STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00441248. Complaint IN00441248 - Federal/State deficiencies related to the allegations are cited at F684, F686. F697. Survey dates: September 9, 10 & 12, 2024 Facility number: 000091 Provider number: 155689 AIM number: 100290080 Census Bed Type: SNF/NF: 111 SNF: 1 Total:112 Census Payor Type: Medicare: 1 Medicaid: 88 Other: 23 Total: 112 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 9/17/2024	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensured bowel protocol was followed 1 of 3 residents reviewed for bowel movements, (Resident B).	F 0684	**F684 – Quality of Care** It is the practice of this facility to ensure bowel protocol is followed for all residents.	09/27/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Caley Nixon	Executive Director	09/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
	Finding includes: The clinical record for Resident B was reviewed on 9/9/24 at 12:28 P.M. Diagnoses included, but were not limited to: right femur fracture, cardiomyopathy and chronic kidney disease. Resident B's hospital Inpatient Transfer Report form, dated 7/19/24 at 9:56 A.M., indicated Resident B had been treated for fractures of the left fifth, sixth and eighth ribs, and fracture of the right femur with surgical repair following a fall on 7/13/24. The resident had been receiving Hydrocodone 5 mg-acetaminophen 325 mg tablet for pain management, (narcotic pain medication with a potential adverse side effect of constipation) and Docusate Sodium 100 mg daily for constipation. The discharge physician orders from the hospital, included orders for Docusate Sodium 100 mg capsule daily as needed for constipation. A Nursing Admission/Readmission Evaluation assessment, dated 7/19/24 at 12:35 P.M. for Resident B, indicated the resident had not had a bowel movement while hospitalized for 7 days, since 7/12/24. The evaluation indicated Resident B normally had 2 bowel movements daily. An Admission Minimum Data Set (MDS) assessment, dated 7/26/24, indicated Resident B required extensive assistance for transfers and toilet use. Resident B's Continence tracking report indicated Resident B did not have a bowel movement at the facility until 7/21/24. The current Physician's Orders for Resident B included Docusate Sodium 100 mg capsule daily		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B – resident has discharged from facility. **How other residents having the 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 to be affected by this deficient practice. All residents reviewed to ensure appropriate bowel protocol in place. All resident's bowel elimination reviewed to ensure appropriate measures in place if needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 09/27/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of facility bowel protocol and notification to MD/NP. **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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
	as needed for constipation, ordered on 7/19/24, but review of the resident's Medication Administration Record (MAR) for July 2024, indicated the medication had not been administered. During an interview on 9/10/24 at 9:33 A.M., Resident B's responsible party indicated the facility was not giving the resident a prescribed stool softener as ordered and the resident was in a great deal of discomfort due to the constipation issues. During an interview on 9/12/24 at 11:23 A.M., the Administrator indicated some of Resident B's physician's orders were not put in the Electronic Medical Record (EMR) on the day the resident was admitted to the facility, causing a delay in medication administration. During an interview on 9/12/24 at 11:25 A.M., the Assistant Director of Nursing indicated when Resident B did not have a bowel movement for 3 days, the facility's bowel movement protocol should have been initiated but was not. The Assistant Director of Nursing indicated the resident should have received his bowel medication upon admission to the facility as ordered. The Assistant Director of Nursing indicated, in addition, a 3-day Voiding and Elimination Patter assessment should have been completed and had not been completed. On 9/10/24 at 12:25 P.M., the Administrator provided a policy, indicating it was the current policy, titled, "Bowel and Bladder Program," dated 1/2/24. The policy indicated each resident would be assessed at admission with any change in bowel continence via the 3 Day Voiding/Elimination Pattern. After completion of		**into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Change of Condition” weekly for 4 weeks, and monthly for at least 6 months. The Director or Nursing/Designee will audit all facility 24-hour report daily to ensure all changes of condition related to bowel elimination are identified, NP/MD are updated, and bowel elimination protocol is followed appropriately for all residents. If 100% 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: 09/27/2024** Compliance Date = 09/27/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
	the 3-day Voiding and Elimination Pattern, the Interdisciplinary Team would review and update the care plan as needed. This citation relates to Complaint IN00441248. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for pressure wounds, received timely care and treatment to prevent the development of a pressure wound, (Resident B). Finding includes: The clinical record for Resident B was reviewed on 9/9/24 at 12:28 P.M. Diagnoses included, but was not limited to: right femur fracture, cardiomyopathy and chronic kidney disease. An Admission Minimum Data Set (MDS) assessment, dated 7/26/24, indicated Resident B was severely cognitively impaired, had no pressure wounds and required extensive assistance for bed mobility, transfers, and toilet use. The portion of the MDS to assess bowel and bladder continence was not completed. Resident B's hospital Inpatient Transfer Report, dated 7/19/24 at 9:56 A.M., indicated Resident B had been treated for a fracture of the right femur with surgical repair following a fall on 7/13/24. There was no documentation of any pressure wounds in the report. The facility Nursing Admission/Readmission	F 0686	**F686- Treatment/Svcs to Prevent/Heal Pressure Ulcer** It is the practice of this facility to ensure residents receive timely care and treatment to prevent the development of pressure areas. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B – resident has been discharged from facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents at risk for pressure areas have the potential to be affected by this deficient practice. All current residents at risk for pressure areas have been reviewed to ensure that appropriate interventions are in place and all orders and interventions are carried out	09/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
	Evaluation assessment for Resident B, dated 7/19/24 at 12:35 P.M., indicated the resident had been newly admitted to the facility from a local hospital on 7/19/24 at 11:30 A.M. following right hip surgery. The skin evaluation section of the assessment indicated Resident B had a surgical wound to the right hip as a result of hip surgery. The care planning portion of the evaluation indicated the resident was at risk for skin breakdown. Interventions included, but were not limited to, preventive skin care as ordered and a pressure reducing mattress on the bed. There was no documentation of any pressure wounds at the time of the evaluation. An Acute Note, dated 7/22/24 and signed by Nurse Practitioner 1, indicated the reason for the visit was due to Resident B's recent admission. The Nurse Practitioner indicated the resident was admitted following a fall with right femoral fracture and multiple right sided rib fractures. The physical exam regarding the skin indicated there was a right hip dressing. There was no documentation of any pressure wounds in the Nurse Practitioner's Acute Note for admission for Resident B. The initial facility Wound Assessment Report, dated 7/22/24, indicated the resident was assessed by Nurse Practitioner 2 on 7/22/24. The report indicated Resident B had a right buttock Stage 1 pressure wound measuring 4 cm by 4 cm. The report indicated the wound had been present on admission. An initial wound treatment as follows was ordered to be completed twice a day: cleanse the area with soap and water, pat dry, apply Zinc Oxide paste and leave open to air. The current Physician's Orders related to skin care and treatment included the following: 1. Treatment for right buttock pressure ulcer,		timely. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 09/27/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of the skin management program, pressure injury prevention guidelines, and following plan of care. The Director or Nursing/Designee will audit all residents with current or closed pressure areas to ensure that appropriate interventions are in place and any new changes in orders are being completed in a timely manner. Director of Nursing/Designee will also audit all new residents to ensure that all orders and interventions are carried out upon admission. **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 Director of Nursing/Designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
	ordered 7/22/23 to begin on 7/23/24- to cleanse with soap and water, pat dry, apply zinc oxide paste two times daily. 2. Treatment ordered 7/19/24 with treatment to being on 7/21/24 - apply house barrier cream to buttock, coccyx, and peri-area every shift with incontinent episodes. 3. Treatment ordered 7/22/24 with treatment to begin on 7/23/24 - Apply skin prep to bilateral heels daily for 14 days for prevention. Treatment ordered on 7/22/24 for treatment to begin on 7/23/24. 4. Intervention ordered on 7/19/24 with intervention to begin on 7/21/24 - May have pressure reduction mattress. Review of Resident B's Treatment Administration Record (TAR) for July 2024 indicated the resident received the prescribed treatments to the pressure ulcer as ordered, excluding 7/28/24 ,when the treatment was not charted as being done and no documentation to explain why treatment was not done. A current Care Plan, initiated on 7/19/24, indicated the resident required assistance with activities of daily living. Interventions included, but were not limited to, assist with incontinence care, bed mobility, transfers, and personal hygiene. A current Care Plan, imitated on 7/19/24, indicated the resident had impaired skin integrity. Interventions, included but were not limited to, pressure reducing mattress on the bed. On 9/12/24 at 1:04 P.M., the Administrator provided a policy titled, "Wound Prevention & Management," dated 1/2/24, and indicated it was the current facility policy. The policy indicated it was committed to the prevention of avoidable		be responsible for completing the QAPI Audit tools labeled “Skin Management” weekly for 4 weeks, and monthly for at least 6 months. The Director of Nursing/Designee will audit all new residents and current residents with current or closed pressure areas to ensure that appropriate interventions and treatment orders are in place and being carried out. If 100% 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: 09/27/2024** Compliance Date = 09/27/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
	pressure injures, and the term avoidable meant the facility had not implemented interventions that were consistent with the resident's needs and professional standards of practice. The policy indicated interventions would be based on factors including moisture management and impaired mobility and evidence-based interventions for the prevention of pressure ulcers would be implemented including but not limited to the provision of pressure-redistributing mattresses. During an interview on 9/12/24 at 11:23 A.M., the Administrator indicated some of Resident B's physician's orders were not put in the Electronic Medical Record (EMR) on the day the resident was admitted to the facility, causing a delay in care related to the initiation of the pressure reducing mattress. During an interview on 9/12/24 at 11:25 A.M., the Assistant Director of Nursing (ADON) indicated a skin assessment should have been completed on admission for Resident B but was not. The ADON indicated although the Nurse Practitioner documented, on 9/22/24, that the resident was admitted with a pressure wound to the buttock, the hospital had not identified a pressure wound at the time of the resident's discharge from the hospital. In addition, there had been no skin assessments completed before the assessment from the Nurse Practitioner's on 7/22/24. The ADON indicated there had been no admission orders regarding a pressure wound to Resident B's buttock. This citation relates to Complaint IN00441248. 3.1-40(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on interview and record review, the facility failed to ensure pain management was provided and a pain assessment was completed upon admission for 1 of 3 residents reviewed for pain, (Resident B). Finding includes: The clinical record for Resident B was reviewed on 9/9/24 at 12:28 P.M. Diagnoses included, but were not limited to, a right femur fracture, cardiomyopathy and chronic kidney disease. Resident B's hospital Inpatient Transfer Report, dated 7/19/24 at 9:56 A.M., indicated Resident B had fractures of the left fifth, sixth, eighth ribs, and fracture of the right femur with a surgical repair following a fall on 7/13/24. Hospital discharge orders included, but were not limited to the following: 1. Hydrocodone 5 mg-Acetaminophen 325 mg (a narcotic pain medication) one tablet every six hours as needed for pain. The medication had last been administered by the hospital on 7/19/24 at 4:00 A.M. In addition, the report indicated Resident B had been treated with Morphine Sulfate (a narcotic pain medication) 2mg every two hours for pain. The last documented dose of Morphine Sulfate was given on 7/18/24,the day before discharge from the local hospital. A facility Nursing Admission/Readmission Evaluation assessment, dated 7/19/24 at 12:35 P.M., indicated the resident had been newly admitted to the facility from a local hospital on	F 0697	**F697 – Pain Management** It is the practice of this facility to ensure that pain management is provided to residents who require such services consistent with professional standards of practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B – resident has been discharged from facility. **How other residents having the 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 to be affected by this deficient practice. All residents reviewed to ensure a pain assessment has been completed and pain management is being provided as needed and ordered by physician. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 09/27/2024. This in-service will be conducted by the Director of Nursing or Designee	09/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
	7/19/24 at 11:30 A.M., following right hip surgery. The skin evaluation portion of the form indicated Resident B had a wound to the right hip as a result of his hip surgery and the resident had denied any pain at that time, of the evaluation on 7/19/24 at 11:30 A.M. An Admission Minimum Data Set (MDS) assessment, dated 7/26/24, indicated Resident B was severely cognitively impaired and required extensive assistance for bed mobility, transfers, and toilet use. The Pain Assessment Interview portion of the assessment, completed at that time, indicated the resident had frequent pain that made it difficult to sleep at night and his pain frequently limited his day to day activities. The resident described his pain as severe. The current Physician's Orders regarding pain control included, but were not limited to the following: -Observe for signs or symptoms of pain every shift. If pain present, document level and location of pain, treat trying non-pharmalogical interventions prior to medicating if appropriates. Document in the Progress Notes every shift. -Hydrocodone-Acetaminophen Oral Tablet 5-325 MG to give 1 tablet by mouth every six hours as needed -Hydrocodone-Acetaminophen Oral Tablet 5-325 MG to give 1 tablet by mouth four times a day for pain because the resident did not understand to ask for the pain medication. Resident B's Medical Administration Record (MAR), indicated the first dose of Hydrocodone-Acetaminophen was received on 7/19/24 at 8:30 P.M., over 16 hours since his previous dose at the hospital. Resident B rated his pain level at a 10 on a pain scale of 1-10. (1 being		and will include a review of pain management as well as administration of medication from emergency drug system as needed. The Director or Nursing/Designee will audit all residents with at risk for pain and will ensure that appropriate interventions and orders are in place and being followed as well as ensuring that residents pain medication is being administered timely. **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 Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Pain Management” weekly for 4 weeks, and monthly for at least 6 months. The Director of Nursing/Designee will audit all new and current residents to ensure that pain assessment is completed and all interventions and orders are being followed and carried out timely. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
	minimal pain and 10 being the worst pain that is possible) During an interview on 9/10/24 at 9:33 A.M., Resident B's responsible party indicated Resident B had been complaining of severe pain for hours on 7/19/24, but no one would give him pain medication because the medications had not yet been delivered from the pharmacy. Resident B's responsible party indicated he was able to contact the Director of Nursing in the evening on 7/19/24, explained that they had been requesting pain medication for Resident B for several hours but the resident had not received any pain medications because his medications had not yet arrived from the pharmacy, At the time of his phone call with the Director of Nursing, on 7/19/24 in the evening, Resident B had not been given any pain medication since his admission to the facility. Resident B's responsible party indicated the Director of Nursing had informed him that the resident should not have to wait for pain medications because the facility had a system (Pyxis), that would allow nurses to retrieve the medications he needed. Resident B's responsible party indicated Resident B finally got pain medication around 8:30 P.M. on 7/19/24. During an interview on 9/12/24 at 11:23 A.M., the Administrator indicated some of Resident B's physician's orders were not put in the Electronic Medical Record (EMR) on the day the resident was admitted to the facility, causing a delay in medication administration for pain management and a delay in treatments related to wound care and pressure reducing mattresses. The Administrator indicated Resident B's son had a concern about his father not getting pain medication on the day of admission because his pain medications had not been delivered from the		Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 09/27/2024** Compliance Date = 09/27/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	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
	pharmacy, but the Administrator indicated all the medications he would have needed were available in the Pyxis system. The Administrator indicated the facility had identified a problem related to medications not being pulled from the Pyxsis system for new residents and orders not being put in the system timely for new residents. During an interview on 9/12/24 at 11:25 A.M., the Assistant Director of Nursing indicated Resident B should have had a pain assessment completed on admission, but had not. On 9/10/24 at 12:00 P.M., the Administrator provided a policy, indicating it was the current policy, titled, "Pain Management," dated 1/2/24. The policy indicated it used a systemic approach for the recognition, assessment, treatment and monitoring of pain. Residents were to be evaluated for pain and the causes of pain upon admission. On 9/12/24 at 11:30 A.M., the Administrator provided a policy, indicating it was the current policy, titled, "Pharmacy Services" The policy indicated the facility would maintain a supply of medications for emergency and after-hours situations. This citation relates to Complaint IN00441248. 3.1-37(a)			