PRINTED: 10/09/2024
FORM APPROVED

	THE WILLIAM	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155689	B. WING		09/12/2024	
	PROVIDER OR SUPPLIEI		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(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		
TAG	,	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 0000						
Bldg. 00	IN00441248.  Complaint IN0044 related to the allegate F697.  Survey dates: Septe Facility number: 00 Provider number: 1 AIM number: 1002  Census Bed Type: SNF/NF: 111  SNF: 1  Total:112  Census Payor Type Medicare: 1  Medicaid: 88  Other: 23  Total: 112  These deficiencies accordance with 41  Quality Review con 483.25	reflect State Findings cited in	F 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 violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieutia traditional revisit.	not his set ion	
SS=D Bldg. 00	Quality of Care					
5.dg. 00	failed to ensured bo	and record review, the facility owel protocol was followed 1 of ed for bowel movements,	F 0684	F684 – Quality of Care It is the practice of this facility ensure bowel protocol is follow for all residents.		

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

(X6) DATE

TITLE

Caley Nixon Executive Director 09/30/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155689	B. WING		09/12/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹		OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN	GOSH	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Finding includes:			What corrective action(s) wi	II	
				be accomplished for those		
		for Resident B was reviewed		residents found to have bee	n	
		P.M. Diagnoses included, but		affected by the deficient		
		right femur fracture,		practice:		
	cardiomyopathy an	d chronic kidney disease.		Resident B – resident has		
				discharged from facility.		
		al Inpatient Transfer Report				
		at 9:56 A.M., indicated		How other residents having		
		n treated for fractures of the		potential to be affected by the		
		eighth ribs, and fracture of the		same deficient practice will		
	_	rgical repair following a fall on		identified and what corrective	/e	
		ent had been receiving		action(s) will be taken:		
		-acetaminophen 325 mg tablet		All residents have the potential	al to	
		nt, (narcotic pain medication		be affected by this deficient		
	with a potential adv			practice. All residents reviewe		
		Docusate Sodium 100 mg daily		ensure appropriate bowel pro	tocol	
	_	ne discharge physician orders		in place. All resident's bowel		
	_	included orders for Docusate		elimination reviewed to ensure	e	
		psule daily as needed for		appropriate measures in place	e if	
	constipation.			needed.		
	A Nursing Admissi	on/Readmission Evaluation		What measures will be put in	nto	
	_	7/19/24 at 12:35 P.M. for		place or what systemic		
		ed the resident had not had a		changes will be made to		
		while hospitalized for 7 days,		ensure that the deficient		
		evaluation indicated Resident B		practice does not recur:		
		vel movements daily.		All nursing staff will be in-serv	riced	
		j		on or before 09/27/2024. This		
	An Admission Min	imum Data Set (MDS)		in-service will be conducted b		
		7/26/24, indicated Resident B		Director of Nursing or Designe	·	
		assistance for transfers and		and will include a review of fa		
	toilet use.			bowel protocol and notification	-	
				MD/NP.		
	Resident B's Contir	nence tracking report indicated				
		have a bowel movement at the		How the corrective action(s)		
	facility until 7/21/2			will be monitored to ensure		
	,			deficient practice will not		
	The current Physici	ian's Orders for Resident B		recur, i.e., what quality		

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included Docusate Sodium 100 mg capsule daily

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assurance program will be put

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  09/12/2024	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF GOSHEN		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526	•	
MAJEST  (X4) ID  PREFIX  TAG	summary:  (EACH DEFICIEN  REGULATORY OR  as needed for constite of the resident of the resident administration recipied indicated the medical administered.  During an interview resident B's responsive facility was not give stool softener as ore great deal of disconsissues.  During an interview resident administrator indical physician's orders where the medical record (EI) was admitted to the medication administrator or constitution of the medical record of t	TATEMENT OF DEFICIENCIE BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Deation, ordered on 7/19/24, ident's Medication and (MAR) for July 2024, tion had not been  on 9/10/24 at 9:33 A.M., ible party indicated the ag the resident a prescribed ered and the resident was in a fort due to the constipation  on 9/12/24 at 11:23 A.M., the ted some of Resident B's ere not put in the Electronic IR) on the day the resident facility, causing a delay in ration.		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  into place: Ongoing compliance with this corrective action will be monithough the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee be responsible for completing QAPI Audit tools labeled "Ch of Condition" weekly for 4 we and monthly for at least 6 months. The Director or Nursing/Designee will audit a facility 24-hour report daily to ensure all changes of conditi related to bowel elimination a identified, NP/MD are update and bowel elimination protoc followed appropriately for all residents. If 100% is not ach an action plan will be develop Findings will be submitted to	a will g the ange eks,  ill on are ed, ool is ieved bed.
	days, the facility's be should have been in Assistant Director or resident should have medication upon ad ordered. The Assist indicated, in addition Elimination Patter a completed and had On 9/10/24 at 12:25 provided a policy, it policy, titled, "Bow 1/2/24. The policy is be assessed at admit bowel continence vi	nave a bowel movement for 3 owel movement protocol initiated but was not. The if Nursing indicated the e received his bowel mission to the facility as ant Director of Nursing in, a 3-day Voiding and assessment should have been not been completed.  if P.M., the Administrator indicating it was the current el and Bladder Program," dated indicated each resident would assion with any change in it the 3 Day in Pattern. After completion of		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 = 09/27/20	24

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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 <u>00</u>	(X3) DATE SURVEY  COMPLETED  09/12/2024	
	PROVIDER OR SUPPLIE		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Interdisciplinary To the care plan as need	and Elimination Pattern, the earn would review and update eded.  s to Complaint IN00441248.			
F 0686 SS=D Bldg. 00	Ulcer Based on record re failed to ensure 1 o pressure wounds, r	o Prevent/Heal Pressure view and interview, the facility of 3 residents reviewed for eccived timely care and at the development of a desident B).	F 0686	F686- Treatment/Svcs to Prevent/Heal Pressure Ulcer It is the practice of this facility ensure residents receive timel care and treatment to prevent development of pressure area	y the s.
	on 9/9/24 at 12:28 was not limited to: cardiomyopathy and An Admission Min assessment, dated 7 was severely cogni pressure wounds at assistance for bed 1 use. The portion of bladder continence Resident B's hospit dated 7/19/24 at 9:: Resident B had be right femur with su 7/13/24. There was pressure wounds in	en treated for a fracture of the argical repair following a fall on no documentation of any		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 practical. 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	n che e e e e e e e e e e e e e e e e e e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155689	B. W	ING		09/12/2	2024
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u> 3			ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN		GOSHE	EN, IN 46526		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ent for Resident B, dated			timely.		
		M., indicated the resident had					
		d to the facility from a local			What measures will be put i	nto	
	_	at 11:30 A.M. following right			place or what systemic		
		in evaluation section of the			changes will be made to		
		d Resident B had a surgical			ensure that the deficient		
	_	hip as a result of hip surgery.			practice does not recur:		
		portion of the evaluation			All nursing staff will be in-serv		
		nt was at risk for skin			on or before 09/27/2024. Thi		
		entions included, but were not			in-service will be conducted b	-	
		ive skin care as ordered and a			Director of Nursing or Design		
		nattress on the bed. There was			and will include a review of th	ne	
		of any pressure wounds at the			skin management program,		
	time of the evaluation	on.			pressure injury prevention		
					guidelines, and following plan	n of	
		ed 7/22/24 and signed by			care. The Director or		
		I, indicated the reason for the			Nursing/Designee will audit a	ıll	
		sident B's recent admission.			residents with current or close	ed	
		ner indicated the resident was			pressure areas to ensure that		
	_	a fall with right femoral fracture			appropriate interventions are		
		ided rib fractures. The physical			place and any new changes i		
		skin indicated there was a right			orders are being completed in	n a	
		was no documentation of any			timely manner. Director of		
	_	the Nurse Practitioner's Acute		Nursing/Designee wil		udit	
	Note for admission	for Resident B.			all new residents to ensure th	nat all	
					orders and interventions are		
	· ·	Wound Assessment Report,			carried out upon admission.		
	· · · · · · · · · · · · · · · · · · ·	cated the resident was assessed					
	_	er 2 on 7/22/24. The report			How the corrective action(s)		
		B had a right buttock Stage 1			will be monitored to ensure	the	
	-	asuring 4 cm by 4 cm. The			deficient practice will not		
	_	wound had been present on			recur, i.e., what quality		
		al wound treatment as follows			assurance program will be p	put	
		ompleted twice a day: cleanse			into place:		
	_	and water, pat dry, apply Zinc			Ongoing compliance with this		
	Oxide paste and lea	ve open to air.			corrective action will be monit	tored	
					though the facility Quality		
		an's Orders related to skin care			Assurance and Performance		
	and treatment inclu-	<del>-</del>			Improvement Program. The		
	Treatment for rig	Treatment for right buttock pressure ulcer,			Director of Nursing/Designee	will	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		COMPLETED	
155689		B. WIN	G		09/12/	2024	
NAME OF I	DROWNED OF CURPUSE		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER			2400 C	OLLEGE AVE		
MAJEST	IC CARE OF GOSH	HEN		GOSHE	N, IN 46526		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		begin on 7/23/24- to cleanse			be responsible for completing		
	paste two times dail	r, pat dry, apply zinc oxide			QAPI Audit tools labeled "Skin		
	_	ed 7/19/24 with treatment to			Management" weekly for 4 we	eks,	
		apply house barrier cream to			and monthly for at least 6 months. The Director of		
	1	d peri-area every shift with			Nursing/Designee will audit all	new	
	incontinent episode				residents and current residents		
	_	ed 7/22/24 with treatment to			with current or closed pressure		
		Apply skin prep to bilateral			areas to ensure that appropria		
	_	ays for prevention. Treatment			interventions and treatment or		
		for treatment to begin on			are in place and being carried		
	7/23/24.				If 100% is not achieved an ac		
	4. Intervention orde	ered on 7/19/24 with			plan will be developed. Findin	gs	
	intervention to begi	n on 7/21/24 - May have		will be submitted to the Quality			
	pressure reduction i	nattress.			Assurance and Performance		
					Improvement Committee for re	eview	
		B's Treatment Administration			and follow-up.		
	1 '	uly 2024 indicated the resident			By what date the systemic		
		bed treatments to the pressure			changes will be		
		cluding 7/28/24 ,when the			completed: 09/27/2024		
		harted as being done and no			Compliance Date = 09/27/202	4	
		xplain why treatment was not					
	done.						
	A current Care Plan	, initiated on 7/19/24, indicated					
		d assistance with activities of					
	_	entions included, but were not					
		ith incontinence care, bed					
		and personal hygiene.					
	A current Cara Dlam	, imitated on 7/19/24, indicated					
		n, imitated on 7/19/24, indicated paired skin integrity.					
		ded but were not limited to,					
	pressure reducing n						
	pressure reducing in	ium obs on the oot.					
	On 9/12/24 at 1:04	P.M., the Administrator					
	provided a policy ti	tled, "Wound Prevention &					
	Management," date	d 1/2/24, and indicated it was					
	the current facility p	policy. The policy indicated it					
	was committed to the	ne prevention of avoidable					

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155689	 UILDING	INSTRUCTION 00	(X3) DATE COMPI 09/12	LETED
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	pressure injures, an facility had not imp were consistent wit professional standar indicated interventificulating moisture mobility and evider prevention of pressure implemented including provision of pressure.  During an interview Administrator indic physician's orders with Medical Record (El was admitted to the care related to the in reducing mattress.  During an interview Assistant Director of skin assessment she admission for Resid ADON indicated al documented, on 9/2 admitted with a prethe hospital. In addition assessments complefrom the Nurse Prach ADON indicated the second control of the residual control of the resi	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION  d the term avoidable meant the elemented interventions that the the resident's needs and rds of practice. The policy cons would be based on factors management and impaired nee-based interventions for the the re-redistributing mattresses.  To on 9/12/24 at 11:23 A.M., the material some of Resident B's were not put in the Electronic MR) on the day the resident facility, causing a delay in mitiation of the pressure  To on 9/12/24 at 11:25 A.M., the of Nursing (ADON) indicated a muld have been completed on dent B but was not. The though the Nurse Practitioner (2/24, that the resident was soure wound to the buttock, t identified a pressure wound sident's discharge from the m, there had been no skin meted before the assessment cititioner's on 7/22/24. The ere had been no admission pressure wound to Resident	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	This citation relates	to Complaint IN00441248.				

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3.1-40(a)(1)

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155689	B. W	B. WING 09/12/202			2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER			2400 C	OLLEGE AVE		
MAJESTI	IC CARE OF GOSH	IEN		GOSHE	EN, IN 46526		
(X4) ID	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
F 0697	483.25(k)						
SS=D	Pain Management	İ					
Bldg. 00	D 1 ' / '	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					00/07/0004
		and record review, the facility n management was provided	F 00	597	F697 – Pain Management	4	09/27/2024
	-	ent was completed upon			It is the practice of this facility		
	_	residents reviewed for pain,			ensure that pain management provided to residents who req		
	(Resident B).	residents reviewed for pain,			such services consistent with	ulle	
	(Resident B).				professional standards of prac	tica	
	Finding includes:				professional standards of prac	ilice.	
	C				What corrective action(s) wil	I	
	The clinical record	for Resident B was reviewed			be accomplished for those		
	on 9/9/24 at 12:28 P	P.M. Diagnoses included, but			residents found to have been	ı	
		a right femur fracture,			affected by the deficient		
	cardiomyopathy and	d chronic kidney disease.			practice:		
					Resident B – resident has bee	en	
	-	al Inpatient Transfer Report,			discharged from facility.		
		6 A.M., indicated Resident B					
		left fifth, sixth, eighth ribs,			How other residents having		
		ight femur with a surgical			potential to be affected by th		
		all on 7/13/24. Hospital			same deficient practice will be		
		eluded, but were not limited to			identified and what correctiv	е	
	the following:	ng-Acetaminophen 325 mg (a			action(s) will be taken:	ıl to	
		ation) one tablet every six			All residents have the potential be affected by this deficient	II tO	
	*	pain. The medication had last			practice. All residents reviewe	ad to	
		by the hospital on 7/19/24 at			ensure a pain assessment has		
	4:00 A.M.	J 100ptus 011 // 19/2 ( ut			been completed and pain	-	
					management is being provide	d as	
	In addition, the repo	ort indicated Resident B had			needed and ordered by physic		
	_	orphine Sulfate (a narcotic			]		
		ng every two hours for pain.			What measures will be put ir	ito	
	The last documented	d dose of Morphine Sulfate			place or what systemic		
		4,the day before discharge			changes will be made to		
	from the local hospi	tal.			ensure that the deficient		
					practice does not recur:		
		Admission/Readmission			All nursing staff will be in-serv	iced	
		ent, dated 7/19/24 at 12:35			on or before 09/27/2024. This		
		resident had been newly			in-service will be conducted by		
	admitted to the facil	ity from a local hospital on			Director of Nursing or Designe	ee	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/12/2024 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 7/19/24 at 11:30 A.M., following right hip surgery. and will include a review of pain The skin evaluation portion of the form indicated management as well as Resident B had a wound to the right hip as a administration of medication from result of his hip surgery and the resident had emergency drug system as denied any pain at that time, of the evaluation on needed. The Director or 7/19/24 at 11:30 A.M. Nursing/Designee will audit all residents with at risk for pain and An Admission Minimum Data Set (MDS) will ensure that appropriate assessment, dated 7/26/24, indicated Resident B interventions and orders are in was severely cognitively impaired and required place and being followed as well extensive assistance for bed mobility, transfers, as ensuring that residents pain and toilet use. The Pain Assessment Interview medication is being administered portion of the assessment, completed at that time, timely. indicated the resident had frequent pain that made it difficult to sleep at night and his pain frequently How the corrective action(s) limited his day to day activities. The resident will be monitored to ensure the described his pain as severe. deficient practice will not recur, i.e., what quality The current Physician's Orders regarding pain assurance program will be put control included, but were not limited to the into place: following: -Observe for signs or symptoms of Ongoing compliance with this pain every shift. If pain present, document level corrective action will be monitored and location of pain, treat trying though the facility Quality non-pharmalogical interventions prior to Assurance and Performance medicating if appropriates. Document in the Improvement Program. The Progress Notes every shift. Director of Nursing/Designee will -Hydrocodone-Acetaminophen Oral Tablet 5-325 be responsible for completing the MG to give 1 tablet by mouth every six hours as QAPI Audit tools labeled "Pain Management" weekly for 4 weeks, -Hydrocodone-Acetaminophen Oral Tablet 5-325 and monthly for at least 6 months. The Director of MG to give 1 tablet by mouth four times a day for pain because the resident did not understand to Nursing/Designee will audit all new ask for the pain medication. and current residents to ensure that pain assessment is Resident B's Medical Administration Record completed and all interventions (MAR), indicated the first dose of and orders are being followed and Hydrocodone-Acetaminophen was received on carried out timely. If 100% is not 7/19/24 at 8:30 P.M., over 16 hours since his achieved an action plan will be previous dose at the hospital. Resident B rated his developed. Findings will be pain level at a 10 on a pain scale of 1-10. (1 being submitted to the Quality

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

PRINTED: 10/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155689		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  09/12/2024	
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF GOSHEN			2400 0	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	minimal pain and 10 possible)  During an interview Resident B's respond B had been complain on 7/19/24, but no comedication because been delivered from responsible party in the Director of Nursexplained that they medication for Resident had not medications because arrived from the phaphone call with the in the evening, Resident Beaust and pain medications because (Pyxis), that would medications because (Pyxis), that would medication around a During an interview Administrator indice physician's orders we Medical Record (El was admitted to the medication administrator indice concern about his famedication on the direction of the direction on the direction of the direction on the direction of the direction on the direction on the direction of the direction on the direction of the direction of the direction on the direction of the	o being the worst pain that is  of on 9/10/24 at 9:33 A.M., sible party indicated Resident ning of severe pain for hours one would give him pain the medications had not yet at the pharmacy. Resident B's dicated he was able to contact sing in the evening on 7/19/24, had been requesting pain dent B for several hours but received any pain this medications had not yet farmacy, At the time of his Director of Nursing, on 7/19/24 dent B had not been given the since his admission to the the stresponsible party indicated sing had informed him that the have to wait for pain the the facility had a system allow nurses to retrieve the ded. Resident B's responsible dent B finally got pain 8:30 P.M. on 7/19/24.  of on 9/12/24 at 11:23 A.M., the atted some of Resident B's the rere not put in the Electronic MR) on the day the resident facility, causing a delay in tration for pain management ments related to wound care	TAG	Assurance and Performance Improvement Committee for and follow-up.  By what date the systemic changes will be completed: 09/27/2024  Compliance Date = 09/27/2026	

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

Event ID:

**YYG911** Facility ID: 000091

If continuation sheet

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PRINTED: 10/09/2024 FORM APPROVED 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 <u>00</u>			COMPLETED		
155689			B. WING			09/12/	2024
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF GOSHEN			STREET ADDRESS, CITY, STATE, ZIP COD 2400 COLLEGE AVE GOSHEN, IN 46526				
MAJESTI (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCE REGULATORY OR Pharmacy, but the A medications he wou in the Pyxis system. the facility had iden medications not bein system for new reside in the system timely.  During an interview Assistant Director of B should have had a on admission, but had on admission, but had a on admission, but had a negative to the policy, it policy, titled, "Pain The policy indicated for the recognition, monitoring of pain. evaluated for pain a admission.  On 9/12/24 at 11:30 provided a policy, in policy, titled, "Pharmindicated the facility medications for emeritations.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Administrator indicated all the ld have needed were available The Administrator indicated tified a problem related to ng pulled from the Pyxsis dents and orders not being put of for new residents.  Ton 9/12/24 at 11:25 A.M., the of Nursing indicated Resident a pain assessment completed	ID PREFIX TAG	PROVIDI (EACH CORRI CROSS-REFER	ER'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE IENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	3.1-37(a)						

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