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	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Goshen	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure showers were completed for 2 of 4 residents reviewed for activities of daily living. (Residents C & B)Findings include:1.A record review for Resident C was completed on 1/5/2026 at 9:07 A.M. Diagnoses included, but were not limited to: intertrochanteric fracture of right femur, cerebral palsy, and bipolar disorder.An admission Minimum Data Set (MDs) assessment, dated 9/5/2025, indicated Resident C was cognitively intact, had impairment with range of motion on one side of the upper and lower extremity and required substantial assistance for showering.A Care Plan Conference had been held, on 9/4/2025 at 8:49 A.M. for Resident C. The Care Plan Conference note indicated the family had concerns related to Resident C's care.The medical record indicated Resident C should have received showers on Tuesdays and Fridays. From admission, on 8/29/2025 through discharge on [DATE], Resident C had only received a shower on 9/5/2025, 9/16/2025 and 9/19/2025. The medical record had no indication Resident C had refused showers.A Care Plan, initiated on 8/31/2025, indicated Resident C needed assistance with activities of daily living with the goal of having care needs met on a daily basis. Interventions included, but were not limited to: showers two times per week and as needed per Resident C's preference.During an interview, on 1/6/2026 at 9:13 A.M., Resident C's wife indicated she had spoken to the facility concerning Resident C not receiving his showers and the facility had been apologetic. Resident C's wife indicated the facility indicated Resident C had not received his showers because he had signed documentation he had refused his showers. Resident C's wife indicated Resident C would not have kept asking for a shower had he refused. She indicated the facility social worker had come to Resident C's room and tried to convince Resident C he had signed documentation for refusal of showers, but the paperwork that indicated Resident C's refusal could not be found.During an interview, on 1/7/2026 at 12:54 P.M., LPN 2 indicated resident should receive a shower twice weekly and if a refusal of a shower had occurred, a signature from the resident on a shower sheet, would have been obtained and documented in the nursing progress notes.During an interview, on 1/7/2026 at 1:26 P.M., the Interim Director of Nursing indicated shower sheets had not been utilized in September of 2025. She indicated showers that had been received would be documented in the medical record and refusals would have been documented in the nursing progress notes.2. During an interview, on 1/2/2026 at 11:52 A.M., Resident B indicated he was supposed to have showers on Tuesdays and Fridays on second shift but he had not had a shower in awhile. Resident B indicated when he asked for a shower, he staff would tell him, If we can fit you in. Resident B indicated he had gone weeks without a shower. He indicated the Director of Nursing had asked him if he had been refusing showers. He indicated he refused to sign a shower sheet paper because he had not refused his showers.A record review for Resident B was completed on 1/6/2026 at 11:23 A.M. Diagnoses included, but were not limited to: neuromuscular dysfunction of the bladder, benign prostatic hypertrophy, cerebrovascular accident (stroke) and anxiety disorder.A Quarterly Minimum Data Set (MDS) (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

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 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Goshen	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, dated 11/13/2025, indicated Resident B was cognitively intact and required substantial assistance for showering.The medical record indicated Resident B should have received showers on Tuesdays and Fridays on second shift. Resident B had been absent from the facility due to hospitalization from 12/19/2025-12/24/2025 and 12/27/2025-1/1/2026. The only recorded shower in the medical record had been on 12/9/2025. Shower sheets had been completed for 12/2/2025, 12/12/2025 and an undated sheet. The medical record did not have any documentation that Reisdent B had refused any showers.A Care Plan, initiated on 2/21/2023 and revised on 11/14/2025, indicated Resident B required assistance with activities of daily living with a goal of having daily care needs met. Interventions included, but were not limited to: Showers on second shift on Tuesdays and Fridays and as necessary.During an interview, on 1/7/2026 at 12:54 P.M., LPN 2 indicated residents should receive a shower twice weekly and if a refusal of a shower had occurred, a signature from the resident on a shower sheet would have been obtained and documented in the nursing progress notes.A policy was provided by the Executive Director, on 11/7/2026 at 2:08 P.M. The policy titled, Showers, indicated, .It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulant circulation and help prevent skin issues as per current standards of practice.1. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety.This citation relates to Intake 2622065.3.1-38(b)(2)

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 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Goshen	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to follow physician orders for 1 of 3 residents reviewed for medication administration and failed to ensure an appointment for a specialized physician had been scheduled for 1 of 3 residents reviewed for resident rights. (Residents C & E)Findings include:1.A record review for Resident C was completed on 1/5/2026 at 9:07 A.M. Diagnoses included, but were not limited to: exocrine pancreatic insufficiency, cerebral palsy, and diabetes mellitus type 2.An admission Minimum Data Set (MDs) assessment, dated 9/5/2025, indicated Resident C was cognitively intact.Home Discharge Instructions from the hospital, dated 8/29/2025, indicated the resident was to receive the medication, pancrelipase (Creon) 36,000 units three times a day with meals and snacks.A Physician's Order, dated 8/29/2025 and discontinued on 9/4/2025, indicated Creon 36,000-114,000 units one capsule three times daily to treat exocrine pancreatic insufficiency.The Medication Administration Record, dated August 2025, indicated pancrelipase had been administered daily, from 8/30/2025-8/31/2025, at 6:00 A.M., 2:00 P.M. and 6:00 P.M. These administration times were outside of the facility's scheduled meal times.The Medication Administration Record, dated September 2025, indicated pancrelipase had been administered daily, from 9/2/2025-9/4/2025, at 6:00 A.M., 2:00 P.M. and 6:00 P.M. These administration times were outside of the facility's scheduled mealtimes.The Medication Administration Record, for August and September 2025, indicated the pancrelipase had not been administered on 8/30/2025 at 2:00 P.M., on 8/29/2025 at 6:00 P.M., on 8/31/2025 at 2:00 P.M., on 9/1/2025 at 6:00 A.M., on 9/1/2025 at 2:00 P.M., on 9/1/2025 at 6:00 P.M., on 9/2/2025 at 6:00 A.M. and on 9/2/2025 at 2:00 P.M. The physician nor the nurse practitioner had been notified of the missed medication administrations.A Care Plan Conference had been held for Resident C on 9/4/2025 at 8:49 A.M. The Care Plan Conference note indicated the family had concerns related to making sure Resident C had been receiving medications before every meal.A Physician's Order, dated 9/8/2025, indicated Resident C was to receive the medication, metoprolol succinate ER 25 milligrams daily for hypertension and the medication was to be held for a systolic blood pressure less than 100 mmHg (millimeters of mercury) and a heart rate of less than 60 beats per minute.The Medication Administration Record, dated September 2025, indicate metoprolol succinate ER had been administered on 9/17/2025 even though the Resident's heart rate was 59 beats per minute and on 9/19/2025 with a heart rate of 55 beats per minute.During an interview, on 1/6/2026 at 9:13 A.M., Resident C's wife indicated she had spoken to the facility concerning Resident C's pancrelipase and the correct administration times for the medication.2. During an interview, on 1/2/2026 at 11:25 A.M., Resident E indicated she had asked the facility staff for a doctor's appointment beyond the facility medical staff onsite and the facility would not make the appointment. Resident E indicated she had asked facility staff for over two months to make an appointment with her neurologist due to new symptoms she was experiencing with her multiple sclerosis illness.A record review for Resident E was completed, on 1/7/2026 at 10:47 A.M. Diagnoses included, but were not limited to: trigeminal neuralgia and multiple sclerosis.A Quarterly Minimum Data Set (MDS) assessment, dated 11/6/2025, indicated Resident E was cognitively intact.A Physician's Order, dated 8/10/2025, included an order to schedule a neurological consultation for Resident EA facility grievance form was submitted, on 10/9/2025, by Resident E that had requested an appointment to be made with a neurologist. The grievance indicated a previous request had been made without a follow-up appointment completed. The response indicated an appointment had been made with a neurologist. However, there was no evidence that an appointment had actually been scheduled.A Nurse Practitioner's Note, on 10/23/2025 at 12:59 A.M., indicated Resident E had been seen for uncontrollable trigeminal neuralgia. Per nursing, Resident E had been screaming out in pain, especially in the (continued on next page)

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 01/07/2026
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evenings. Resident E had requested to return to her neurologist, and a referral had already been ordered. The note indicated the facility was working on setting up the appointment.During an interview, on 1/7/2026 at 12:54 P.M., LPN 2 indicated that all appointments were scheduled through the transportation director.During an interview, on 1/7/2026 at 1:38 P.M., the transportation director indicated all outside doctor appointments came through her for scheduling appointments. The transportation director indicated she had not transported Resident E to any appointments. She indicated the facility nurse practitioner, and the facility nurse, would have informed her if any appointments had been needed or were to have been scheduled. She indicated she had not scheduled any appointments for Resident E.A policy was provided by the Executive Director, on 1/7/2026 at 2:08 P.M. The policy titled, Physician Orders, indicated, .The purpose of this policy is to provide a reliable process for the proper and consistent provisions of physician ordered services according to professional standards of quality.A policy was provided by the Executive Director, on 1/7/2026 at 2:08 P.M. The policy titled, Physician Orders, indicated, .The purpose of this policy is to provide a reliable process for the proper and consistent provisions of physician ordered services according to professional standards of quality.This citation relates to Intake 2622065.3.1-37(a)

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 01/07/2026
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)
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. Based on interview and record review, the facility failed to ensure urinary output was monitored for 1 of 3 residents reviewed for urinary catheters. (Resident B)Finding includes:During an interview, on 1/2/2026 at 11:52 A.M., Resident B indicated he had been hospitalized recently for sepsis.During an interview, on 1/6/2026 at 9:59 A.M., Resident B's sister indicated she had been notified that Resident B had been sent to the emergency room for a slight fever. She indicated when Resident B had arrived at the Emergency Room, he had a fever of 104.3 degrees Fahrenheit and had been diagnosed with an infection in his blood and urine. Resident B's sister indicated the emergency room physician had indicated Resident B's Foley catheter had been dislodged or had been incorrectly placed. Resident B's sister indicated Resident B's roommate had reported to her when Resident B's Foley (urinary) catheter had been last changed , there was bloody and purulent urine in the tubing and the nursing staff had shoved another urinary catheter into Resident B's urethra.A record review for Resident B was completed on 1/6/2026 at 11:23 A.M. Diagnoses included, but were not limited to: neuromuscular dysfunction of the bladder, benign prostatic hypertrophy, cerebrovascular accident (stroke) and anxiety disorder.A Quarterly Minimum Data Set (MDS) assessment, dated 11/13/2025, indicated Resident B was cognitively intact, had an indwelling urinary catheter and required substantial assistance for toileting and hygiene.A Physician's Order, dated 6/18/2025, indicated staff were to monitor the urinary (Foley) catheter output every shift. However, this order had been discontinued on 12/15/2025.A Nursing Progress Note, dated 12/17/2025, indicated Resident B had complained of penial pain and there had been pus coming from the head of the penis. Resident B had requested for the urinary (Foley) catheter to be removed and left out. Resident B had complained of severe pain all evening. Tylenol had been administered and lubricant had been placed around the inside of the penis to prevent tugging on the head of the penis when the resident had moved in his bed.A Nursing Progress Note, on 12/18/2025 at 12:10 A.M., indicated Resident B's urinary (Foley) catheter had been changed and a urine sample had been obtained via a clean catch method thru the newly placed urinary (Foley) catheter. A Nursing Progress Note, on 12/19/2025 at 12:02 P.M., indicated a verbal order had been obtained to send Resident B via ambulance to the hospital. Resident B had been found with a temperature of 99.7 degrees Fahrenheit, shaking and turning a gray tone color in his hands and lips. Resident B had complained of pain with his urinary (Foley) catheter and had a white drainage coming from his penis around the urinary (Foley) catheter.An emergency room History and Physical, dated 12/19/2025, indicated Resident B had a chronic indwelling urinary (Foley) catheter and had arrived at the emergency room with lethargy, nausea and vomiting and mild shortness of breath. The Foley catheter had been found to have been displaced with the catheter bulb in the penile shaft. The emergency room workup indicated Resident B had a urinary tract infection with a temperature of 102.6 F. Resident B had been diagnosed with early sepsis with borderline shock related to a urinary tract infection due to a displaced Foley catheter.During an interview, on 1/7/2025 at 12:54 P.M., LPN 2 indicated urinary output from a urinary (Foley) catheter should have been documented in the medical record every shift. It was unclear why the physician's order regarding urinary outputs had been discontinued in December and it was unclear why nursing staff had not obtained urinary outputs every shift.A current policy, dated 12/12/023, was provided by the Executive Director, on 1/7/2026 at 2:08 P.M. The policy titled, Indwelling Catheter, indicated, .It is the policy of this facility to ensure that indwelling urinary catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice. Indwelling urinary catheters are catheters that remain in the bladder to assist with urinary elimination. The (continued on next page)

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 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Goshen	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use of indwelling catheters for managing incontinence is not appropriate and increase the risk of urinary tract infections.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 and resident care policies and procedures that include but not limited to: d. Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures; e. Response of the resident during the use of the catheter; and f. Ongoing monitoring for changes in condition related to potential catheter-associated urinary tract infections, recognizing, reporting and addressing such changes.This citation relates to Intake 2698825.3.1-41(a)