STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Goshen	2400 College Ave Goshen, IN 46526

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 31719 Based on observation, interview and record review, the facility failed to ensure bathing opportunities and oral care were provided for 2 of 3 residents, who required assistance and who were dependent on staff for Activities of Daily Living (ADL). (Residents B and G) Finding includes: 1. During an observation/interview, on 11/13/24 at 9:05 A.M., Resident B was observed lying in his bed. His hair appeared greasy and had flakes of white throughout his scalp. The resident's teeth had a white film on them. The resident was alert and oriented to self, place and time. He indicated he does not get his showers on Mondays and Thursdays and he had to shave himself with an electric razor but explained he had difficulty holding the razor and only parts of his face got shaved. He indicated staff never offered him a tooth brush and he thought he had two toothbrushes somewhere in his room but staff were unable locate them. On 11/13/24 at 9:40 A.M., a review of the clinical record for Resident B was conducted. The resident's diagnosis included, but were not limited to: neurogenic bladder, end stage renal disease (ESRD), spinal injury and quadriplegia (paralysis that effects all limbs and body). A Quarterly Minimum Data Set (MDS) Assessment, dated 9/4/24, indicated the resident required substantial/maximal assist with bathing/showers and oral hygiene. A current Care Plan, dated 10/11/24, indicated the resident needed assistance with ADLs related to contractures of bilateral hands and quadriplegia (syndrome of cervical spine). The interventions included but were not limited to: bathing/showering two times a week and as need per resident's preference, nail care on bath day, personal hygiene with extensive assist of 2 persons. The November shower sheets indicated the resident received a bed bath on 11/1, a shower on 11/7 and on 11/11 had refused a shower. The shower sheets did not indicate if his hair had been shampooed, facial hair shaved or if his teeth were brushed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 11/13/24 at 10:55 A.M., Resident G requested an interview. The resident was observed in her bed. She was alert and oriented to person, place and time. She indicated her shower days were on Mondays, Thursdays and Saturdays, however she had not been getting her showers as per her preference. She had explained to the Director of Nursing and the Administrator she especially wanted a shower on Saturdays due to attending church on Sundays, outside the facility, with a friend. She would even have accepted an early morning shower on Sunday, if they were unable to provide a shower on Saturday. Many times she had been told by staff they were short staffed and could not provide her a shower on her preferred days. She indicated she was never offered her toothbrush, which was sitting on the dresser, out of her reach. He teeth were observed to have debris and a white film on them. On 11/14/24 at 11:03 A.M., a review of the clinical record for Resident G was conducted. The resident's diagnosis included, but were not limited to: cervical spina bifida and neuromuscular dysfunction of the bladder. A current Care Plan, dated 9/24/24 indicated the resident needed assistance with ADLs related to diagnosis of cervical spina bifida, paraplegia and weakness. The interventions included, but were not limited to: resident will have care needs met daily with the assistance of staff, bathing/showering on Tuesday, Thursday and Saturday first shift and extensive assist of 2 persons with personal hygiene needs. A Quarterly Minimum Data Set (MDS) Assessment, dated 10/14/24, indicated the resident required substantial/maximal assist with bathing/showers and partial/moderate assist with oral hygiene. The Septembers shower sheet forms indicated the resident only received 1 shower, on a Saturday for the month of September. The October shower sheet forms indicated the resident had never received a shower on any of the Saturdays in October. The November shower sheets also had no recorded shower being completed on a Saturday. None of the shower sheets from September through November documented if her hair had been shampooed. During an interview, on 11/14/24 at 9:35 A.M., the Resident Council President indicated there had been discussions regarding showers not occurring and the president indicated they had been told the facility would do something about it but it seemed to be an ongoing problem. A review of the Resident Council minutes for September indicated .Residents discussed concerns about showers some people in the council have 2-3 showers a week a couple of residents have one a week The Department Manager response had been .showers can be adapted for resident's preference The Resident Council minutes for October were reviewed and the Resident Council response indicated .Is there a way that we can please change our shower dates? For some residents (2) they are not working out . Shower schedule had been previously revamped and will be adjusted again. Will discuss with residents what their preferences are and update shower schedule accordingly The Resident Council minutes, for 11/12/24, indicated one of the concerns brought to council, by the residents, had been showers. They did not indicate any specific complaints regarding the showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 12:22 P.M., the Administrator provided a policy titled, Activities of Daily Living (ADLs), dated 1/2/24, and indicated the policy was the one currently used by the facility. The policy indicated .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene 3.1-38(a)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31719 Based on observation, interview and record review, the facility failed to implement interventions to prevent falls, for 1 of 3 residents reviewed for falls. (Resident C) Finding includes: On 11/12/24 at 7:50 A.M., Resident C was observed, seated in a wheelchair, near the nurse's station. The wheel chair had a padded seat cushion. On 11/12/24 at 8:23 A.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: Alzheimer's Disease, dementia, anxiety and depression. A current Care Plan for risk of falls, intiated 9/3/24, indicated the resident was at risk for a fall related to a history of falls, impaired cognition and poor safety awareness. The interventions included but were not limited to: offer/encourage to get up later in the morning, no chux pad in wheelchair and offer to assist resident to bed or recliner after meals A Morse Fall Risk Assessment, dated 10/7/24, indicated the resident had scored a 75. The Morse Fall scoring indicated a score of 45 or high indicated resident had been a high risk for a fall. A Nursing Progress Note, dated 10/7/24 at 2:18 P.M., indicated Resident C had been in the activity room at 10:15 A.M. and slid off the seat of her wheelchair. The resident was assessed and had no injuries. A Nursing Progress Note, dated 10/8/24 at 9:58 A.M., indicated the IDT (Interdisciplinary team) had met to review the witnessed fall Resident C had while in the activity room. The IDT members indicated the new intervention would be to provide a dycem (non-slip pad) to be placed on the resident's wheelchair. The Resident's Fall Care Plan interventions was updated, on 10/8/24, to include the following: .place dycem on top of w/c [wheelchair] cushion On 10/30/24 at 10:59 A.M., a Nursing Progress Note indicated at 8:47 A.M., Resident C was found on the floor. The resident had been propelling herself in the wheelchair, when she slid off of it. No injuries had been noted. During an observation, on 11/12/24 at 9:20 A.M., the Regional Nurse and another staff member assisted Resident C to a standing position to determine if there had been a dycem placed on the wheelchair pad. The pad had no dycem located on the resident's wheelchair, above the cushion, nor below the cushion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 10:54 A.M., Resident C's family member indicated she was concerned with the resident having had several falls during last month due to sliding out of her wheelchair. The family member could not understand why this had been happening. On 11/13/24 at 11:25 A.M.,, the Administrator provided a policy titled, Incidents, Accident & Supervision, dated 1/2/24, and indicated the policy was the one currently used by the facility. The policy indicated . SUPERVISION The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s) This citation relates to Complaint IN00445192. 3.1-45(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31719 Based on observation, interview and record review, the facility failed to ensure urinary catheters were emptied for 2 of 3 residents and urine output had been documented for 3 of 3 residents reviewed for urinary catheter use. (Residents B, E and G) Findings include: 1. On 11/12/24 at 10:45 A.M., Resident B was observed in his room, in bed, with his eyes closed. The resident's urinary (Foley) catheter had approximately 350 milliliters (ml) in the collection meter which could only hold 350 ml and then would spill into the collection bag. The collection bag had approximately 200-250 ml (milliliters) of urine. During an interview, on 11/1/2/24 at 10:47 A.M., RN 2 indicated urinary Foley was placed while Resident B had been in hospital and the collection meter would spill over into the collection bag, if more than 350 in collection meter. She indicated those type of catheters were used if someone needed to know the output every hour or whatever the order indicated. On 11/13/24 at 9:05 A.M., Resident B was observed in bed. The resident was alert and oriented to person, place and time. The resident's urinary (Foley) catheter had approximately 300 ml in Foley catheter's collection meter, with a small amount in the collection bag. Resident indicated staff hardly ever empty the thing. On 11/13/24 at 9:40 A.M., a review of the clinical record for Resident B was conducted. The resident's diagnosis included, but were not limited to: neurogenic bladder, End Stage Renal Disease (ESRD), spinal injury and quadriplegia (paralysis that effects all limbs and body). A current Care Plan, intiated on 8/14/24 indicated the resident was at risk for infection/complication related to an indwelling catheter. The interventions included, but were not limited to: .document Catheter output every shift The Treatment Administration Record (TAR) for October and November 2024 for Resident B, indicated . every shift Document mL output The TARs indicated the staff had never documented, on any shift, the amount of urine that was drained from the urinary (Foley) catheter bag. On 11/13/24 at 3:09 P.M., Resident B's Foley catheter collection meter was completely full (350 ml) and the collection bag had approximately 200 ml. of urine it it. The resident indicated the staff had not emptied the catheter and second shift had already began at 2:00 P.M. On 11/14/24 at 9:33 A.M., Resident B's Foley catheter collection meter had 325 ml of urine and an addition 100-150 ml in the drainage bag. The resident indicated no one from the night shift had emptied the drainage bag, before the end of their shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 11/13/24 at 10:55 A.M., Resident G requested an interview. The resident was observed in her bed . She was alert and oriented and had a urinary catheter collection bag positioned on her bed rail. She indicated she had concerns regarding the emptying of her urinary (Foley) catheter. She indicated staff usually emptied it once a day and she believed it needed to be emptied more often. On 11/13/24 at 3:13 P.M., Resident G's Foley collection bag was observed and had approximately 300 ml of urine in it. The Resident indicated no one from the first shift had emptied her catheter collection bag. The TAR indicated, on 11/13/24, the day shift nurse had documented 700 ml of urine had been drained from the resident's urostomy (a tube to assist to help pass urine when [NAME] the bladder has been removed or was not working) collection bag. On 11/14/24 at 11:03 A.M., a review of the clinical record for Resident G was conducted. The resident's diagnosis included, but were not limited to: cervical spina bifida and neuromuscular dysfunction of the bladder. A current Care plan, intiated on 8/16/24 indicated the resident was at risk for an infection/complications related to a urostomy . The interventions included, but were not limited to: .document Catheter output every shift The TAR for October 2024, indicated the catheter output documentation had been left blank 15 times and the TAR for November had 2 placed where the urine output was undocumented. 3. Resident E's TAR for October and November indicated every shift Document mL output The resident's TAR indicated staff had never documented the resident's urinary catheter output for either month. On 11/14/24 at 9:30 A.M., the Administrator provided a policy titled, Indwelling Catheter, dated 1/2/24, and indicated the policy was the one currently uses by the facility. The policy indicated .4. If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice This citation relates to Complaint IN00443893. 3.1-41(a)(2)