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	02/03/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and record review, the facility failed to implement their policy related to reporting, two allegations of abuse in a timely manner for 1 of 3 residents reviewed for allegations of abuse, (Resident C). Finding includesOn 1/28/26 at 11:52 A.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to Alzheimer's Disease, dementia, seizures, weakness, and depression.Resident C's Minimum Data Set (MDS) Quarterly assessment dated [DATE], indicated the resident had severe cognitive impairment, utilized a wheelchair for locomotion, and required substantial assistance for eating, dressing, toileting, bathing, transfers, and bed positioning.Resident C's Care Plans included but were not limited to: the resident had a preference for video recording in her room and a STOP sign across the door frame, dated 8/26/25. Interventions included but were not limited to protecting residents' privacy and not capturing other residents or staff in shared or common areas.Facility Incident Number 236 was submitted to the State Agency on 9/17/25 and indicated the incident date was 9/17/25 at 11:30 A.M. The report indicated on 9/17/25 a male resident walked into Resident C's room and sat on the resident's bed. The immediate action taken indicated Resident F was removed from the room and a head-to-toe assessment was completed for Resident C with no findings and the family and the physician were notified of the incident. Preventive Measure indicated Resident F was placed on every 15 minute checks . The Follow up dated 9/24/25 indicated on 9/17/25, Resident C had reported a male resident was in her room but had not reported any physical contact. On 9/18/25 Resident F was discharged from the facility with a return not anticipated.Facility Incident Number 254 was submitted to the State Agency on 2/3/25 and indicated on 2/3/26 at 10:42 A.M., the Administrator was made aware that a report was never filed for an incident that had occurred on 10/20/25 by the previous administrator, and that the incident involved Resident D climbing into bed with Resident C after undressing herself.Review of a Care Plan Conference Summary, dated 12/12/25 at 10:20 A.M., indicated those in attendance included Resident C's responsible parties, Social Services, Nursing Services, the local Ombudsman and the Administrator. The Care Plan notes indicated the meeting was due to Resident C's family's concerns and that the local Ombudsman had been invited to help find appropriate interventions that could be put into place to prevent other residents from wandering into Resident C's room, specifically at night.On 2/2/26 at 11:58 A.M., Resident C's responsible party provided an email dated 9/12/25 at 10:09 P.M., sent to Previous Administrator 2. The email indicated Resident C's responsible party was following up about an incident she had reported earlier. The email indicated the responsible party viewed, via family installed security room cameras, an incident on 9/7/25 at 4:47 A.M. Resident F had entered Resident C's room while Resident C was asleep in her bed, and had attempted to sit on the bed, had opened his robe, had closed the robe, then had sat in a chair in the room. The email indicated Resident F then stood and moved again to Resident C's bed and had sat on the bed, then had sat directly on Resident C's chest and left shoulder, causing (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident C to groan and call out in pain. Resident F then sat on ground next to the bed and fell asleep where nursing staff found Resident F at 4:57 A.M. and escorted him out of the room.A second email dated 10/20/25 at 12:18 P.M., also from Resident C's responsible party to the Previous Administrator, Employee 2, indicated on 10/20/25 at 10:09 A.M., she and notified them that Resident D had entered Resident C's room in the morning of 10/20/25, completely undressed, wiped her genital area with a blanket from Resident C's bed and had then gotten into bed with Resident C.On 2/3/26 at 1:57 P.M., during an interview, the Administrator indicated he was aware of the allegations of abuse that occurred on 9/8/25 and on 10/20/25 and that he assumed both allegations had been reported timely to the State Agency as directed by the facility policy by Previous Administrator, Employee 2, but they had not been reported. The Administrator indicated the allegations of residents wandering into Resident C's room were discussed at a Care Plan meeting on 12/12/25.On 1/29/26 at 2:47 P.M., a policy titled Abuse, Mistreatment, Neglect, Exploitation and Mistreatment, dated 7/1/25, was provided by the Administrator who indicated it was the current facility policy. The policy indicated, .Purpose [was to] investigate all alleged violations.Alleged Violation is a situation or occurrence that is observed or reported by.resident, relative.Care Plan members should immediately report allegations to the Administrator and to the Department of Health.completing ongoing assessments and care planning for appropriate interventions and monitoring of resident.including.wondering into other resident/patient's rooms.if abuse is alleged.the Administrator or his/her designee will notify the Department of Health immediately, but no later than 2 hours after the allegation is made.all other allegations.will be reported to the Department of Health immediately, but in no event later that 24 hours from the time the incident/allegation was made known to the Care Team Member.This citation relates to Intake 2715458.3.1-28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and record review, the facility failed to implement their policy related to investigating, an allegation of abuse for 1 of 3 residents reviewed for allegations of abuse, (Resident C). Finding includesOn 1/28/26 at 11:52 A.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to Alzheimer's Disease, dementia, seizures, weakness, and depression.Resident C's Minimum Data Set (MDS) Quarterly assessment dated [DATE], indicated the resident had severe cognitive impairment, utilized a wheelchair for locomotion, and required substantial assistance for eating, dressing, toileting, bathing, transfers, and bed positioning.Resident C's Care Plans included but were not limited to the following plan: The resident had a preference for video recording in her room and a STOP sign across the door frame, dated 8/26/25. Interventions included but were not limited to protecting residents' privacy and not capturing other residents or staff in shared or common areas.Facility Incident Number 236 was submitted to the State Agency on 9/17/25 and indicated the incident date had occurred on 9/17/25 at 11:30 A.M. The report indicated on 9/17/25 a male resident had walked in Resident C's room and sat on the resident's bed. The immediate action taken indicated Resident F was removed from the room and a head-to-toe assessment was completed for Resident C with no findings and family and physician were notified. Preventive Measure indicated Resident F was placed on every 15 minute checks . The Follow up dated 9/24/25 indicated on 9/17/25, Resident C reported a male resident was in her room and had not reported any physical contact. On 9/18/25 Resident F was discharged from the facility with a return not anticipated.Review of a Care Plan Conference Summary dated 12/12/25 at 10:20 A.M., indicated those in attendance included Resident C's responsible parties, Social Services, Nursing Services, local Ombudsman, and the Administrator. The Care Plan notes indicated the meeting was due to Resident C's family's concerns and that the local Ombudsman had been invited to help find appropriate interventions that could be placed to prevent other residents from wandering into Resident C's room, specifically at night.On 2/2/26 at 11:58 A.M., Resident C's responsible party provided an email, dated 9/12/25 at 10:09 P.M., sent to Previous Administrator (Employee 2). The email indicated Resident C's responsible party was following up about an incident she had reported earlier. The email indicated the responsible party had viewed, via a family installed security room cameras, an incident on 9/7/25 at 4:47 A.M. Resident F had entered Resident C's room while Resident C was asleep in her bed, and had attempted to sit on the bed, had opened his robe, had closed the robe, then had sat in a chair in the room. The email indicated Resident F then had stood back up and had moved again to Resident C's bed and had sat on the bed, then Resident F had sat directly on Resident C's chest and left shoulder causing Resident C to groan and call out in pain. Resident F then sat on ground next to the bed and fell asleep where nursing staff found Resident F at 4:57 A.M. and had escorted him out of the room.On 2/3/26 at 1:57 P.M., during an interview, the Administrator indicated he was aware of the allegation of abuse that had occurred on 9/8/25 and that a thorough investigation had not been completed by the previous administrator. The Administrator indicated the allegations of residents wandering into Resident C's room had been discussed at a Care Plan meeting on 12/12/25.On 1/29/26 at 2:47 P.M., a policy titled Abuse, Mistreatment, Neglect, Exploitation and Mistreatment, dated 7/1/25, was provided by the Administrator who indicated it was the current facility policy. The policy indicated, .Purpose [was to] investigate all alleged violations.Alleged Violation is a situation or occurrence that is observed or reported by.resident, relative.Care Plan members should immediately report allegations to the Administrator and to the Department of Health.completing ongoing assessments and care planning for appropriate interventions and monitoring of resident.including.wondering into other resident/patient's (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms.if abuse is alleged.the Administrator or his/her designee will notify the Department of Health.Once the Administrator and Department of Health are notified, and investigation of the allegation violation will be conducted.This citation relates to Intake 2715458.3.1-28(d)