

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/24/2026
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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to ensure post fall assessments and monitoring had been completed for 1 of 6 residents reviewed for falls. (Resident B) This deficient practice resulted in Resident B serious injuries due to having a delay in treatment related to a broken occipital bone and subarachnoid hemorrhages in April and a delay of treatment related to a broken humerus bone in June. In addition to the Immediate Jeopardy, the facility failed to ensure 2 of 6 residents reviewed for falls received thorough post fall assessments and monitoring which resulted in the potential for harm, that is not immediate jeopardy. (Resident J and H)The Immediate jeopardy that began on 4/6/2026 when Resident B had an unwitnessed fall and staff failed to complete thorough post fall assessments. The Executive Director and the [NAME] President of Operations were notified of the immediate jeopardy on 7/22/2026 at 2:18 P.M. The immediate jeopardy was removed on 7/24/2026, but noncompliance remained at the lower scope and severity level of isolated with actual harm that is not immediate jeopardy. Findings include: During an interview with Resident B's Power of Attorney (POA) on 7/19/2026 at 2:15 P.M., she indicated Resident B had had two falls that she had been concerned about at the facility. The first fall happened on 4/6/2026, when Resident B was complaining of nausea and vomiting, and had a headache for several days after the fall and was not sent to the hospital for an evaluation. Resident B's POA stated, I am frustrated because when she had reported the resident's headache, on 4/7/2026 to the nurse, the nurse had replied, She is still complaining about that again today? A few days later, the facility sent Resident B to a local hospital related to her kidney function and Resident B told the emergency room (ER) doctor she had fallen a few days before at the facility and was not sure if she had hit her head. A Computed Tomography (CT) scan of Resident B's head indicated the resident had an active brain bleed. The resident was then transferred to larger hospital in a nearby town because she required intensive monitoring and care. She indicated the second fall she was concerned about had occurred on 6/12/2026. Resident B's POA indicated when she had visited the resident, on 6/12/2026, Resident B told her she had fallen the night before and her arm hurt. Resident B reported to the POA that an aide had found her on the floor and put her back into the bed. The POA indicated she had reported the fall to RN 2. The POA indicated RN 2 had told her it would have been impossible for Resident B to have fallen because the resident was not able to walk. The POA indicated RN 2 did not go and assess Resident B and she then had called the Hospice company and had requested a visit from a Hospice nurse. The Hospice nurse assessed Resident B, the next day, and had ordered an Xray and discovered Resident B had broken her arm. The Hospice Nurse also reported to the POA that the (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 7/21/2026 10:01 A.M., Resident B indicated she had fallen in April and sustained a brain bleed resulting in hospitalization. However, she had not been able to recall any of the details leading up to the hospitalization, including details of the fall. Resident B indicated she had fallen in June and had broken her shoulder. The resident indicated she had gotten up in the middle of the night, had not used the call light to request help, and had walked by herself to the bathroom. When she had finished in the bathroom, she had attempted to walk back to bed unassisted by staff and had tripped and fallen. She could not recall what she had tripped on, but recalled an aide had helped her to bed a short time later. The resident indicated her shoulder had hurt after the fall and she had told staff multiple times and had reported the fall to her daughter later that same day. A Late Entry Note, dated 6/15/2026, indicated the Interdisciplinary Team (IDT) had met to review a fall for Resident B which had occurred on 6/12/2026. The note indicated the CNA had walked into the resident's room and found the resident sitting upright on floor with her back against the bottom part of the bed, next to the foot board. Resident B had told the CNA she was going to the bathroom when she tripped over trashcan. The CNA indicated Resident B had stated that she was fine, and just needed help up. Resident B had been transferred back to bed with the assistance of the CNA. Resident B's record lacked any documentation before 6/15/2026 to indicate that the resident had fallen on 6/12/2026. However, review of the Hospice Note for Resident B, dated 6/13/2026, indicated the Hospice nurse had visited related to a triage call from the resident's daughter the day before about a fall. The Hospice nurse had spoken with RN 2, and RN 2 had reported that it was unlikely the resident had fallen because she had been non-ambulatory and there had been nothing documented related to a fall in the resident's record. RN 2 went with the Hospice nurse to assess the resident, and the resident was grimacing in pain when she was asked to extend her arm. The resident had not been able to extend her arm and an arm sling was ordered as well as an Xray. The resident had been administered Tylenol for pain after the assessment at the request of the Hospice nurse. A review of the facility's Incident Report, submitted to the Indiana Department of Health, completed on 7/21/2026 at 12:45 P.M., indicated the resident had had a fall that resulted in a fracture to the humeral neck with a mild displacement. During an interview with the [NAME] President of Operations on 7/21/2026 at 1:50 P.M., she indicated there were no neurological assessments completed for the unwitnessed fall on 6/12/2026, but there should have been. During an interview with the ED, on 7/21/2026 at 1:50 P.M., the ED indicated the CNA had failed to notify a nurse of a fall after the CNA had found the resident sitting on the floor. The ED indicated the CNA had moved the resident before a nurse had assessed the resident and should not have moved her. The ED indicated the resident's record lacked any information that the resident had an unwitnessed fall on 6/12/2026 before 6/15/2026. During an interview on 7/22/2026 at 9:40 P.M., RN 2 indicated on 6/12/2026 she had not been notified by anyone, including Resident B or anyone in her family, that the resident had fallen. RN 2 denied (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the physical environment remained free of vermin and pests and failed to promptly eradicate an ongoing insect infestation. This deficient practice affected the main kitchen and dry storage areas and had the potential to affect all 121 residents who resided in the facility and received food from the kitchen. See F0812 for additional information regarding storing and serving food in a safe and sanitary manner. Findings include: During an observation of the kitchen and dry storage areas on 7/19/2026 at 9:50 A.M., accompanied by the Assistant Dietary Manager 4, dead cockroaches were on the floor behind appliances, on shelves and on a windowsill. She indicated the facility was working on getting rid of the cockroaches. During an additional observation on 7/21/2026 at 10:25 A.M., a dead cockroach remained on the windowsill in the kitchen, on the floor in the kitchen and in the dry storage room. During an interview on 7/24/2026 at 9:29 A.M. with the Maintenance Director (11), he indicated the facility has had a contract with a pest control service since January 2026. He indicated he had followed their recommendations. A service summary report from the pest control company, dated January 20, 2026, indicated. An employee reported cockroaches crawling around the drains in the dishwashing area. The findings reported food residue under appliance/machinery/equipment. The entire area under the dishwasher needs to be deep cleaned. An exterior dumpster/trash can was overflowing. They recommended emptying the garbage can and cover (sic) it securely and cleaning up the surrounding area. This was first observed on 12/24/2025. This still needs addressed. An application of cockroach gel was placed in dishwasher area. A service summary report from the pest control company dated February 14, 2026, indicated. applied cockroach treatment to the locker room area. An exterior dumpster/trash can was overflowing. They recommended emptying the garbage can and covering the can securely. Clean the surrounding area up. This was first observed on 12/24/2025. This still needs addressed. An application of cockroach gel was placed in the locker room. A service summary report from the pest control company dated March 19, 2026, indicated. Applied interior supplemental crawling insect treatment. The findings reported food residue under appliance/machinery/equipment. The entire area under the dishwasher needs to be deep cleaned. This still needs addressed from 1/20/2026. They recommended empty garbage cans and cover securely. Clean up the surrounding area. This was first observed on 12/24/2025. This still needs addressed. A service summary report from the pest control company dated May 11, 2026, indicated. Did a supplemental crawling insect barrier treatment. Treated mop room for cockroach activity. A service summary report from the pest control company dated June 5, 2026, indicated. the mop storage room has excessive holes that need patched. Treated cracks and crevices with cockroach gel bait. A service summary report from the pest control company dated June 20, 2026, indicated. discussed ongoing sanitation issues with the dishwasher area and dirty towels in locker room and breakroom. Did a supplemental treatment of cockroaches in kitchen, break room, mop room, ice machine area and locker room. Recommended having breakroom, locker room, dish washing room areas deep cleaned. The drain by the dishwasher is backing up with food debris. There are dirty towels in the locker room that need picked up. The ice machines are leaking water, and wet towels need to be removed. All areas are harborage for roaches. The hole under the time clock needs to be sealed up. Active harborage, treated it heavily. A policy titled, Pest Control was provided by the Executive Director on 7/20/2026 at 2:45 P.M. The policy indicated. 1. Purpose- To maintain an effective pest control program that eradicates and contains common household pests and rodents. 2. Responsibility- This applies to every Care Team Member (including volunteers, providers, contractors, (continued on next page)		

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

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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 07/24/2026
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.			
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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Care Partners, trainees, students and other persons) in the performance of work. 4. Policy-We maintain a report system of issues that may arise in between scheduled visits with the outside pet service and treat as indicated. 410 Indiana Administrative Code (IAC) 16.2-3.1-19(f)(4) This Federal tag relates to Intake 3055774 & 3051678		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare and serve food under sanitary conditions in to prevent the growth of potential foodborne pathogens and reduce the risk of cross-contamination. Specifically, the facility failed to enforce proper infection control techniques during meal service, failed to maintain appropriate cold storage capacity by over-stacking units, failed to track and remove expired food items, failed to ensure effective chemical sanitization levels, and failed to maintain kitchen floors and areas underneath appliances in a clean, dry, and sanitary manner. This deficient practice had the potential to affect all 121 residents who consumed meals prepared by the facility kitchen. See F0925 for additional findings related to pest control. Findings include: During an observation of the kitchen on 7/19/2026 at 9:50 A.M., with the Assistant Dietary Manager (Employee 4), the following was noted: There was dirt and food on the floor throughout the kitchen. There was an accumulation of old debris, including dead cockroaches, three discarded resident plates, two plastic cups, multiple paper plates, and multiple forks heavily covered in dust and grease lying directly on the floor underneath counters and behind and around appliances. A test of the sanitizer water bucket, that was used to clean and sanitize all kitchen surfaces, measured at 50 parts per million (ppm), which fell significantly below the manufacturer-required effective cleaning range of 100 ppm to 400 ppm. During an interview with [NAME] 6, on 7/19/2026 at 10:15 P.M., she indicated the sanitizer water had not been changed since she had started her shift at 5:00 A.M. The Assistant Dietary Manager 4 indicated the water should have been changed every 2 hours. Observation of the kitchen refrigeration and freezer units, on 7/19/2026 at 10:25 A.M., indicated the following: The temperature logs on all refrigeration and freezer units had the afternoon dates for 7/19/2026 already completed on the logs. The Assistant Dietary Manager 4 indicated these temperatures should not have been recorded yet. Frozen food boxes were stacked directly against the cooling fans and up to the ceiling in the main walk in freezer, completely blocking essential airflow. In the main walk-in refrigerator, multiple boxes were stacked directly against the automated fire sprinkler line and ceiling pipes, exposing the food packaging to potential moisture from pipe condensation and accumulated dust. In the 2-door refrigerator, multiple items were stored past their expiration dates, including 48 cups of poppyseed dressing dated 7/9/2026 and 60 cups of tatar sauce dated 7/15/2026. In the 3-door refrigerator, multiple items were stored past their expiration dates, including 19 cups of yogurt dated 7/18/2026, 4 bowls of tossed salad with hard-boiled eggs with no labeled expiration date. In addition, there were 3 containers of Nectar thickening liquid opened and not dated when opened nor was there any expiration date on them. During an interview with the Assistant Dietary Manager, on 7/19/2025 at 10:35 A.M., she indicated the expired items should have been removed from the refrigerators. On 7/19/2026 at 11:28 A.M., during an observation of the dishwashing operations, a large pool of standing water was observed covering the dish room floor. Loose cardboard was observed under the dishwasher along with several rags. Standing water was also observed under the ice machine. During an interview with the Assistant Dietary Manager 4, on 7/19/2026 at 11:40 A.M., she indicated the pooling water has been an ongoing issue for months. During an interview with the Maintenance Director (11) on 7/24/2026 at 9:29 A.M., he indicated the standing water in the dish room was from a busted water pipe under the dish room floor. He indicated he had requested a quote for repair from a vendor. When asked to provide a copy of obtained quote, no documentation was provided before the survey exit. During an observation of food service in the main dining room, on 7/19/2026 at 11:42 A.M., Dietary Aide 5 was observed plating entrees onto resident (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dinner plates. Dietary Aide 5 repeatedly placed her bare thumb directly onto the eating surface of the plates while moving them down the line. She touched the food surface on 28 of 28 plates observed. In addition, although she had washed her hands prior to serving food, she had retrieved items from a refrigerator 5 separate times and had touched her clothes and face without re-washing her hands. During an interview on 7/19/2026 at 12:05 P.M., Dietary Aide 5 indicated she should have re-washed her hands and not placed her thumb on the food surface of plates. Assistant Dietary Manager 4 also indicated the aide should have rewashed her hands and not placed her thumb on the eating surface of the plates while placing food on the plates. On 7/29/2026 at 12:28 P.M., during the lunch dining service, Employee 9 was observed serving plates to residents at Tables 5 and 6 with his bare thumbs directly on top of the food-contact borders of the plates. On 7/20/2026 at 3:00 P.M., Employee 9 was observed carrying an uncovered bowl of ice cream through the lobby with his thumb inside the bowl in contact with the ice cream. During an interview on 7/23/2026 at 2:50 P.M. with Employee 9, he indicated the ice cream was for a resident. He said he understood the concern with placing his thumb on the food surface of meal plates but he strongly denied having done this or having his fingers come in contact with the ice cream he had served. A policy titled Safe Food Handling was provided by the Executive Director on 7/22/2026 at 12:17 P.M. He indicated this is the current policy the facility is using. The policy indicated. Purpose: To provide Care Team Members the best practices for safe handling of food. Policy: B.b. Leftover foods will be protected, labeled, and dated with the date of original preparation and date of discard. D.c. ppm for chemical sanitizing will be monitored throughout the day. A policy for safe food service was requested but not provided prior to the end of the survey. 410 Indiana Administrative Code (IAC) 16.2-3.1-21(i)		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly dispose of cooking grease and maintain refuse storage in a sanitary manner in 1 of 1 kitchen and refuse storage area. Findings include: During an observation, on 7/19/ 2026, at 10:00 A.M., the outside refuse containers' lids were left open and an open trash bag had been placed on the ground next to the dumpsters. There was also trash noted on the ground around the dumpster. During an interview with the FSS, on 7/20/2026, at 9:15 A.M., it was disclosed that the facility frequently poured used grease along the fence line. She indicated sometimes the grease was placed in the dumpster or was ran down the kitchen sinks. Observations of the fence line adjacent to the dumpster, on 7/20/2026 at 9:20 A.M., indicated there was an area devoid of plant life and grass with bare soil exposed. During an interview with the Executive Director, on 7/20/2026 at 10:00 A.M., he indicated the facility maintained a contract with a grease extraction company and he was not sure why the kitchen staff were not following the facility policy regarding grease disposal. 410 IAC 16.2-3.1-21(i)(5)		