
TAG REGULATORY OR ISC IDENTIFYING REFORMATION Planning-Interdisciplinary Team", dated 9/28/2017 was provided by the Executive Director who indicated it was the current policy. The policy was reviewed at that time and indicated, "A comprehensive acre plan for each resident is developed within 7 days of the completion of the resident Minimum Data SetA baseline care plan for each residentwhich includes the instructions needed to provide effective and person-centered care that meets professional standards of quality of care" This Federal tag relates to complaint IN00394527. 3.1-35(a)(b)(1) F 0657 483.21(b)(2)(0)(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and their resident representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative(s).	(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
Planning-Interdisciplinary Team", dated 9/28/2017 was provided by the Executive Director who indicated it was the current policy. The policy was reviewed at that time and indicated, "A comprehensive care plan for each resident is developed within 7 days of the completion of the resident. Minimum Data SetA baseline care plan for each resident. Which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality of care" This Federal tag relates to complaint IN00394527. 3.1-35(a)(b)(1) F 0857 483.21(b)(2)(i)-(iii) SS=E Care Plan Timing and Revision \$483.21(b)(2)(i)-(iii) S483.21(b)(2)(a) comprehensive Care Plans \$483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident representative(s). An explanation must be included in a resident medical record if the participation of the resident and their resident representative(s). An explanation must be included in a resident medical record if the participation of the resident and their resident representative(s).		`				CROSS-REFERENCED TO THE APPROPRIA	ATE	
plan.	TAG F 0657 SS=E	Planning-Interdiscip was provided by the indicated it was the reviewed at that tim comprehensive care developed within 7 resident Minimum I for each residentw needed to provide etcare that meets profe of care" This Federal tag relation of care" This Federal tag relation of care Plan Timing \$483.21(b)(2)(i)-(iii) Care Plan Timing \$483.21(b)(2) A comust be- (i) Developed within of the comprehens (ii) Prepared by an includes but is not (A) The attending (B) A registered nuthe resident. (C) A nurse aide we resident. (D) A member of festaff. (E) To the extent participation of the representative(s). included in a residing participation of the representative is defor the development.	elinary Team", dated 9/28/2017 elexecutive Director who current policy. The policy was e and indicated, "A plan for each resident is days of the completion of the Data SetA baseline care plan which includes the instructions elective and person-centered essional standards of quality attest to complaint IN00394527. The policy was e and indicated, "A plan for each resident is days of the completion of the Data SetA baseline care plan which includes the instructions elective and person-centered essional standards of quality attest to complaint IN00394527. The policy was elected to plan the plan to the plan that a limited to-physician. The policy was elected to plan the plan that a limited to-physician. The policy was elected to plan that a limited to-physician. The policy was elected to plan the plan that a limited to-physician. The policy was elected to plan that a limited to-physician. The policy was elected to plan that a limited to-physician. The policy was elected to plan that a limited to-physician. The policy was elected to plan that a limited to-physician that a limited to-physician. The policy was elected to plan that a limited to-physician that a limited to-ph			CROSS-REFERENCED TO THE APPROPRIA	ATE	

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	PROVIDER OR SUPPLIER		2400	r address, city, state, zip cod COLLEGE AVE HEN, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	disciplines as dete needs or as reque (iii)Reviewed and interdisciplinary te including both the quarterly review a Based on record rev failed to provide car residents reviewed: Residents 16, 46, 47 Findings include: 1. During an intervi Resident 16 indicate care plan meetings. A clinical record reviewed included, but were themiplegia, anxiety seizures. A Quarter Assessment, dated included, but were seidents' BIMS (Bistatus) score was 15 The only electronic dated 1/4/2022. A review of the Prothrough 12/2022, la further Care Confer plan meetings had review Social Service staff	am after each assessment, comprehensive and sessments. Fiew and interview, the facility re plan meetings for 6 of 6 for care plan meetings. (7, 71, 22, & H) ew, on 1/9/2023 at 2:50 P.M., ed she had not attended any view was completed, on M. Resident 16 diagnoses no limited to: hypertension, depression, diabetes and ly MDS (Minimum Data Set) 12/12/2022, indicated the rief Interview for Mental 5, cognition intact. Care Conference sheet, was gress notes, dated 1/2022 cked the documentation of any ence sheets indicating care not been held. 7, on 1/13/2023 at 9:32 A.M., 22 indicated she had gotten blan meetings and there were	F 0657	F657 – Care Plan Timing and Revision It is the practice of this facility ensure that all residents are provided care plan meetings. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 16 – care plan meeting has been offered and schedul for resident. Resident 46- care plan meeting has been offered and schedul for resident. Resident 47 – care plan meeting has been offered and schedul for resident. Resident 71 – care plan meeting has been offered and schedul for resident. Resident 72 – care plan meeting has been offered and schedul for resident. Resident 22 – care plan meeting has been offered and schedul for resident. Resident H – unable to correct alleged deficient practice due resident no longer residing in facility.	In ing ed ing ed ing ed ing ed ing ed it the to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155689	B. W	ING		01/18/	2023
				CTREET	A DDDESG CITY CT ATE 7ID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
		IEA.			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN		GOSH	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED BY AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	' ⁻	DATE
	2. During an intervi	iew, on 1/09/2023 at 11:30 A.M.,			potential to be affected by th	e	
		ed he had been to one care			same deficient practice will be		
	plan meeting.				identified and what correctiv		
					action(s) will be taken:		
	A clinical record re	view was completed on,			(0,		
	1/11/2023 at 10:53 A.M. Resident 46's diagnoses				All residents have the potentia	l to	
		not limited to: chronic			be affected by this deficient		
		Parkinson's disease, diabetes,			practice. All residents records	,	
		ctive disorder, and dementia.			have been audited to ensure		
		•			facility has provided care plan		
	A Quarterly MDS (Minimum Data Set)			meetings and meetings are be	eina	
		12/21/2022 indicated Resident			scheduled in conjunction with		
		ief Interview for Mental Status)			quarterly MDS assessments of	ras I	
	score of 15, cogniti				needed.		
	The last date of a ca	are plan conference that had			What measures will be put in	ito	
	been held was dated	-			place or what systemic		
					changes will be made to		
	A review of the Pro	ogress notes, dated 1/2022			ensure that the deficient		
		icked the documentation of any			practice does not recur:		
	-	rence sheets indicating care			•		
	plan meetings had r	not been held.			All IDT staff will be in-serviced	on	
					or before 1/31/2023. This		
	During an interview	v on 1/13/2023 at 9:32 A.M.,			in-service will be conducted by	/ the	
	Social Service Staff	f 2 she had gotten behind with			Executive Director or Designe		
		ngs and there were no other			and will include a review of		
	meetings that had b	een held.3. During an			resident comprehensive care		
	interview, on 1/10/2	2023 at 2:59 P.M., Resident 47			planning. The Social Services		
	indicated she did no	ot know what a care			Director/Designee will audit all		
	conference was and	l did not remember attending			resident assessment schedule	s	
	one.				weekly ensure all resident car	e	
					plan meetings are being offere	ed	
	A clinical record re	view was completed on,			and completed in a timely mar		
	1/17/2023 at 9:52 A	A.M., and indicated Resident					
	47"s diagnoses included, but were not limited to:				How the corrective action(s)		
	hypertensive heart disease, hemorrhagic disorder,				will be monitored to ensure t	he	
	spondylosis, major depressive disorder,				deficient practice will not		
	hyperlipidemia, chronic respiratory failure, type 2				recur, i.e., what quality		
	diabetes and muscle				assurance program will be p	_{ut}	
	diabetes and musere weakness.				into place:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155689	B. WI	NG		01/18	/2023
		l	<u> </u>	STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			OLLEGE AVE		
MA IESTI	IC CARE OF GOSH	IEN			EN, IN 46526		
IVIAJEOTI	IO OANE OF GOSE	ILIN		GUSHE	.iv, iiv +0020		_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Minimum Data Set)					
	· ·	2/21/202 indicated Resident			Ongoing compliance with this		
	,	ef Interview for mental status)	corrective action will be monitored			ored	
	12 indicating mode	rately impaired.			though the facility Quality		
					Assurance and Performance		
	_	on 1/17/2023 at 9:58 A.M., the			Improvement Program. The S		
		ctor indicated Resident 47 has			Services Director/Designee wi		
	•	meeting since 2021. She			responsible for completing the		
		e she was by herself and could			QAPI Audit tools labeled "Care		
		e meetings and indicated			Plan Meeting Audit" weekly for		
		are supposed to be completed			weeks and monthly for at least		
	quarterly and as nee				months. If 100% is not achiev		
	_	ew, on 1/2023 at 9:37 A.M.,			an action plan will be develope		
	•	sentative indicated that she			Findings will be submitted to the	ne	
		l in a care plan conference			Quality Assurance and		
	since she requested	one in March of 2022.			Performance Improvement		
	A 11 1 1	. 1 1 1/12/2022			Committee for review and		
		view completed, on 1/13/2023			follow-up.		
	at 11:45 A.M., indic				Decombat data the accetomaic		
	-	ded a care plan conference on The clinical record lacked			By what date the systemic		
		ny other care plan conferences			changes will be		
	since March 2022.	ny other care pian conferences			completed: 02/10/2023 Compliance Date = 02/10/202	2	
	Since Maich 2022.				Compliance Date = 02/10/202	3	
	During an interview	y, on 1/13/2023 at 12:14 P.M.,					
	_	Director indicated care plan					
		y behind schedule and have					
		istently and should have been					
	done quarterly and/	-					
		interview on 1/10/2023 at 9:46					
	_	ndicated, she was not informed					
	· ·	ges and could not recall having					
	a care plan meeting	_					
	,						
	A clinical record re	view was conducted on					
	1/13/2023 at 10:07	A.M. Diagnoses included, but					
		chronic kidney disease,					
fibromyalgia, chronic obstructive pulmonary							
		d congestive heart failure.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE A. BUILDING B. WING	construction 00	COM	te survey ipleted 18/2023
	PROVIDER OR SUPPLIER		2400	ET ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE HEN, 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
mo	A Significant Chang	ge MDS on 12/31/2022 22 was cognitively intact.	mo			DATE
		Resident 22 were reviewed for was not an entry that n had occurred.				
		plinary Team) Care Conference red on 6/21/2022. This Summary				
	the Social Service I in the Social Service reaches out to famil been behind on care indicated the care p completed quarterly	or on 1/13/2023 at 12:12 P.M., Director indicated, she has been the Department by herself, but the ies. She indicated she had to plan conferences. She than conferences should be the ies. On 1/10/2022 at 3:30 P.M., I records were reviewed. The				
	resident was most re on date of 9/20/202 included, but were re obstructive pulmona	n Record indicated the ecently admitted to the facility 1, with diagnoses that not limited to: chronic ary disease, heart failure, istance with personal care.				
	Minimum Data Set assessment dated 9/ resident had a Brief 1, indicating moder. Resident H required persons for persona transfers, dressing, dependant on staff f an indwelling cathe bowel, received dai diuretics. The MDS members or represe	ecent comprehensive (MDS), was a quarterly 27/2022 and indicated the Interview for Mental Status of ate cognitive impaired. I extensive assistance of 2 I hygiene, bed mobility, toilet use, and was totally for bathing. The resident had ter, was always incontinent of ly anticoagulants and indicated there were no family intatives who participated in clanning and goal setting.				

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

PRINTED: 03/15/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	ľ	UILDING	NSTRUCTION 00	(X3) DATE : COMPL 01/18/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	resident's representate been invited to nor for the resident at an On 1/13/2023 at 12 Social Service Dire most recent Care Pl that the resident sho conference with his	19 P.M., an interview with the ative indicated she had not attended a Care Plan meeting my time. 115 P.M., and interview with the ctor indicated Resident H's an conference was 6/09/22 and ould have a Care Plan representative every quarter eduling the resident's Care						
	On 1/18/2022 at 9:0 Planning-Interdiscip was provided by the indicated it was the reviewed at that time comprehensive care developed within 7 resident Minimum I resident's family an representative/guare participate in the de the resident's care p printed and reviewee ConferenceA write	200 A.M., a policy titled, "Care plinary Team", dated 9/28/2017 be Executive Director who current policy. The policy was are and indicated, "A be plan for each resident is days of the completion of the Data Setthe resident, the d/or the resident's legal dianare encouraged to evelopment of and revisions to be defor accuracy prior to Care the summary or copy of the will be given to the resident ye"						
	_	ates to complaint IN00394527.						
F 0677 SS=E Bldg. 00	§483.24(a)(2) A recarry out activities	ed for Dependent Residents esident who is unable to s of daily living receives the es to maintain good						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	ING	<u> </u>	01/18/	2023
		l .		CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	JEN					
IVIAJES I	IC CARE OF GOSF	1EIN		GUSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
	nutrition, grooming, and personal and oral						
	hygiene;						
	Based on observation, record review and		F 00	677	F677- ADL Care Provided for	•	02/10/2023
	interview, the facili	ty failed to ensure showers			Dependent Residents		
	were provided time	ly for 7 of 8 residents reviewed			It is the practice of this facility	to	
	for Adl care (Activi	ities of Daily Living).			ensure that all residents recei	ve	
	(Residents 16, 46, 4	14, D, L, 180)			showers per their preference.		
	Findings include:				What corrective action(s) will	II	
					be accomplished for those		
	During an intervi	iew, on 1/9/2023 at 2:51 P.M.,			residents found to have been	n	
	Resident 16 indicat	ed she does not get showers.			affected by the deficient		
					practice:		
	A clinical record review was completed, on						
		M. Resident 16 diagnoses			Resident 16 – residents bathir	ng	
		no limited to: hypertension,			preferences reviewed and upo		
		, depression, diabetes and			Resident 46- residents bathing	_	
	seizures.				preferences reviewed and upo		
					Resident 44- residents bathing	_	
		finimum Data Set) Assessment,			preferences reviewed and upo		
		dicated: How important is it to			Resident D – resident no long	er in	
	1 -	een a tub bath, shower, bed			facility		
		h? The response checked was			Resident L – resident no longe	er in	
	Very Important.				facility		
	1.0 (1.100)	1 . 110/10/2022			Resident 180 – residents bath	•	
		Assessment, dated 12/12/2022,			preferences reviewed and upo	dated	
		nts' BIMS (Brief Interview for				41	
		e was 15, cognition intact.			How other residents having		
	*	assist of 2 staff for bed			potential to be affected by the		
		toilet use, total assist of 2 staff			same deficient practice will I		
		thing and limited assist for			identified and what corrective	'e	
	eating.				action(s) will be taken:		
	A aumont same #1	dated 11/14/2017 and navigad			All regidents have the material	N 40	
	-	, dated 11/14/2017 and revised			All residents have the potentia	ai lO	
		ated the resident required ADL akness, stroke, rheumatoid			be affected by this deficient		
					practice. All residents bathing)	
	arthritis, chronic pain syndrome and fibromyalgia.			preferences reviewed and			
	Interventions included but were not limited to: Bathing Monday & Thursday on the 2nd shift.				updated.		
	bauning Monday &	Thursday on the 2nd snift.			M/hat magazinas will be wet to		
					What measures will be put in	เเบ	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	CONSTRUCTION (X3) DATE		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155689	B. WI	NG	_	01/18/	/2023
				_			
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					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	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Resident 16's show	er documentation, dated	place or what systemic				
	12/14/2022 to 1/13/	2023, indicated the resident			changes will be made to		
	received a shower on 12/17/2022 and refused on				ensure that the deficient		
	1/5/2023. There was no further documentation to				practice does not recur:		
	indicate Resident 16 had received showers twice						
	weekly.				All nursing staff will be in-servi	ced	
					on or before 1/31/2023. This		
	During an interview	v, on 1/13/2023 at 10:10 A.M.,			in-service will be conducted by	/ the	
	CNA 7 indicated th	e resident should have			Director of Nursing or Designe	ee	
	received a shower 2	times a week and did not.			and will include a review of		
					resident ADLs related to show	er	
	2. During an interview, on 1/09/2023 at 11:29 A.M.,				preferences. The Director or		
	Resident 46 indicated he does not receive				Nursing/Designee will audit all		
	showers twice a we	ek.			resident shower schedules da	ily to	
					ensure that all residents are		
	A clinical record re	eview was completed on,			receiving showers per prefere	nce.	
	1/11/2023 at 10:53	A.M. Resident 46's diagnoses					
	included, but were	not limited to: chronic			How the corrective action(s)		
	respiratory failure,	Parkinson's disease, diabetes,			will be monitored to ensure t	he	
	obesity, Schizoaffe	ctive disorder, and dementia.			deficient practice will not		
					recur, i.e., what quality		
		Minimum Data Set)			assurance program will be p	ut	
	•	12/21/2022 indicated Resident			into place:		
	,	ief Interview for Mental Status)					
	_	ion intact. Required limited			Ongoing compliance with this		
		bed mobility, transfers,			corrective action will be monitor	ored	
	1	limited assist for eating and			though the facility Quality		
	total assist of 1 staf	f for bathing.			Assurance and Performance		
					Improvement Program. The		
	_	, dated 7/29/2016 and revised			Director of Nursing/Designee		
		ated Resident 46 required ADL			be responsible for completing		
		akness, polyneuropathy, low			QAPI Audit tools labeled "Sho		
		and history of Covid-19.			QAPI" weekly for 4 weeks and		
		x 1 staff. Interventions			monthly for at least 6 months.		
		not limited to: Bathing:			100% is not achieved an actio		
	Monday and Thurso	day on the day shift.			plan will be developed. Findin	•	
					will be submitted to the Quality	/	
		er documentation, dated	·		Assurance and Performance	_	
		2023, indicated the resident had			Improvement Committee for re	eview	
	received a shower		1		and follow-up.		l

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLET	
		155689	B. WI	NG		01/18/20	023
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD 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
	documented refusal	1/12/2023 and had no			By what date the systemic		
	documented refusal				changes will be		
	During an interview	y, on 1/13/2023 at 10:10 A.M.,		completed: 02/10/2023			
		e resident should have			Compliance Date = 02/10/202	3	
		times a week and did not.3.					
	1	y, on 1/09/2023 at 10:15 A.M., ed he does not receive					
	showers.	ed he does not receive					
	1	ion, on 1/09/2023 at 10:15					
		was observed sitting in his					
		red greasy, stains and food					
	noted on the front o	f his shirt.					
	During an observati	ion, on 1/10/2023 at 1:15 P.M.,					
		served sitting in his recliner,					
		y and observed wearing the					
	dirty shirt from prev	vious day.					
	During an observati	ion, on 1/11/2023 at 10:08					
		was observed sitting in his					
		red greasy, and observed					
		irt that was observed on					
	1/09/2023 at 10:15	A.M.					
	A clinical record re	view was completed on					
		.M., and indicated Resident 44's					
		but were not limited to:					
		pulmonary disease, acute and					
		failure with hypoxia,					
		nilure, obstructive sleep apnea,					
	1 ^	onary edema, pleural effusion, edema, chronic atrial					
		mia, polyosteoarthritis,					
		llucinations, benign prostatic					
	hyperplasia, major o						
	1 "	with mixed anxiety and					
		somnia, mesothelioma and					
	visual hallucination	S.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/18/2023		
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COI 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
IAU	A 5 day MDS (Min dated 1/6/2023, indicating intact cog indicating intact cog A 5 day MDS (Min dated 1/6/2023, indicated 1/6/2023, indicated 1/6/2023, indicated 1/6/2023 indicated showers documente 1/12/2023 indicated shower on 12/21/200 On 1/12/2023 at 10 Daily Living) carep Resident 44 will rec ADL's. Intervention x2 care in pairs only Thursday evenings. During an interview RN (registered nurs should be receiving 1/10/2022 at 2:10 Precords were review record indicated an with diagnoses that to macular degenera osteoarthritis. Resident D's most r Minimum Data Set assessment dated 9/resident had a Brief	imum Data Set) assessment, icated Resident 44 had a BIMS Mental Status) score of 15, gnition. imum Data Set) assessment, icated Resident 44 required ith bathing and extensive hygiene. iew, on 01/12/23 at 10:55 A.M., d between 12/14/2022 and d Resident 44 had recieved one 23. 557 A.M., an ADL (Activities of lan was reviewed and indicated reive appropriate assistance for its will receive extensive assist y for showers on Monday and	IAG			DATE
	impaired. Resident	D required extensive ons for personal hygiene and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/18/	ETED	
	PROVIDER OR SUPPLIEI			2400 C0	DDRESS, CITY, STATE, ZIP COD DLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	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
	Resident D's Care I limited to Activitie 3/05/2019 that indiassistance with bath Saturdays on evenification of Resident from 9/01/2022 to resident received sl 9/05/2022 shower 2/9/07/2022 bedbath 9/12/2022 shower 2/9/19/2022 shower 2/9/19/2022 shower 10/12/2022 shower 10/12/2022 shower 10/14/2022 sh	t D's Skin Check/Shower Sheets 11/04/2022, indicated the nowers at the following times: 2nd shift Monday 2nd shift Wednesday 2nd shift Wednesday 2nd shift Monday 2nd shift Monday 2nd shift Monday 2nd shift Thursday 2nd shift Thursday 4 2nd shift Friday 4 2nd shift Friday 5 2nd shift Monday 6 2nd shift Monday 7 2nd shift Monday 7 2nd shift Monday 8 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3					
	Data Set (MDS), w dated 9/29/2022 an	ecent comprehensive Minimum as a quarterly assessment d indicated the resident had a Mental Status of 11, indicating					

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155689		onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/18/2023	
	PROVIDER OR SUPPLIER TIC CARE OF GOSHEN	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
	moderate cognitive impaired. Resident L required extensive assistance of 1 person for personal hygiene and was totally dependant on staff for bathing.				
	Resident L's Care Plans included but were not limited to Activities of Daily Living, initiated on 1/27/2020 and most recently revised on 9/16/2021, and indicated the resident required assistance with bathing on Mondays and Thursdays on day shift.				
	Review of Resident L's Skin Check/Shower Sheets from 12/01/2022 to 1/10/2022, indicated the resident received showers at the following times: 12/19/2022 shower 1st shift Monday 12/20/2022 bed bath 2nd shift Tuesday 12/24/2022 shower 1st shift Saturday Resident was out of the facility from 12/28/2022 to 12/31/2022 1/2/2023 shower 1st shift Monday 1/10/2023 shower 1st shift Tuesday The resident did not have any form of bathing on the following scheduled days: December 5, 8, 12, 15, 22, 26, 2022 January 5, 9, 2022				
	6. On 1/10/2022 at 3:30 P.M., Resident H's clinical records were reviewed. The resident's Admission Record indicated the resident was most recently admitted to the facility on date of 9/20/2021, with diagnoses that included but were not limited to chronic obstructive pulmonary disease, heart failure, stroke, need for assistance with personal care.				
	Resident H's most recent comprehensive Minimum Data Set (MDS), was a quarterly assessment dated 9/27/2022 and indicated the resident had a Brief Interview for M(a)ental Status				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155689	B. WI	NG		01/18/	2023
				CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
NAA IEGTI	10 04 DE 0E 0001	IEN!			OLLEGE AVE		
MAJESTI	IC CARE OF GOSH	1EN		GOSHE	N, 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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
		lerate cognitive impaired.					
Resident H required extensive assistance of 2							
persons for personal hygiene and was totally							
	dependant on staff f						
	dependant on start for causing.						
	Resident H's Care P	lans included but were not					
		s of Daily Living, initiated on					
		at recently revised on 2/4/2022,					
		sident required assistance					
		esdays, Thursdays, and					
	Sundays on 2nd shi	-					
	Sundays on 2nd sin						
	Review of Resident	H's Skin Check/Shower Sheets					
		1/10/2023, indicated the					
		owers at the following times:					
	11/15/2022 shower	_					
	12/01/2022 shower	_					
	12/01/2022 shower 12/09/2022 bedbath						
	12/10/2022 shower						
		_					
		The facility from 12/13/2022 to					
	12/14/2022	l- 2 41-16 T 4					
	12/27/2022 bed batl						
	12/30/2022 bed batl						
		The facility from 1/04/23 to					
	1/9/2023	0 1 1 ° E					
	1/10/2023 bed bath	zna smit Tuesday					
	Th	41					
		t have any form of bathing on					
	the following sched	-					
	November 17, 20, 2						
	December 4, 6, 8,19	9, 22, 25, 29, 2022					
	January 1, 3, 2023						
	<u>-</u>	1/10/2020					
		ew, on 1/10/2023 at 2:14 P.M.,					
		ted she has not had a shower					
	or bed bath for awh	ıle.					
		view was completed on,					
		.M., and indicated Resident					
	180's diagnoses incl	luded, but were not limited to:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/18/2023		
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) OMPLETION DATE
	Necrotic bowel second metabolic encephalogy dysfunction of the b	ondary to small obstruction, opathy, anemia, neuromuscular oladder, altered mental status, on, dysphonia, hypertension				
	shower documentat	iew, on 1/13/23 at 11:28 A.M., ion indicated between 2/2023 Resident received one				
	assessment, dated 1	(Minimum Data Set) 2/29/2022, indicated Resident rief Interview for Mental cognition intact.				
	assessment, dated 1 180 requires extens	(Minimum Data Set) 2/29/2022 indicated Resident ive assist of two staff for bed aygiene, toilet use and				
	Resident needs assi	dated 12/22/2022, indicated stant with activities of daily tiene: extensive with 2 staff				
	(registered nurse) 6 be receiving shower	r, on 1/13/2023 11:36 A.M., RN indicated Resident 180 should rs every week, she also at know if Hospice or facility				
	provided the policy Living (ADL's), Su indicated the policy by the facility. The who are unable to c	P.M., the Executive Director titled, "Activities of Daily pporting", dated 3/2018, and was the one currently used policy indicated"Residents arry out activities of daily y will receive the services				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 01/18/2023	
	PROVIDER OR SUPPLIER		2400	r address, city, state, zip cod COLLEGE AVE HEN, 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
F 0679 SS=D Bldg. 00	and personal and or and services will be are unable to carry of independently, with and in accordance wappropriate support (bathing, dressing, gardinary of the service of	facility must provide, based sive assessment and care rences of each resident, and to support residents in their s, both facility-sponsored ral activities and rities, designed to meet the ripport the physical, mental, well-being of each resident, independence and community. In interview, and record failed to provide activities of ridents reviewed for activities.	F 0679	F679- Activities Meet Interest/Needs Each Reside It is the practice of this facility ensure that all residents are provided activities of resident choice or preference. What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice:	/ to

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	00	COMPL	
		155689	B. WIN	IG		01/18/	2023
NAME OF E	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					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	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		39 A.M., Resident 280 was ed in a facility gown watching			Daridant 000 maridant mar		
	the television.	ed in a facility gown watening			Resident 280- resident was	a o	
	the television.			provided materials to encourage individual activities in resident			
	An observation and	interview on 1/12/2023 at 1:42			room.		
		was observed lying in bed with					
		She indicated during an			How other residents having	the	
	interview, she enjoys horseback riding, crocheting, listening to music and coloring. No				potential to be affected by th		
					same deficient practice will b	ре	
	independent activiti	es were observed in the room.			identified and what correctiv	е	
		1/10/0000			action(s) will be taken:		
	During observations on 1/13/2023 at 11:12 A.M.				l.,, ., ., ., ., ., ., ., ., ., ., ., .,		
	and 2:58 P.M., Resident 280 was observed lying in				All residents have the potentia	al to	
	bed with a facility gown on and the television				be affected by this deficient practice. All residents reviewe	ad ta	
	playing.				ensure that materials are prov		
	A clinical record re	view was completed on			for residents who choose to ta		
		A.M. Diagnoses included, but			part in individual activities with		
		displaced trimalleolar fracture			their rooms.		
		miplegia and hemiparesis					
	following a cerebra	l infarction affecting			What measures will be put in	ito	
		anxiety disorder, and			place or what systemic		
	osteoarthritis.				changes will be made to		
	0 1/10/2022	M. D. M. 1000			ensure that the deficient		
		31 P.M., Resident 280 was ed. She indicated she had			practice does not recur:		
		in the dining room. The			All activity staff will be in-servi	ced	
		as observed coming to			on or before 1/31/2023. This	o c u	
	-	as observed coming to and invited her to bingo.			in-service will be conducted by	v the	
		ot have any visible activities in			Executive Director or Designe		
	her room.	-			and will include a review of		
					Individual Activities and Room	1	
		S (Minimum Data Set)			Visit Program. The Activity		
		mpleted on 1/3/2023. The			Director/Designee will audit all		
		d that Resident 280 had			resident Activity Care Plans to		
		impairment. She required			ensure accuracy and that facil	-	
		e with one staff member for			is providing appropriate mater		
		unit. The Interview for Daily			to residents in room as neede	a.	
	and Activity Prefere	ences was not assessed.			How the corrective action(s)		
					LINGS THE COLLECTIVE ACTIONS		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING <u>00</u> CO		COMPL	DATE SURVEY COMPLETED 01/18/2023	
	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	REGULATORY OR A Care Plan on 1/12 involved in her own welcomes visits from intervention include will help Resident 2 activities during the During an interview the Activity Director the residents about the questions for Set Assessment, Intervity Preferences. She inconstruction indicated so for Resident 280's inter Director indicated so for Resident 280. The she did not complet assessment for Resident 280's activity partice reviewed with the Aworksheet indicated Resident 280 had on There were no furth On 11/17/2023 at 3 by the Activity Director indicated Resident 280 had on There were no furth Assessment". The public Assessment in the Activity Assessment develop an activity and interests of the Activities Care Plan	2/2023, indicated, Resident is a activity during the day, but m the activity staff. An ed, to provide materials that 280 to be successful in her own e day. 7 on 1/18/2023 at 11:17 A.M., or indicated that she interviews their interests and includes ection F of the MDS ew for Daily and Activity dicated she keeps the interview ent. When asked to see view sheet, the Activity he did not have an interview he Activity Director indicated e a comprehensive dent 280. She indicated the and not person centered. 233 A.M., a review of Resident ipation worksheet was activity Director. The 1 on 1/12/2023 at 2:19 P.M., are on one active conversation. Her entries on the worksheet. 222 P.M., a policy was provided exter titled, "Activity bolicy indicated,"1. Within at's admission to the facility, and the will be conducted to help plan that reflects the choices resident5. Each resident's a shall relate to his/her sessment and should reflect		will be monitored to ens deficient practice will no recur, i.e., what quality assurance program will into place: Ongoing compliance with corrective action will be me though the facility Quality Assurance and Performan Improvement Program. The Activity Director/Designed responsible for completin QAPI Audit tools labeled Activities" weekly for 4 we monthly for at least 6 mon 100% is not achieved an plan will be developed. Find will be submitted to the Quality Assurance and Performan Improvement Committee and follow-up. By what date the system changes will be completed: 02/10/2023 Compliance Date = 02/10	this nonitored fine will be g the fin-Room eeks and enths. If action findings equality ence for review	
	3.1-33(a)					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155689	B. W	ING		01/18/	2023
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of Quality of care is a applies to all treate facility residents. E comprehensive as facility must ensur treatment and care professional stand comprehensive pe and the residents' Based on observation review, the facility thospice regarding the comprehensive hosp communication of r nutrition, skin and e reviewed for hospice A clinical record rev 1/13/2023 at 9:57 A 180's diagnoses inclinecrotic bowel secon metabolic encephale dysfunction of the b intestinal obstructio and hypothyroidism An Admission MDS assessment, dated 1: 180 had a BIMS (B: Status) score of 15, Current physician of	of care a fundamental principle that ment and care provided to Based on the sessment of a resident, the e that residents receive e in accordance with lards of practice, the erson-centered care plan, choices. on, interview and record failed to collaborate with the development of a poice care plan related to esident changes i.e.: pain, end of life for 1 of 3 residents e. (Resident 180) wiew was completed on, a.M., and indicated Resident luded, but were not limited to: ndary to small obstruction, opathy, anemia, neuromuscular oladder, altered mental status, n, dysphonia, hypertension a. S (Minimum Data Set) 2/29/2022, indicated Resident rief Interview for Mental cognition intact. rders, dated January 2023, 180 was receiving Hospice	F 00		F684 – Quality of Care It is the practice of this facility ensure that hospice and the facility collaborate to develop a comprehensive hospice care prelated to communication of resident changes. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 180- hospice contact for all up to date communication for facility records. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential be affected by this deficient practice. All residents receiving hospice communication binded.	a blan I ted bn the e be e	02/10/2023

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	NG	_	01/18/	2023
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUGHER N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		, dated 12/23/2023, indicated			updated with all current		
	_	eiving hospice services and			communications in collaboration	on I	
		y would work cooperatively			with hospice providers.	-	
		to ensure the resident's			With Hoopide providers.		
	_	, intellectual, physical and			What measures will be put in	ıto l	
	social needs are me				place or what systemic		
	Social needs are me				changes will be made to		
	During an observation, on 1/13/2023 at 10:02				ensure that the deficient		
	A.M., (Company name) Hospice binder was noted				practice does not recur:		
	in nursing unit for Resident 180 and was empty.				practice does not recur.		
	in nursing unit for Resident 180 and was empty.				All pursing stoff will be in conv	iood	
	During an intervious	y on 1/12/2022 at 10:12 A M			All nursing staff will be in-served on or before 1/31/2023. This	iceu	
	During an interview, on 1/13/2023 at 10:12 A.M., CNA (certified nursing assistant) 7 indicated there					. 41	
	is no schedule when hospice comes in to				in-service will be conducted by		
		-			Director of Nursing or Designe	ee	
	-	and the nurses will let us know			and will include a review of		
	who is on hospice.				hospice services. The Director		
	D	1/12/2022 - 10 20 4 34			Nursing/Designee will audit all		
	_	v, on 1/13/2023 at 10:20 A.M.,			current hospice residents to		
		sing assistant) 5 indicated			ensure that proper communica		
		howers in the evening but she			between facility and hospice is	3	
	was not sure.				maintained.		
	Daning a 1 to 1						
	-	v on 1/13/2023 at 10:22 A.M.,			How the corrective action(s)		
		se) 6 indicated she would		will be monitored to ensure the			
		hospice while they are in the			deficient practice will not		
		Resident or call the hospice			recur, i.e., what quality	_	
		tered nurse) 6 went to the			assurance program will be p	ut	
		opened the Hospice binder to			into place:		
		information and noted the					
	binder was empty.				Ongoing compliance with this		
					corrective action will be monitor	ored	
	_	v on 1/13/2023 at 10:25 A.M.,			though the facility Quality		
		se) 6 indicated the Hospice			Assurance and Performance		
		Resident 180's information in			Improvement Program. The		
		s, shower schedules and			Director of Nursing/Designee	will	
	information to cont	act Hospice.			be responsible for completing	the	
					QAPI Audit tools labeled "Hos	pice	
	On 1/19/2023 at 10	:40 A.M., the Executive Director		Communication" weekly for 4			
	provided the policy	titled, "Hospice Services",			weeks and monthly for at leas	t 6	
		ndicated the policy was the one			months. If 100% is not achieve		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	NG		01/18/	2023
				CTD FFT A	DDDFGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE		
MAA JECTI		IENI					
MAJEST	IC CARE OF GOSH	IEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	currently used by th	e facility. The policy			an action plan will be develope	ed.	
	indicated"It is the	policy of this facility that			Findings will be submitted to the	ne	
	when a resident elec	ets the hospice benefit that the			Quality Assurance and		
	contracted hospice	company and facility will			Performance Improvement		
	coordinate to estable	ish both a centered plan of			Committee for review and		
	care refelecting the physical, spiritual, mental and psychosocial needs of the resident as well as a				follow-up.		
	pattern of communi	cation between the hospice			By what date the systemic		
	company, healthcar	e professionals, facility staff			changes will be		
	and resident"				completed: 02/10/2023		
					Compliance Date = 02/10/2023	3	
	3.1-37(a)						
F 0690	483.25(e)(1)-(3)						
SS=D		ontinence, Catheter, UTI					
Bldg. 00	§483.25(e) Inconti						
	- , , , ,	facility must ensure that					
		ntinent of bladder and					
		on receives services and					
		ntain continence unless his					
		dition is or becomes such					
	that continence is	not possible to maintain.					
	0.400.004.\\0\0						
	- ',','	a resident with urinary					
		ed on the resident's					
		sessment, the facility must					
	ensure that-						
		enters the facility without					
	_	eter is not catheterized					
		it's clinical condition					
		catheterization was					
	necessary;						
	• •	enters the facility with an					
	_	r or subsequently receives					
		or removal of the catheter					
	· ·	le unless the resident's					
	clinical condition d						
	catheterization is r	-					
	(III) A resident who	is incontinent of bladder					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	NG		01/18/	/2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			OLLEGE AVE		
MAILCE	IC CARE OF GOSH	IENI					
MAJEST	IC CARE OF GOSF	1EIN		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'	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE
	receives appropria	ate treatment and services					
	to prevent urinary	tract infections and to					
	restore continence	e to the extent possible.					
	§483.25(e)(3) For	a resident with fecal					
	incontinence, based on the resident's comprehensive assessment, the facility must						
		dent who is incontinent of					
	bowel receives ap	propriate treatment and					
	·	e as much normal bowel					
	function as possible. Based on observation, record review and						
			F 0	590	F690 – Bowel, Bladder		02/10/2023
	interview, the facili	ty failed to ensure catheter care			Incontinence, Catheter, UTI		
	was completed appropriately for 2 of 3 residents				It is the practice of this facility to		
	reviewed for cathete	er care. (Resident 28 and			ensure catheter care is provide	ed	
	Resident L)				appropriately for all residents.		
	Findings include:				What corrective action(s) will	l	
					be accomplished for those		
	1. During and obser	rvation, on 1/17/2023 at 1:55			residents found to have beer	1	
	P.M., CNA 12 was	observed to provide catheter			affected by the deficient		
	care to Resident 28.	. The CNA washed her hands			practice:		
	and applied gloves.	A basin of water, one with					
	soapy water and wa	sh cloths and towels were on			Resident 28 – appropriate cath	neter	
	the bed side table. T	The CNA removed the tape			care was provided with no issu	ies	
	from the sides of the	e resident's brief and then with			noted.		
		washed the penis from the			Resident L – appropriate cathe	eter	
	abdomen towards th	he meatus (opening of the			care was provided with no issเ	ies	
	penis). She then wa	shed the catheter, by using			noted.		
	different parts of the	e wash cloth washing the tube					
		s opening. she then washed			How other residents having t	he	
	the groin area and r	emoved her gloves. The CNA			potential to be affected by th	е	
	applied new gloves	and used a wet wash cloth to			same deficient practice will b	e	
	rinse the penis and	groin area by moving towards			identified and what corrective	е	
		out washing her hands, she			action(s) will be taken:		
	applied new gloves	and then turned the resident					
	to wash his buttock	s. She removed the brief,			All residents utilizing a cathete	r	
	washed the buttocks	s and then applied new gloves			have the potential to be affected	ed	
	and removed the be	ed pad from under the resident.			by the deficient practice. All		
	She applied new glo	oves and applied a new brief			residents utilizing a catheter h	ave	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	ING		01/18/	/2023
		l .	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			OLLEGE AVE		
ΜΔ ΙΕςΤ	IC CARE OF GOSH	HEN			EN, IN 46526		
IVIAUEUI	OAKE OF GOOF	ILI V		30311	-14, 114 70020		
(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
	on the resident.				been reviewed to ensure no		
					negative affects as result.		
	_	v, on 1/17/2023 at 2:10 P.M.,					
		she should not have washed			What measures will be put in	ito	
		f the penis and should have			place or what systemic		
	washed her hands between changing gloves.				changes will be made to		
	1/0/2022 - 2 40 734				ensure that the deficient		
	_	iew, on 1/9/2023 at 2:49 P.M.,			practice does not recur:		
		ed staff do not clean his					
	catheter tubing very	у опен.			All nursing staff will be in-servi	iced	
					on or before 1/31/23. This		
	A clinical record review was completed on 1/11/2023 at 10:54 P.M., and indicated Resident L's				in-service will be conducted by	•	
					Director of Nursing or Designe	ee	
	_	, but were not limited to:			and will include a review of		
		matory syndrome, basal cell		catheter care and hand hygiene policies. The Director or			
		right ear and external auricular			·	11	
		ey disease stage 4, dysphagia,			Nursing/Designee will observe		
		n of rectum, major depressive neuromuscular dysfunction of			CNAs performing catheter car		
		ljustment disorder with anxiety,			ensure appropriate care being	l	
	I	encephalopathy, osteomyelitis			provided. The Director of	ł-a	
		and sacrococcygeal region,			Nursing/Designee will complet catheter care skills validation v		
	dysphagia and mus				nursing staff.	WILII	
	aysphagia and musi	ore wearness.			i nursing stan.		
	A Significant chang	ge MDS (Minimum Data Set)			How the corrective action(s)		
		2/16/2022, indicated Resident			will be monitored to ensure t		
	l '	ef Interview for Mental Status)			deficient practice will not	0	
	,	ing moderately impaired.			recur, i.e., what quality		
					assurance program will be p	ut	
	Physician orders. da	ated 1/12/2023, indicated			into place:		
	Resident L had a su				mis piass.		
		•			Ongoing compliance with this		
	A current care plan	, dated 1/27/2020, indicated			corrective action will be monitor	ored	
	•	prapubic catheter related to a			though the facility Quality		
		. Interventions included, but			Assurance and Performance		
	"	: cleanse supra-pubic site every			Improvement Program. The		
		water, change catheter/bag as	Director of Nursing/Designee will				
	_	cover drainage bag to promote			be responsible for completing		
	_	igate catheter as ordered, keep			QAPI Audit tools labeled "Cath		
		of kinks and keep drainage			Care" and "Infection Control"		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155689	B. W	ING		01/18	/2023
				OTP PET	ADDRESS STATE OF SOF		
NAME OF F	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
	10 0 A DE 05 000°	IEA!			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	1EN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	bag below level of	bladder, labs as ordered, meds			weekly for 4 weeks and month	ıly	
	as ordered, notify n	urse if catheter is leaking,			for at least 6 months. If 100%	o is	
	notify nurse if resid	ent is incontinent of urine,			not achieved an action plan wi	ill be	
	observe for/docume	ent color, clarity, odor of urine,			developed. Findings will be		
	notify charge nurse of abdominal urine,				submitted to the Quality		
	observe/document s	signs and symptoms of UTI			Assurance and Performance		
	(urinary tract infect	ion), treatments as ordered.			Improvement Committee for re	eview	
					and follow up.		
	During an observati	ion, on 1/12/2023 at 1:44 P.M.,					
		ohol wipe to clean catheter			By what date the systemic		
	tubing and used the	same alcohol wipe to clean			changes will be		
	the stoma.				completed: 02/10/2023		
					Compliance Date = 02/10/202	3	
	During an interview	on 1/12/2023 at 1:52 P.M.,					
	CNA 9 indicated sh	e should have used a new					
	alcohol wipe to clea	an area and not the used one.					
		:31 A.M, the Administrator					
		titled,"Handwashing/Hand					
		2018, and indicated the policy					
		ly used by the facility. The					
		5. Employees must wash their					
	1	conds using antimicrobial or					
		oap and water under the					
		s:d. After removing					
	gloves"						
	0 1/10/2022						
		2 P.M., the Administrator					
		titled, "Policies and					
		Control". The policy					
		icilities infection prevention,					
		n (ICPC) is designed to					
	1 ~	tary, and comfortable					
	environment and to						
	_	ansmission of communicable					
	diseases and infecti	ons"					
		:00 A.M., the Administrator					
		titled, "Catheter Care,					
	∪rınary", dated Sep	tember 2014, and indicated the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		r í	ILDING	nstruction 00	(X3) DATE : COMPL 01/18/	ETED	
	PROVIDER OR SUPPLIER			2400 C0	NDDRESS, CITY, STATE, ZIP COD OLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0692 SS=D Bldg. 00	facility. The policy resident: Use a wash soap to cleanse arouglans using circular outward. Change the with each cleansing washcloth, rinse wit technique. Return f Discard disposal ite. Remove gloves and container. Wash and thoroughly" This Federal tag rela and IN00398585. 483.25(g)(1)-(3) Nutrition/Hydration §483.25(g) Assiste (Includes naso-gastubes, both percut gastrostomy and piejunostomy, and resident's comprel facility must ensure \$483.25(g)(1) Main parameters of nutrusual body weight range and electrol resident's clinical of that this is not pospreferences indicated \$483.25(g)(2) Is of to maintain proper	a Status Maintenance ed nutrition and hydration. stric and gastrostomy aneous endoscopic ercutaneous endoscopic enteral fluids). Based on a nensive assessment, the e that a resident-itional status, such as or desirable body weight yte balance, unless the condition demonstrates sible or resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155689	B. WI			01/18/	
				_		0 1, 10,	
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDER OR SETTEME			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	(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
	health care provid	ler orders a therapeutic diet.					
	Based on interview	, and record review, the facility	F 06	592	F692 – Nutrition/Hydration		02/10/2023
	failed to ensure a re	esident maintained their			Status Maintenance		
	admission weight w	when not on a prescribed			It is the practice of this facility	to	
	weight loss program for 1 of 3 residents reviewed				ensure residents maintain thei		
	for weight loss, (Re				admission weight when not		
		,			prescribed a weight loss progr	am.	
	Findings include:				procenied a weight look progr	u	
					What corrective action(s) will	I	
	On 1/13/2023 at 11	:00 A.M., an interview with			be accomplished for those		
	Resident G indicate	ed she has had unplanned			residents found to have beer	1	
	weight loss since ac	lmission. The resident			affected by the deficient		
	indicated she has no	ot had an appetite and that no			practice:		
	one from nursing, d	lietary, nor the physician have					
	talked to her about	concerns they may have			Resident G – resident added t	0	
		nt loss. The resident indicated			weekly risk review and dietary		
		fered any form of supplements			interventions added.		
	for her weight loss.						
					How other residents having t	he	
	01/13/2033 at 11:34	4 A.M., an interview with the			potential to be affected by th		
		of Nursing indicated the			same deficient practice will b		
		eam was discussing Resident			identified and what corrective		
		was going to start the resident			action(s) will be taken:	•	
	on a dietary supple				donon(o) will be taken.		
	on a distanty suppre				All residents at risk for weight	loss	
	On 1/13/2033 at 1-3	30 P.M., Resident G's clinical			have the potential to be affected		
	record was reviewe				by the deficient practice. All	J u	
	13001a was leviewe	 .			residents with significant weigh	ht	
	The resident's Adm	ission Record indicated an			loss reviewed to ensure that the		
		2/05/22 and the most recent				-	
		nimum Data Set dated			have been added to weekly ris review and interventions	or.	
	_	mission Assessment indicated					
		rief Interview for Mental Status			appropriately added.		
					Miles American Control of the Control	4-	
		, indicating moderate cognitive			What measures will be put in	ito	
	_	sident required supervision and			place or what systemic		
		g. Diagnoses included but			changes will be made to		
		diabetes, acquired absence of			ensure that the deficient		
	-	act, femoral fracture, kidney			practice does not recur:		
		iplegia, and surgical wound for					
	femoral fracture rep	pair.			All nursing staff will be in-servi	ced	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	ING		01/18	/2023
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	₹			OLLEGE AVE		
МД ІЕСТ	IC CARE OF GOSH	4EN			EN, IN 46526		
IVIAJEST	O OANL OF GOOF	ILIN		GOSITE	_IN, IN 40020 -		
(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
					on or before 1/31/23. This		
		t G's physician's dietary orders			in-service will be conducted by	y the	
	dated 12/05/2022, indicated a reduced				Director of Nursing or Designe	ee	
	carbohydrate diet r	egular texture, thin			and will include a review of we	eight	
	consistency.				monitoring program. The Direct	ctor	
					or Nursing/Designee will revie	w all	
		t G's Care Plans included but			weights weekly to ensure that	any	
	were not limited to:				resident with significant weigh		
		balance due to diabetes type 2,			loss are added to risk review a		
		niparesis following a stroke,			interventions appropriately ad-	ded.	
	kidney disease, ede						
		led but were not limited to,			How the corrective action(s)		
		ument intake, weights as			will be monitored to ensure t	he	
		fy physician of significant			deficient practice will not		
	weight changes.				recur, i.e., what quality		
					assurance program will be p	ut	
	_	ations and symptoms of			into place:		
		perglycemia due to diagnosis					
	of diabetes. Interve	ntions included but were not			Ongoing compliance with this		
		t meal/snack intake. Both			corrective action will be monitor	ored	
		2. And a potential for nutritional			though the facility Quality		
	-	ntial for delayed healing			Assurance and Performance		
	-	to diabetes type 2, chronic			Improvement Program. The		
	kidney disease, and				Director of Nursing/Designee		
		led but were not limited to,			be responsible for completing		
		d intakes, which was initiated			QAPI Audit tools labeled "Wei	-	
	on 12/12/2022.				Monitoring" weekly for 4 week	S	
					and monthly for at least 6		
		dent G's documented weights			months. If 100% is not achieved		
		sion weight on 12/06/2022 of			an action plan will be develope		
		4/2023 Resident G's weight was			Findings will be submitted to the	he	
	195 lbs which indic	ated a 10.55 % Loss.			Quality Assurance and		
					Performance Improvement		
		t G's documented meal intake			Committee for review and follo	W	
		from 12/16/2022 to 1/04/2023,			up.		
		no meal intake documentation					
	on the following da				By what date the systemic		
	12/17/2022 breakfa	st and lunch			changes will be		
	12/19/2022 breakfa	st and lunch			completed: 02/10/2023		
	12/20/2022 breakfa	et and lunch			Compliance Date - 02/10/202	2	

	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COMP	E SURVEY LETED 8/2023
	F PROVIDER OR SUPPLIER		2400	T ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE HEN, IN 46526	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
IAU	12/21/2022 breakfa 12/22/2022 breakfa 12/23/22 dinner 12/24/2022 breakfa 12/25/2022 breakfa 12/26/2022 breakfa 12/29/2022 breakfa 12/30/2022 breakfa 12/31/2022 breakfa 12/31/2022 breakfas 1/1/2023 breakfast 1/4/2023 breakf	st lunch and dinner st and lunch and lunch and lunch and lunch and lunch and lunch lity policy. The policy ght report will be generated and by the DM [Dietary gistered Dietician], DNS g Services], and MDS t] for significant changes. A change is defined as 5% in 30 and 10% in 180 days. The and family/guardian will be fied significant weight DO P.M. the policy titled, and, dated 2001 and revised ded by the Executive Director be current facility policy. The and healthcare practitioners, tional assessment for each ed a change in condition that	IAU			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING B. WING			
	ROVIDER OR SUPPLIER		240	EET ADDRESS, CITY, STATE, ZIP COD 0 COLLEGE AVE SHEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION DATE
F 0694	the resident at risk for or with impaired nutrition" 3.1-46(a)(1)(2) 483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids.				
Bldg. 00	Parenteral fluids in consistent with propractice and in accorders, the comprisance plan, and the preferences. Based on observation interview, the facility	nust be administered ofessional standards of cordance with physician ehensive person-centered resident's goals and on, record review and ty failed to change PICC	F 0694	F694- Parenteral/IV Fluids It is the practice of this facility	02/10/2023 y to
	interview, the facility failed to change PICC (peripherally inserted central catheter) line dressings for 1 of 1 resident reviewed for intravenous antibiotic therapy (Resident 101) During an observation on 1/10/2023 at 2:26 P.M., Resident 101's PICC line dressing had a PICC line kit dated tape adhered to the clear Tegaderm with the date of 12/4/2022. The Tegaderm was observed to be rolled on the edges and not adhered around the PICC lines. A clinical record review of Resident 101 was completed on 1/13/2023 at 9:13 A.M. Diagnoses included, but were not limited to: congestive heart failure, atrial fibrillation, chronic kidney disease, and osteomyelitis. A Significant Change MDS (Minimum Data Assessment) Assessment on 12/15/2022 indicated Resident 101 was cognitively intact. He received intravenous therapy with antibiotics for 7 of 7 days of the assessment period. There was no documented rejection of care.			ensure that all PICC line dressare changed per physicians orders. What corrective action(s) was be accomplished for those residents found to have be affected by the deficient practice: Resident 101- PICC dressing changed per physician order. How other residents having potential to be affected by the same deficient practice will identified and what correcting action(s) will be taken: All residents with dressing changed by the deficient practice to affected by the deficient practice will residents with dressing changed by the deficient practice will residents with dressing changed by the deficient practice will residents with dressing changed by the deficient practice will residents with dressing changed by the deficient practice.	ssings ill in the be ve nange pe petice. nange

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURV		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155689	B. W	ING		01/18/2023	3
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			COLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN			EN, IN 46526		
	T		1		· 	<u> </u>	(V.F.)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	CON	(X5)
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	MPLETION DATE
TAG		as antibiotics due to diabetes		IAG			DATE
	_	a foot ulcer and wound vac,			What measures will be put in	ito	
					place or what systemic changes will be made to		
	multi-drug resistant organisms, Escherichia coli, Extended Spectrum Beta-Lactamase, and				ensure that the deficient		
	vancomycin-resistant enterococci. An						
	intervention was to change the dressing as				practice does not recur:		
		the site dry and clean.			All nursing staff will be in-serv	iced	
	ordered and to keep	, the site dry and clean.			on or before 1/31/23. This		
	Physician Order's o	n 12/8/2022, indicated, to			in-service will be conducted by	, the	
		ne dressing every seven days			Director of Nursing or Designe	·	
		(central venous catheter) kit			and will include a review of PI		
		islodgement and soilage.			and dressing changes and		
	und as needed for a	islougement und sonage.			following physician orders. Th		
	A Nurse's Note on	1/12/2023 at 7:30 A.M.,			Director or Nursing/Designee		
		apper arm PICC line dressing			review all residents with order		
	changed using steri				dressing changes to ensure the		
	changea asing sterr	ie teemique			dressings are being changed		
	During an observati	ion and interview on 1/13/2023			physician orders.		
	_	PICC line dressing had a been			physician stacts.		
		ing was adhered to the skin			How the corrective action(s)		
	-	3. Resident 101 indicated this			will be monitored to ensure	he	
		ne dressing had been changed			deficient practice will not		
		n the hospital on 12/8/2022.			recur, i.e., what quality		
		•			assurance program will be p	ut	
	During an interview	v on 1/18/2023 at 11:07 A.M.,			into place:		
	_	tor of Nursing (ADON)					
		line dressing was to be			Ongoing compliance with this		
	changed every seve	n days. When the observed			corrective action will be monit	ored	
	date of the PICC lir	ne dressing was verbalized to			though the facility Quality		
		lied, "That is not okay." A			Assurance and Performance		
	_	cation Administration Record			Improvement Program. The		
	indicated that nursi	ng had signed the PICC line			Director of Nursing/Designee	will	
		nged on 1/1/2023, 1/8/2023,			be responsible for completing		
	1/15/2023 and as no	eeded on 1/12/2023. The ADON			QAPI Audit tools labeled		
	indicated the nurses had signed off on the				"Dressing Change QAPI" wee	kly	
	dressing change and	d did not complete the			for 4 weeks and monthly for a		
	dressing change.				least 6 months. If 100% is no		
					achieved an action plan will be	e	
	On 1/18/2023 at 3:1	12 P.M., the Executive Director			developed. Findings will be		
	provided a policy ti	tled. "PICC/Midline/CVAD			submitted to the Quality		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155689	B. W	NG		01/18/	2023
				CED DEET A	ADDRESS OF A STATE OF COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
NAA IEGTI	0.0405.05.0001	IENI			OLLEGE AVE		
MAJESTI	C CARE OF GOSH	IEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	[central venous acce	ess device] Dressing Change".			Assurance and Performance		
	The policy indicated	d, "It is the policy of this			Improvement Committee for re	eview	
	facility to change pe	eripherally inserted central			and follow up.		
		dline or central access device			· ·		
		reekly or if soiled, in a manner			By what date the systemic		
		l for infection and/or			changes will be		
	-	a. Physician orders will specify			completed: 02/10/2023		
		I frequency of changes"			Compliance Date = 02/10/202	3	
	51 0	1 3 2					
	3.1-47(a)(2)						
F 0695	483.25(i)						'
SS=D	Respiratory/Trach	eostomy Care and					
Bldg. 00	Suctioning	,					
	•	atory care, including					
	- ,,	and tracheal suctioning.					
	-	nsure that a resident who					
	needs respiratory						
	•	e and tracheal suctioning,					
	-	are, consistent with					
	-	ards of practice, the					
	•	erson-centered care plan,					
		s and preferences, and					
	483.65 of this sub	•					
		on, record review and	F 06	505	F695 –		02/10/2023
		ty failed to maintain oxygen	1 00	173	Respiratory/Tracheostomy C	aro	02/10/2023
		invasive respiratory			and Suctioning	arc	
		in a sanitary manner for 2 of 4			It is the practice of this facility	to	
		for oxygen use. (Resident 44			ensure that oxygen equipment		
	and 279)	or oxygen use. (resident 44			non-invasive respiratory	anu	
	and 277)				mechanical devices are stored	lino	
	Findings include;				sanitary manner.	ша	
	r manigs merade,				Samary mamer.		
	1 During an observ	ation, on 1/10/2023 at 10:17			What corrective action(s) will		
	•	oxygen tubing was undated,			What corrective action(s) will be accomplished for those	•	
					residents found to have beer		
	hanging over the trash can and on the floor.						
During an observation, on 1/11/2023 at 9:21 A.M.,				affected by the deficient			
	-				practice:		
		n tubing was undated, and			Desident 44		
	under a pile of dirty	ciotnes.			Resident 44 – oxygen tubing		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/18/2023 155689 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2400 COLLEGE AVE MAJESTIC CARE OF GOSHEN GOSHEN. IN 46526 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE changed and labeled/dated and A clinical record review was completed on stored appropriately. 1/11/2023 at 2:40 P.M., and indicated Resident 44's Resident 279 – bipap accessories diagnoses included, but were not limited to: changed and labeled/dated chronic obstructive pulmonary disease, acute and appropriately and order received chronic respiratory failure with hypoxia, and carried out for cleaning of hypoxemia, heart failure, obstructive sleep apnea, bipap. chronic atrial pulmonary edema, pleural effusion, chronic pulmonary edema, chronic atrial How other residents having the fibrillation, polyosteoarthritis, insomina, visual potential to be affected by the hallucinations, benign prostatic hyperplasia, major same deficient practice will be depressive disorder, adjustment disorder with identified and what corrective mixed anxiety and depressed mood, and action(s) will be taken: mesothelioma. All residents utilizing respiratory A 5 day MDS (Minium Data Set) assessment, devices have the potential to be dated 1/6/2023, indicated Resident 44 had a BIMS affected by the deficient practice. (Brief Interview for Mental Status) score of 15, All residents utilizing respiratory indicating intact cognition. devices have been reviewed for order accuracy and observed to A current careplan, dated 9/28/2022, indicated ensure appropriate labeling and Resident 44 is at risk for respiratory distress dating of accessories and storage. related to chronic obstructive pulmonary disease, sleep apnea, chronic respiratory failure with What measures will be put into hypoxia, pleural effusion, and chronic pulmonary place or what systemic edema. changes will be made to ensure that the deficient Physician's orders, dated January 12, 2023, practice does not recur: indicated Resident 44 was receiving 02 at 2 liters via NC (nasal cannula) continuous and to change All nursing staff will be in-serviced and date 02 tubing, humidifier and bag weekly on or before 1/31/23. This every night shift on Sunday. in-service will be conducted by the Director of Nursing or Designee During an interview, on 1/11/2023 at 11:18 A.M., and will include a review of oxygen RN 6 indicated 02 tubing should be changed administration and cpap/bipap weekly, dated and not be laying on the floor. cleaning. The Director or Nursing/Designee will review all 2. During an observation on 1/9/2023 at 11:11 residents with orders for A.M., Resident 279's BiPap (bilevel positive respiratory devices to ensure that airway pressure) mask was observed hanging all orders are accurate and

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155689	B. W	ING		01/18/2	023
				CTREET	ADDRESS OF A STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE		
MA IFOT	IC CARE OF COOL	JEN					
IVIAJES I	IC CARE OF GOSH	7EIN		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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	over the machine or	n the bedside table.			observe all devices to ensure	all	
					accessories are labeled/dated	,	
	On 1/10/2023 at 10	:16 A.M., the BiPap mask was			stored, and cleaned approrpia	tely.	
	observed lying on the	he bedside table. The					
	equipment did not l	nave any indication of a date			How the corrective action(s)		
	attached to the changeable equipment (mask,				will be monitored to ensure t	he	
	headgear, or tubing).			deficient practice will not		
					recur, i.e., what quality		
	A clinical record re	view was completed on			assurance program will be p	ut	
	1/12/2023 at 11:39	A.M. Diagnoses included, but			into place:		
	were not limited to:	urinary tract infection, chronic					
	respiratory failure,	congestive heart failure,			Ongoing compliance with this		
	obstructive sleep ap	onea, and history of MRSA			corrective action will be monitor	ored	
	(Methicillin-resistar	nt Staphylococcus aureus)			though the facility Quality		
	infection.				Assurance and Performance		
					Improvement Program. The		
	An Admission MD	S Assessment indicated			Director of Nursing/Designee \	will	
	Resident 279 did no	ot have any special treatments.			be responsible for completing	the	
	Resident 279 had m	noderate cognitive impairment.			QAPI Audit tools labeled		
					"Respiratory" weekly for 4 wee	ks	
		nt's 279's Physician's Orders			and monthly for at least 6		
	_	order in cue, but not activated.			months. If 100% is not achieve	/ed	
	1	er's did not include cleaning of			an action plan will be develope	ed.	
	BiPap equipment or	r changing the BiPap			Findings will be submitted to the	ne	
	equipment.				Quality Assurance and		
					Performance Improvement		
		/2023, indicated Resident 279 as			Committee for review and follo	w	
	_	ry distress. An intervention			up.		
	included BiPap as o	ordered.					
					By what date the systemic		
	_	v on 1/18/2023 at 11:00 A.M.,			changes will be		
		tor of Nursing indicated the			completed: 02/10/2023		
		s, headgear, and water reservoir			Compliance Date = 02/10/202	3	
		laily. She indicated a					
		y comes into the facility to					
	_	ing of masks, tubing,					
	_	servoir and filters. The ADON					
		the BiPap order was in the cue					
		lary orders for maintenance					
	were not completed	I. She indicated the mask	1				

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> B. WING			COMPLETED 01/18/2023	
	PROVIDER OR SUPPLIER			2400 CC	DDRESS, CITY, STATE, ZIP COD DLLEGE AVE N, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION en not in use in a respiratory		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	provided the policy Hygiene", dated 2/2 was the one current policy indicated"5 hands for twenty see non-antimicrobial se	31 A.M, the Administrator titled,"Handwashing/Hand 018, and indicated the policy ly used by the facility. The facility wash their conds using antimicrobial or pap and water under the second. After removing						
	provided the policy Practices-Infection of indicated, "The fa and control program provide a safe, sanit environment and to	Control". The policy cilities infection prevention, a (ICPC) is designed to ary, and comfortable help prevent the ansmission of communicable						
	provided the policy, policy indicated, " use with CPAP clea Dry well. Cover wi enclosed in machine Weekly cleaning ac Wash headgear/strajair dry. b. Wash tub nd air dry8. Follow for the frequency of servicing the machine routinely in accordance recommendations.	8/2023, The Administrator "CPAP/BiPap Cleaning". The 6. Clean mask frame daily after ning wipe or soap and water. th plastic bag or completely e storage when not in use7. ticity (specify day of week): a. ps in warm soapy water and ing with warm, soapy water a w manufacturer instructions cleaning/replacing filters a nd ine. Only the supplier may10. Replace equipment ance with manufacturer General guidelines: a. Face m						
	ask and tubingone Headgear, non-disp	e every three months, b. osible filters, and						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		155689	B. WING		01/18/2023		
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
		mberonce every six months,					
F 0757 SS=D Bldg. 00	Drugs §483.45(d) Unnect Each resident's dr from unnecessary drug is any drug w §483.45(d)(1) In eduplicate drug the §483.45(d)(2) For §483.45(d)(3) Withor \$483.45(d)(4) With for its use; or §483.45(d)(5) In the consequences whishould be reduced §483.45(d)(6) Any reasons stated in (5) of this section. Based on record revialled to ensure a refunceessary antibio	excessive dose (including rapy); or excessive duration; or hout adequate monitoring; hout adequate indications he presence of adverse ich indicate the dose d or discontinued; or excessive dose (including rapped); or (including ra	F 0757	F757 – Drug Regimen is Free from Unnecessary Drugs It is the practice of this facility ensure that residents do not receive unnecessary antibiotic. What corrective action(s) will	to es.		
	_	rerview on 1/10/2023 at 10:22		be accomplished for those residents found to have been			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	ING		01/18/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2			OLLEGE AVE		
MAILCE		IENI					
WAJEST	IC CARE OF GOSH	1EIN		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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A.M., Resident 279	indicated she had a urinary			affected by the deficient		
	tract infection.				practice:		
					Resident 279 – antibiotic has been		
	A clinical record re	view was completed on			discontinued.		
	1/12/2023 at 11:39 A.M. Diagnoses included, but were not limited to: urinary tract infection, chronic respiratory failure, congestive heart failure,						
					How other residents having t	he	
					potential to be affected by th	е	
	obstructive sleep ap	onea, and history of MRSA			same deficient practice will b	е	
	(Methicillin-resistar	nt Staphylococcus aureus)			identified and what correctiv	е	
	infection.				action(s) will be taken:		
		S Assessment on 1/6/2023,			All residents have the potentia	l to	
		279 was frequently incontinent			be affected by the deficient		
		ys incontinent of bowel. She			practice. All residents receivir	•	
	_	two or more staff members for			antibiotics have been reviewed	d to	
	toileting.				ensure antibiotic usage meets		
					criteria.		
		1/8/2023 at 6:07 P.M.,					
		ent has had mild confusion for			What measures will be put in	ito	
		in the morning. Urine dipstick			place or what systemic		
	1 ~	eukocytes, {and} nitrite. NP			changes will be made to		
		notified. Urine sent to			ensure that the deficient		
		for UA with C&S [urinalysis			practice does not recur:		
		nsitivity]. New orders for oral			l		
	antibiotic received.	"			All nursing staff will be in-servi	ced	
	O.: 1/0/2022 4.7.20	A.M Normal- N. (on or before 1/31/23. This	. 41	
		A.M., a Nurse's Note			in-service will be conducted by		
	_	placed to [hospital lab name]			Director of Nursing or Designe	ee	
	•	re and sensitivity be added on			and will include a review of	_	
	' ' '	results. New order faxed to lab			antibiotic stewardship program		
	"				The Director or Nursing/Desig will review all residents with or		
	A Dhygiaian's Orda	r on 1/9/2023, indicated,					
		milligrams) one capsule by			for antibiotics to ensure that al		
	_ ·	day for urinary tract infection			antibiotic usage meets criteria		
	for ten days.	day for urmary tract infection			How the corrective action(s)		
	101 ten days.				will be monitored to ensure t	ho	
	On 1/10/2022 a DL	ysician's Order indicated,			deficient practice will not	ii e	
		m intramuscularly daily for			<u>-</u>		
	three days for a urir				recur, i.e., what quality		
	unce days for a urif	iary tract infection.			assurance program will be p	uί	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689			ILDING	instruction 00	(X3) DATE SURVEY COMPLETED 01/18/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	A laboratory result The urinalysis with indicated mixed ger were not indicative During an interview Assistant Director of an antibiotic should discovered an infect indicated Resident 2 administered the Mareceived on January On 1/18/2023 at 3:1 provided a policy to The policy indicated Antibiotic Stewards the use of antibiotic a culture and sensitire results and the curre communicated to the available to determine the communicated to the sensitire of the current of	was received on 1/12/2023. culture and sensitivity hital flora isolated. The bacteria of a urinary tract infection. on 1/18/2023 at 1:51 P.M., the f Nursing (ADON) indicated, be discontinued when it is hition is not present. The ADON 279 was still being hacrobid when the culture was			into place: Ongoing compliance with this corrective action will be monithough the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee be responsible for completing QAPI Audit tools labeled "Antibiotic Therapy" weekly for weeks and monthly for at lear months. If 100% is not achie an action plan will be develop Findings will be submitted to Quality Assurance and Performance Improvement Committee for review and folup. By what date the systemic changes will be completed: 02/10/2023 Compliance Date = 02/10/2020	will I the or 4 st 6 eved oed. the	
F 0758 SS=D Bldg. 00	Use §483.45(e) Psychology §483.45(c)(3) A pso- drug that affects b with mental proces	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any rain activities associated sses and behavior. These are not limited to, drugs in gories:					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155689	B. W	ING		01/18/	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN			EN, IN 46526		
	T		1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DE TELEKET I		DATE
	(iv) Hypnotic						
	Based on a comp	rehensive assessment of a					
		ty must ensure that					
	Toolagni, are lagin	ty mast should that					
	§483.45(e)(1) Res	sidents who have not used					
	- ' ' ' '	s are not given these drugs					
	unless the medica	ation is necessary to treat a					
	specific condition	as diagnosed and					
	documented in the	e clinical record;					
	§483.45(e)(2) Res						
		s receive gradual dose					
	· ·	ehavioral interventions,					
		ontraindicated, in an effort					
	to discontinue the	se arugs;					
	8/83 /5(a)(3) Ray	sidents do not receive					
	- ' ' ' '	s pursuant to a PRN order					
		ation is necessary to treat					
		ific condition that is					
	-	e clinical record; and					
	§483.45(e)(4) PR	N orders for psychotropic					
	drugs are limited t	to 14 days. Except as					
	provided in §483.4	45(e)(5), if the attending					
		cribing practitioner believes					
		te for the PRN order to be					
		14 days, he or she should					
		tionale in the resident's					
		d indicate the duration for					
	the PRN order.						
	\$492.45(a)(5).DD	N ordere for anti navehatia					
		N orders for anti-psychotic to 14 days and cannot be					
	_	ne attending physician or					
		ioner evaluates the resident					
		eness of that medication.					
		view and interview, the facility	F 0'	758	F758 – Free from Unnecessa	ry	02/10/2023
		gradual dose reduction for a			Psychotropic Meds/PRN Use	_	
	1				l -		l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	TED
		155689	B. W	. WING 01/18/2023			2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				OLLEGE AVE		
MAJESTI	IC CARE OF GOSH	IEN			EN, IN 46526		
			ı		I		OVE.
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG		+-	DATE
		osychotopic medications for 1 wed for unnecessary			It is the practice of this facility	io	
	medications. (Resid	•			ensure all residents receiving		
	medications. (Resid	EII 1 0)			psychotropic medications have		
	Finding includes:				gradual dose reduction comple	eteu.	
	i manig merades.				What corrective action(s) wil	,	
	A clinical record re	view was completed on,			be accomplished for those	.	
		A.M. Resident 46's diagnoses			residents found to have been	,	
		not limited to: chronic			affected by the deficient	.	
	·	Parkinson's disease, diabetes,			practice:		
		ctive disorder, Bipolar, anxiety,			Resident 46 – gradual dose		
	depression and dem	-			reduction completed.		
	A Quarterly MDS (Minimum Data Set)			How other residents having	the	
		7/23/2022, indicated Resident			potential to be affected by th		
	received antipsycho				same deficient practice will be		
		cations routinely. No GDR			identified and what correctiv		
	was documented.	-			action(s) will be taken:		
		dated 9/27/2022, indicated the			All residents utilizing		
		ed the same medications. No			antipsychotic medications hav		
	GDR was complete				the potential to be affected by		
	contraindicated, dat	ed 8/22/22.			deficient practice. All resident		
					utilizing antipsychotic medicat		
		dated 12/21/2022, indicated			have been reviewed for gradu	al	
		BIMS (Brief Interview for			dose reduction accuracy.		
	· ·	e of 15, cognition intact.				_	
		otic, antianxiety, and			What measures will be put in	ito	
	_	cations and had no GDR			place or what systemic		
	(gradual does reduc	tions) completed.			changes will be made to		
	A	4-4-4 <i>5</i> /2/2010 :: 1: 4 14			ensure that the deficient		
	_	dated 5/3/2019, indicated the			practice does not recur:		
		idepressant medication			All managings of off and the		
	related to Major De	_			All nursing staff will be in-serv	icea	
		led, but were not limited to:			on or before 1/31/23. This	, the	
	_	medications ordered by			in-service will be conducted by		
		ally review medication for			Director of Nursing or Designe	ee	
	•	ossible reduction, changing or			and will include a review of		
	dc'ing.				psychotropic medication		
					management and antipsychot	ic	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155689	B. W	ING		01/18/	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN			EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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
	_	, dated 8/11/2020, indicated the			medication use. The Director of		
		for signs and symptoms of			Nursing/Designee will review a		
		related to anxiety, depression,			residents receiving antipsycho		
		Interventions included but			medications to ensure that gra	adual	
		Realize the resident has had			dose reductions have been		
		luring attempts to reduce			completed as appropriate.		
	psychoactive medic				l		
	_	ety medication. Carefully			How the corrective action(s)		
	_	isks vs. potential benefits of			will be monitored to ensure t	he	
	dose reductions/GD	Rs prior to implementing.			deficient practice will not		
		1 . 10/10/2020 : 1 1 1			recur, i.e., what quality		
	1	r, dated 8/10/2020, included			assurance program will be p	ut	
		ssant) 50 mg (milligram) every			into place:		
	night for depression	1 from, 8/10/2020 to 1/18/2023.					
	A DI CC D	17. 1. 1. 1. 1. 1.			Ongoing compliance with this		
		imendation Form, initiated on			corrective action will be monito	orea	
		d the antidepressant is due for			though the facility Quality		
		ontinued use. Doxepin 50 mg			Assurance and Performance		
	1	nnual review). The Nurse			Improvement Program. The	•••	
	Practitioner indicate				Director of Nursing/Designee		
		discontinuation likely will be			be responsible for completing	tne	
		and/or others or it will disrupt			QAPI Audit tools labeled	_	
	their provision of ca	are.			"Antipsychotic Medication Car		
	The clinical reserva	lacked the documentation to			Audit" weekly for 4 weeks and		
		duction had been tried on the			monthly for at least 6 months. 100% is not achieved an actio		
	Doxepin since 2020				plan will be developed. Finding		
	Dovebili silice 7050	,.			l '	•	
	A Physicians! Order	r, dated 5/10/2019, indicated			will be submitted to the Quality	y	
		eived Klonopin 0.5 mg three			Assurance and Performance	oviow	
	times a day for anxi				Improvement Committee for re	SVICW	
	unics a day for allx	iciy.			and follow up.		
	On 9/6/2019 a Phy	sicians' Order was to decreased	1		By what date the systemic		
	I -	mg twice a day until 9/26/2019.			changes will be		
	_	v order was written to increase			completed: 02/10/2023		
		mg every 8 hours and is			Compliance Date = 02/10/202	3	
	currently being adm					J	
	carreinly being aun	imistered.					
	The clinical record	lacked the documentation to					
		duction had been tried on the	1				

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	· /	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/18 /	ETED	
	PROVIDER OR SUPPLIER		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	
	A Physicians' Orde Resident 46 was to (antidepressant) 50 The clinical record show a trial dose re Zoloft since 2021. A Physicians' Orde resident was to rece 100 mg every day f disorder. A Note to Attendin 8/8/2022, indicated Quetiapine ER (Ser Doxepine 50 mg every day and Klon Please consider red ER (Seroquel) 50 mg every day and	r, dated 1/28/2021, indicated receive Sertraline mg every day for depression. lacked the documentation to duction had been tried on the r, dated 1/21/202, indicated the eive Seroquel (antipsychotic) for Bipolar and Schizoaffective g Physician/Prescriber, printed: The resident is receiving: roquel) 100 mg every evening. For yield this time Quetiapine mg every evening if able or ally contraindicated. The form, 2 by the Nurse Practitioner, cian/Prescriber disagreed with an and documented: reduction distressed behaviors. Int 46's behavior documentation was documented on 12/272022 b/2022 at 5:57 A.M., 1/42023 at 23 at 5:59 A.M., and on A.M. The form did not indicate						
	the Administrator in papers from the pha	v, on 1/17/2023 at 11:53 A.M., ndicated there were no other armacy, and they probably kept same because he was stable:						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/18/2023
	ROVIDER OR SUPPLIEF		2400	T ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE HEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	ADON indicated prompleted the Behar for residents who were appropriately an interview ADON indicated the been tried for a GD on 1/13/2023 at 2:4 provided the policy Medication Use", depolicy was the one of The policy indicate will be prescribed at for the shortest pering gradual dose reduct on 1/17/2023 at 11 provided the policy Management", date indicated the policy by the facility. The will initiate a requer Reduction (GDR) as schedule for each deantipsychotic medicated by the facility of the following gradients who use a must be initiated per the following physician/NP For antidepressant medinitiated per the following control indicated per the following physician/NP For antidepressant medinitiated per the following properties and the first year, annually unless climphysician/NP For antidepressant medinitiated per the following properties and the properties are properties and the pr	w, on 1/17/2023 at 1:40 P.M., the reviously the facility had avioral Health Meeting review were on the psych med's. w, on 1/19/23 at 10:14 A.M., the e medications should have R. 47 P.M., the Administrator titled,"Antipsychotic ated 2016, and indicated the currently used by the facility. d"Antipsychotic medications at the lowest possible dosage od of time and are subject to ion and re-review" 100 A.M., the Administrator titled," Psychotropic d September 2020, and was the one currently used policy indicated"The facility st for a Gradual Dose t least on the following rug: For residents who use cation a GDR must be initiated uidelinesafter the first year, a apted annually unless clinically the physician/NP For nxiolytic medications a GDR rust be attempted aically contraindicated by the resident who use ications a GDR must be lowing guidelines: After first			
	year, a GDR must b	ne attempted annually unless			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILE	DING	00	COMPL	ETED	
		155689	B. WING			01/18/	2023	
				TDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	ROVIDER OR SUPPLIER	t			OLLEGE AVE			
MAJEST	IC CARE OF GOSH	IEN.			:N, IN 46526			
				700112	111, 111 10020			
(X4) ID		STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE	
	clinically contraindi	icated by the physician/NP"						
	2.1.40(1)(2)							
	3.1-48(b)(2)							
F 0761	483.45(g)(h)(1)(2)							
SS=D	Label/Store Drugs							
Bldg. 00	•	ng of Drugs and Biologicals						
Diag. 00		cals used in the facility						
		accordance with currently						
		onal principles, and include						
	· ·	cessory and cautionary						
		he expiration date when						
	applicable.	·						
	§483.45(h) Storag	je of Drugs and Biologicals						
	§483.45(h)(1) In a	ccordance with State and						
	Federal laws, the	facility must store all drugs						
	_	locked compartments						
		perature controls, and						
	•	ized personnel to have						
	access to the keys	S.						
	. , , ,	facility must provide						
		, permanently affixed						
		storage of controlled drugs						
		II of the Comprehensive						
	-	ention and Control Act of ugs subject to abuse,						
		acility uses single unit						
	•	ribution systems in which						
		d is minimal and a missing						
	dose can be readi							
		on and interview, the facility	F 0761		F761 – Label/Storage Drugs		02/10/2023	
		dications/treatments were kept	1.0/01		and Biologicals		02/10/2023	
		n unattended, failed to ensure			It is the practice of this facility	to		
		areas were free from loose			ensure that all			
		to have medications labeled;			medication/treatment carts are	;		
	failed to date medic	ations when opened; and			kept locked when unattended,	that		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	ΓED
		155689	B. W	ING		01/18/2	023
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
NAA JEGT	10 04 DE 05 000I	IEN			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	1EN		GOSH	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(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
	failed to destroy me	edications that were			loose medications are properly	v	
	discontinued /refuse	ed or the resident had been			destroyed, that all medications	s	
	discharged and no l	onger being used during			opened are properly dated, ar	nd	
	medication storage	reviews for 1 of 2 medication			that all discontinued/refused		
	rooms observed and	1 3 of 5 medication carts			medications are properly		
	observed. (Dogwoo	d Medication carts, Birch			destroyed.		
	Medication carts an	d med room, and Cedar					
	treatment cart.)				What corrective action(s) wil	ll	
	·				be accomplished for those		
	Findings include:				residents found to have been	n	
					affected by the deficient		
	1. During a random	observation, on 1/11/2023 at			practice:		
	4:50 A.M., 3 of 3 m	nedication carts on the					
	Dogwood hall were	unlocked and unattended.			All medication carts, treatmen	t	
					carts, and medication rooms h	nave	
	During an interview	y, on 1/11/2023 at 4:55 A.M.,			been audited by pharmacy to		
	LPN (Licensed Prac	ctical Nurse) 13 indicated the			ensure compliance.		
	medications carts sl	nould have been locked.					
					How other residents having	the	
	2. During a medicat	tion observation, on 1/11/2023			potential to be affected by th	ie	
	at 5:01 A.M., LPN	14 left the medication cart on			same deficient practice will I	be	
	Birch hall unlocked	when going into a residents			identified and what correctiv	re	
	room to administer	a residents medication.			action(s) will be taken:		
	During an interview	y, on 1/11/2023 at 5:04 A.M.,			All residents have the potentia	al to	
	LPN 14 indicated the	ne medication cart should have			be affected by the deficient		
	been locked.				practice. All medication carts,	,	
					treatment carts, and medication	on	
	1	observation, on 1/11/2023 at			rooms have been audited by		
	5:26 A.M., the treat	ment cart on the Cedar hall was			pharmacy to ensure complian	ce.	
	unlocked and unatte	ended.					
					What measures will be put ir	nto	
	_ ~	y, on 1/11/2023 at 5:27 A.M.,			place or what systemic		
		edication Aide) 15 indicated			changes will be made to		
	the treatment cart sl	nould have been locked.			ensure that the deficient		
					practice does not recur:		
	1	tion observation, on 1/11/2023					
	l '	ght Birch hall medication cart			All nursing staff will be in-serv	iced	
		ve a soufflé cup with different			on or before 1/31/23. This		
	pills in it was in the	top drawer. RN 16 indicated			in-service will be conducted by	y the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/18/2023 155689 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2400 COLLEGE AVE MAJESTIC CARE OF GOSHEN GOSHEN, IN 46526 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE she had pulled them out earlier and forgot to give Director of Nursing or Designee them to the resident. She indicated the and will include a review of storage medications should not have been in the of medications, labeling of medication cart. medication containers, and discarding and destroying 5. During a medication storage observation, on medications. The Director or 1/12/2023 at 10:58 A.M., in the med room on the Nursing/Designee will review Birch Hall with LPN 17, the following were pharmacy audit of medication observed: a plastic bin with 4 insulin pens without carts, treatment carts, and resident labels. One individual pill package for medication rooms to ensure Resident 32, dated 7/5/2022. A box of Lice killer facility remains in compliance. with no label. Ten Acetaminophen 650 mg (milligram) suppositories for a resident who How the corrective action(s) expired on 7/3/2022, and for a resident who was will be monitored to ensure the discharged from the facility on 11/23/2022. A deficient practice will not medication card with 28 yellow round pills with recur, i.e., what quality the label removed and no resident identifiers. A assurance program will be put medication card with 29 red oblong pills with no into place: label or resident identifiers. An opened box of Metoprolol (heart medication) for a resident who Ongoing compliance with this expired on 4/30/2022. corrective action will be monitored though the facility Quality In another bin was 12 bottles of different Assurance and Performance medications for Resident 46. LPN 17 indicated Improvement Program. The they were waiting on the family or the VA to either Director of Nursing/Designee will send back or pick up. An opened box with 15 be responsible for completing the Nexium packets for Resident 71, that had dc QAPI Audit tools labeled (discontinue) after 7/5/2022. An opened undated "Medication/Treatment Cart & bottle of Mira lax for Resident 9. An opened vial Medication Room Audit" weekly of Aplisol (tuberculin serum) dated 9/6/2022, and for 4 weeks and monthly for at another opened vial of Aplisol with no opened least 6 months. If 100% is not date. An opened bottle of Mintox (stomach acid) achieved an action plan will be with the label removed. A box of Albuterol developed. Findings will be (inhalation medication) for a resident who was submitted to the Quality discharge on 2/10/2022. A bottle of Ferrous Assurance and Performance Sulfate (iron) for a resident that was discharged Improvement Committee for review on 11/23/2022. Two Glucagon (insulin) pens for a and follow up. resident who expired on 9/16/2022. A Glucagon (insulin) pen for a resident who expired on By what date the systemic 8/7/2022, and 1 insulin pen for another resident changes will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		155689	B. W	ING		01/18/2023	
NAME OF E	PROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN		GOSHE	EN, IN 46526		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ON
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
	_	11/2022. A bottle with 8 with the label of Cephalexin			completed: 02/10/2023	,	
	_	ys discontinue on 3/29/2021 for			Compliance Date = 02/10/202	٥	
		ened bottle of Stomach Relief					
	_	who expired on 11/8/2022, and					
	1 -	n (inhalation medication) for a					
		ischarged on 5/30/2022.					
	6. During a medicat	tion storage observation, on					
	1/12/2023 at 11:30	A.M., on the Left med cart for					
	Birch hall the cart h	ad 3 loose pills in 2 drawers.					
	_	y, on 1/12/2023 at 11:37 A.M.,					
		e pills should not be loose in					
	the med cart.						
	7 During a medicat	tion storage observation, on					
	_	.M., on the Dogwood middle					
		9, the following were observed:					
		ne (antibiotic)100 mg (milligram)					
	1	ackages with no name or					
		An opened and undated					
		lk of Magnesia). An opened					
	1	c drops with no label or					
	_	An opened box of Ipratropium					
		vas discharged on 1/2/2023.					
	An opened and und	ated bottle of Docusate					
	Sodium (laxative) f	or Resident 110.					
	Daning a ' ' '	1/10/2022 -4 1 20 D.M. D.T.					
	_	y, on 1/12/2023 at 1:38 P.M., RN					
		lividual pills should not be in sened medications should have					
		nedications should have a					
	_	ation for the discharged					
		out of the medication cart.					
	residents should be	out of the incurcation cart.					
	8. During a medicat	tion storage observation, on					
	_	.M., with LPN 20 on the right					
	hall Birch unit med	ication cart the following was					
	observed: an opene	d bottle of Equate allergy relief					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	ì í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/18/	ETED	
	PROVIDER OR SUPPLIEF		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)	ATE	(X5) COMPLETION DATE	
TAG	tablets with no laber Hair/Nails/Skin 500 resident identifiers. Senior (vitamins) widentifiers. An oper MOM. A container the oral medication During an interview LPN 20 indicated the date opened, the methere should be no cart. On 1/13/2023 at 9: provided the policy Medications", dater indicated the policy by the facility. The and biological's use locked compartment light and humidity is responsible for mand preparation are manner. 4. Drug coincomplete, impropreturned to the phane before storing. Discutted drugs of the dispensing phane Compartments (incompartments (inc	el. An opened bottle of 20 mg Biotin with no label or An opened bottle of Sentry with no label or resident ned and undated bottle of of Hemp/Vana cream in with st. Two loose pills in 2 drawers. It was no 1/12/2023 at 2:33 P.M., the opened med's should have a redications should be labeled, loose pills in the medication of November 2020, and the was the one currently used policy indicated"1. Drugs and in the facility are stored in the sunder proper temperature, controls3. The nursing staff maintaining medication storage as is a clean, safe, and sanitary notations that have missing, there, or incorrect labels are macy for proper labeling continued, outdated, or or biological's are returned to macy or destroyed6. Cluding, but not limited to, rooms, refrigerators, carts, and drugs and biological's are use. Unlocked medication		TAG	DEFICIENCY		DATE	
	provided the policy Medication Contain	15 A.M., the Administrator titled, "Labeling of ners", dated April 2019, and was the one currently used						

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	· /	ILDING	nstruction 00	(X3) DATE COMPL 01/18/	ETED
	ROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE :N, IN 46526		
WA ID	CVD O () DV	CT A TEN CENTE OF DEFICIENCE		I			(7/5)
(X4) ID		STATEMENT OF DEFICIENCIE	l ,	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		R LSC IDENTIFYING INFORMATION policy indicated"1.	1	TAG	Difficient 17		DATE
		nust be legible at all times. 2. ckaging or containers that are					
		properly labeled are returned to					
		ey. 3. Labels for individual					
		s include all necessary					
		s: a. The resident's name; b.					
		vsician's name; c. The name,					
		one number of the issuing					
	_	ame, strength, and quantity of					
		scription number (if					
		date that the medication was					
	dispensed; g. Appro	opriate accessory and					
	cautionary statemen	nts; h. The expiration date					
	when applicable; an	nd i. Directions for use 6.					
	Labels for over-the-	-counter drugs include all					
	necessary informati	on, such as: a. The original					
	label indicating the	name, strength, and quantity					
		o. The expiration date when					
		Directions for use and					
		ry/cautionary statements. 7.					
		g pharmacy can label or alter					
	the label on a medic	cation container or package"					
	On 1/13/2023 at 9:1	5 A.M., the Administrator					
	provide the policy to	itled," Discarding and					
	Destroying Medicat	tions", dated April 2019, and					
	indicated the policy	was the one currently used					
		policy indicated"2. Non-					
		edule V (non- hazardous)					
		e will be disposed of in					
		te regulations and federal					
	guidelines regarding						
	non-hazardous med	ications"					
	3.1-25(j)(m)(q)(r)						
F 0812	483.60(i)(1)(2)						
SS=F	Food						
			1				

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, ´		ľ í	E CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>00</u>	COMPLETED		
		155689	B. WING		01/18/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	Y (EACH CORRECTIVE ACTION SHOULD BE	ATE COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE		
	Procurement, Store §483.60(i) Food sa The facility must - §483.60(i)(1) - Proapproved or consifederal, state or lo (i) This may includ directly from local applicable State a regulations. (ii) This provision of facilities from using gardens, subject to applicable safe gropractices. (iii) This provision from consuming for facility. §483.60(i)(2) - Store serve food in accostandards for food Based on observation interview, the facility refrigerator and food	e/Prepare/Serve-Sanitary afety requirements. coure food from sources dered satisfactory by cal authorities. le food items obtained producers, subject to nd local laws or does not prohibit or prevent g produce grown in facility o compliance with powing and food-handling does not procured by the ore, prepare, distribute and ordance with professional		CROSS-REFERENCED TO THE APPROPRI	02/10/2023 ary // to r and		
	Findings include:			What corrective action(s) w	au		
	P.M., the 100-unit n dried substance in the	ation, on 1/12/2023 at 2:30 nutrition pantry freezer had a he bottom and a lower cabinet spill on the bottom shelf.		be accomplished for those residents found to have bee affected by the deficient practice:	en		
	2. The 200-unit free	zer had a spill on the bottom.		100 hall – freezer and cabine cleaned	ıs		
	There was also a co	at in the lower cabinet.		200 hall – freezer and cabine	ts		
	3. The microwave o	on the 300-unit had a dried		cleaned 300 hall – microwave cleaned	t t		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155689	B. WING 01/18/2023					
	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	DROWINED'S DLANLOS 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	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	brown liquid spilled	d on the plate.						
	During an interview, on 1/12/2023 at 2:38 P.M., the Dietician indicated the spills should have been cleaned up and coats should not be stored in the nutrition pantry.				How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	e oe		
	On 1/13/2023 at 2:0	00 P.M., the Administrator			All residents have the potentia	ıl to		
		tled, "Refrigerators and			be affected by the deficient			
		ovember 2014. The policy			practice. All resident pantries			
	`	gerators and freezers will be			audited and cleaned appropria	ately.		
	*	lebris, and mopped with a			NA/1 4	.4		
	sanitizing solution on a scheduled basis and more often as necessary" 3.1-21(i)(3)				What measures will be put in	το		
					place or what systemic changes will be made to			
					ensure that the deficient			
					practice does not recur:			
					All staff will be in-serviced on a before 1/31/23. This in-service be conducted by the Executive Director or Designee and will include a review of resident pantries and refrigerator and freezer cleaning. The Executive Director/Designee will audit all pantries to ensure all are clear as appropriately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:	e will e /e I ned		
					Ongoing compliance with this corrective action will be monitor though the facility Quality Assurance and Performance	ored		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING B. WING	00	COMPLETED 01/18/2023				
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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F 9999				Improvement Program. The Executive Director/Designee was be responsible for completing QAPI Audit tools labeled "Nourishment Pantry Observa weekly for 4 weeks and month for at least 6 months. If 100% not achieved an action plan was developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow up. By what date the systemic changes will be completed: 02/10/2023 Compliance Date = 02/10/202	the tion" ally 6 is ill be			
Bldg. 00	each employee of a prior to employmen include a tuberculin method (5 TU PPD) having documentation department-approve intradermal tuberculin recording unless a p can be documented. in millimeters of includer read, and by with tuberculin skin test employee stating dathe following: (1) A	ination shall be required for facility within one (1) month t. The examination shall skin test, using the Mantoux, administered by persons on of training from a d course of instruction in lin skin testing, reading, and reviously positive reaction The result shall be recorded duration with the date given, nom administered. The must be read prior to the te. The facility must assure t the time of employment, or h prior to employment, and at	F 9999	F9999 – Final Observations, Personnel It is the practice of this facility ensure that all employee files contain health examinations. What corrective action(s) wil be accomplished for those residents found to have beer affected by the deficient practice: RN 6 – health examination provided and in employee rece RN 23 – health examination provided and in employee rece CNA 24 – health examination	n ord			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 01/18/2023 01/18/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE			X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE		INSTRUCTION	(X3) DATE S	OKVEI
155689 B. WING STREET ADDRESS, CITY, STATE, ZIP COD STREET ADDRESS, CITY, STATE, ZIP COD	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD			155689				01/18/2023	
NAME OF PROVIDER OR SUPPLIER					_	_		
2400 COLLEGE AVE	NAME OF PROVI	VIDER OR SUPPLIER	1					
L								
MAJESTIC CARE OF GOSHEN GOSHEN, IN 46526	MAJESTIC CARE OF GOSHEN				GOSHE	EN, IN 46526		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)	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	REFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
least annually thereafter, employees and non pain provided and in employee record	lea	east annually therea	after, employees and non pain			provided and in employee reco	ord	
personnel of facilities shall be screened for Housekeeper 26 – health	per	ersonnel of facilitie	es shall be screened for			Housekeeper 26 – health		
tuberculosis. For health care workers who have examination provided and in	tub	uberculosis. For hea	alth care workers who have			examination provided and in		
had a documented negative tuberculin skin test employee record	hac	ad a documented n	negative tuberculin skin test					
result during the proceeding twelve (12) months, CNA 27 – health examination	res	esult during the pro	occeding twelve (12) months,					
the baseline tuberculin skin testing should employ provided and in employee record							ord	
the two-step method. If the first step is negative, a						' '		
second test should be performed one (1) to three How other residents having the		-				How other residents having t	the	
(3) weeks after the first step. The frequency of potential to be affected by the						_		
repeat testing will depend on the risk of infection same deficient practice will be						-		
with tuberculosis. identified and what corrective	_		1					
action(s) will be taken:								
This state rule is not met as evidenced by:	Th	This state rule is not met as evidenced by:						
No residents have the potential to			Ž			No residents have the potentia	al to	
Based on record review and interview, the facility be affected by this deficient	Bas	Based on record rev	view and interview, the facility			·		
failed to ensure employee files were complete with practice.						<u> </u>		
health examinations for 5 of 10 employees whose		_	-			F		
records were reviewed. RN 6, Staff Development What measures will be put into						What measures will be put in	ito	
RN 23, CNA (Certified Nursing Assistant) 24, place or what systemic			-			-		
housekeeper 26, and CNA 27. changes will be made to		·	- · · · · · · · · · · · · · · · · · · ·			T -		
ensure that the deficient		• ,						
Findings include: practice does not recur:	Fin	indings include:				practice does not recur:		
On 1/18/2023 at 10:30 A.M., employee files were Human Resource Director will be						Human Resource Director will	be	
reviewed and the following was noted: in-serviced on or before 1/31/23.	rev	eviewed and the fol	llowing was noted:			in-serviced on or before 1/31/2	23.	
This in-service will be conducted							ed	
1. RN 6's start date in the facility was 12/9/2022. by the Executive Director or						by the Executive Director or		
The employee file lacked the documentation to Designee and will include a review						Designee and will include a re	view	
show a physical exam had been completed prior of employee records and						of employee records and		
to starting. A Post-Offer Physical Form indicated: requirements. The Executive	to s	o starting. A Post-C	Offer Physical Form indicated:			requirements. The Executive		
date of offer: 12/1/2022, Date of Physical Director will review all employee			_			Director will review all employe	ee	
12/5/2022. I {name of RN)} understand that I have records to ensure that all	12/					records to ensure that all		
received a conditional offer of employment with employees have an appropriate	rec	eceived a condition	nal offer of employment with			employees have an appropriat	te	
{name of facility} that is contingent upon receipt health examination and it is	{na	name of facility} th	hat is contingent upon receipt			health examination and it is		
of the results of a post offer physical examination present in the employee record.	of	of the results of a po	ost offer physical examination			present in the employee record	d.	
designed solely to determine my physical fitness	des	lesigned solely to d	etermine my physical fitness			_		
to perform the essential job duties of the position How the corrective action(s)	to j	o perform the essen	ntial job duties of the position			How the corrective action(s)		
that I have been offered. Accordingly, I will be monitored to ensure the	tha	hat I have been offe	ered. Accordingly, I				he	
voluntarily consent to a post offer physical deficient practice will not						deficient practice will not		
examination conducted at the request of and paid recur, i.e., what quality		•						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	r í	UILDING	onstruction 00	(X3) DATE : COMPL 01/18/	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	examiner with addi	. I may also provide the tional information related to my ne duties of the position. I			assurance program will be p into place:	ut		
	understand that I m examiner and may a time. I understand t examination or do n released to the com weeks (7 days) of tl offer, the job offer of the post-offer phys assess your physical demands of the pos positions require sig form was initialed of Practitioner/Medical 12/5/2022, and doc 2. The Staff Develo 11/28/2022. The endocumentation to sl completed prior to se Form indicated: dat Physical 11/30/2022 that I have received employment with { contingent upon recoffer physical examined termine my physical examined the position also provide the examiner of the position questions of the position questions of the examination at any	ay ask questions of the also stop the examination at any hat if I fail to complete the not authorize the results to be pany within one calendar ne date of the conditional job may be withdrawn. Purpose of ical exam is designed to safely l abilities to meet the physical ition offered, as some gnificant physical effort. The			Ongoing compliance with this corrective action will be monitor though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee was the responsible for completing QAPI Audit tools labeled "Employee Records Checklist" weekly for 4 weeks and month for at least 6 months. If 100% not achieved an action plan was developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow up. By what date the systemic changes will be completed: 02/10/2023 Compliance Date = 02/10/2023	vill the nly 6 is ill be		
	_	mination or do not authorize eased to the company within						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 01/18/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE	(X5) COMPLETION DATE	
	conditional job offe withdrawn. Purpose exam is designed to abilities to meet the position offered, as significant physical on the Nurse Practit	(7 days) of the date of the r, the job offer may be of the post- offer physical safely assess your physical physical demands of the some positions require effort. The form was initialed ioner/Medical Director 11/30/2022, and documented d.						
	The employee file I show a physical exato starting. A Post-C date of offer: 10/14, 10/24/2022. I {nam have received a con with {name of facil receipt of the result examination design physical fitness to p of the position that Accordingly, I voluphysical examination and paid for by the	ntarily consent to a post offer on conducted at the request of company. I may also provide						
	my ability to perfor understand that I may examiner and may a time. I understand the examination or do not released to the complex weeks (7 days) of the offer, the job offer of the post-offer phys assess your physical demands of the post-	dditional information related to m the duties of the position. I ay ask questions of the also stop the examination at any that if I fail to complete the not authorize the results to be pany within one calendar are date of the conditional job may be withdrawn. Purpose of ical exam is designed to safely I abilities to meet the physical ition offered, as some gnificant physical effort. The						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULT: A. BUILD B. WING		NSTRUCTION 00	(X3) DATE : COMPL 01/18/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE	
	10/14/2022, and do 4. Housekeeper 26	on the Nurse I Director Signature and dated cumented Reviewed/Approved. s start date in the facility was uployee file lacked the						
	completed prior to s Form indicated: dat Physical: No date w housekeeper} under	now a physical exam had been starting. A Post-Offer Physical e of offer: 11/10/2022. Date of ras documented. I {name of restand that I have received a						
	facility} that is cont results of a post off designed solely to d	employment with {name of ingent upon receipt of the er physical examination letermine my physical fitness intial job duties of the position pered. Accordingly, I						
	voluntarily consent examination conduct for by the company examiner with addit	to a post offer physical sted at the request of and paid . I may also provide the cional information related to my						
	understand that I may a examiner and may a time. I understand t	ne duties of the position. I hay ask questions of the halso stop the examination at any hat if I fail to complete the hot authorize the results to be						
	weeks (7 days) of the offer, the job offer the post- offer phys	pany within one calendar ne date of the conditional job may be withdrawn. Purpose of ical exam is designed to safely						
	demands of the positions require signorm was initialed of	l abilities to meet the physical ition offered, as some gnificant physical effort. The on the Nurse l Director Signature and dated						
	11/23/2022, and do 5. CNA 27's start d 11/9/2022. The emp	ate in the facility was ployee file lacked the now a physical exam had been						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 01/18/2023			ETED			
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 LISC 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	
	Form indicated: dat Physical 11/11/2022 that I have received employment with { contingent upon rec offer physical exam determine my physi essential job duties been offered. Accor to a post offer physi the request of and p also provide the exa information related duties of the positio questions of the exa examination at any to complete the exa the results to be rele one calendar weeks conditional job offe withdrawn. Purpose exam is designed to abilities to meet the position offered, as significant physical on the Nurse Practit Signature and dated Reviewed/Approve On 1/17/2023 at 10 provided the policy dated January 2008 the one currently us indicated"1. Fede require that our faci personnel record fo shall be the employ the HR director with	starting. A Post-Offer Physical e of offer: 11/11/2022. Date of 2. I {name of CNA} understand a conditional offer of name of facility} that is eipt of the results of a post ination designed solely to ccal fitness to perform the of the position that I have dingly, I voluntarily consent ical examination conducted at aid for by the company. I may miner with additional to my ability to perform the on. I understand that I may ask miner and may also stop the time. I understand that if I fail mination or do not authorize eased to the company within (7 days) of the date of the r, the job offer may be of the post- offer physical safely assess your physical physical demands of the some positions require effort. The form was initialed tioner/Medical Director 11/11/2022, and documented d. 31 A.M., the Administrator titled,"Personnel Records", and indicated the policy was ed by the facility. The policy ral and state regulations lity maintain an individual r each employee. However, it ee's responsibility to provide the the required data. This entails notifying, in writing, the						

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AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/18/2023				
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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	HR Director of any changes in the required data (i.e., the employee is responsible for keeping the required data current.). 2. Should it become necessary for an employee to furnish additional data or records, the employee will be notified in writing by the HR Director, and such data must be completed and provided to the HR Director within the time frame specified on the written notice" During an interview on 1/17/2023 at 11:28 A.M., the Administrator indicated the Post - Offer Physical Form was the only form the facility uses for the employee physicals.								

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