

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 08/27/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155689                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>06/12/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Majestic Care of Goshen                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2400 College Ave<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                   |                                                 |
| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, record review and interview, the facility failed to maintain a sanitary kitchen for 1 of 1 main kitchen observed for sanitation. This deficient practice had the potential to affect 120 of 120 residents who consumed food from the kitchen. Finding includes: During an initial kitchen observation, on 6/12/2026 from 8:48 A.M. through 8:57 A.M., a live cockroach was seen crawling out from underneath the refrigerator, another live cockroach was seen crawling under the stove and two live cockroaches were crawling under the stainless-steel food prep counter that housed a microwave. There was a bag of sleeved bowl lids on the floor against the wall underneath the food prep counter close to the crawling roaches. In addition, there was food and general debris covered in dust and a grease buildup on the floor, along the back of the oven. Dead unidentifiable bugs and dead cockroaches were also noted along the edges of the kitchen walls, including the dish room. Live cockroaches were observed by the refrigerator, behind the stove, by the serving steamtable and along the walls of the kitchen. During an interview, on 6/12/2026 at 8:50 A.M., the Dietary Manager indicated she had not been aware of cockroaches in the kitchen. She indicated there had been a problem in the employee breakroom, which was located close to the kitchen. During an observation of the kitchen, on 6/12/2026 at 9:27 A.M., seven dead cockroaches were observed between the wall and food service steam table on the floor. During an interview, on 6/12/2026 at 9:28 A.M., the Assistant Director of Food Service indicated the back door to the kitchen had a metal pest control box and there was also a cardboard pest control box under the handwashing sink in the kitchen. She indicated cockroaches had been seen in the kitchen for the past year. During an interview, on 6/12/2026 at 10:53 A.M., the Assistant of Dietary Services, confirmed she had been aware of cockroaches in the kitchen for the past year. She indicated she had previously informed the former Director of Maintenance of the cockroach issue about two months ago. During an interview, on 6/12/2026 at 11:38 A.M., the Dietary Director indicated staff had a form for daily cleaning and the floor and equipment should have been cleaned every night for food debris, dust and general dirt. A Daily Cleaning Schedule was provided by the Dietary Director, on 6/12/2026 at 12:16 P.M. The schedule indicated sweep and mop the kitchen, had been signed as completed from 6/1-6/7/2026. Review of facility pest control reports for the past year, indicated the company had checked and performed preventative pest control throughout the building on a monthly basis. However, the reports, dated 6/5/2026 and 6/10/2026 indicated roaches had been noted in the employee break room, mop room and kitchen dish room and drains. The pest control notes for April 2026 had referred to debris in the dietary dish room that needed cleaned. The June pest control company notes included pictures of cockroaches and dirt and debris underneath and around the dish room floor and drains, as well as the mop room. A policy was provided, on 6/12/2026 at 12:16 P.M., by the Dietary Manager. The policy titled, Kitchen Sanitation, indicated, .To ensure a clean, safe, and sanitary food service environment that prevent foodborne illness, promotes resident/patient health, and meets all, federal, and local regulatory requirements, including CMS, FDA Food Code, and State Department of Health regulations. Policy.A. The Culinary Manager is responsible for overseeing the provision of safe food to all residents. A. Cleaning schedules will be posted and followed. b. The Culinary Manager or designee will make regular inspections. J. The kitchen will be (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

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| NAME OF PROVIDER OR SUPPLIER<br><br>Majestic Care of Goshen                                                                        |                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2400 College Ave<br>Goshen, IN 46528 |                                                 |
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| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | kept free from of pests through contracted pest management and Care Team Member vigilance. This<br>citation relates to Intake 3040629.410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(2) |                                                                                   |                                                 |