PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING B. WING		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42 Survey Date: 02/02 Facility Number: 02 Provider Number: 100 At this Emergency Care of Goshen wa Emergency Prepare Medicare and Medicare and Medicare and Medicare and Suppliers, 42 C The facility has 186 the survey, the censure of the survey of	200091 155689 290080 Preparedness survey, Majestic s found not in compliance with edness Requirements for icaid Participating Providers CFR 483.73 6 certified beds. At the time of sus was 132. Impleted on 02/06/23	E 0000	The creation and submission this plan of correction does constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or of any violate of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu a traditional revisit.	not his set ion
E 0004 SS=F Bldg	484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §416 §441.184(a), §466 §483.73(a), §483. §485.68(a), §485. §485.920(a), §486 §494.62(a). The [facility] must Federal, State and	5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),		TITLE	(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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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION		ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ЛLDING		COMPLETED		
		155689	B. W	ING		02/01/	2023	
	ROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526			
			1				(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
	*				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE		
TAG	preparedness required must develop estate comprehensive errorgram that mee section. The emer program must include the following eleminated at least must do all of the section. The emer program must include the following eleminated at least must do all of the section. The emergency Plate and updated at least must do all of the section. State, and preparedness required comprehensive errorgram that mee section, utilizing a section, utilizing a section. The section is section, utilizing a section. The section is section in the section is section. The section is section in the section is section. The section is section is section is section. The section is section is section is section. The section is section is section. The section is section is section. The section is section is section is section is section. The section is section is section is section. The section is section. The sec	uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this regency preparedness ude, but not be limited to, ments: an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or app and maintain a mergency preparedness ts the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], in that must be [evaluated], in that must be [evaluated],		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		DATE	
	could not be assured	d review and interview, it d the facility maintained an dness Plan (EPP) that was	E 00	004	E004 – Develop EP Plan, Review and Update Annually It is the practice of this facility		02/17/2023	

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	T OF DEFICIENCIES OF CORRECTION	i '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023	
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD	-	
				COLLEGE AVE		
MAJESTI	C CARE OF GOSH	1EIN	GOSI	HEN, 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 B CROSS-REFERENCED TO THE APPROPE	E COMPLETION	
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	•	ty in accordance with 42 CFR		maintain an Emergency		
		cient practice could affect all		Preparedness Plan that is sp	pecific	
	occupants.			to the facility.		
	Findings include:			What corrective action(s) what corrective action(s) when the accomplished for those		
	Based on records re	view with the Maintenance		residents found to have be		
	Director on 02/01/2	3 at 10:00 a.m., the facility		affected by the deficient		
	_	ent EPPs with conflicting		practice:		
		st EPP provided was a generic		Emergency Preparedness P		
	_	ng specific information. The		has been updated to reflect	· ·	
		ed did address some but not all		specific policies and procedu		
		tion for Majestic Care. Based		education has been provided		
	on an interview during records review, the			staff, and scheduled review	dates	
	Maintenance Director agreed there were two			have been implemented.		
	different EPPs in th	e facility.		Harrist the same state at a few day	41	
	#2) Basad on racor	d review and interview, the		How other residents having		
		iew and update the Emergency		potential to be affected by same deficient practice will		
	_	EPP) at least annually in		identified and what correct		
	_	CFR 483.73(a). This deficient		action(s) will be taken:	146	
	practice could affec	* *		All residents have the poten	tial to	
	1	1		be affected by this deficient		
	Findings include:			practice. The Emergency		
	_			Preparedness Plan has bee	n	
	Based on records re	view with the Maintenance		updated to reflect facility spe		
		ant Director of Nursing on		policies and procedures,		
		m., the provided EPP did not		education has been provided	d to all	
		n of when the EPP was last		staff, and scheduled review	dates	
		s a form provided dated		have been implemented.		
		tures without job titles that				
		m at Majestic Care of Goshen		What measures will be put	into	
	_	odated all policies for 2022		place or what systemic		
	_	he form did not specifically		changes will be made to		
	say the EPP was rev	-		ensure that the deficient		
	-	on record review, it could not		practice does not recur:		
		es and procedures had been		All will be in-serviced on or b		
	-	ack of a documented risk resident & staff tracking		2/17/2023. This in-service v	viii be	
		ace policy, use of volunteer		conducted by the Executive	.	
	poncy, sheller-in-pl	ace policy, use of volunteer	1	Director or Designee and wi	II	

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	D PLAN OF CORRECTION IDENTIFICATION NUMBER A. B		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023		
	PROVIDER OR SUPPLIEF		2400 0	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	interview during red Director stated it was specifically has been a Director of Nursing during the exit confidence of the properties of th			include a review of the Emerger Preparedness Plan. The Executive Director/Designee audit the Emergency Preparedness Plan monthly of QAPI to ensure compliance is maintained and policies/procedures are revie and updated as appropriate. How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto 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 reviewing Emergency Preparedness Pl monthly in QAPI for at least 6 months and annually. If 100 compliance is not achieved a action plan will be developed Findings will be submitted to Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	will during s wed) the put s tored will the an s % n . the		
E 0006 SS=F	. , , , , ,	416.54(a)(1)-(2), 418.113(a))(1)-(2), 482.15(a)(1)-(2),					

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		IDENTIFICATION NUMBER 155689	JILDING		COMPL 02/01/	ETED
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
Bldg	483.475(a)(1)-(2), (1)-(2), 485.625(a) 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2) §418.113(a)(1)-(2) §483.73(a)(1)-(2) §485.625(a)(1)-(2) §485.920(a)(1)-(2) §491.12(a)(1)-(2), (a) Emergency Pl develop and maint preparedness plar and updated at learn ust do the follow (1) Be based on al facility-based and assessment, utilizing approach.* (2) Include strateg emergency events assessment. * [For Hospices at Plan. The Hospices at Plan. The Hospices at Plan. The Hospices maintain an emergency every 2 years. The following: (1) Be based on all follo	483.73(a)(1)-(2), 484.102(a) p(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 494.62(a) Hazards Risk Assessment p(1), §416.54(a)(1)-(2), §482.15(a)(1)-(2), §483.475(a)(1)-(2), p(1), §485.68(a)(1)-(2), p(1), §485.727(a)(1)-(2), p(1), §486.360(a)(1)-(2), p(1), §494.62(a)(1)-(2) an. The [facility] must tain an emergency of that must be reviewed, ast every 2 years. The planting:] Ind include a documented, community-based risk ing an all-hazards sites for addressing and include a documented, community-based risk ing an all-hazards §418.113(a):] Emergency of the must develop and gency preparedness planting and updated at least the planting and upd				

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	OF CORRECTION	IDENTIFICATION NUMBER 155689		JILDING	INSTRUCTION	COMPL 02/01/	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 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
	emergency events assessment, inclu the consequences disasters, and oth affect the hospice *[For LTC facilities Emergency Plan. develop and main preparedness plan and updated at lead of the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency preberviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment, utiliz approach, includir (2) Include strategemergency events assessment.	The LTC facility must tain an emergency in that must be reviewed, ast annually. The plan must and include a documented, community-based risk ing an all-hazards ag missing residents. It is for addressing is identified by the risk at the second and maintain apparedness plan that must apparedn					
	failed to maintain at Plan (EPP) that was documented, facility risk assessment, uti	riew and interview, the facility in Emergency Preparedness is (1) based on and includes a y-based and community-based lizing an all-hazards approach, esidents and (2) included	E 00	006	E006 – Plan Based on All Hazards Risk Assessment It is the practice of this facility maintain an Emergency Preparedness Plan that is bas on and includes a documented	ed	02/17/2023

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	OF CORRECTION	IDENTIFICATION NUMBER 155689	A. BUILDING B. WING		COMPLETED 02/01/2023
NAME OF F	PROVIDER OR SUPPLIER		2400 (ADDRESS, CITY, STATE, ZIP COD	
MAJEST	IC CARE OF GOSH	IEN	GOSH	IEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	identified by the risl with 42 CFR 483.73 This deficient practic Findings include: Based on records re Director on 02/01/2 documentation could documented facility risk assessment utili Based on interview the Maintenance Diassessment form but This finding was revenue.	d be found regarding a -based and community-based zing an all-hazards approach. at the time of record review, rector stated he has a risk t was not completed. viewed with the Assistant and Maintenance Director		facility-based, and community-based risk assessment, utilizing all-haze approach using events identiby the risk assessment. What corrective action(s) where accomplished for those residents found to have been affected by the deficient practice: Risk assessment has been reviewed and updated to reflected in the residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: All residents have the potentible affected by this deficient practice. The Risk Assessment has been reviewed and update reflect facility specific information. What measures will be put it place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on before 2/17/2023. This in-se will be conducted by the Executive Director or Designee and will include a review of the Emergeredness Plan and Risk Assessment. The Executive Director/Designee will audit to Emergency Preparedness Plan and Risk Emergency Preparedness Plan and Risk Emergency Preparedness Plan and Risk Assessment.	fied iiii en ect the he be ve al to ent ted to ation. nto or rvice cutive gency he

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	e survey Pleted 1/2023
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIF COLLEGE AVE EN, IN 46526	PCOD	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 0013	403.748(b), 416.5	4(h) 418 113(h)		monthly during QAPI compliance is maintal policies/procedures a and updated as appr How the corrective a will be monitored to deficient practice we recur, i.e., what qual assurance program into place: Ongoing compliance corrective action will though the facility Quality Assurance and Perform Improvement Prograe Executive Director/D be responsible for referency Prepared monthly in QAPI for a months and annually compliance is not action plan will be defindings will be submated Quality Assurance and Performance Improvement Prograe in the program of the prog	ained and are reviewed opriate. action(s) ensure the ill not lity will be put with this be monitored uality ormance m. The esignee will viewing the dness Plan at least 6 c. If 100% hieved an eveloped. In the independent of and estemic second sec	
SS=F Bldg	441.184(b), 482.1 484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),				

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	OF CORRECTION	IDENTIFICATION NUMBER 155689	UILDING	nstruction 	COMPL 02/01/	ETED
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	§485.68(b), §485. §485.920(b), §486 §494.62(b).	475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b), cocedures. [Facilities] must				
	develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) c communication pla section. The polic					
	and procedures. To develop and imples preparedness policing on the emergency (a) of this section, paragraph (a)(1) communication plasection. The policing	s at §483.73(b):] Policies The LTC facility must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.				
	*[For PACE at §46 procedures. The develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) c communication pla section. The police	60.84(b):] Policies and PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023		
	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 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		
	limited to: Fire; eq failure; care-related disasters likely to safety of the partic. The policies and previewed and upd *[For ESRD Facility and procedures. develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) occommunication plasection. The policibe reviewed and uyears. These emenot limited to, fire, failures, care-related supply interruption likely to occur in the area. Based on record rev	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 argencies include, but are equipment or power sed emergencies, water in, and natural disasters he facility's geographic	E 0013	E013 – Development of EP	02/17/2023		
	Preparedness Plan (at least annually in	Lupdate the Emergency EPP) Policies and Procedures accordance with 42 CFR cient practice could affect all		Policies and Procedures It is the practice of this facility review and update the Emerging Preparedness Plan, Policies, and Procedures at least annually.	ency		
	Director and Assista 02/01/23 at 10:01 a have documentation Procedures were las provided dated 01/1	eview with the Maintenance ant Director of Nursing on a.m., the provided EPP did not a of when the EPP Policies and at reviewed. There was a form 3/23 with signatures without "The IDT team at Majestic		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Emergency Preparedness Plan, Policies, and Procedure have been reviewed and updated and all staff have been educated.	s s s ted		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		DNSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI	ILDING NG		COMPLETED	
		155689	B. WI			02/01/2023	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF GOSH	IEN			OLLEGE AVE EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		Ŋ
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		reviewed and updated all					
	1 ~	rough 2023" but the form did	How other residents having the				
		the EPP was reviewed and			potential to be affected by th		
	_	an interview during records nance Director stated it was			same deficient practice will to identified and what corrective		
	i i	EPP Policies and Procedures			action(s) will be taken:	e	
	have been reviewed				All residents have the potentia	l to	
		•			be affected by this deficient		
	This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.				practice. The Emergency		
					Preparedness Plan, Policies, a		
					Procedures have been review		
					and updated and all staff have		
					been educated.		
					What measures will be put in	to	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					All staff will be in-serviced on		
					before 2/17/2023. This in-serv		
					will be conducted by the Exec	utive	
					Director or Designee and will include a review of the Emerg	ency	
					Preparedness Plan, Policies, a	7	
					Procedures. The Executive		
					Director/Designee will audit th	e	
					Emergency Preparedness Pla		
					monthly during QAPI and anni		
					to ensure compliance is		
					maintained and		
					policies/procedures are review	red	
					and updated as appropriate.		
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
	Ī		- 1		into place:	1	

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AND PLAN OF (IDENTIFICATION NUMBER 155689	A. BUILDING B. WING		COM	PLETED 1/2023
	VIDER OR SUPPLIER	EN	2400 C	ADDRESS, CITY, STATE, ZII OLLEGE AVE EN, IN 46526	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
SS=F	nd (v), 441.184(b 83.475(b)(2), 483 85.920(b)(1), 486 Procedures for Tra 403.748(b)(2), §4 i) and (v), §441.1482.15(b)(2), §48 485.625(b)(2), §4 i), §494.62(b)(1). b) Policies and proparedness policing the emergency a) of this section,	6.54(b)(1), 418.113(b)(6)(ii))(2), 482.15(b)(2), 6.73(b)(2), 485.625(b)(2), 6.360(b)(1), 494.62(b)(1) 6.654(b)(1), §418.113(b)(6) 84(b)(2), §460.84(b)(2), 63.73(b)(2), §483.475(b)(2), 85.920(b)(1), §486.360(b) rocedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at f this section, and the		Ongoing compliance corrective action will though the facility Quassurance and Perform Improvement Prograe Executive Director/D be responsible for months and annually compliance is not action plan will be subtraction for review follow-up. By what date the sy changes will be completed: 02/17/20 Compliance Date = 0	be monitored uality primance am. The pesignee will eviewing the dness Plan at least 6 gr. If 100% whieved an eveloped. The module of the modul	

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Event ID:

WPUV21 Facility ID: 000091

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		ľ í	UILDING	NSTRUCTION	COMPL 02/01/	ETED	
	PROVIDER OR SUPPLIER			2400 C	DLLEGE AVE N, 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)	TE	(X5) COMPLETION DATE
	reviewed and upd [annually for LTC the policies and potential the following:]	ies and procedures must be ated at least every 2 years facilities]. At a minimum, rocedures must address					
	on-duty staff and s [facility's] care dur on-duty staff and s relocated during th must document th	em to track the location of sheltered patients in the ring an emergency. If sheltered patients are ne emergency, the [facility] e specific name and eiving facility or other					
	§483.73(b), ICF/III §460.84(b):] Polici system to track the and sheltered resi ICF/IID or PACE] emergency. If on- residents are reloce emergency, the [F PACE] must docu	A41.184(b), LTC at Ds at §483.475(b), PACE at ies and procedures. (2) A e location of on-duty staff dents in the [PRTF's, LTC, care during and after an duty staff and sheltered cated during the PRTF's, LTC, ICF/IID or ment the specific name e receiving facility or other					
	Policies and proce (ii) Safe evacuation includes consideraneeds of evacuee transportation; idealocation(s) and pring of communication assistance. (v) A system to transemployees' on-dur	spice at §418.113(b)(6):] edures. on from the hospice, which ation of care and treatment s; staff responsibilities; entification of evacuation mary and alternate means with external sources of ack the location of hospice ty and sheltered patients in e during an emergency. If					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155689		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/01/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (FACE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG	the on-duty emplorare relocated durinospice must document and treatment new responsibilities; the of evacuation local alternate means of external sources of the actual donor information, and savailability of procedures. (2) A documentation the actual donor information, and savailability of procedures. (2) A dialysis facility, where the actual donor information and savailabilities, and all all all all all all all all all al	byees or sheltered patients ong the emergency, the ument the specific name is receiving facility or other (485.920(b):] Policies and afe evacuation from the sudes consideration of care eds of evacuees; staff ansportation; identification ation(s); and primary and of communication with of assistance. (86.360(b):] Policies and system of medical at preserves potential and mation, protects potential and actual donor secures and maintains the	E 0018	E018 – Procedures for Trac of Staff and Patients It is the practice of this facility ensure emergency prepared policies and procedures inclusystem to track the location of on-duty staff and sheltered residents. What corrective action(s) w	y to ness ide a of		
		ould affect all occupants,		be accomplished for those residents found to have bee affected by the deficient			

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AND PLAN OF CORRECTION 155689	i i				· ′	B) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Based on records review with the Maintenance Director on 02/01/23 at 10:30 a.m., the reviewed EPP did not have a policy and procedure that includes a system to track the location of residents and staff during and after an emergency. Based on interview during records review, the Maintenance Director agreed the reviewed EPP did not contain a staff and resident tracking policy. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. STREET ADDRESS, CITY, STATE, ZIP COD 2440 COLLEGE AVE GOSHEN, IN 46526 ID PREFIX TAG PREFIX TAG PREVIDERS PLAN OF CORRECTION (X5) COMPLETION DATE Providers PLAN OF CORRECTION (COMPLETION DATE Providers AVE GOSHEN, IN 46526 (X5) COMPLETION DATE Providers PLAN OF CORRECTION (COMPLETION DATE Providers AVE CROSS-REFERENCES TO THE APPROPRIATE (CROSS-REFERENCES TO THE APP	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155689				COMPLETED 02/01/2023	
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Director of Nursing and Maintenance Director during the exit conference. be affected by this deficient practice. The policy for tracking of residents and staff was reviewed and updated to be included in the Emergency Preparedness Plan. What measures will be put into							,	
during the exit conference. practice. The policy for tracking of residents and staff was reviewed and updated to be included in the Emergency Preparedness Plan. What measures will be put into							al to	
residents and staff was reviewed and updated to be included in the Emergency Preparedness Plan. What measures will be put into		_				_		
and updated to be included in the Emergency Preparedness Plan. What measures will be put into		during the exit conf	erence.				-	
Emergency Preparedness Plan. What measures will be put into								
						T		
place or what systemic						_	nto	
						_	ļ	
changes will be made to ensure that the deficient						_	ļ	
practice does not recur:							ļ	
All staff will be in-serviced on or						All staff will be in-serviced on	or	
before 2/17/2023. This in-service								
will be conducted by the Executive Director or Designee and will						_	utive	
include a review of the Emergency							encv	
Preparedness Plan, Policies, and							-	
Procedures. The Executive						Procedures. The Executive		
Director/Designee will audit the						_		
Emergency Preparedness Plan								
monthly during QAPI and annually to ensure compliance is							ually	
maintained and						· ·		
policies/procedures are reviewed						policies/procedures are review	ved	
and updated as appropriate.						and updated as appropriate.		
How the corrective action(s) will be monitored to ensure the								

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	e survey Pleted 1/2023	
	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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
				deficient practice will recur, i.e., what quality assurance program with place: Ongoing compliance will be though the facility Quay Assurance and Perfor Improvement Program Executive Director/Debe responsible for review Emergency Prepared monthly in QAPI for at months and annually. compliance is not ach action plan will be deview Findings will be submit Quality Assurance and Performance Improve Committee for review follow-up. By what date the syschanges will be completed: 02/17/202 Compliance Date = 02/17/202 Compliance Date = 02/17/202	will be put with this be monitored ality mance h. The signee will iewing the hess Plan t least 6 If 100% ieved an veloped. itted to the d ment and temic		
E 0022 SS=F Bldg	441.184(b)(4), 485.483.73(b)(4), 485.485.727(b)(2), 485.494.62(b)(3) Policies/Procedure §403.748(b)(4), §4(1), §441.184(b)(4), §485.73(b)(4), (2), §485.625(b)(4), §485.920(b)(3), §4485.920(b)(3), §4485.920(b)(4), §4485.920(b)(4	6.54(b)(3), 418.113(b)(6)(i), 2.15(b)(4), 483.475(b)(4), 625(b)(4), 485.68(b)(2), 5.920(b)(3), 491.12(b)(2), es for Sheltering in Place 416.54(b)(3), §418.113(b)(6) 1), §460.84(b)(5), §482.15(b) 2, §483.475(b)(4), §485.68(b) 4), §485.727(b)(2), 491.12(b)(2), §494.62(b)(3).					

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i '		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED		
		155689	B. WING		02/01/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	preparedness polion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and use reviewed and research follow [(4) or (2),(3),(5),(6) place for patients, remain in the [faction of the following and for hospice and process and pro	6)] A means to shelter in staff, and volunteers who lity]. spices at §418.113(b):] edures. are additional requirements ted inpatient care facilities and procedures must ring: elter in place for patients, as who remain in the	E 0022	E022 – Policies/Procedures	for 02/17/2023	
	and procedures incl for residents, staff, a the LTC facility in a	ergency preparedness policies ude a means to shelter in place and volunteers who remain in accordance with 42 CFR deficient practice could affect all		Sheltering in Place It is the practice of this facility ensure the emergency preparedness policies and procedures include a means the shelter in place for residents, and volunteers who remain in	o staff,	
	Findings include:			facility.		
	Director on 02/01/2 EPP did not have a included a means to	view with the Maintenance 3 at 10:30 a.m., the reviewed policy and procedure that b shelter in place for residents, s who remain in the LTC		What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice:		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIP A. BUILDIN B. WING	PLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED 02/01/2023	
	ROVIDER OR SUPPLIER		24	REET ADDRESS, CITY, STATE, ZIP COI 00 COLLEGE AVE DSHEN, IN 46526	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF facility. Based on i review, the Mainter reviewed EPP did n policy. This finding was re	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Interview during records nance Director agreed the not contain a shelter in place viewed with the Assistant and Maintenance Director	ID PREF TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP	Itering in and ewed and in the ss Plan. ving the by the will be rective Iterital to ent sheltering aff, and ewed and in the ss Plan. put into out: d on or in-service Executive d will mergency cies, and tive adit the ss Plan d annually reviewed ate.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/22/2023 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023	
	PROVIDER OR SUPPLIEF			2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, 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
					will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monit though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee who responsible for reviewing the Emergency Preparedness Plamonthly in QAPI for at least 6 months and annually. If 1000 compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	ored will he an % h	
E 0024 SS=F Bldg	441.184(b)(6), 484 483.73(b)(6), 484 485.68(b)(4), 485 491.12(b)(4), 494 Policies/Procedur §403.748(b)(6), § §441.184(b)(6), § §483.73(b)(6), §4 §485.68(b)(4), §4	6.54(b)(5), 418.113(b)(4), 2.15(b)(6), 483.475(b)(6), .102(b)(5), 485.625(b)(6), .727(b)(4), 485.920(b)(5), .62(b)(5) es-Volunteers and Staffing 416.54(b)(5), §418.113(b)(4), 460.84(b)(7), §482.15(b)(6), 83.475(b)(6), §484.102(b)(5), 85.625(b)(6), §485.727(b)(4), 491.12(b)(4), §494.62(b)(5).					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING COMPLETED B. WING 02/01/2023			ETED		
	PROVIDER OR SUPPLIER			2400 C0	DLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	must develop and preparedness poli on the emergency (a) of this section, paragraph (a)(1) communication plasection. The policible reviewed and uyears [annually forminimum, the policiaddress the follow (6) [or (4), (5), or (of volunteers in aremergency staffin process and role of Federally designal professionals to an emergency. *[For RNHCls at § procedures. (6) Themergency and of strategies to address the follow of the follow of the follows of the fol	7) as noted above] The use a emergency or other g strategies, including the for integration of State and ted health care ddress surge needs during 403.748(b):] Policies and the use of volunteers in another emergency staffing tess surge needs during an 418.113(b):] Policies and the use of hospice emergency and other g strategies, including the for integration of State and ted health care ddress surge needs during					
	failed to ensure Em (EPP) includes the emergency or other	view and interview, the facility ergency Preparedness Plan use of volunteers in an emergency staffing strategies, and role for integration of	E 00	24	E024 - Policies/Procedures – Volunteers and Staffing It is the practice of this facility to ensure the Emergency Preparedness Plan includes the	to	02/17/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023			
	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	professionals to add emergency in accor	esignated health care dress surge needs during an dance with 42 CFR 483.73(b) ractice could affect all		use of volunteers in an emergency or other emerger staffing strategies.	ncy		
	(6). This deficient poccupants. Findings include: Based on records re Director on 02/01/2 EPP did not have a volunteers in an em during records revie stated a policy on the emergency could not This finding was re-	view with the Maintenance 3 at 10:40 a.m., the reviewed policy on the use of ergency. Based on interview ew, the Maintenance Director are use of volunteers in an ot be found. viewed with the Assistant and Maintenance Director		What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice: The policy related to volunter and staffing has been review and updated to be included in Emergency Preparedness Plant 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 have the potent be affected by this deficient practice. The policy related to volunteers and staffing has been reviewed and updated to be included in the Emergency Preparedness Plan. What measures will be put place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced or before 2/17/2023. This in-service will be conducted by the Exervice or Designee and will	ers red in the dan. g the the be ive ial to to peen		
				include a review of the Emer Preparedness Plan, Policies Procedures. The Executive Director/Designee will audit t	, and		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155689	B. W	ING		02/01/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	SUMMARY : (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION			EN, IN 46526 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Emergency Preparedness Pla monthly during QAPI and annito ensure compliance is maintained and policies/procedures are review and updated as appropriate. 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: Ongoing compliance with this corrective action will be monitored to the monitored to ensure the program will be printo place: Ongoing compliance with this corrective action will be monitored to ensure the program will be printo place: Ongoing compliance with this corrective action will be monitored to ensure the program will be printo place: Ongoing compliance with this corrective action will be monitored to the program. The executive Director/Designee was the program of the pro	ually ved the ut ored vill ne in	(X5) COMPLETION DATE
					Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/202	3	
E 0026 SS=F Bldg	(iv), 441.184(b)(8)	6.54(b)(6), 418.113(b)(6)(C) , 482.15(b)(8), 483.475(b) 485.625(b)(8), 485.920(b)					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 02/01/2023						
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	(X5) COMPLETION DATE			
	§403.748(b)(8), §4(C)(iv), §441.184(§482.15(b)(8), §4§485.625(b)(8), §4[(b) Policies and preparedness polion the emergency (a) of this section, paragraph (a)(1) communication placetion. The policibe reviewed and uyears [annually for minimum, the poliaddress the follow (8) [(6), (6)(C)(iv), [facility] under a was Secretary, in according to the Act, in the paragraph (a) (b) emergency material to the procedures (b) The procedures (c) The procedures (d) The procedures (e) The procedures	aiver Declared by Secretary 416.54(b)(6), §418.113(b)(6) b)(8), §460.84(b)(9), 83.73(b)(8), §483.475(b)(8), 485.920(b)(7), §494.62(b)(7). Arocedures. The [facilities] implement emergency cies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 or LTC facilities]. At a cies and procedures must ring:] (7), or (9)] The role of the raiver declared by the ordance with section 1135 crovision of care and ternate care site identified nagement officials. (403.748(b):] Policies and the role of the RNHCI under a by the Secretary, in frection 1135 of Act, in the						
	identified by emer officials. Based on record rev failed to ensure the (EEP) include the r waiver declared by with section 1135 of	at an alternative care site gency management view and interview, the facility Emergency Preparedness Plan tole of the LTC facility under a the Secretary, in accordance of the Act, in the provision of the at an alternate care site	E 0026	E026- Roles Under a Waiver Declared by Secretary It is the practice of this facility ensure the Emergency Preparedness Plan includes the roles of the LTC facility under	ne			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPL 02/01/	ETED
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP CO COLLEGE AVE EN, IN 46526	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMI		(X5) COMPLETION DATE
	accordance with 42 deficient practice of Findings include: Based on records re	ency management officials in CFR 483.73(b) (8). This buld affect all occupants. Eview with the Maintenance 3 at 11:11 a.m., the reviewed		waiver declared by the What corrective action be accomplished for to residents found to have affected by the deficie practice: The policy related to the	n(s) will hose ve been ent	
	EPP did not have a role of the LTC fac the Secretary, in act the Act. Based on in review, the Mainter	policy and procedure for the ility under a waiver declared by cordance with section 1135 of ance Director agreed the ot contain the 1135 waiver		the LTC facility under a been reviewed and upo included in the Emerge Preparedness Plan. How other residents h	n waiver dated to be ency	
	_	viewed with the Assistant and Maintenance Director erence.		potential to be affected same deficient practice identified and what contact action(s) will be taken All residents have the properties of the LTC facility waiver has been review updated to be included Emergency Preparedness	e will be orrective: cotential to cient lated to the under a wed and in the	
				What measures will be place or what systemi changes will be made ensure that the deficie practice does not recu. All staff will be in-service before 2/17/2023. This will be conducted by the Director or Designee and include a review of the Preparedness Plan, Poprocedures. The Exect Director/Designee will a Emergency Preparedness	to ent ur: eed on or e in-service ee Executive nd will Emergency olicies, and eutive audit the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BU	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 02/01/2023	
		133069	B. W1			02/01/	2023
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΛΤΕ	(X5) COMPLETION
E 0029 SS=F Bldg	403.748(c), 416.5	5(c), 483.475(c), 483.73(c),		TAG	monthly during QAPI and ann to ensure compliance is maintained and policies/procedures are review and updated as appropriate. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to ensure the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee who he responsible for reviewing the Emergency Preparedness Plamonthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	ually ved the ut ored will he in % or	DATE
ычу	485.727(c), 485.9 491.12(c), 494.62	20(c), 486.360(c),					

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D	DEPARTMENT OF HEALTH AND HUMAN SERVICES							
C	ENTERS FOR MEDICARE & MEDICAID SERVICES							
Γ	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION					
ı	AND BLAN OF CORRECTION	IDENTIFICATION AND DED	A DIJII DIDIC					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BU	A. BUILDING CO. B. WING 02/			ATE SURVEY MPLETED /01/2023	
	PROVIDER OR SUPPLIE FIC CARE OF GOSI			STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	§441.184(c), §46i §483.73(c), §483 §485.68(c), §485 §485.920(c), §48f §494.62(c). (c) The [facility] man emergency proplement that complied local laws and must least every 2 year facilities]. Based on record refailed to review and Preparedness Plandleast annually in act 483.73(a). This defoccupants. Findings include: Based on records mandle properties of the properti	an was last reviewed. There was ted 01/13/23 with signatures nat stated "The IDT team at coshen has reviewed and s for 2022 through 2023" but the fically say the EPP was ted. Based on an interview ew, the Maintenance Director	E 0	029	E029 – Development of Communication Plan It is the practice of this facility ensure the Emergency Preparedness Plan communication plan is review and updated at least annually What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice: The policy related to communication has been revi and updated to be included in Emergency Preparedness Pla How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: All residents have the potential be affected by this deficient practice. The policy related to communication has been revi	red III n ewed the an. the be ve al to	02/17/2023

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING B. WING		COMPLETED 02/01/2023				
	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	ID PREFIX TAG	PROFILE PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)				
	during the exit confe	erence.		and updated to be included in Emergency Preparedness Pl	an.			
				What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on before 2/17/2023. This in-se will be conducted by the Exe Director or Designee and will include a review of the Emery Preparedness Plan, Policies, Procedures. The Executive Director/Designee will audit to Emergency Preparedness Plan monthly during QAPI and and to ensure compliance is maintained and policies/procedures are revied and updated as appropriate. How the corrective action(so will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place: Ongoing compliance with this corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place: Ongoing compliance with this corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be 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 reviewing Emergency Preparedness Pl monthly in QAPI for at least 6 months and annually. If 100 compliance is not achieved as	or rvice cutive gency and he an hually wed y the put stored will the an so we will the an so we will the an so we we we we will the an so we we we we we we will the an so we we we we we we we will the an so we			

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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 02/01/2023	
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
					action plan will be developed. Findings will be submitted to to Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/202		
E 0031 SS=C Bldg	441.184(c)(2), 482.483.73(c)(2), 484.485.68(c)(2), 485.486.360(c)(2), 495.486.360(c)(2), \$45.486.3748(c)(2), \$45.486.373(c)(2), \$45.485.68(c)(2), \$45.485.68(c)(2), \$45.485.920(c)(2). \$494.62(c)(2). \$49	nation for the following: tribal, regional, and local redness staff.					
	-	on for the following:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					ETED
		155689	B. WING	B. WING 02/01/2023			2023
MAJEST	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	(i) Federal, State, emergency prepared (ii) The State Lice Agency. (iii) The Office of the Ombudsman. (iv) Other sources "[For ICF/IIDs at State information for the (i) Federal, State, emergency prepared (ii) Other sources (iii) The State Lice Agency. (iv) The State Propagency. (iv) The State Propagency (iv) The State Pro	he State Long-Term Care of assistance. (483.475(c):] (2) Contact following: tribal, regional, and local redness staff. of assistance. ensing and Certification tection and Advocacy view and interview, the facility Emergency Preparedness Plan on plan included contact the following: (i) Federal, State, ocal emergency preparedness Licensing and Certification effice of the State Long-Term iv) Other sources of assistance 42 CFR 483.73(c) (2). This ould affect all occupants. eview with the Maintenance 3 at 11:17 a.m., the reviewed in plan was missing the contact is Office of the State Long-Term Based on interview during Maintenance Director agreed id not contain contact	E 003	l	E031 – Emergency Officials Contact Information It is the practice of this facility ensure the Emergency Preparedness Plan communication plan includes to contact information for The Off of the State Long-Term Care Ombudsman. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The policy related to communication has been revie and updated to include the appropriate contact informatio be included in the Emergency Preparedness Plan.	the ifice I n ewed n to	02/17/2023

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	of correction (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION (IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, 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 APPROPRIA DEFICIENCY)	5.112			
	This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference.		potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: All residents have the potential be affected by this deficient practice. The policy related to communication has been reviand updated to include the appropriate contact information be included in the Emergency Preparedness Plan. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on before 2/17/2023. This in-ser will be conducted by the Executive Director or Designee and will include a review of the Emergy Preparedness Plan, Policies, Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plan monthly during QAPI and annoto ensure compliance is maintained and policies/procedures are review and updated as appropriate. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this	be ye all to contact t			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION _ 	(X3) DATE SURVEY COMPLETED 02/01/2023		
	ROVIDER 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 & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE COMPIAPPROPRIATE DA	X5) LETION TE	
				corrective action will be though the facility Qual Assurance and Perford Improvement Program Executive Director/Deside responsible for review Emergency Prepared monthly in QAPI for at months and annually. compliance is not achinaction plan will be deventially for a submit of the compliance of the complete for review follow-up. By what date the system completed: 02/17/202 Compliance Date = 02	lity mance . The signee will ewing the ess Plan least 6 If 100% eved an eloped. tted to the ment and eemic		
				E032 – Primary/Alterr Means for Communic It is the practice of this ensure the Emergency Preparedness Plan ind communication plan for and alternate means for communication for; LT staff, Federal, State, tr regional, or local emer management agencies What corrective action be accomplished for residents found to hat affected by the deficient practice:	ation facility to cludes the r primary or C facility ibal, gency s. n(s) will those ve been		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING		COMPI	LETED
		155689	B. W	ING		02/01	/2023
							
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJEST	IC CARE OF GOSH	1EN		GOSH	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	CIENCIE ID PROVIDEN				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			T-	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
					communication has been review	ewed	
					and updated to be included in		
					Emergency Preparedness Pla		
					How other residents having	the	
					potential to be affected by th		
				same deficient practice will k			
				identified and what correctiv			
				action(s) will be taken:	•		
				All residents have the potentia	ıl to		
				be affected by this deficient			
				practice. The policy related to			
				communication has been review			
				and updated to be included in			
					Emergency Preparedness Pla		
					Emergency r reparedness r la	11.	
					What measures will be put in	ito	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					All staff will be in-serviced on	or	
					before 2/17/2023. This in-service		
					will be conducted by the Exec		
					Director or Designee and will	all V C	
					include a review of the Emerg	encv	
					Preparedness Plan, Policies, a	-	
					Procedures. The Executive	ai IU	
					Director/Designee will audit th	e	
					Emergency Preparedness Pla		
					monthly during QAPI and anni		
					to ensure compliance is	uany	
					maintained and		
					policies/procedures are review	,ed	
					1 -	/c u	1
					and updated as appropriate.		
					How the corrective action (a)		
					How the corrective action(s)	L .	
					will be monitored to ensure t	ne	

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deficient practice will not recur, i.e., what quality

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY PLETED 1/2023	
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR. (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	
E 0032 SS=C Bldg	441.184(c)(3), 482 483.73(c)(3), 484.	5.54(c)(3), 418.113(c)(3), 2.15(c)(3), 483.475(c)(3), 102(c)(3), 485.625(c)(3),		assurance program we into place: Ongoing compliance we corrective action will be though the facility Qual Assurance and Perform Improvement Program. Executive Director/Desibe responsible for revie Emergency Preparedneonthly in QAPI for at months and annually. compliance is not achie action plan will be deverindings will be submit Quality Assurance and Performance Improvem Committee for review a follow-up. By what date the systechanges will be completed: 02/17/2023 Compliance Date = 02/19	with this e monitored lity mance . The signee will ewing the ess Plan least 6 If 100% eved an eloped. ted to the ment and emic		
	486.360(c)(3), 49 ⁻ Primary/Alternate §403.748(c)(3), §4 ⁻ §441.184(c)(3), §4 ⁻ §483.73(c)(3), §4 ⁻ §485.68(c)(3), §4 ⁻ (3), §485.920(c)(3) §491.12(c)(3), §4 ⁻						

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB N				
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155689	B. Wl	ING		02/01/	/2023	
NAME OF I	DROVIDED OD CUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF PROVIDER OR SUPPLIER			2400 C	OLLEGE AVE				
MAJESTIC CARE OF GOSHEN			GOSHE	EN, IN 46526				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTI		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 APPROPRIATI DEFICIENCY)		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION					DATE	
TAG	an emergency preplan that complies local laws and must least every 2 ye facilities]. The coinclude all of the foliation of th	eparedness communication s with Federal, State and lest be reviewed and updated lears [annually for LTC mmunication plan must collowing: liternate means for lith the following: tribal, regional, and local	E 00		E032 – Primary/Alternate Means for Communication It is the practice of this facility ensure the Emergency Preparedness Plan includes th communication plan for primal and alternate means for communication for; LTC facility staff, Federal, State, tribal, regional, or local emergency management agencies. What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice: The policy related to	to ne ry y	DATE 02/17/2023	
		_			•			

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

This finding was reviewed with the Assistant

Director of Nursing and Maintenance Director

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Emergency Preparedness Plan.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION _ 	COMI	e survey pleted 1/2023		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	during the exit con	reference.		How other residents potential to be affected same deficient practice identified and what continues action(s) will be taken All residents have the be affected by this definance. The policy recommunication has be and updated to be included and updated by the practice does not reconcluded a review of the Preparedness Plan, Procedures. The Executive Director or Designed and updated and policies/procedures are and updated as approached to ensure compliance maintained and policies/procedures are and updated as approached to ensure compliance maintained and policies/procedures are and updated as approached to ensure compliance will be monitored to en	ed by the ice will be corrective in: potential to ficient elated to een reviewed luded in the ness Plan. De put into nic e to ient cur: iced on or is in-service he Executive and will e Emergency colicies, and cutive audit the ness Plan and annually is re reviewed epriate. Ction(s) ensure the I not ty will be put			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/22/2023 FORM APPROVED

ENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING <u></u>	COMPLETED
	155689	B. WI	ING	02/01/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER			2400 COLLEGE AVE	

NAME OF PROVIDER OR SUPPLIER	
MAJESTIC CARE OF GOSHEN	

MAJESTIC CARE OF GOSHEN			GOSHEN, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
E 0033 SS=C Bldg	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c) (4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c) (4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information \$403.748(c)(4)-(6), \$416.54(c)(4)-(6), \$418.113(c)(4)-(6), \$441.184(c)(4)-(6), \$460.84(c)(4)-(6), \$441.184(c)(4)-(6), \$460.84(c)(4)-(6), \$483.475(c)(4)-(6), \$483.73(c)(4)-(6), \$483.475(c)(4)-(6), \$484.102(c)(4)-(5), \$485.68(c)(4), \$485.625(c) (4)-(6), \$485.727(c)(4), \$485.920(c)(4)-(6), \$491.12(c)(4), \$494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated		though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for reviewing the Emergency Preparedness Plan monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(x3) date survey completed 02/01/2023
	PROVIDER OR SUPPLIEF		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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
		ears [annually for LTC mmunication plan must ollowing:			
	medical documen [facility's] care, as	charing information and tation for patients under the necessary, with other o maintain the continuity of			
	release patient inf under 45 CFR 16- provision is not re	e event of an evacuation, to formation as permitted 4.510(b)(1)(ii). [This quired for HHAs under RFs under §485.68(c)]			
	about the general patients under the	eans of providing information condition and location of [facility's] care as 5 CFR 164.510(b)(4).			
	for sharing inform documentation for care, as necessar maintain the conti written election st	(403.748(c):] (4) A method ation and care repatients under the RNHCl's y, with care providers to nuity of care, based on the atement made by the er legal representative.			
	means of providin	Cs at §491.12(c):] (4) A g information about the and location of patients care as permitted under 45			
	Based on record rev failed to ensure the (EPP) communicate for sharing informated documentation for the	view and interview, the facility emergency preparedness on plan includes (4) A method	E 0033	E033 – Methods for Sharing Information It is the practice of this facility ensure the Emergency Preparedness Plan communication plan includes a	

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	ľ	UILDING	NSTRUCTION	(X3) DATE COMPL 02/01/	ETED
	OF PROVIDER OR SUPPLIEI			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, 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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	providers to maintal means, in the event resident information 164.510(b)(1)(ii); (information about the location of resident permitted under 45 accordance with 42 deficient practice of the providers include: Based on records respond to the providers of the providers to maintal Based on interview Maintenance Directly. This finding was resident permitted under 45 accordance with 42 deficient practice of the providers of the providers of the providers are not providers to maintal Based on interview Maintenance Directly.	in the continuity of care; (5) A of an evacuation, to release in as permitted under 45 CFR 6) A means of providing the general condition and is under the facility's care as CFR 164.510(b)(4) in CFR 483.73(c)(4). This could affect all occupants. Eview with the Maintenance 23 at 11:32 a.m., the reviewed in plan did not include a method attion and medical residents under the LTC excessary, with other health care in the continuity of care. In the continuity of care, during records review, the tor agreed the reviewed EPP ethod for sharing information eviewed with the Assistant grand Maintenance Director			method for sharing information medical documentation for residents under the LTC faciliticare, a means for release of information during an evacuar and a means of providing information about the general condition and location of residents founder the facilities care. What corrective action(s) with be accomplished for those residents found to have been affected by the deficient practice: The policy related to communication has been reviand updated to be included in Emergency Preparedness Plate How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: All residents have the potentiable affected by this deficient practice. The policy related to communication has been reviand updated to be included in Emergency Preparedness Plate What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on before 2/17/2023. This in-ser will be conducted by the Execution in the Execution of the Ex	n and ty tion, dents II n ewed the an. the he be /e al to o ewed the an. nto	

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f í		X2) MULTIPLE CONSTRUCTION XX A. BUILDING		X3) DATE SURVEY COMPLETED	
		155689	B. WING		02/01/2023
	PROVIDER OR SUPPLIEF		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				Director or Designee and will include a review of the Emerg Preparedness Plan, Policies, a Procedures. The Executive Director/Designee will audit the Emergency Preparedness Plamonthly during QAPI and annoto ensure compliance is maintained and policies/procedures are review and updated as appropriate. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee who be responsible for reviewing the Emergency Preparedness Plamonthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023 Compliance Date = 02/17/2023	ency and ee in ually wed the ut ored will he in % he he

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155689 B. WING		NSTRUCTION 	COM	TE SURVEY MPLETED 01/2023			
	PROVIDER OR SUPPLIER		•	2400 C0	ADDRESS, CITY, STATE, ZIP CO DLLEGE AVE EN, IN 46526	OD	
(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 CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
E 0034 SS=C Bldg	441.184(c)(7), 482, 483.73(c)(7), 484, 485.68(c)(5), 485, 491.12(c)(5), 494, Information on Oc §403.748(c)(7), §483.73(c)(7), §483.73(c)(7), §486.68(c)(5), §485.625(c)(7), §491.12(c)(5), §485.625(c)(7), §485.625(c), §485.625(c), §485.625(c), §485.625(c), §485.625(c), §485.625(cupancy/Needs 116.54(c)(7), §418.113(c)(7) 182.15(c)(7), §460.84(c)(7), 183.475(c)(7), §484.102(c) §485.68(c)(5), §485.727(c) 1), §485.920(c)(7), 104.62(c)(7). Instructed develop and maintain exparedness communication expared					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPLETED
		155689	B. W	ING		02/01/2023
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA	DATE
	Command Center	, or designee.				
	Based on record rev	view and interview, the facility	E 0	034	E034 – Information on	02/17/2023
	failed to ensure the	emergency preparedness			Occupancy/Needs	02/1//2028
	(EPP) communication plan includes a means of				It is the practice of this facility	to
	providing informati	on about the LTC facility's			ensure the Emergency	
	occupancy, needs, a	and its ability to provide			Preparedness Plan	
		thority having jurisdiction or			communication plan includes	
		and Center, or designee in			means of providing informatio	n
		CFR 483.73(c)(7). This			about the LTC facility's	
	deficient practice co	ould affect all occupants.			occupancy, needs, and its abi	lity
					to provide assistance.	
	Findings include:				l	
	D 1 1	talah seti.			What corrective action(s) will	
		eview with the Maintenance			be accomplished for those	
		3 at 11:34 a.m., the reviewed			residents found to have been	n
		n plan did not address a means ation about the LTC facility's			affected by the deficient	
		and its ability to provide			practice:	
		thority having jurisdiction or			The policy related to occupancy/needs has been	
		and Center, or designee. Based			reviewed and updated to be	
		records review, the			included in the Emergency	
	-	for agreed the reviewed EPP			Preparedness Plan.	
		an that address a means of			l repareunese riam	
	_	on about the LTC facility's			How other residents having	the
		and its ability to provide			potential to be affected by the	
	assistance.	· -			same deficient practice will I	
					identified and what corrective	re e
	This finding was re	viewed with the Assistant			action(s) will be taken:	
	-	and Maintenance Director			All residents have the potentia	al to
	during the exit conf	erence.			be affected by this deficient	
					practice. The policy related to	
					occupancy/needs has been	
					reviewed and updated to be	
					included in the Emergency	
					Preparedness Plan.	
					What measures will be put in	nto
					-	ilo
					place or what systemic changes will be made to	
					ensure that the deficient	
1			- 1		Chause that the delibitiff	i

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	OF CORRECTION	IDENTIFICATION NUMBER 155689	A. BUILDING B. WING	JNSTRUCTION	COMPLETED 02/01/2023
	ROVIDER OR SUPPLIER C CARE OF GOSH		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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPROFICIENCY)	N (X5) BE COMPLETION DATE
				practice does not recur: All staff will be in-serviced of before 2/17/2023. This in-s will be conducted by the Exportance of the Englian procedures of the Emeroperation of the E	ervice ecutive ill ergency s, and ethe Plan nnually dewed e. (s) e the e will g the Plan e6 00% an ed. o the

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023	
	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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
E 0035 SS=C Bldg	483.475(c)(8), 483 LTC and ICF/IID \$ \$483.73(c)(8); \$48	Sharing Plan with Patients		changes will be completed: 02/17/2023 Compliance Date = 02/17/202	3	
Diug	*[For LTC Facilitie [(c) The LTC facili maintain an emery communication plane Federal, State and reviewed and upd	· / · /				
	emergency prepar plan that complies local laws and mu at least every 2 years	483.475(c):] sust develop and maintain an redness communication with Federal, State and st be reviewed and updated ears. The communication all of the following:]				
	emergency plan, to determined is apportional clients and their for Based on record reversaled to ensure the (EEP) communicated sharing information the facility has determined their facil	charing information from the that the facility has ropriate, with residents [or amilies or representatives. View and interview, the facility emergency preparedness on plan includes a method for a from the emergency plan that rmined is appropriate with families or representatives in CFR 483.73(c)(8). This build affect all occupants.	E 0035	E035 – LTC and ICF/IID Shari Plan with Patients It is the practice of this facility ensure the Emergency Preparedness Plan communication plan includes a method for sharing information from the emergency plan that facility has determine is	a n	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023
	PROVIDER OR SUPPLIER		2400 (CADDRESS, CITY, STATE, ZIP COD COLLEGE AVE IEN, 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE COMPLETION OPRIATE DATE
	Findings include: Based on records re	eview with the Maintenance		appropriate with residents their families or representation	
	Director on 02/01/2 EPP communicatio method for sharing emergency plan tha appropriate with re- representatives. Base records review, the the reviewed EPP discussed a method the emergency plan residents and their in	at 11:39 a.m., the reviewed in plan failed to include a information from the it the facility has determined is sidents and their families or sed on interview during Maintenance Director agreed id not contain a plan that for sharing information from deemed appropriate with families or representatives.		What corrective action(s) be accomplished for those residents found to have affected by the deficient practice: The policy related to communication; including method for sharing inform been reviewed and update included in the Emergency Preparedness Plan. How other residents have potential to be affected by same deficient practice widentified and what correaction(s) will be taken: All residents have the potential to be affected by this deficient practice. The policy related communication; including method for sharing inform been reviewed and update included in the Emergency Preparedness Plan. What measures will be public or what systemic changes will be made to ensure that the deficient	a ation has ed to be y ing the py the will be ective ential to ent ed to a ation has ed to be y ut into
				practice does not recur: All staff will be in-serviced before 2/17/2023. This inwill be conducted by the E Director or Designee and include a review of the En Preparedness Plan Polici	-service Executive will nergency

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155689	B. Wl	ING		02/01/	2023
	PROVIDER OR SUPPLIEI			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
MAJEST (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION				ne an aually wed the out	(X5) COMPLETION DATE
E 0036 SS=C Bldg	403.748(d), 416.5 441.184(d), 482.1 484.102(d), 485.6	5(d), 483.475(d), 483.73(d),			be responsible for reviewing t Emergency Preparedness Pla monthly in QAPI for at least 6 months and annually. If 1000 compliance is not achieved at action plan will be developed. Findings will be submitted to t Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/202	he an % n	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023
	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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
	485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §466 §483.73(d), §485. §485.68(d), §485. §485.920(d), §486 §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testir develop and main preparedness train that is based on the in paragraph (a) or assessment at paragraph (b) of this section, plan at paragraph training and testin reviewed and upd *[For LTC facilities and testing. The I and maintain an eraining and testing the emergency play of this section, risk (a)(1) of this section at paragraph (b) or communication play section. The training last that is the emergency play of this section, risk (a)(1) of this section at paragraph (b) or communication play section. The training last the training last that is paragraph (b) or communication play section. The training last that is paragraph (b) or communication play section. The training last that is paragraph (b) or communication play section. The training last that is paragraph (b) or communication play section. The training last that is paragraph (b) or communication play section. The training last that is paragraph (b) or communication play section. The training last that is paragraph (b) or communication play section. The training last that is paragraph (b) or communication play section. The training last that is paragraph (b) or communication play section.	20(d), 486.360(d), (d) festing 5.54(d), §418.113(d), 0.84(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), 6.360(d), §491.12(d), 403.748, ASCs at §416.54, 13, PRTFs at §441.184, Hospitals at §482.15, 2, CORFs at §485.68, 5, "Organizations" under at §485.920, OPOs at IC/FHQs at §491.12:] (d) ng. The [facility] must tain an emergency ning and testing program ne emergency plan set forth			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	testing. The ICF/II maintain an emergand testing progratemergency plans this section, risk at (a)(1) of this section at paragraph (b) of communication placetion. The train must be reviewed 2 years. The ICF/requirements for at §483.470(i). *[For ESRD Facility Training, testing, adialysis facility mulemergency preparand patient orient on the emergency	A83.475(d):] Training and D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every IID must meet the evacuation drills and training ties at §494.62(d):] and orientation. The lest develop and maintain an redness training, testing ation program that is based of plan set forth in paragraph risk assessment at			
	procedures at par and the communion of this section. The orientation prograte updated at every the Based on record reversed failed to develop ar	view and interview, the facility and maintain an emergency	E 0036	E036 – EP Training and Test It is the practice of this facility	_
	that is based on the with 42 CFR 483.7 could affect all occ	training and testing program emergency plan accordance 3(d). This deficient practice upants.		ensure the Emergency Preparedness Plan includes a training and testing program to is based on the emergency pl	nat an.
	Findings include: Based on records re	eview with the Maintenance		What corrective action(s) will be accomplished for those residents found to have been	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPI 02/01	
	PROVIDER OR SUPPLIER		2400 0	ADDRESS, CITY, STATE, ZIP C COLLEGE AVE EN, IN 46526	COD	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	EPP table of conter in section T. Section Preparedness Train the page was blank records review, the the reviewed EPP to was left blank. This finding was re	at 10:30 a.m., the reviewed ats listed the training program in T was titled Emergency ing and Testing, but the rest of a Based on interview during Maintenance Director agreed raining program policy page wiewed with the Assistant and Maintenance Director and Maintenance Director are are and Maintenance Director are and Maintenance Director and M		affected by the deficiency practice: The policy related to encompared prepared prepa	mergency and testing d updated to ergency having the ed by the ce will be orrective n: potential to icient lated to ess training reviewed and d in the ness Plan. be put into ic ent ur: ced on or s in-service ne Executive and will e Emergency olicies, and cutive audit the ness Plan and annually is	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED B. WING 02/01/2023			PLETED	
	PROVIDER OR SUPPLIE		2400 C	ADDRESS, CITY, STATE, ZIP COI COLLEGE AVE EN, IN 46526)	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
				How the corrective action will be monitored to ensideficient practice will not recur, i.e., what quality assurance program will into place: Ongoing compliance with corrective action will be rethough the facility Quality Assurance and Performal Improvement Program. Executive Director/Design be responsible for review Emergency Preparedness monthly in QAPI for at lemonths and annually. If compliance is not achieve action plan will be development of the program of the	be put this monitored y ance The inee will wing the is Plan ast 6 100% red an opped. d to the intic	
E 0037 SS=C Bldg	441.184(d)(1), 484 483.73(d)(1), 484 485.68(d)(1), 485 486.360(d)(1), 49 EP Training Prog §403.748(d)(1), § §441.184(d)(1), § §483.73(d)(1), §4 §485.68(d)(1), §	. , . ,				

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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		COMPLETED	
		155689	B. W	NG		02/01/	/2023
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	§491.12(d)(1).						
	3 (= /(. / .						
	*IFor RNCHIs at 8	§403.748, ASCs at §416.54,					
		.15, ICF/IIDs at §483.475,					
		2, "Organizations" under					
	_	at §486.360, RHC/FQHCs					
	at §491.12:]	at 3 100.000, 14 10/1 Q1100					
		ram. The [facility] must do					
	all of the following						
	_	n emergency preparedness					
	``	edures to all new and					
		viduals providing services					
	_	nt, and volunteers,					
	_	eir expected roles.					
		ency preparedness training					
	at least every 2 ye						
		mentation of all emergency					
	preparedness trai						
		-					
		staff knowledge of					
	emergency proce						
		cy preparedness policies					
	-	re significantly updated, the					
		duct training on the					
	updated policies a	and procedures.					
	*r= 11 · ·	0440 440(I) 1 (4) T ::					
		§418.113(d):] (1) Training.					
	<u>-</u>	do all of the following:					
	``	n emergency preparedness					
		edures to all new and					
		employees, and individuals					
		s under arrangement,					
		eir expected roles.					
	(ii) Demonstrate s	_					
	emergency proce						
	, ,	gency preparedness training					
	at least every 2 years.						
	. ,	view and rehearse its					
	emergency prepa	redness plan with hospice					
	employees (include	ling nonemployee staff),					
	with special emph	asis placed on carrying out					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING		COMPL	
		155689	B. W	ING		02/01/	/2023
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJEST	IC CARE OF GOSH	1EN		GOSHE	EN, IN 46526		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DZI Telzive I I		DATE
	and others.	ecessary to protect patients					
		mentation of all emergency					
	preparedness training. (vi) If the emergency preparedness policies						
		re significantly updated, the					
		duct training on the					
	updated policies a	•					
	procedures.						
	***	144 404(I) 1 (4) T					
	-	41.184(d):] (1) Training					
	1	ΓF must do all of the					
	following:						
		n emergency preparedness					
		edures to all new and					
	under arrangemer	viduals providing services					
	consistent with the						
		ning, provide emergency					
	' '	ning, provide emergency ning every 2 years.					
	(iii) Demonstrate s						
	emergency proced	_					
		mentation of all emergency					
	preparedness train						
	l ' '	cy preparedness policies					
		re significantly updated, the					
	-	ict training on the updated					
	policies and proce	edures.					
	*(Ear DAGE at \$4/	20 04/d\:1/1\ The DACE					
		60.84(d):] (1) The PACE do all of the following:					
		•					
		n emergency preparedness edures to all new and					
	1 '	viduals providing on-site					
	_	rangement, contractors,					
		olunteers, consistent with					
	their expected role						
		ency preparedness training					
	at least every 2 ye						
	(iii) Demonstrate s						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	l í	JILDING	NSTRUCTION	COMP	E SURVEY LETED 1/2023	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	(X5) COMPLETION	
PREFIX TAG	emergency proceiparticipants of whom to contact i (iv) Maintain docu (v) If the emerger and procedures a PACE must condupolicies and procedures and procedur	dures, including informing at to do, where to go, and in case of an emergency. Imentation of all training. Incy preparedness policies are significantly updated, the fuct training on the updated edures. Ses at §483.73(d):] (1) The LTC facility must do all in emergency preparedness edures to all new and viduals providing services int, and volunteers, eir expected role. It is in emergency preparedness training in emergency ining. Staff knowledge of dures. 485.68(d):](1) Training. The lift of the following: raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. It is individuals providing rangement, and volunteers, eir expected roles. It is included the procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. It is included the procedures training in emergency preparedness training in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. It is included the procedures training in emergency preparedness training in emergen		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LU BE ROPRIATE	COMPLETION DATE	
	(iv) Demonstrate s emergency proce- must be oriented	mentation of the training. staff knowledge of dures. All new personnel and assigned specific						
	emergency plan w	garding the CORF's vithin 2 weeks of their first ning program must include						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted 2023
	PROVIDER OR SUPPLIER		•	2400 CC	DDRESS, CITY, STATE, ZIP COD DLLEGE AVE N, IN 46526		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	(X5) COMPLETION
TAG	instruction in the losystems and signal equipment. (v) If the emerge and procedures and CORF must condupolicies and procedures and existing and exting protection, and who for patients, persong prevention, and consistent with the existing staff, individuals arrangement consistent with the (ii) Provide emergat least every 2 yes (iii) Maintain document (iv) Demonstrate and procedures to all remergency prepared procedures to all remergency provide individuals provided.	cation and use of alarm als and firefighting ncy preparedness policies re significantly updated, the act training on the updated adures. 85.625(d):] (1) Training H must do all of the nemergency preparedness adures, including prompt anguishing of fires, here necessary, evacuation annel, and guests, fire properation with firefighting prities, to all new and viduals providing services and, and volunteers, here expected roles. ency preparedness training here significantly updated, the act training on the updated adures. 485.920(d):] (1) Training. provide initial training in redness policies and new and existing staff, ang services under volunteers, consistent with		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	DATE
		the training. The CMHC staff knowledge of					

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Event ID:

WPUV21 Facility ID: 000091

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PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/01/2023	
	OF PROVIDER OR SUPPLIED STIC CARE OF GOSH			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, 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
	emergency proce CMHC must provi preparedness trai Based on record re- failed to conduct ar Emergency Prepare facility must do all training in emergen procedures to all ne individuals providir and volunteers, con roles; (ii) Provide e training at least and documentation of a training; (iv) Demo emergency procedu 483.73(d) (1). This all residents in the re- Findings include: Based on records re- Director and Assist 02/01/23 at 11:55 a EPP training and ne could demonstrate available for review time of records review time of records review Nursing stated train a computer training print or show the E	dures. Thereafter, the ide emergency ning at least every 2 years. view and interview, the facility inual training for the edness Program (EPP). The LTC of the following: (i) Initial acy preparedness policies and ew and existing staff, ing services under arrangement, is istent with their expected emergency preparedness instrate staff knowledge of ires in accordance with 42 CFR deficient practice could affect facility. Eview with the Maintenance ant Director of Nursing on it.m., no documentation of annual to documentation to show staff knowledge of the EPP was it. Based on an interview at the itew, the Assistant Director of iting was conducted by use of a program but was unable to PP training documentation.	E 0	037	E037 – EP Training Program It is the practice of this facility ensure that annual training is conducted to review the Emergency Preparedness Pla What corrective action(s) wil be accomplished for those residents found to have been affected by the deficient practice: The policy related to emergen preparedness training and tes has been reviewed and update be included in the Emergency Preparedness Plan. How other residents having a potential to be affected by the same deficient practice will a identified and what corrective action(s) will be taken: All residents have the potential be affected by this deficient practice. The policy related to emergency preparedness train and testing has been reviewed updated to be included in the Emergency Preparedness Pla What measures will be put in 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 2/17/2023. This in-servi	to in. I cy ting ed to the ne ne d and in. hto	02/17/2023

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/22/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	VG	COMPL	ETED
		155689	B. WING		02/01/	2023
NAME OF P	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP COD		
01 1	no vibbit on borr bibit		240	00 COLLEGE AVE		
MAJEST	IC CARE OF GOSH	IEN	GC	SHEN, IN 46526		
(VA) ID	CIDADA DV	CTATEMENT OF DESIGNACIE	ID.	T		(VE)
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	N	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPROP	PRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAC			DATE
				will be conducted by the Ex	ecutive	
				Director or Designee and w	ill	
				include a review of the Eme	ergency	
				Preparedness Plan, Policie	s, and	
				Procedures. The Executive		
				Director/Designee will audit		
				Emergency Preparedness I		
				monthly during QAPI and a		
				_	iniuany	
				to ensure compliance is		
				maintained and		
				policies/procedures are rev		
				and updated as appropriate).	
				How the corrective action	(e)	
				will be monitored to ensur		
					e tile	
				deficient practice will not		
				recur, i.e., what quality	4	
				assurance program will be	put	
				into place:		
				Ongoing compliance with the		
				corrective action will be mo	nitored	
				though the facility Quality		
				Assurance and Performance		
				Improvement Program. Th		
				Executive Director/Designe	e will	
				be responsible for reviewing	g the	
				Emergency Preparedness I	Plan	
				monthly in QAPI for at least	: 6	
				months and annually. If 10	00%	
				compliance is not achieved		
				action plan will be develope		
				Findings will be submitted t		
				Quality Assurance and		
				Performance Improvement		
				Committee for review and		
				follow-up.		
				By what date the systemic	;	
				changes will be		
				completed: 02/17/2023		

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Compliance Date = 02/17/2023

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689 AND PLAN OF CORRECTION IDENTIFICATION NUMBER B. WING		COMPL 02/01/	ETED		
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §48 §483.475(d)(2), §48 §485.625(d)(2), §4 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization CMHCs at §485.93 §491.12, and ESR (2) Testing. The [faction following: (i) Participate in a community-based (A) When a community-based (A) When a community community for accessible, confunctional exercises (B) If the [faction following function of the entity of the en	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 848.102(d)(2), §485.68(d)(2), 8485.727(d)(2), §485.920(d) 8494.62(d)(2). 6.54, CORFs at §485.68, 90s" under §485.727, 20, RHCs/FQHCs at 8D Facilities at §494.62]: acility] must conduct the emergency plan sility] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is induct a facility-based				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155689	B. W	NG		02/01/	/2023
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	ROVIDER OR SUPPLIER			2400 C	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	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	i e	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	s conducted, that may					
		limited to the following:					
	' '	scale exercise that is					
	community-based or individual, facility-based						
	functional exercise						
	(B) A mock disast						
		ercise or workshop that is and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta						
	· ·	pared questions designed					
	to challenge an er						
	_	acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	*[For Hospices at	· · -					
		spices that provide care in					
		e. The hospice must					
		to test the emergency					
	the following:	ally. The hospice must do					
		a full-scale exercise that is					
	community based						
	1	nunity based exercise is not					
		et an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
	, ,	ency that requires activation					
	_	plan, the hospital is					
	,	nging in its next required full					
		based exercise or individual					
		tional exercise following the					
	onset of the emer	_					
		dditional exercise every 2					
	years, opposite th	e year the full-scale or					
	functional exercise	e under paragraph (d)(2)(i)					
	of this section is c	onducted, that may					

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Event ID:

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PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/01/2023	
	PROVIDER OR SUPPLIEI			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	†	limited to the following:					
		-scale exercise that is					
	community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a						
	set of problem sta						
	messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct						
	1	he emergency plan twice					
		spice must do the following:					
	1 ' '	an annual full-scale exercise					
	that is community						
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ıct an annual individual					
	facility-based fund	ctional exercise; or					
		experiences a natural or					
	1	ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event	dditional annual exercise					
		but is not limited to the					
	following:	sat is not innited to the					
	_	-scale exercise that is					
		or a facility based					
	functional exercis	-					
	(B) A mock disas						
		ercise or workshop led by a					
		udes a group discussion					
	using a narrated,	- .					
	_	rio, and a set of problem					

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Event ID:

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PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689		JILDING	NSTRUCTION	СОМ	E SURVEY PLETED 1/2023	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AD DEFICIENCY)	OULD BE	(X5) COMPLETION	
TAG	statements, direct questions designe emergency plan. (iii) Analyze the h maintain document exercises, and en	ted messages, or prepared ed to challenge an hospice's response to and intation of all drills, tabletop hergency events and revise ergency plan, as needed.		TAG			DATE	
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu- facility-based func (B) If the [PRTF, I an actual natural that requires activ plan, the [facility] its next required f	PRTF, Hospital, CAH] must sto test the emergency ar. The [PRTF, Hospital, stollowing: an annual full-scale exercise						
	following the onse (ii) Conduct of the conduct of the follomate of the following of the fol	et of the emergency event. an [additional] annual nat may include, but is not wing: -scale exercise that is l or individual, a ctional exercise; or ock disaster drill; or o exercise or workshop that tor and includes a group a narrated, emergency scenario, and a						

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689		UILDING	NSTRUCTION	СОМ	E SURVEY PLETED 11/2023	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
	1			1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENC!		DATE	
	and maintain doci	mergency plan. he [facility's] response to umentation of all drills, s, and emergency events cility's] emergency plan, as						
	*[For PACE at §4(2) Testing. The Foonduct exercises plan at least annuorganization must (i) Participate in a that is community (A) When a community (A) When a community (B) If the PACE error man-made emactivation of the error is exempt from error full-scale community facility-based functionset of the emer (ii) Conduct at 2 years opposite to functional exercise.	PACE organization must a to test the emergency hally. The PACE and the following: an annual full-scale exercise abased; or munity-based exercise is not act an annual individual, actional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE agaging in its next required mity based or individual, actional exercise following the gency event. In additional exercise every the year the full-scale or expended and the paragraph (d)(2)(i) conducted that may include,						
	(A) A second full-	scale exercise that is or individual, a facility exercise; or						
	(C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem sta messages, or pre	ercise or workshop that is and includes a group a narrated, emergency scenario, and a itements, directed pared questions designed						
	to challenge an e	mergency plan.	ı					

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PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689		UILDING	NSTRUCTION	СОМ	e survey pleted 11/2023
	PROVIDER OR SUPPLIER		•	2400 C0	.DDRESS, CITY, STATE, ZIP COI DLLEGE AVE N, IN 46526	D	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION
	,				CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	
PREFIX TAG	(iii) Analyze the F maintain documer exercises, and en the PACE's emergence at the PACE's emergence at the PACE's emergence at the emergency properties to test the emergency properties at the emerge	ity] must conduct exercises ency plan at least twice per cannounced staff drills using occdures. The [LTC facility, the following: an annual full-scale exercise elased; or nunity-based exercise is not uct an annual individual, etional exercise. Elity] facility experiences an man-made emergency that in of the emergency plan, the empt from engaging its next ale community-based or based functional exercise et of the emergency event. dditional annual exercise		PREFIX TAG	(EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP	ULD BE	COMPLETION DATE
	following:	but is not limited to the					
	, ,	-scale exercise that is					
	community-based based functional e	l or an individual, facility					
	(B) A mock disas						
		ercise or workshop that is					
	led by a facilitator	•					
	discussion, using	- ·					
		emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an e						
		LTC facility] facility's					
		naintain documentation of					
	all drills, tabletop	exercises, and emergency					1

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PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155689	î í	UILDING	nstruction 	COMPL 02/01/	LETED
	ROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	events, and revise emergency plan, a	the [LTC facility] facility's as needed.					
	exercises to test the twice per year. The following: (i) Participate in any that is community- (A) When a community- (A) When a community- (B) If the ICF/IID enders and the isexempt from endill-scale community-based functions of the emerging of the emer	cr/IID must conduct the emergency plan at least the ICF/IID must do the an annual full-scale exercise thased; or unity-based exercise is not ct an annual individual, tional exercise; or. experiences an actual ade emergency that requires mergency plan, the ICF/IID gaging in its next required ity-based or individual, tional exercise following the gency event. ditional annual exercise out is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or rcise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed					
	*[For HHAs at §48	4.102]					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689		UILDING	NSTRUCTION	COMP	E SURVEY PLETED 1/2023
	PROVIDER OR SUPPLIEI		<u>, </u>	2400 C0	DDRESS, CITY, STATE, ZIP COD DLLEGE AVE N, IN 46526	<u>.</u>	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE
1710	 	e HHA must conduct	+	1710			Dille
		he emergency plan at					
		e HHA must do the					
	following:	io i ii ii i ii ii ii ii ii ii ii ii ii					
		full-scale exercise that is					
	community-based						
	1	community-based exercise					
	, ,	conduct an annual					
		based functional exercise					
	every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual,						
	facility based fund	ctional exercise following the					
	onset of the emer	gency event.					
	' '	lditional exercise every 2					
		ne year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is o						
		limited to the following:					
	, ,	full-scale exercise that is					
	community-based						
		ctional exercise; or					
	, ,	isaster drill; or					
		p exercise or workshop that					
	_	tor and includes a group					
	discussion, using						
	· ·	emergency scenario, and a atements, directed					
		pared questions designed					
	to challenge an e	·					
		HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
		interpretation of the second o					
	*[For OPOs at §4	86.3601					
		e OPO must conduct					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTII A. BUILDII B. WING	PLE CONSTRUCTION NG <u></u>	(X3) DATE SURVEY COMPLETED 02/01/2023
	PROVIDER OR SUPPLIE		24	REET ADDRESS, CITY, STATE, ZIP COD 00 COLLEGE AVE DSHEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE
	exercises to test to OPO must do the (i) Conduct a paper or workshop at least exercise is led by group discussion, relevant emergent problem statemer prepared question emergency plan. actual natural or requires activation OPO is exempt for required testing exercises, and enthe [RNHCl's and needed. *[RNCHIs at §40: (d)(2) Testing. The exercises to test to RNHCl must do the conduct a paper at least annually. Group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain document exercises, and enthe RNHCl's emergency	he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ats, directed messages, or as designed to challenge an afthe OPO experiences an anan-made emergency that an of the emergency plan, the own engaging in its next exercise following the onset event. PO's response to and anation of all tabletop and anation of all tabletop and anation of all tabletop aregency events, and revise OPO's] emergency plan, as	E 0039	E039 – EP Testing	02/17/2023
	failed to conduct ar to test the emergen	a additional exercise of choice by plan at least twice per year. ust do the following:	L 0039	Requirements It is the practice of this facility participate in an annual full-s	ı to

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	ONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u></u>	COMPLETE	D
		155689	B. W	/ING		02/01/202	23
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			OLLEGE AVE		
MAJEST	IC CARE OF GOSH	IEN			EN, IN 46526		
	T				· 	ı	(V.F.)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) OMPLETION
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	DATE
IAU		annual full-scale exercise that	+	IAU	exercise that is community ba	eed lee	DATE
	is community-based				a mock disaster drill, or tableto		
	1	ity-based exercise is not					
		-			exercise designed to challeng		
	accessible, conduct an annual individual, facility-based functional exercise.				the Emergency Preparedness Plan.		
	1	y experiences an actual natural			1 Iall.		
		gency that requires activation			What corrective action(s) wil	,	
	I -	lan, the LTC facility is exempt			be accomplished for those	'	
	from engaging its next required full-scale in a				residents found to have been	,	
	community-based or individual, facility-based				affected by the deficient	'	
	full-scale functional exercise for 1 year following				practice:		
	the onset of the actual event.				The policy related to emergen	CV	
	(ii) Conduct an additional exercise that may				preparedness training and tes		
	include, but is not limited to the following:				has been reviewed and update	·	
	a. A second full-sca	_			be included in the Emergency		
		or an individual, facility-based			Preparedness Plan. An additi		
	functional exercise.				table top drill was executed ar		
	b. A mock disaster				reviewed with the entire team.		
		se or workshop that is led by a			Tovioned war are chare teams		
	_	des a group discussion, using			How other residents having	the	
		y-relevant emergency scenario,			potential to be affected by th		
	·	n statements, directed		same deficient practice will be			
	_	red questions designed to			identified and what correctiv		
	challenge an emerg	-			action(s) will be taken:		
	(iii) Analyze the LT	C facility's response to and			All residents have the potentia	ıl to	
	maintain documenta	ation of all drills, tabletop			be affected by this deficient		
		gency events, and revise the			practice. The policy related to		
	LTC facility's emer	gency plan, as needed in			emergency preparedness train	ning	
	accordance with 42	CFR 483.73(d)(2). This			and testing has been reviewed	d and	
	deficient practice co	ould affect all occupants.			updated to be included in the		
					Emergency Preparedness Pla	n.	
	Findings include:				The facility will plan dates for		
					participation for all annual		
		view with the Maintenance			exercises.		
		3 at 9:54 a.m., there was					
	1	th the fire department in			What measures will be put ir	ito	
	_	but documentation of an			place or what systemic		
		xercise of choice within the last			changes will be made to		
	1 -	ble for review. Based on			ensure that the deficient		
	interview at the tim	e of records review, the			practice does not recur:		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION _ 		ESURVEY LETED 1/2023
	PROVIDER OR SUPPLIEF		2400 C	ADDRESS, CITY, STATE, ZIP COLLEGE AVE EN, IN 46526	COD	
(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 CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	exercise of choice values 12 months. This finding was re	tor stated an additional annual was not conducted within the viewed with the Assistant and Maintenance Director ference.		All staff will be in-serve before 2/17/2023. The will be conducted by the Director or Designee as include a review of the Preparedness Plan, Procedures; including requirement for annual exercises. The Execut Director/Designee will Emergency Prepared monthly during QAPI to ensure compliance maintained and policies/procedures at and updated as approximate to ensure compliance will be monitored to deficient practice will recur, i.e., what quality assurance program winto place: Ongoing compliance will be though the facility Quality Assurance and Perfor Improvement Program Executive Director/Debe responsible for revene Emergency Prepared monthly in QAPI for at months and annually; will ensure that sched full-scale exercises are through. If 100% connot achieved an action developed. Findings submitted to the Quality Assurance and Performance and Performanc	is in-service the Executive and will the Emergency colicies, and the the la full-scale utive I audit the mess Plan and annually is the reviewed topriate. ction(s) the la not tity will be put with this the monitored topriate will the mess Plan the la full-scale utive the mess Plan and annually is the reviewed topriate. ction(s) the monitored topriate will the mess Plan the least 6 this review the la annual the followed the followed mpliance is the pill be tity	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/01/2023	
	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 LISC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	Improvement Committee for reand follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/202		DATE
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this s §483.73(e), §485.4 (e) Emergency an The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location requir Care Facilities Cool Interim Amendme 12-4, TIA 12-5, an Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or buildir	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. Individual the CAH] must ency and standby power the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new of when an existing					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 02/01/2023				ETED	
	OVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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
TAG ETT irr irr f C 4 E a s h p e *I § T ttr re F 5 ttr Y Irr B A (I)	Emergency general The [hospital, CAI-mplement the emenspection, testing, equirements foundations are also and LTC facilities]. Source to power enamergency general and LTC facilities] source to power enamergency, unless are appeared to the standards income and the standards income section are appeared to the standards income section are appeared to the material from the material at NA poto:	ator inspection and testing. If and LTC facility] must ergency power system and [maintenance] do in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) and fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency erational during the sit evacuates. 3.482.15(h), LTC at AHs §485.625(g):] corporated by reference in proved for incorporation by Director of the Office of the accordance with 5 U.S.C. part 51. You may obtain the sources listed below. In a copy at the CMS arce Center, 7500 Security fore, MD or at the National bords Administration mation on the availability of a RA, call 202-741-6030, or es.gov/federal_register/code				TE	
If ir d a ('	f any changes in t ncorporated by re locument in the Fo announce the chai	rotection Association, 1					
	Quincy, MA 02169						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 02/01/2023					
	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		D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	2012 edition, issued (ii) Technical inter NFPA 99, issued A (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Lit edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xii) NFPA 110, S Standby Power Sy including TIAs to a 2009 Based on records refailed to implement requirements found Code, NFPA 110, a accordance with 42 deficient practice corrections of the control of th	FPA 99, issued August 9, FPA 99, issued March 7, PA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012	E 0041	E041 – Hospital CAH and LTC Emergency Power It is the practice of this facility ensure emergency generators properly tested and document as required by LSC and NFPA What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The facility generators have be	are ed		

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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	(X3) DATE SURVEY COMPLETED 02/01/2023	
	ROVIDER OR SUPPLIER		2400	T 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 APPROPE DEFICIENCY)	(X5) COMPLETION DATE
TAG	required by LSC an interview at the time	d NFPA 110. Based on e of record review, the	IAG	placed on weekly testing tha require documentation.	
	interview at the time Maintenance Direct were missing proper required testing. This finding was re-	e of record review, the or agreed both generators r documentation and some viewed with the Assistant and Maintenance Director			the the be tive tial to to to tiewed in the dan. ced tieve tial to tieve tiev
			1	Policies/brocedures are tevie	weu

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	OF CORRECTION	IDENTIFICATION NUMBER 155689	A. BUILDING B. WING		COMPLETED 02/01/2023
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0000				and updated as appropriate. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto 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 "TELS" weekly for 4 we and monthly for at least 6 months. If 100% compliance not achieved an action plan will developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for mand follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	out stored will g the eeks e is vill be
Bldg. 01	Licensure Survey w		K 0000	The creation and submission this plan of correction does constitute an admission by provider of any conclusion forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these	not this set tion

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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	01	COMPL	ETED
		155689	B. W	ING _		02/01/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				OLLEGE AVE		
ΜΔ ΙΕςΤ	IC CARE OF GOSH	IEN			EN, IN 46526		
WI WEST	00/11/2 01 0001	ILIV		000112			
(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
	Provider Number:				findings we respectfully		
	AIM Number: 1002	290080		request a desk review in lieu of			
					a traditional revisit.		
	-	Code survey, Majestic Care of					
		not in compliance with					
	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the						
	National Fire Protection Association (NFPA) 101,						
	Life Safety Code (LSC) and 410 IAC 16.2.						
	This one story facility was determined to be of Type V (111) construction and was fully sprinklered with the exception of the spee behid						
	_	lity has a fire alarm system					
	-	on in the corridors and in areas					
		s. The resident rooms are					
	_	e station, hard wired smoke					
	-	ding is partially protected by					
		gas powered emergency					
		ility has a capacity of 186 and					
	had a census of 137	at the time of this survey.					
	All areas where resi	dents have customary access					
	were sprinklered. T	The facility had a storage shed					
	on the roof that was	not sprinklered and two					
		zed storage sheds used for					
	storage by the facili	ty that were not sprinklered.					
	Quality Review con	npleted on 02/06/23					
K 0211	NFPA 101	_					
SS=E	Means of Egress -						
Bldg. 01	Means of Egress -						
	Aisles, passagewa	-					
	_	cations, and accesses are					
		n Chapter 7, and the means					
	-	uously maintained free of					
	all obstructions to						
	emergency, unles	s modified by 18/19.2.2					

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MU		2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPLETED	
		155689	B. W	ING		02/01/2023	
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
NAA IEGT	10 04 DE 05 000L	IENI			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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	through 18/19.2.1	1.					
	18.2.1, 19.2.1, 7.1	1.10.1					
	Based on observation	on and interview, the facility	K 0	211	K211 – Means of Egress –		02/17/2023
	failed to maintain 1	of 12 exit discharges doors			General		
	were free of impedi	ments to full instant use in the			It is the practice of this facility	to	
	case of fire or other	emergency in accordance with			ensure exit discharge doors a		
	LSC 7.1.10.1. LSC	7.2.1.7.1 states where a door			free of impediments to full inst		
	assembly is require	d to be equipped with panic or			use in the case of fire or other		
	fire exit hardware, ((3) It shall be constructed so			emergency.		
	that a horizontal for	rce not to exceed 15 lbf (66 N)					
	actuates the cross b	ar or push pad and latches.			What corrective action(s) wil	ı	
	This deficient pract	ice could 30 residents in the			be accomplished for those		
	Cedar Wing.				residents found to have been	n	
					affected by the deficient		
	Findings include:				practice:		
					The Cedar Wing dining room	exit	
	Based on observation	ons with the Maintenance		door was adjusted to ensure the			
	Director on 02/01/2	3 at 12:33 p.m., the Cedar Wing		door opens immediately when		ı	
	dining room exit do	oor was equipped with panic			pressed.		
	hardware, but the de	oor would not open on the					
	first try. It took the	Maintenance Director three			How other residents having	the	
	_	or and took excessive force to			potential to be affected by th	ie	
	_	e fourth try. Based on			same deficient practice will be	эе	
		e of observation, the			identified and what correctiv	e	
		tor stated the door is sticking			action(s) will be taken:		
	on the frame and w	ill need to be adjusted.			All residents residing on Ceda	r	
					Wing have the potential to be		
		viewed with the Assistant			affected by this deficient pract	ice.	
	_	and Maintenance Director			The Maintenance		
	during the exit conf	erence.		Director/Designee will be			
					responsible for completing QA		
	3.1-19(b)				audit tool "Life Safety Rounds"	,	
					3x/week for the first month,		
					2x/week for the second month		
					and weekly for at least 6 mont	.hs.	
					What measures will be put in	ito	
					place or what systemic		
					changes will be made to		
				ensure that the deficient			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. Building <u>01</u>			COMPLETED	
		155689	B. WING 02/0			02/01/	2023
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NEARLOS CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TC	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
					practice does not recur: All staff will be in-serviced on before 2/17/2023. This in-servill be conducted by the Maintenance Director or Designed and will include a review of most of egress. The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to ensure though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designed will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance in not achieved an action plan will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow-up. By what date the systemic changes will be	vice gnee eans API " the ut ored ee ting d t 6 is ill be	

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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	onstruction 01	CON	TE SURVEY MPLETED 01/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
				completed: 02/17/20 Compliance Date =			
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special locking arresponding to the special lock or locks or	king arrangements for the seds of the patient are eking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the					

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED			
		155689	B. WING		02/01/2023			
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN			2400 C	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)	COMPLETION DATE			
	upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT: Approved, listed of systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, supe detection system of automatic sprinkled 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblied throughout by an a	2.2.5.2, TIA 12-4 SS LOCKING S lelayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 OLLED EGRESS NGEMENTS I Egress Door assemblies lance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in 2.1.6.3 shall be permitted les in buildings protected approved, supervised ection system and an sed automatic sprinkler						
	Based on observation failed to ensure 2 of arrangements were LSC 7.2.1.6.1(3) which process shall release egress within 15 secapproved by the automatical security of the secapproved by the automatical secaps.	on and Interview, the facility of 10 delayed egress locking installed in accordance with hich states an irreversible the lock in the direction of conds, or 30 seconds where hority having jurisdiction, a force to the release device	K 0222	K222 – Egress Doors It is the practice of this facility ensure all delayed egress lock arrangements are installed an functioning properly. What corrective action(s) will be accomplished for those	king d			
		10 under all of the following		residents found to have been affected by the deficient	1			

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(a) The force shall not be required to exceed 15 lbf

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ЛLDING	01	COMPLETED	
		155689	B. W	ING		02/01/2	2023
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	NOVIDER OR SUPPLIER	•		2400 C	OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN		GOSHEN, IN 46526			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	(67 N).	.1			A) The exit door in the Main		
		not be required to be			Dining has been adjusted and	IS	
		d for more than 3 seconds.			functioning properly.		
	1 1	the release process shall			B) The exit door near room 3	317	
		signal in the vicinity of the			has been adjusted and is		
	door opening. (d) Once the lock has	as been released by the			functioning properly.		
		to the releasing device,			How other residents having	the	
		y manual means only. This			potential to be affected by th		
	_	ould affect 30 residents and			same deficient practice will be		
	_	ning and 300 hall area			identified and what correctiv		
					action(s) will be taken:	Ĭ	
Findings include:				All residents have the potentia	al to		
	8				be affected by this deficient		
	Based on observation	on during a tour of the facility			practice. The Maintenance		
		ce Director and House			Director/Designee will be		
	Keeping Director or	n 02/01/23 between 12:00 p.m.			responsible for completing QAPI		
	and 2:45 p.m., the f	following was noted:		audit tool "Life Safety Rounds"			
	a) The exit door in t	the Main Dining area was		3x/week for the first month,			
	equipped with 15 se	econd delay egress		2x/week for the second month,			
	arrangements. When	n tested, it took 3 tries to		and weekly for at least 6 months.			
	activate the delayed	l egress function.					
		ar room 317 had delayed egress			What measures will be put in	nto	
		ed egress did not activate on		place or what systemic			
		y, the second try activated the	changes will be made to				
	function, but took lo	onger than 15 seconds.			ensure that the deficient		
					practice does not recur:		
		reviewed with the Maintenance			All staff will be in-serviced on		
		ant Director of Nursing during			before 2/17/2023. This in-serv	vice	
	the exit conference.				will be conducted by the		
	2.1.10/13				Maintenance Director or Design	-	
	3.1-19(b)				and will include a review of eg	ress	
					doors. The Maintenance		
					Director/Designee will be	, DI	
					responsible for completing QA		
					audit tool "Life Safety Rounds"		
					3x/week for the first month,		
					2x/week for the second month and weekly for at least 6 month		
					and weekly for at least of IIIOIII	u 13.	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/01/2023				
	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION			
				How the corrective action will be monitored to ensu deficient practice will not recur, i.e., what quality assurance program will be into place: Ongoing compliance with the corrective action will be monitored to action will be monitored to action will be monitored and Performance Improvement Program. The Maintenance Director/Desi will be responsible for come QAPI audit tool "Life Safety Rounds" 3x/week for the firm month, 2x/week for the seemonth, and weekly for at lemonths. If 100% complianed to the Quality Assurance and Performance Improvement Committee for and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	e put his onitored be e gnee pleting rest cond cast 6 ce is a will be e ce			
K 0232 SS=E Bldg. 01	unobstructed) ser at least 4 feet and	Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the all of nonambulatory patients ept as modified by						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED				
		155689	B. W	ING		02/01/2023		
NAME OF P	DOMNED OF CURRITER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF P	PROVIDER OR SUPPLIER			2400 C	OLLEGE AVE			
MAJESTI	IC CARE OF GOSH	HEN		GOSHEN, IN 46526				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRI		(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	77. ^	TAG		DATE		
		on and interview, the facility	K 0	232	K232 – Aisle, Corridor, or Ra	mp 02/17/2023		
		lear width requirement for 2 of 3			Width	,		
		Wing or met an exception per			It is the practice of this facility			
		nich states where the corridor			ensure clear width is met for a	111		
		eet, projections into the l be permitted for fixed			corridors.			
	_	that all of the following			What corrective action(s)!	.		
	conditions are met:	mai an or me ronowing			What corrective action(s) will be accomplished for those			
		re is securely attached to the			residents found to have been	,		
	floor or to the wall.				affected by the deficient	'		
		re does not reduce the clear			practice:			
	unobstructed corridor width to less than six feet,				A. The chairs in the corridor	bv		
	except as permitted				the Cedar nurses station were	·		
		re is located only on one side			removed and staff educated o			
	of the corridor.	•			corridor width requirements.			
		are is grouped such that each			B. The recliners stored in the	;		
		exceed an area of 50 square						
	feet.	_			removed and staff have been			
	(e) the fixed furnitu	re groupings addressed in		educated on corridor width				
	19.2.3.4(5) (d) are s	separated from each other by a			requirements.			
	distance of at least							
	1 1	re is located so as to not			How other residents having			
		uilding service and fire			potential to be affected by th	II.		
	protection equipmen				same deficient practice will be			
		hout the smoke compartment			identified and what correctiv	е		
		electrically supervised			action(s) will be taken:			
		etection system in accordance			All residents have the potentia	al to		
		ixed furniture spaces are			be affected by this deficient			
	_	d to allow direct supervision			practice. The Maintenance			
		from a nurse's station or similar			Director/Designee will be	.DI		
	space.	continuant is protected			responsible for completing QA			
		partment is protected proved, supervised automatic			audit tool "Life Safety Rounds"			
		accordance with 19.3.5.8			3x/week for the first month,			
	1 -	ice could affect 40 residents			2x/week for the second month and weekly for at least 6 month			
	Cedar Wing.	ice could affect 40 festuents			and weekly for at least 6 mont	uio.		
	Codai Willig.				What measures will be put in	nto		
	Findings include:				place or what systemic	110		
	i mamga metade.				changes will be made to			
	Based on observation	on with the Maintenance			ensure that the deficient			
1	_ ===================================		1		Jingara triat tria delibrollt	i		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPI 02/01	LETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRIATE DEFICIENCY)			
	chairs in the corridor extending about two corridor and were n wall when tested. A corridor had 8 reclipobstructing the corrinterview at the time Maintenance Direct securely attached to tested and recliners corridor.	3 at 1:04 p.m., there were three or by the Cedar nurses station of-feet into the eight-foot of affixed to the floor or to the clso, the Cedar annex exit mers stored in the hall idor by 4 feet. Based on the of the observations, the corragreed the chairs were not to the floor or to the wall when are being stored in a exit wiewed with the Assistant and Maintenance Director derence.		practice does not recu All staff will be in-service before 2/17/2023. This will be conducted by the Maintenance Director of and will include a review of egress and corridor w requirements. The Main Director/Designee will be responsible for complete audit tool "Life Safety R 3x/week for the first mod 2x/week for the second and weekly for at least of How the corrective act will be monitored to endeficient practice will r recur, i.e., what quality assurance program wi into place: Ongoing compliance wideorrective action will be though the facility Quality Assurance and Perform Improvement Program. Maintenance Director/D will be responsible for c QAPI audit tool "Life Sa Rounds" 3x/week for the month, 2x/week for the month, and weekly for a months. If 100% compl not achieved an action of developed. Findings wi submitted to the Quality Assurance and Perform Improvement Committe and follow-up. By what date the system	ed on or in-service er Designee v of means vidth intenance be ing QAPI ounds" inth, month, 6 months. ion(s) insure the not via monitored ty in ince in ingerial inge		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING B. WING	01	COMPLETED 02/01/2023			
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0324 SS=E	NFPA 101 Cooking Facilities			changes will be completed: 02/17/2023 Compliance Date = 02/17/202	3		
Bldg. 01	Cooking Facilities Cooking equipmer accordance with N Ventilation Control Commercial Cooking residential cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartmen patients comply wi 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer pacconditions under 1 Cooking facilities p NFPA 96 per 9.2.3 enclosed as hazar be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observation failed to ensure staff switch for 1 of 1 coo LSC 19.3.2.5.4 state residential or commis used to prepare m	IFPA 96, Standard for and Fire Protection of and Fire Protection of and Operations, unless: and equipment (i.e., small smicrowaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer in the conditions under 5.3, or in smoke compartments attents comply with 8.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be adous areas, but shall not ridor. 18.3.2.5.4, 19.3.2.5.1	K 0324	K324 – Cooking Facilities It is the practice of this facility ensure staff have access to necessary shutoff switches. What corrective action(s) will be accomplished for those			

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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	01	COMPL	ETED
		155689	B. W	ING	02/01/2023		
		<u> </u>	<u> </u>	CTDEET /	ADDRESS CITY STATE ZID COD	I	
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
MAILOT	IC CARE OF GOSH	JEN .		2400 COLLEGE AVE GOSHEN, IN 46526			
IVIAJEST	OARE OF GOSP	TEIN		GOSHE	=in, iin 40020 		
(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
	facility complies w	ith all of the following			residents found to have been	n	
	conditions:				affected by the deficient		
		ining the cooking equipment			practice:		
	is not a sleeping roo				Contractors have been sched	uled	
		ining the cooking equipment			to install switch for staff acces	s to	
	_	rom the corridor by partitions			necessary shut off for the coo	ktop	
		3.6.2 through 19.3.6.5.			in the therapy gym.		
		ts of 19.3.2.5.3(1) through (10)					
	and (13) are met.				How other residents having		
	1 1	A switch meeting all of the			potential to be affected by th		
	following is provide				same deficient practice will be		
		, or a switch located in a		identified and what corrective			
	restricted location, is provided within the cooking				action(s) will be taken:		
	1	ates the cooktop or range.			All residents in the therapy gy		
	1 ' '	sed to deactivate the cooktop			have the potential to be affect	ed	
	_	the kitchen is not under staff	by this deficient practice. The				
	supervision.		Maintenance Director/Designee				
	1	ice could affect five residents	will be responsible for completing				
	in the therapy gym.				QAPI audit tool "Life Safety		
			Rounds" 3x/week for the first				
	Findings include:		month, 2x/week for the second				
					month, and weekly for at least	6	
		on with the Maintenance			months.		
		3 at 2:14 p.m., there was a					
	_	apy gym that was separated			What measures will be put into		
		out staff were unable to		place or what systemic			
		top from power. Based on			changes will be made to		
		e of observation, the			ensure that the deficient		
		tor was asked if staff were able			practice does not recur:		
		oktop and lock the switch.			All staff will be in-serviced on		
		Director stated no, staff do not			before 2/17/2023. This in-ser	vice	
	nave access to disco	onnect power to the stove.			will be conducted by the		
	TE1 ' C' 1'	1 11 11 1 1 1 1 1			Maintenance Director or Design	-	
	I -	viewed with the Assistant			and will include a review of sh	ut off	
	1	and Maintenance Director			switches; location and use as		
	during the exit conf	erence.			neccessary. The Maintenance	е	
	21.10(1)		1		Director/Designee will be		
	3.1-19(b)				responsible for completing QA		
					audit tool "Life Safety Rounds"	"	
			1		3x/week for the first month,		l

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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	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/01/2023			
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				2x/week for the second month and weekly for at least 6 month	•		
				How the corrective action(s) will be monitored to ensure a deficient practice will not recur, i.e., what quality assurance program will be p into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designal will be responsible for comple QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance not achieved an action plan will 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: 02/17/2023 Compliance Date = 02/17/2023	the ut ored ee ting d t 6 is ill be eview		
K 0346 SS=C Bldg. 01	Fire Alarm - Out of Where required fi services for more period, the autho	m - Out of Service of Service re alarm system is out of than 4 hours in a 24-hour rity having jurisdiction shall ne building shall be					

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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 01 B. WING 02/01/2023 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 COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility K 0346 02/17/2023 K346 – Fire Alarm System – Out failed to provide a complete 1 of 1 written policy of Service for the protection of residents indicating It is the practice of this facility to procedures to be followed in the event the fire ensure a policy is provided for the alarm system has to be placed out of service for protection of residents indicating four hours or more in a twenty-four-hour period in procedures to be followed in the accordance with LSC, Section 9.6.1.6. This event the fire alarm system has to deficient practice affects all occupants. be placed out of service for four hours or more in a twenty-four Findings include: hour period. Based on observation with the Maintenance What corrective action(s) will Director on 02/01/23 at 10:24 a.m., the fire watch be accomplished for those plan stated to contact the department of health residents found to have been but failed to include contacting the Indiana affected by the deficient Department of Health via the IDOH Gateway link practice: at https://gateway.isdh.in.gov as the primary The fire watch policy has been method or by the secondary method when the updated to include contacting the IDOH Gateway is nonoperational by completing Indiana Department of Health via the Incident Reporting form and e-mailing it to the IDOH Gateway link or by incidents@isdh.in.gov. Also, the fire watch plan secondary method as well as stated to contact the fire department, insurance contact updates to all local fire carrier, facility operator, and mongering company departments, insurance carriers, but the space to list phone numbers was blank. and facility operator. Based on interview during the record review, the Administrator acknowledged the fire watch How other residents having the documentation provided stated to contact the potential to be affected by the department of health but not via the IDOH same deficient practice will be Gateway link or at the e-mail address listed above identified and what corrective and the other contacts were left blank. action(s) will be taken: All residents have the potential to This finding was reviewed with the Assistant be affected by this deficient Director of Nursing and Maintenance Director practice. The policy related to the during the exit conference. protection of residents indicating procedures to be followed in the

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/01/2023			
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CCTION (X5) ULD BE PROPRIATE COMPLETION DATE			
	3.1-19(b)			event the fire alarm syste be placed out of service hours or more in a twent hour period has been recupdated, and included in emergency preparedness all staff have been educated policy. What measures will be place or what systemic changes will be made to ensure that the deficient practice does not recurted before 2/17/2023. This is will be conducted by the Maintenance Director or and will include a review watch policy and reporting requirements. The Exect Director/Designee will at Emergency Preparedness monthly during QAPI and to ensure compliance is maintained and policies/procedures are and updated as appropriate the corrective active will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will into place: Ongoing compliance with corrective action will be a though the facility Quality Assurance and Performating Improvement Program.	for four ty-four viewed, in the ss plan and ated on put into o nt : ed on or in-service Designee or of fire ing cutive cudit the iss Plan id annually reviewed iate. on(s) sure the iot I be put th this is monitored by annoe			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	X3) DATE SURVEY COMPLETED 02/01/2023
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0351 SS=E Bldg. 01	by construction ty throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II con protection measur substituted for spring areas where state sprinklers. In hospitals, spring clothes closets of where the area of 6 square feet and	Installation nd hospitals where required		Executive Director/Designee value be responsible for reviewing the Emergency Preparedness Pla monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/202	ne n 6 n

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Standard for Installation of Sprinkler

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	
	TICATION NUMBER	A. BU	ILDING	01	COMPLETED	
15568	39	B. WI	NG		02/01/	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 STATEME	ENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUST	T BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG REGULATORY OR LSC IDE	NTIFYING INFORMATION		TAG	DEFICIENCY		DATE
Systems. 19.3.5.1, 19.3.5.2, 19.3.5.1 19.3.5.5, 19.4.2, 19.3.5.1 Based on observation and ir failed to provide an automat that provided complete cove compartments. This deficie 10 staff. Findings include: Based on observation on 02 p.m. and 2:45 p.m. during a the Maintenance Director at Manager, in the laundry roo behind three dryers which w sprinkler head could be loca at the time of observation. Ethe time of observation, the acknowledged a sprinkler head could not confirm if the coverage in the room. This finding was reviewed w Director of Nursing and Mathe exit conference. 3.1-19(b)	20, 9.7, 9.7.1.1(1) Interview, the facility Itic sprinkler system Berage in 1 of 5 smoke Interview and practice could affect 201/23 between 12:00 101/23 between 12:00 101/23 between 12:00 101/24 tour of the facility with 101/25 determine was a room 101/26 are gas powered. No 101/26 are gas powered. No 101/26 are gas powered. No 101/26 are gas powered at Maintenance Director	K 03	351	K351 – Sprinkler System – Installation It is the practice of this facility provide an automatic sprinkler system that covers all smoke compartments. What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice: All residents have the potential be affected by this deficient practice. Vendor contacted to install sprinkler heads behind dryers in laundry room. 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. The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month. What measures will be put in place or what systemic changes will be made to ensure that the deficient	the see all to	02/17/2023

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T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/01/2023	
ROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
C CARE OF GOSH SUMMARY S (EACH DEFICIEN			2400 C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) practice does not recur: The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds 3x/week for the first month, 2x/week for the second month and weekly for at least 6 mon How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be p into place: Ongoing compliance with this corrective action will be monit though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designe will be responsible for comple QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the secon month, and weekly for at leas months. If 100% compliance not achieved an action plan w developed. Findings will be submitted to the Quality	API " ths. the ored ee ting d t 6 is	(X5) COMPLETION DATE
				Assurance and Performance Improvement Committee for reand follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/202		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	O1 COMPLETED		ETED
		155689	B. W	NG		02/01/	2023
	ROVIDER OR SUPPLIER		<u> </u>	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0352	NFPA 101						
SS=E	•	- Supervisory Signals					
Bldg. 01	•	- Supervisory Signals					
	•	er system supervisory					
		nstalled and monitored for					
		ance with NFPA 72,					
		n and Signaling Code, and					
		at sounds and is displayed					
	-	attended location or					
		facility when sprinkler					
	operation is impair	red.					
	9.7.2.1, NFPA 72	1			Kara Control Control		
		on and interview, the facility	K 0	352	K352 – Sprinkler System –		02/17/2023
		nonitoring of 1 of 1 mechanical			Supervisory Signals		
		system in accordance with			It is the practice of this facility	to	
		9.3.5.1 states buildings			maintain monitoring of all		
		nomes shall be protected			mechanical penthouse sprinkle	er	
		proved, supervised automatic			systems.		
		accordance with Section 9.7. where supervised automatic			\A/\bat == \mu = \tau_1 = \tau_2 = \tau_1 = \tau	ī	
		re required by another section			What corrective action(s) will	l	
		visory attachments shall be			be accomplished for those residents found to have beer		
	-	ored for integrity in accordance			affected by the deficient	ı	
		ional Fire Alarm and Signaling			practice:		
		ive supervisory signal shall be			Vendor has been contacted to		
		a condition that would impair			repair wire control valve for		
	•	ration of the sprinkler system.			sprinkler line in maintenance		
		shall sound and shall be			office.		
		location within the protected			omos.		
		stantly attended by qualified			How other residents having t	he	
	-	pproved, remotely located			potential to be affected by th		
	•	his deficient practice affects			same deficient practice will b		
		ts in below the mechanical			identified and what corrective		
	penthouse.				action(s) will be taken:		
	_				All residents have the potentia	l to	
	Findings include:				be affected by this deficient		
	-				practice. The Maintenance		
	Based on observation	on with the Maintenance			Director/Designee will be		
	Director on 02/01/2	3 at 10:14 a.m., in the			responsible for completing QA	PI	
	maintenance office	there was a control valve on			audit tool "Life Safety Rounds"		

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NAME OF PROVIDER OR SUPPLIER IX4 ID SUMMAN STATEMENT OF DEFICIENCIE PREFIX TAG SUMMAN STATEMENT OF DEFICIENCIE CORPLETION DATE SX/Week for the first month, 2x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will be recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool 'Life Safety Rounds' 3x/week for the first Maintenance Director/Designee will be responsible for completing QAPI audit tool 'Life Safety Rounds' 3x/week for the first Maintenance Director/Designee will be responsible for completing QAPI audit tool 'Life Safety Rounds' 3x/week for the first Maintenance Director/Designee will be responsible for completing QAPI audit tool 'Life Safety Rounds' 3x/week for the first Maintenance Director/Designee will be responsible for completing Completion Comple	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			<i>'</i>	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF GOSHEN IX4) D SUMMARY STATEMENT OF DEFICIENCIE PREFX TAG REGULATORY OF LISC IDENTIFYING INFORMATION The sprinkler line that went to the sprinklers in the mechanical penthouse. The valve had an electrical monitoring box, but wires were hanging from the box and not hooked up to anything. Based on interview at the time observation, the Maintenance Director agreed the valve controlled the sprinklers in the mechanical penthouse and was not electronically supervised by the fire alarm system. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the second month, and weekly for at least 6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action (s) will be monitored through the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety S	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED
MAJESTIC CARE OF GOSHEN (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR ISC IDENTIFYING INFORMATION the sprinkler in that went to the sprinkler is the mechanical penthouse. The valve had an electrical monitoring box, but wires were hanging from the box and not hooked up to anything. Based on interview at the time observation, the Maintenance Director agreed the valve controlled the sprinkler is in the mechanical penthouse and was not electronically supervised by the fire alarm system. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.11-19(b) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the second month, and weekly for at least 6 months. How the corrective action(s) will be monitored to ensure the deficient practice does not recur: The Maintenance will be put into place or what systemic changes will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the second month, and weekly for at least 6 months. How the corrective action(s) will be monitored to ensure the deficient practice does not recur: The Maintenance will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety" and the program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety" and the program of the program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety" and the program of the program			155689	B. W	ING		02/01/2023
PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION the sprinkler line that went to the sprinklers in the mechanical penthouse. The valve had an electrical monitoring box, but wires were hanging from the box and not hooked up to anything. Based on interview at the time observation, the Maintenance Director agreed the valve controlled the sprinklers in the mechanical penthouse and was not electronically supervised by the fire alarm system. This finding was reviewed with the Assistant Director during the exit conference. 3.1-19(b) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety) Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety)				•	2400 C	OLLEGE AVE	
the sprinkler line that went to the sprinklers in the mechanical penthouse. The valve had an electrical monitoring box, but wires were hanging from the box and not hooked up to anything. Based on interview at the time observation, the Maintenance Director agreed the valve controlled the sprinklers in the mechanical penthouse and was not electronically supervised by the fire alarm system. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b) 3.1-19(b) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least 6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety	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 DEFICIENCY)	COMPLETION
system. This finding was reviewed with the Assistant Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b) The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety Rounds" 3x/week for the second month, and weekly for at least 6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing QAPI audit tool "Life Safety		the sprinkler line the mechanical penthous monitoring box, but box and not hooked interview at the time. Maintenance Direct the sprinklers in the	at went to the sprinklers in the use. The valve had an electrical twires were hanging from the up to anything. Based on e observation, the tor agreed the valve controlled e mechanical penthouse and			2x/week for the second month	Ι,
month, 2x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be		was not electronical system. This finding was re Director of Nursing during the exit confidence of the confidence of th	lly supervised by the fire alarm viewed with the Assistant and Maintenance Director			place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month. 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: Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designed will be responsible for complete QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance in the second months. If 100% compliance in the second months.	aPI , ths. the ut pred ee ting d 66 is

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 02/01/2023
	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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				submitted to the Quality Assurance and Performance Improvement Committee for re and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system	supply source			
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8 #1.) Based on recorfacility failed to main accordance with automatic sprinkler and maintained in a Standard for the Ins Maintenance of Wa Systems. NFPA 25	•	K 0353	K353 – Sprinkler Systems – Maintenance and Testing It is the practice of this facility t maintain sprinkler systems and ensure all automatic sprinkler systems shall be inspected and maintained. What corrective action(s) will	1

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 02/01/2023 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 testing. NFPA 25, 5.2.4.1 states gauges on wet be accomplished for those pipe sprinkler systems shall be inspected monthly residents found to have been and gauges on dry systems (5.2.4.2) shall be affected by the deficient inspected weekly to ensure normal water or air practice: pressure is being maintained. NFPA 25 13.3.2.1 1) All sprinklers have been states valves should be inspected weekly or placed on a monthly inspection valves secured locks or supervised (13.3.2.1.1) and documentation schedule in shall be permitted to be inspected monthly. This TELS. deficient practice could affect all occupants. 2) All sprinkler heads have been inspected and cleaned and Findings include: needed. Based on records review with the Maintenance How other residents having the Director on 02/01/23 between 09:45 a.m. and 12:00 potential to be affected by the p.m., there was no monthly inspection of the wet same deficient practice will be pipe sprinkler system's gauges and valves for the identified and what corrective past 12 months. Checks shown from the "TELS" action(s) will be taken: program, checks were documented as "N/A". All residents have the potential to During an interview at the time of record review, be affected by this deficient the Maintenance Director stated the inspections practice. The Maintenance of gauges and valves are conducted monthly, but Director/Designee will be could not upload documentation for confirmation. responsible for completing QAPI audit tool "Life Safety Rounds" #2.) Based on observation and interview, the 3x/week for the first month, facility failed to ensure 12 of 45 sprinkler heads of 2x/week for the second month, the exterior eaves, 3 of 5 sprinkler heads in and weekly for at least 6 months. laundry, and 1 of 2 sprinkler heads in room 125 were not loaded or covered with foreign material What measures will be put into in accordance with LSC 9.7.5. NFPA 25, 2011 place or what systemic edition, at 5.2.1.1.1 sprinklers shall not show signs changes will be made to of leakage; shall be free of corrosion, foreign ensure that the deficient materials, paint, and physical damage; and shall practice does not recur: be installed in the correct orientation (e.g., All staff will be in-serviced on or up-right, pendent, or sidewall). Furthermore, at before 2/17/2023. This in-service 5.2.1.1.2 any sprinkler that shows signs of any of will be conducted by the the following shall be replaced: (1) Leakage (2) Maintenance Director or Designee Corrosion (3) Physical Damage (4) Loss of fluid in and will include a review of egress the glass bulb heat responsive element (5) doors. The Maintenance Loading (6) Painting unless painted by the Director/Designee will be

sprinkler manufacturer. This deficient practice

responsible for completing QAPI

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED			
		155689	B. W	'ING		02/01/2023	
MAJEST	PROVIDER OR SUPPLIER	HEN	·	STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG		,,	DATE
	with the Maintenand between 12:00 p.m. sprinkler heads were signs of loading, a) 12 sprinkler head outside of Birch Willoaded with dirt and b) Three sprinkler he the dryers were covicy. One sprinkler head red fabric attack Based on interview Maintenance Direct aforementioned sprinaccumulation and load Findings were discurbirector of Nursing exit conference. 3.1-19(b)	on during a tour of the facility ce Director on 02/01/23 and 2:45 p.m. the following e covered in dust or showed as under the eaves on the mg and Dogwood Wing were dother foreign material needs in the laundry room near ered with dust and lint. and in the closet of room 125 heed to the deflector plate. at the time of observation, the or confirmed the inkler heads showed dirt			audit tool "Life Safety Rounds 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designe will be responsible for comple QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance not achieved an action plan will 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: 02/17/2023 Compliance Date = 02/17/2023	the ut ored d 6 is ill be	
K 0354 SS=C	NFPA 101	Out of Comics					
SS=C Bldg. 01	Sprinkler System - Sprinkler System -						
J.49. 01	Chillivici Olarelli.	Out of Oct vice	- 1		1		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/01/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	extent and duration been determined, are inspected and recommendations management or do and the fire depart having jurisdiction the sprinkler system than 10 hours in a building or portion evacuated or an aprovided until the returned to service 18.3.5.1, 19.3.5.1, Based on record reversity failed to provide 1 of the event the autom placed out-of-service 24-hour period in as 9.7.5. LSC 9.7.6 recomprocedures comply the Standard for the Maintenance of Wasystems. NFPA 25 procedures that the follow. A.15.5.2 (4) consist of trained period the affected and extinguishers and the fire department consider. During the should not only be I sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the other finding such as egal are available and further sure that the sure that the other finding such as egal are available and further sure that the other finding such as egal are available an	esignated representative, sment and other authorities have been notified. Where m is out of service for more 24-hour period, the of the building affected are pproved fire watch is sprinkler system has been	K 0354	K354 – Sprinkler System – Cof Service It is the practice of this facility ensure a policy is provided for protection of residents indicat procedures to be followed in the event the fire alarm system has be placed out of service for for hours or more in a twenty-four hour period. What corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice: The fire watch policy has bee updated to include contacting Indiana Department of Health the IDOH Gateway link or by secondary method as well as contact updates to all local fire departments, insurance carried and facility operator.	to r the ing he as to ur r II n the via	

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T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 02/01/2023	
ROVIDER OR SUPPLIER		2400	r address, city, state, zip cod COLLEGE AVE HEN, IN 46526		
SUMMARY S (EACH DEFICIEN REGULATORY OR Based on observation Director on 02/01/2 plan stated to contact but failed to include Department of Heal at https://gateway.is method or by the se IDOH Gateway is n the Incident Reporti incidents@isdh.in.g stated to contact the carrier, facility oper but the space to list Based on interview Administrator acknowledges documentation provide a transported to the state Gateway link or at the stand the other contact This finding was revenue.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION on with the Maintenance 3 at 10:24 a.m., the fire watch of the department of health of contacting the Indiana th via the IDOH Gateway link dh.in.gov as the primary condary method when the onoperational by completing ng form and e-mailing it to ov. Also, the fire watch plan fire department, insurance ator, and mongering company phone numbers was blank during the record review, the owledged the fire watch ided stated to contact the in but not via the IDOH the e-mail address listed above of the watch with the Assistant and Maintenance Director	2400	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) 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. The policy related to protection of residents indica procedures to be followed in event the fire alarm system h be placed out of service for for hours or more in a twenty-four hour period has been review updated, and included in the emergency preparedness place all staff have been educated policy. What measures will be put if place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on before 2/17/2023. This in-se will be conducted by the	the he be ve dal to the ting the as to our ur ed, an and on into	
			Maintenance Director or Des and will include a review of fi watch policy and reporting requirements. The Executive Director/Designee will audit t	re e	
			Emergency Preparedness Pl monthly during QAPI and and to ensure compliance is maintained and policies/procedures are revie and updated as appropriate.	an nually	
			How the corrective action(s)	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		155689	B. W			02/01/2023	
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION	1
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be positive into place: Ongoing compliance with this corrective action will be monitor though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee who be responsible for reviewing the Emergency Preparedness Plat monthly in QAPI for at least 6 months and annually. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	he ut ored vill ne n 6	
K 0363 SS=D Bldg. 01	than required encl exits, or hazardou of smoke and are solid-bonded core capable of resistin	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in g fire for at least 20 fully sprinklered smoke					

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	OF CORRECTION	IDENTIFICATION NUMBER 155689	A. BUILDING B. WING	01	COMPLETED 02/01/2023
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE	
MAJEST	IC CARE OF GOSH	IEN		EN, IN 46526	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		only required to resist the			
	1	. Corridor doors and doors			
	to rooms containin	ig flammable or			
		rials have positive latching			
		atches are prohibited by			
	I -	hese requirements do not			
	flammable or com	spaces that do not contain			
		n bottom of door and floor			
		ceeding 1 inch. Powered			
	_	vith 7.2.1.9 are permissible			
	if provided with a	device capable of keeping			
	the door closed wh	nen a force of 5 lbf is			
		no impediment to the			
	•	rs. Hold open devices that			
		door is pushed or pulled are			
	I ¹³	ed protective plates of			
	_	re permitted. Dutch doors 6 are permitted. Door			
	_	peled and made of steel or			
		compliance with 8.3,			
	unless the smoke	-			
		fire window assemblies are			
	allowed per 8.3. In	sprinklered compartments			
		ctions in area or fire			
	1	s or frames in window			
	assemblies.				
	19.3.6.3, 42 CFR I	Parts 403, 418, 460, 482,			
	483, and 485				
		S details of doors such as			
	· ·	ngs, automatics closing			
	devices, etc.	on and informations of 100 MM	W 02/2	Kooo Ot-t D	00/17/2022
		on and interview, the facility 1 doors to the corridor would	K 0363	K363 – Corridor - Doors	02/17/2023
		e passage of smoke. This		It is the practice of this facility all doors to the corridor compl	
		ould affect approximately 15		resist the passage of smoke.	Citory
	residents and staff.	<i></i>			
				What corrective action(s) will	ı [
	Findings include:			be accomplished for those	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155689	B. W	NG		02/01/2023	
			<u> </u>	2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	Based on observation 02/01/23 between the House Keeping 126 had a one-half above the handle to corridor. This was a Keeping Manager a	on during a tour of the facility en 12:00 p.m. and 2:45 p.m. with Manager, the door to room inch half-moon shaped hole the door that opened to the acknowledged by the House at the time of observation. sussed with the Assistant g and the Maintenance Director			residents found to have been affected by the deficient practice: 1. Door to room 126 hole was appropriately filled and fixed to ensure the resistance of passes of smoke. 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. The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month which will ensure the checking doors. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month and weekly for at least 6 month who the corrective action(s) will be monitored to ensure the contraction of the second month and weekly for at least 6 month.	the ne coe re al to API " API "	

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICAT		IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPL	ETED
		155689	B. WING 02/01/202				/2023
				T			
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
NAA 1507	10 04DE 05 000'	IENI			OLLEGE AVE		
MAJEST	IC 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)	•	DATE
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place:		
					Ongoing compliance with this		
					corrective action will be monite	ored	
					though the facility Quality		
					Assurance and Performance		
					Improvement Program. The		
					Maintenance Director/Designe		
					will be responsible for comple	ting	
					QAPI audit tool "Life Safety		
					Rounds" 3x/week for the first		
					month, 2x/week for the second		
					month, and weekly for at least		
					months. If 100% compliance		
					not achieved an action plan w	ill be	
					developed. Findings will be		
					submitted to the Quality		
					Assurance and Performance		
					Improvement Committee for re	eview	
					and follow-up.		
					By what date the systemic		
					changes will be		
					completed: 02/17/2023		
					Compliance Date = 02/17/202	3	
K 0274	NEDA 404						
K 0374	NFPA 101	Idina Canana Caratta					
SS=E		lding Spaces - Smoke					
Bldg. 01	Barrie	Idina Canana Caratta					
		lding Spaces - Smoke					
	Barrier Doors						
	2012 EXISTING						
		arriers are 1-3/4-inch thick					
	solid bonded wood						
		esists fire for 20 minutes.					
	•	ve plates of unlimited height					
		ors are permitted to have					
	fixed fire window a	assemblies per 8.5. Doors					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u>			COMPLETED		
	155689		B. W	B. WING			02/01/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	8		l	OLLEGE AVE			
MAJEST	IC CARE OF GOSH	IEN		1	EN, IN 46526			
				000112	1			
(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	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	automatic-closing, do not						
		and are not required to swing						
		egress travel. Door opening						
	•	um clear width of 32 inches						
	for swinging or ho							
	19.3.7.6, 19.3.7.8,		17.0	27.4			00/17/2022	
		on and interview, the facility	K 0	5/4	K374 – Subdivision of Buildin	ng	02/17/2023	
		f 7 sets of smoke barrier doors novement of smoke for at least			Spaces – Smoke Barrier	ta.		
		9.3.7.8 requires doors in smoke			It is the practice of this facility			
		ly with LSC Section 8.5.4. LSC			maintain sprinkler systems and	ı		
	_	ors in smoke barrier shall close			ensure all automatic sprinkler			
	_	only the minimum clearance		systems shall be inspected and maintained.		u		
		r operation. This deficient						
		et 30 residents in two smoke			What corrective action(s) will	ı		
	compartments.	to 50 residents in two smoke		be accomplished for those		<u> </u>		
	compartments.				residents found to have beer	,		
	Findings include:				affected by the deficient			
	1 managa merada.				practice:			
	Based on observation	on with the House Keeping			1. Set of smoke barrier doors	s in		
		23 between 12:00 p.m. and 2:45			the Birch Wing were adjusted to			
	-	oke barrier doors in the Birch			ensure they fully close when			
	Wing near room 12	5 would not fully close when			tested.			
	tested three times. V	When tested, the door would						
	rub up against the to	op of the frame and would			How other residents having the			
	stop the door from t	fully closing. This condition			potential to be affected by th	е		
	creates a one-half ir	nch gap between the doors			same deficient practice will b	е		
	when shut. Based of	n interview during the time of			identified and what corrective	е		
		ouse Keeping Manager			action(s) will be taken:			
	agreed that the smo	ke doors would not close			All residents residing on Birch			
	when tested.				Wing have the potential to be			
					affected by this deficient practi	ce.		
	_	viewed with the Maintenance			The Maintenance			
		sistant Director of Nursing			Director/Designee will be			
	during the exit conf	erence.			responsible for completing QA			
	2.1.10(1)				audit tool "Life Safety Rounds"	•		
	3.1-19(b)				3x/week for the first month,			
					2x/week for the second month	•		
					and weekly for at least 6 mont	ns.		
		ı		1				

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PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/01/2023	
NAME OF F	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD	
MAJEST	IC CARE OF GOSH	HEN		COLLEGE AVE HEN, IN 46526	,
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	REGULATORY OR	A LSC IDENTIFYING INFORMATION	TAG	What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will be responsible for completing Quaudit tool "Life Safety Rounds 3x/week for the first month, 2x/week for the second mont and weekly for at least 6 more deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monithough the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Design will be responsible for comple QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the secon month, and weekly for at least months. If 100% compliance not achieved an action plan videveloped. 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: 02/17/2023	API 3" h, oths.) the out stored ee eting ad et 6 is vill be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/01/2023	
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				Compliance Date = 02/17/2023	3
K 0521 SS=E Bldg. 01	comply with 9.2 ar accordance with the specifications. 18.5.2.1, 19.5.2.1, Based on record reversal failed to ensure 2 of were repaired after NFPA 90A. LSC 9 and air conditioning equipment shall be Standard for the Instance of Instance o	riew and interview, the facility of 22 fire dampers in the facility inspection in accordance with .2.1 requires heating, ventilating (HVAC) ductwork and related in accordance with NFPA 90A, tallation of Air-Conditioning tems. NFPA 90A, 2012 .8.1 states fire dampers shall be dance with NFPA 80, Standard Other Opening Protectives. tion, Section 19.2.3.3 states is shall be provided through to gain access for inspection amper's working parts. This build affect 40 residents in two ts. Eview with the Maintenance 3 between 9:45 a.m. and 12:00 the provided due to not having the most of the provided to install access the cumentation was provided to	K 0521	K521 - HVAC It is the practice of this facility to ensure the fire dampers in the facility are repaired after inspection. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Vendor was contacted for additional fire damper inspection and supporting documentation previous fire damper inspection provided. How other residents having 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. The Maintenance Director/Designee will be responsible for ensuring damper inspections are properly	on on ns he e e
	re-inspected. Based	on interview at the time of		scheduled and documented	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155689 B. WING 02/01/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2400 COLLEGE AVE

IVIAJES	TIC CARE OF GOSHEN	GOSH	GOSHEN, IN 46526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	records review, the Maintenance Director		through TELS.		
	confirmed there were dampers on the inspection				
	form that needed repair and stated there no other		What measures will be put into		
	documentation could be found to show if the		place or what systemic		
	repairs were made.		changes will be made to		
			ensure that the deficient		
	The finding was reviewed with the Assistant		practice does not recur:		
	Director of Nursing and Maintenance Director at		The Maintenance		
	the exit conference.		Director/Designee will be		
			responsible for completing QAPI		
	3.1-19(b)		audit tool "Life Safety Rounds"		
			3x/week for the first month,		
			2x/week for the second month,		
			and weekly for at least 6 months		
			to include TELS review.		
			How the corrective action(s)		
			will be monitored to ensure the		
			deficient practice will not		
			recur, i.e., what quality		
			assurance program will be put		
			into place:		
			Ongoing compliance with this		
			corrective action will be monitored		
			though the facility Quality		
			Assurance and Performance		
			Improvement Program. The		
			Maintenance Director/Designee		
			will be responsible for completing		
			QAPI audit tool "Life Safety		
			Rounds" 3x/week for the first		
			month, 2x/week for the second		
			month, and weekly for at least 6		
			months. If 100% compliance is		
			not achieved an action plan will be		
			developed. Findings will be		
			submitted to the Quality		
			Assurance and Performance		
			Improvement Committee for review		
			and follow-up.		
			1		

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DEPARTMEN CENTERS FO	FORM APPROVED OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/01/2023	
	PROVIDER OR SUPPLIE		2400	r address, city, state, zip cod COLLEGE AVE HEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0711 SS=C Bldg. 01	patients and for the of an emergency. Employees are properties and a copy of the with telephone opplan addresses the of staff per 18/19. of the fire safety properties 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3. 19.7.2.1.2, 19.7.2.	relocation Plan plan for the protection of all neir evacuation in the event eriodically instructed and in their duties under the plan, plan is readily available rerator or with security. The ne basic response required 7.2.1.2 and provides for all plan components per 18.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 1.2, 19.7.2.3 I and record review, the facility	K 0711	By what date the systemic changes will be completed: 02/17/2023 Compliance Date = 02/17/2023 K711 – Evacuation and	02/17/2023
	failed to provide a components in 1 of accordance with 19	written plan that addressed all 1 written fire plans in 1.7.2.2. LSC 19.7.2.2 requires a occupancy fire safety plan that	N V/11	Relocation Plan It is the practice of this facility to ensure the fire safety plan contains information on evacuation of smoke compartments include addressed and locations of	o

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evacuation

(2) Transmission of alarm to the fire department

(3) Emergency phone call to fire department

(4) Response to alarms

(9) Extinguishment of fire

(6) Evacuation of immediate area

(7) Evacuation of smoke compartment

(8) Preparation of floors and building for

This deficient practice could affect all occupants.

(5) Isolation of fire

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practice:

smoke/fire barriers.

What corrective action(s) will

residents found to have been

to fire safety plan including the

The policy and facility map related

be accomplished for those

affected by the deficient

evacuation of smoke

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		COMPL	ETED	
		155689	B. WING 02/01/202				
NAME OF P	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	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
					compartments was reviewed a	and	
	Findings include:				updated to be included in the		
	_				emergency preparedness plar	۱.	
	Based on records re	eview with the Maintenance					
	Director on 02/01/2	3 at 11:14 a.m., the provided fire			How other residents having t	the	
		ed information on evacuation			potential to be affected by th		
		nents but did not address the			same deficient practice will b		
	_	fire barriers. Based on			identified and what correctiv		
	interview during red	cords review, the Maintenance			action(s) will be taken:		
	Director stated no d	locumentation was available to			All residents have the potentia	al to	
	show were all smok	ce/fire barriers were located.			be affected by this deficient		
					practice. The Maintenance		
	This finding was re	viewed with the Assistant			Director/Designee will be		
	Director of Nursing	and Maintenance Director			responsible for reviewing the		
	during the exit conf	Perence.			Emergency Preparedness Pla	n	
					monthly during QAPI to ensure		
	3.1-19(b)				policies remain up to date.		
					What measures will be put in	nto	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					All staff will be in-serviced on	or	
					before 2/17/2023. This in-serv		
					will be conducted by the		
					Maintenance Director or Desig	gnee	
					and will include a review of fire	-	
					safety plan including evacuation	on	
					and communication. The		
					Maintenance Director/Designe	ee	
					will be responsible for reviewir	ng	
					the Emergency Operations Pla	an	
					monthly during QAPI to ensure	е	
					policies remain up to date.		
					How the corrective action(a)		
					How the corrective action(s) will be monitored to ensure t		
						,i i C	
					deficient practice will not recur, i.e., what quality		
1	i		1		ı ıccui, i.e., wiidl yudiilv	I I	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		A. BUILDING B. WING	01	COMPLETED 02/01/2023	
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartm liquids, combustibl used or stored and location, and such signs that read NC			assurance program will be p into place: Ongoing compliance with this corrective action will be monitored though the facility Quality. Assurance and Performance Improvement Program. The Maintenance Director/Designed will be responsible for reviewing the Emergency Operations play monthly during QAPI and updates a needed. If 100% complianed not achieved an action plan will 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: 02/17/2023. Compliance Date = 02/17/202	ored ee ng an ating ce is ill be
	(2) In health care of smoking is prohibit	occupancies where ted and signs are d at all major entrances,			

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STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>01</u> COMPL				
155689		B. WING 02/01				/2023	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
				2400 C	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	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		vith language that prohibits					
	smoking shall not	•					
	responsible shall I	atients classified as not					
		ent of 18.7.4(3) shall not					
		atient is under direct					
	supervision.						
	· ·	ncombustible material and					
		be provided in all areas					
	where smoking is						
	(6) Metal containe	ers with self-closing cover					
	devices into which	ashtrays can be emptied					
	shall be readily av	ailable to all areas where					
	smoking is permit	ted.					
	18.7.4, 19.7.4						
		on and interview; the facility	K 0	K 0741 K741 – Smoking Reg			02/17/2023
		f 1 staff smoking areas were			It is the practice of this facility to		
		osing cigarette butts in a metal			ensure staff smoking areas are		
		container with self-closing			maintained by disposing cigar		
		ensured that smoking took			butts in a metal or noncombus		
		ated smoking area. This could affect staff in the service			container with self-closing cover		
	hall and kitchen.	Suid affect staff in the service			devices and ensuring that smo	oking	
	nan and kitchen.				smoking area.		
	Findings include:				Smoking area.		
	_ mamga maraac.				What corrective action(s) wil	I	
	Based on observation	on with the Maintenance			be accomplished for those	-	
		Keeping Manager on 02/01/23			residents found to have been	1	
		and 2:00 p.m., the following			affected by the deficient		
	was observed:	-			practice:		
	a) In the staff smok	ing area there were 20 plus			a. All cigarette butts were		
	cigarette butts on th	•			cleaned up around the staff		
	1 ' -	all exit (a no smoking area) were			smoking area.		
	20 plus cigarette bu	_			b. All cigarette butts were		
		er by the service hall exit (a no			cleaned up around the service	hall	
		e was a metal can without a lid			exit.		
	filled with cigarette				c. The metal can near the		
		tchen exit (a no smoking area)			service hall exit was removed	and	
		tte butts on the ground.			a replacement with a lid was		
Based on interview at the time of observations.		- 1		I placed in the designated smol	rina	I	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>0</u> 1	(X3) DATE SUR COMPLETE 02/01/202	D		
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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PROPRIATE CO	(X5) OMPLETION DATE		
	Manager agreed cig ground and smokin	irector and House Keeping garette butts were on the g took place in non-smoking		area. d. All cigarette butts o kitchen exit were clean				
	_	eviewed with the Assistant g and Maintenance Director ference.		How other residents have deficient practice identified and what contaction(s) will be taken: All residents have the pube affected by this deficient practice. The Maintenar Director/Designee will be responsible for complete audit tool "Life Safety Rayweek for the first mone 2x/week for the second and weekly for at least of All cigarette butts have removed and cleaned under metal container with a life been provided in the desen educated on the puber well as designated smoon. What measures will be place or what systemic changes will be made ensure that the deficient practice does not recurate the def	d by the e will be rrective otential to sient ince se ing QAPI ounds" onth, month, months, been p, a new d has signated taff have solicy as king area. I put into c to int r: ed on or in-service e r Designee v of the ignated intenance se			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl B. W		01	COMPLE	
		155689	B. W			02/01/2	<u>2023</u>
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE		
MAJEST	IC CARE OF GOSH	IEN	GOSHEN, IN 46526				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month. 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: Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designed will be responsible for complete QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance not achieved an action plan with 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: 02/17/2023 Compliance Date = 02/17/2023	the the ut bred d 6 is iill be	DATE
K 0918 SS=F Bldg. 01		s - Essential Electric Syste s - Essential Electric					
_	System Maintenar						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689			A. BUILDING B. WING	<u>01</u>	COMPLETED 02/01/2023
NAME OF I	PROVIDER OR SUPPLIEF	₹		ET ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE	
MAJEST	IC CARE OF GOSH	HEN		HEN, IN 46526	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE CONTINUE TO T
TAG		other alternate power	TAG	DE TELEKET?	DATE
		iated equipment is capable			
		ce within 10 seconds. If the			
	10-second criterion is not met during the				
		ocess shall be provided to			
	l .	his capability for the life			
	safety and critical	branches. Maintenance			
	and testing of the	generator and transfer			
	1	ormed in accordance with			
	NFPA 110.				
		e inspected weekly,			
	exercised under load 30 minutes 12 times a				
	year in 20-40 day intervals, and exercised				
	once every 36 months for 4 continuous hours. Scheduled test under load conditions include				
	a complete simula				
		ual transfer of all EES			
		nducted by competent			
		nance and testing of stored			
	energy power sou	rces (Type 3 EES) are in			
	accordance with N	NFPA 111. Main and feeder			
	circuit breakers ar	e inspected annually, and a			
	1 ' - '	dically exercising the			
	1	tablished according to			
		uirements. Written records			
		nd testing are maintained			
	· ·	ble. EES electrical panels			
		arked, readily identifiable, n normal power circuits.			
	1	ssibility of damage of the			
		source is a design			
	consideration for i	S .			
		(NFPA 99), NFPA 110,			
	NFPA 111, 700.10	0 (NFPA 70)			
		review and interview, the	K 0918	K918 – Electrical Systems –	02/17/2023
		sure 1 of 1 emergency		Essential Electric Systems	
		wed a 5 minute cool down		It is the practice of this facility	
		rest. Chapter 6.4.4.1.1.4(a) of		ensure emergency generator	
		aires monthly testing of the		allowed a 5 minute cool dowr	1
	generator serving th	ne emergency electrical system		period after a load test.	

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Event ID:

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
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	01	COMPLETED	
		155689	B. WI	NG		02/01	/2023
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			OLLEGE AVE		
ΜΔ ΙΕςΤ	IC CARE OF GOSH	HEN			EN, IN 46526		
IVIAJEOT		ILIN		GOSHIL	-14, 114 40320		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e with NFPA 110, the Standard					
	1	Standby Powers Systems,			What corrective action(s) will	11	
	_	10, 6.2.10 Time Delay on Engine			be accomplished for those		
	Shutdown requires that a minimum time delay of 5				residents found to have bee	n	
	_	ovided for unloaded running of			affected by the deficient		
		wer Supply (EPS) prior to			practice:		
		ay provides additional engine			The generator load cool down		
		ne delay shall not be required			has been added to the month	ly	
		r less) air-cooled prime movers.			documentation in TELS.		
	_	tice could affect all residents,					
	as well as staff and	visitors in the facility.			How other residents having		
					potential to be affected by the		
	Findings include:				same deficient practice will		
					identified and what corrective	re	
		view with the Maintenance			action(s) will be taken:		
		23 between 09:45 a.m. and 12:00			All residents have the potentia	al to	
		log form documented the			be affected by this deficient		
	_	ed monthly for at least 30			practice. The Maintenance		
		l, however, there was no			Director/Designee will be		
		the form that showed the			responsible for completing a		
		ol down time following its load			generator load test with an		
		view at the time of record			allowable cool down time mor	ıthly	
		nance Director acknowledged			and documenting in TELS.		
	the aforementioned	condition.					
	Trl ' C' 1'	1 1 1 1 A 1 A			What measures will be put in	ito	
	_	eviewed with the Assistant			place or what systemic		
		g and Maintenance Director at			changes will be made to		
	the exit conference				ensure that the deficient		
	2.1.10(1-)				practice does not recur:		
	3.1-19(b)	marrians and internsions 41-			The Maintenance		
		review and interview, the			Director/Designee will be		
		aintain complete documentation			responsible for completing a		
		tor testing for the last 12			generator load test with an	- 41 ₋ 1	
	1	.4.4.1.1.4(a) of 2012 NFPA 99			allowable cool down time mor	เกเง	
		esting of the generator serving			and documenting in TELS.		
	1	etrical system to be in					
		FPA 110, the Standard for			How the corrective action(s)		
	Emergency and Sta	andby Powers Systems, Chapter	1		will be monitored to ensure	tne	1

8. NFPA 110 8.4.2.4 states spark-ignited (Natural

Gas) generator sets shall be exercised at least

deficient practice will not

recur, i.e., what quality

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155689	B. W	ING		02/01/	/2023
NAME OF I	DDOMINED OD GUIDDI TER	,	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	C			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	· ·	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
		the available EPSS load for 30 water temperature and the oil			assurance program will be p	ut	
		-			into place: Ongoing compliance with this		
	pressure have stabilized. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection,				corrective action will be monit	orod	
	performance, exercising period, and repairs for the				though the facility Quality	oreu	
	_	ularly maintained and available			Assurance and Performance		
	for inspection by th				Improvement Program. The		
		eficient practice could affect all			Maintenance Director/Designe	ee	
	occupants.	F			will be responsible for comple		
					QAPI audit tool "TELS" weekl	•	
	Findings include:				4 weeks and monthly for at lea		
					months. If 100% compliance		
	Based on record review with the Maintenance				not achieved an action plan w		
	Director on 02/01/2	3 between 09:45 a.m. and 12:00			developed. Findings will be		
	p.m., documentation	n for the past 12 months worth			submitted to the Quality		
	of testing did not in	clude the required load			Assurance and Performance		
	percentages. Based	on an interview at the time of			Improvement Committee for re	eview	
	record review, the M	Maintenance Director			and follow-up.		
	acknowledged the r	nonthly load tests did not			By what date the systemic		
	include the load per	centage on the			changes will be		
	documentation.				completed: 02/17/2023		
	This finding	riarrad with the A!-tt			Compliance Date = 02/17/202	3	
	_	viewed with the Assistant					
	the exit conference.	and Maintenance Director at					
	the exit conference.						
	3.1-19(b)						
	3. Based on record	review and interview, the					
	facility failed to ens	sure a complete written record					
	of weekly inspectio	ns for the generator was					
	maintained for 52 w	veeks. NFPA 99, 6.4.4.1.3					
	requires onsite gene	erators shall be maintained in					
		FPA 110, Standard for					
		ndby Power Systems. NFPA					
		an Emergency Power Supply					
	` ` '	luding all appurtenant					
	_	e inspected weekly and					
	exercised monthly. NFPA 99, 6.4.4.2 requires a						
	written record of in	spection, performance,					
	exercising period, and repairs for the generator to						

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	î í	JILDING	nstruction <u>01</u>	(X3) DATE COMPL 02/01 /	ETED
	ROVIDER OR SUPPLIEF			2400 C0	DDRESS, CITY, STATE, ZIP COD DLLEGE AVE N, 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)	ΓE	(X5) COMPLETION DATE
	inspection by the au	ined and available for athority having jurisdiction. ice could affect all residents,					
	Findings include:						
	Director on 02/01/2 p.m., documentatio inspections only industry in the gener of the inspection we interview at the tim Maintenance Direct and agreed the week missing inspected in						
	-	assed with the Assistant and Maintenance Director at					
	3.1-19(b)						
	facility failed to ma Standby System in Standard for Emerg Systems, Section 8. Health Care Faciliti NFPA 110 Section Emergency Power 5 once within every to assigned class is gro- permitted to termin NFPA 99 Section 6 Type 2 essential ele- shall be classified a	review and interview, the intain 1 of 1 Emergency Power accordance with NFPA 110, gency and Standby Power 4.9, as required by NFPA 99 ites Code, Section 6.4.1.1.6.1. 8.4.9 states that all Level 1 Systems shall be tested at least three years. Where the eater than 4 hours, it shall be ate the test after 4 hours. 4.1.1.6.1 states that Type 1 and extrical system power sources t Type 10, Class X, Level 1 is deficient practice could accupants.					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689			l í	JILDING	nstruction 01	(X3) DATE : COMPL 02/01 /	ETED
	ROVIDER OR SUPPLIER			2400 C0	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
	Findings include:						
	Director on 01/01/2 p.m., documentation emergency generate months was not prointerview at the time Maintenance Direct continuous run under but could find no do.	ew with the Maintenance 3 between 09:45 a.m. and 12:00 n of a four hour run test for the or conducted within the last 36 vided for review. Based on e of records review, the or stated a four hour er load could have been done, ocumentation for confirmation. viewed with the Assistant and Maintenance Director at					
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vir non-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re other UL standard	d electrical equipment					

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WPUV21 Facility ID: 000091

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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. BU	A. BUILDING <u>01</u>		COMPL	LETED
		155689	B. W	ING		02/01	/2023
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			OLLEGE AVE		
MA IEST	IC CARE OF GOSI	HEN			EN, IN 46526		
IVIAJEST		ILIN		GOSHL	_11, 111 40320		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	cords are not use	d as a substitute for fixed					
	_	re. Extension cords used					
	1 .	moved immediately upon					
	completion of the	purpose for which it was					
		ets the conditions of 10.2.4.					
	,	9), 10.2.4 (NFPA 99), 400-8					
		(D) (NFPA 70), TIA 12-5					
	Based on observation and interview, the facility		K 0	920	K920 – Electrical Equipment		02/17/2023
		f 6 flexible cords were installed			Power Cords and Extensions		
		n a safe manor, was not used			It is the practice of this facility		
		g, not use for high power draw			ensure flexible cords are insta	lled	
		wer strips in patient care			properly and used in a safe		
		equired UL rating of 1363A or			manor.		
		cient practice could affect staff					
	on the storage hall.				What corrective action(s) wil	.I	
					be accomplished for those		
	Findings include:				residents found to have been	1	
					affected by the deficient		
		on with the Maintenance			practice:		
		e Keeping Manager on 02/01/23			A) The power strip used to po		
		and 2:30 p.m., The following			equipment in the ADON office	was	
	was observed:	00			removed.		
		ffice a power strip used to			B) The power strip used to p		
		was not secured, and was			equipment in the admissions of	office	
		lesk. This condition could put			was removed.		
	1	cord causing damage to the			C) The power strip used to p	ower	
	power cord.	nigh power draw equipment)			equipment in room 216 was		
					removed.	214/05	
	strip in the Admiss:	nd supplied power by a power			D) The power strip used to po		
	_	nigh power draw equipment)			equipment in medical records office was removed.		
		ngn power draw equipment) nd supplied power by a power				ower	
	strip in room 216	nd supplied power by a power			E) The power strip used to p equipment in room 218 was	JWE!	
	_	nigh power draw equipment)			removed.		
		nd supplied power by a power			F) The power strip used to pe	ower	
	strip in the Medical				equipment in the maintenance		
	_	ower strip was in use within 6			office was removed.	•	
		are area that did not meet			onice was removed.		
	1363A or 60601-1.				How other residents having	tho	
		ower strip was in use within 6			potential to be affected by th		
	1 , 100m 50 , a p		ı		potonica to so ancolea by th	. •	I

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155689	B. W	ING		02/01/	2023
				·			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJEST	IC CARE OF GOSI	HEN		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	feet of a resident ca	are area that did not meet			same deficient practice will I	oe .	
	1363A or 60601-1.				identified and what corrective		
	g.) Equipment in the Maintenance office was				action(s) will be taken:		
	supplied power by an extension cord.				All residents have the potentia	al to	
		at the time of observations,			be affected by this deficient		
	the Maintenance D	irector and House Keeping			practice. The Maintenance		
	Manager agreed to	the miss use of the			Director/Designee will be		
		tension cord and power strips.			responsible for completing QA	νPI	
					audit tool "Life Safety Rounds		
	This finding was re	eviewed with the Assistant			3x/week for the first month,		
	Director of Nursing	g and Maintenance Director			2x/week for the second month	١,	
	during the exit con	ference.			and weekly for at least 6 mon	ths	
					which will include checks for		
	3.1-19(b)				various rooms and office to er	isure	
					compliance with extension co	rds	
					and power strips.		
					·		
					What measures will be put in	ıto	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					All staff will be in-serviced on	or	
					before 2/17/2023. This in-ser	vice	
					will be conducted by the		
					Maintenance Director or Desi	gnee	
					and will include a review of		
					extension cords and power st	ip	
					usage. The Maintenance		
					Director/Designee will be		
					responsible for completing QA	√PI	
					audit tool "Life Safety Rounds	19	
					3x/week for the first month,		
					2x/week for the second month	1,	
					and weekly for at least 6 mon	hs.	
					How the corrective action(s)		
					will be monitored to ensure	:he	
					deficient practice will not		
			1		recur, i.e., what quality		

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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 01	(X3) DATE SURVEY COMPLETED 02/01/2023		
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	те	(X5) COMPLETION DATE
				assurance program will be pinto place: Ongoing compliance with this corrective action will be monitor though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designe will be responsible for complet QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance inot achieved an action plan will 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: 02/17/2023 Compliance Date = 02/17/202	ored ee ting d : 6 is ill be eview	
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyganother is in acco Transfilling of Higl Oxygen Used for any gas from one prohibited in patie to liquid oxygen or containers over 50 under 11.5.2.3.1 (Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, n Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling ontainers or to portable D psi comply with conditions NFPA 99). Transfilling to tainers or to portable				

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containers under 50 psi comply with

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155689	B. WI	NG		02/01/2023	
				CEDEEE	ADDRESS CHEW STATE THE SOR		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
NAA IEGT	10 0ADE OF 0001	IENI			COLLEGE AVE		
IVIAJEST	IC CARE OF GOSI	HEIN		GUSH	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conditions under	11.5.2.3.2 (NFPA 99).					
	11.5.2.2 (NFPA 9	9)					
		on and interview, the facility	K 09	927	K927 – Gas Equipment –		02/17/2023
	failed to ensure trai	nsfilling of oxygen took place			Transfilling Cylinders		
	in 1 of 3 oxygen tra	ansfilling rooms that are			It is the practice of this facility	to	
	separated from any	portion of a facility, NFPA 99			ensure transfilling of oxygen to		
	2012 edition 11.5.2	2.3.1, Transfilling to liquid			place in oxygen transfilling roo		
	oxygen base reserv	oir containers or to liquid			that are separated from any		
	oxygen portable co	ontainers over 344.74 kPa (50			portion of the facility.		
	psi) shall include th	ne following:					
	(1) A designated ar	rea separated from any portion			What corrective action(s) wil	ll l	
	of a facility wherei	n patients are housed,			be accomplished for those		
	examined, or treate	ed by a fire barrier of 1 hour			residents found to have been	n	
	fire-resistive constr	ruction.			affected by the deficient		
	(2) The area is med	chanically ventilated, is			practice:		
	sprinklered, and ha	s ceramic or concrete flooring.			The door to the oxygen transf	illing	
	(3) The area is post	ted with signs indicating that			room has been adjusted and f	ixed	
	transfilling is occur	rring and that smoking in the			to ensure proper close and lat	ch of	
	immediate area is r	not permitted.			the frame.		
	(4) The individual	transfilling the container(s) has					
	been properly train	ed in the transfilling			How other residents having	the	
	procedures.				potential to be affected by the	ie	
	_	tice could affect up to 21			same deficient practice will l	эе	
	residents in one sm	oke compartment.			identified and what corrective	e e	
					action(s) will be taken:		
	Findings include:				All residents have the potentia	al to	
					be affected by this deficient		
		on with the House Keeping			practice. The Maintenance		
	_	23 between 12:00 p.m. and 2:45			Director/Designee will be		
		orage/transfer room contained			responsible for completing QA		
		s, oxygen cylinders, and other			audit tool "Life Safety Rounds	,,	
		Upon testing the door, it			3x/week for the first month,		
	_	ely close and latch into the			2x/week for the second month		
		on does not separate			and weekly for at least 6 mont		
		gen from portion of a facility			which will include checks of pr	roper	
	_	e housed. Based on interview			closing and latching of doors.		
		vation, the House Keeping					
		at the door would not			What measures will be put in	ıto	
	completely close as	nd latch into the frame.			place or what systemic		
1					changes will be made to	ļ	

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	OF CORRECTION	IDENTIFICATION NUMBER 155689	A. BUILDING B. WING	01	COMPLETED 02/01/2023
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		viewed with the Assistant and Maintenance Director erence.		ensure that the deficient practice does not recur: All staff will be in-serviced on before 2/17/2023. This in-servill be conducted by the Maintenance Director or Designand will include a review of egators. The Maintenance Director/Designee will be responsible for completing QA audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month and weekly for at least 6 month the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to ensure though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designe will be responsible for complete QAPI audit tool "Life Safety Rounds" 3x/week for the first month, 2x/week for the second month, and weekly for at least months. If 100% compliance in not achieved an action plan will developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow-up. By what date the systemic	vice gnee ress API I, I, Ihs. Ihe ut Dred dee ting di 66 is isili be

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>01</u>	COMPLETED		
		155689	B. WI	B. WING			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 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 APPROPRIATE	ΓF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE	
					changes will be completed: 02/17/2023 Compliance Date = 02/17/2023	3		

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