

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Goshen		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 College Ave Goshen, IN 46528	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to ensure catheter care was completed as ordered for 3 of 3 residents reviewed (Resident B, Resident C, Resident D). Findings include:</p> <ol style="list-style-type: none"> 1. Resident B's record was reviewed on 9/9/25 at 12 PM. Diagnoses included: obstructive and reflux uropathy. An order, dated 6/2/25 - 8/14/25, indicated to complete foley catheter care every shift and document output every shift. The Medication Administration Record (MAR), dated 6/1/25 - 8/4/25, indicated the following: June 2025 - 12 shifts had no documentation to reflect catheter care/ urinary output was completed July 2025 - 5 shifts had no documentation to reflect catheter care/ urinary output was completed August 2025 - 3 shifts had no documentation to reflect catheter care/ urinary output was completed Nursing notes, dated 6/1/25 - 8/24/25, were reviewed. The nursing notes indicated Resident B had a urinary tract infection (UTI) on 6/18/25 and 7/23/25. A nursing note, dated 8/14/25, indicated Resident B's catheter was removed. There was no other documentation regarding catheter care or documentation of urinary output. 2. Resident C's record was reviewed on 9/9/25 at 11:57 AM. Diagnosis included: neuromuscular dysfunction of the bladder. An order, dated 7/1/2024, indicated to document catheter output every shift. The Medication Administration Record (MAR), dated 6/1/25 - 9/4/25, indicated the following: June 2025 - 8 shifts had no documentation to reflect urinary output was obtained July 2025 - 14 shifts had no documentation to reflect urinary output was obtained August 2025 - 3 shifts had no documentation to reflect urinary output was obtained There was no other documentation regarding documentation of urinary output. 3. Resident D's record was reviewed on 9/9/25 at 12:10 PM. Diagnosis included: obstructive and reflux uropathy. An order, dated 11/14/2024, indicated to complete foley catheter care every shift and document output every shift. The Medication Administration Record (MAR), dated 7/1/25 - 9/8/25, indicated the following: June 2025 - 2 shifts had no documentation to reflect catheter care/ urinary output was completed July 2025 - 4 shifts had no documentation to reflect catheter care/ urinary output was completed August 2025 - 6 shifts had no documentation to reflect catheter care/ urinary output was completed There was no other documentation regarding catheter care/ urinary output. In an interview, on 9/10/25 at 1 PM, Unit Manager 3 indicated there was no other documentation regarding catheter care/ urinary output for Resident B, Resident C nor Resident D. In an interview, on 9/8/25 at 11:27 AM, Resident B's family indicated catheter care was not completed as ordered and Resident B had gotten UTIs with the catheter. In an interview, on 9/10/25 at 10:42 AM, Resident B indicated she no longer had a catheter. Resident B indicated when she did have the catheter she had gotten multiple UTIs. In an interview, on 9/9/25 at 12:47 PM, Registered Nurse (RN) 2 indicated catheter care was completed each shift. RN 2 indicated catheter care included emptying the catheter bag, cleaning around the tube insertion and peri-care. RN 2 indicated catheter output was communicated to the nurse and documented in the MAR. When no documentation existed, there was no way to tell if catheter care was completed or urinary output was obtained. In an interview, on 9/10/25 at 11:59 AM, the Director of Nursing (DON) indicated catheter care was completed during each shift. The DON indicated catheter care included peri-care, output documentation and cleaning the tube around the insertion site. The DON indicated outputs were documented on the MAR. The DON also indicated the MAR documentation was reviewed during daily clinical meetings. In an interview, on 9/10/25 at 1:21 PM, the Administrator indicated nurse staffing consisted of 8 hour shifts: 6 AM - 2 PM, 2 PM - 10 PM and 10 PM - 6 AM. A policy, undated, titled Indwelling Catheter, indicated catheter care was completed as ordered and to prevent infection. This finding relates to Intake 1243215.3.1-37(a) 		