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	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Goshen	2400 College Ave Goshen, IN 46526

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38845 Based on observation, interview and record review, the facility failed to ensure infection control practices were followed related to glove use and handwashing for 3 of 3 residents reviewed for perineal/catheter care and for 1 of 1 residents reviewed for nephrostomy care and during 1 of 3 medication administration passes. In addition, the facility failed to follow their policy regarding Enhanced Barrier Precautions (EBP) to ensure residents with wounds and catheters were placed in isolation for 3 of 5 residents reviewed for EBP isolation. Finally, the facility failed to report an illness outbreak to the State Department of Health. These deficient practices potentially affected 101 of 101 residents in the facility. (Residents 18, E, 98, G, 96, 314 & H) Findings include: 1. During an observation, on 1/17/2025 at 9:56 A.M., Certified Nursing Assistant 11 was observed to provide perineal care to Resident 18. CNA 11 obtained a basin with warm water and washcloths. She then applied gloves and washed the Resident's front and inner groin area. CNA 11 rolled the resident over and cleaned the resident's buttocks. Without washing her hands or changing her gloves, CNA 11 applied a clean brief, while touching the residents' legs and the clean brief. She then applied the resident's pants and placed a hoyer sling underneath the resident without removing her soiled gloves and/or washing her hands. During an interview, on 1/17/2025 at 10:00 A.M., CNA 11 indicated she should have washed her hands and changed gloves. 2. The record for Resident E was reviewed on 1/17/2025 at 11:25 A.M. Diagnoses included, but were not limited to: depression, cancer and obstructive uropathy. An Admission Minimum Data Set (MDS) assessment, dated 11/18/2024, indicated the resident required the use of a catheter and needed substantial to maximum assist for toileting. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 1/21/2025 at 2:45 P.M., Certified Nursing Assistant (CNA) 18 was observed to provide incontinence/catheter care to Resident E. She placed a paper towel on the floor underneath the urinary drainage bag and emptied the urine into a urinal. She then used a washcloth and cleaned the urinary catheter and tubing. Without changing her gloves or washing her hands, CNA 18 applied barrier cream to the resident's buttocks. Next she rearranged the brief and attached the catheter drainage tubing to the adhesive strip on the residents upper leg. CNA 18 pulled the resident's shorts off and placed them in the closet. Finally CNA 18, with the same gloves still on, applied blankets over the resident and grabbed a computer cord and handed it to the resident. She then removed her gloves and gown and placed them in the trash bag. During an interview, on 1/21/2025 at 3:02 P.M., CNA 18 indicated she should have changed her gloves and washed her hands. 3. During an observation, on 1/22/2025 at 9:27 A.M., RN 19 was observed to complete a pressure ulcer treatment with assistance from CNA 11 for Resident 98. RN 19 placed a barrier on the bed side table. CNA 11 and RN 19 washed their hands and applied gloves. RN 19 cleaned the coccyx area, removed his gloves and applied new gloves. RN 19 applied triad paste (wound dressing) on the coccyx area. RN 19 removed his gloves and then washed his hands. RN 19 was not wearing a gown while completing the pressure area treatment. There was no Personal Protective Equipment (PPE) or a sign indicating the resident was in Enhanced Barrier Precautions (EBP) available on the door or outside of the room. During an interview, on 1/22/2025 at 9:41 A.M., RN 19 indicated he would change his gloves only if he was contaminated and there should have been Personal Protective Equipment (PPE) available and he should have worn a gown. 4. During a medication administration observation, on 1/17/2025 at 12:06 P.M., RN 19 obtained a Lamictal tablet from the medication cart. RN 19 indicated the tablet had to be cut in 1/2 because it was a 200 mg (milligram) dose, and the resident was to receive 100 mg dose. RN 19 indicated the other half will be discarded. RN 19 placed the tablet in a pill cutter and then with an un-gloved hand, touched the pill to move it to the center. During an interview, on 1/17/25 at 12:07PM the RN indicated he should have worn gloves when touching the pill. 45120 5. A record review for Resident G was completed on 1/17/2025 at 9:18 A.M. Diagnoses included, but were not limited to: nephrostomy, obstructive and reflexive uropathy, overactive bladder and carcinoma of the bladder. A Quarterly Minimum Data Set (MDS) assessment, dated 12/23/2024, indicated Resident G was cognitively intact and had an indwelling catheter. A Physician's Order, dated 1/15/2025, indicated to monitor the nephrostomy output every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan, dated 8/16/2024 and revised 12/17/2024, indicated Resident G was at risk for infection/complications related to the use of nephrostomy tubes. Interventions included, but were not limited to: catheter/peri-care at least every shift and as needed. During an observation, 1/21/2025 at 10:38 A.M., CNA 11 and 12 were providing incontinence care and nephrostomy tube/drainage bag care. CNA 12 brought in a step-by-step instruction guide on nephrostomy tube and drainage bag care provided by the Assistant Director of Nursing, who was also present in the room. CNA 12 indicated she would not have known how to care for a nephrostomy tube if she had not been given the instruction guide. CNA 11 emptied the nephrostomy drainage bag while using a soapy washcloth to release and seal the urinary drainage bag spout. CNA 11 asked, after completing the procedure, if a nephrostomy drainage bag used the same procedure as emptying a Foley urinary drainage bag and using an alcohol prep pad for cleansing the spout. 51598 6. The record for Resident 96 was completed on 1/21/2025 at 10:09 A.M. Diagnosis included but were not limited to: diabetes mellitus type 2 (DM) with chronic kidney disease, iron deficiency anemia, legal blindness, hypertensive heart disease without heart failure, and vitamin D deficiency. A current Care Plan, initiated 6/26/2024 and updated 1/16/2025, indicated Resident 96 had impaired skin integrity stage 3 pressure ulcer to the right heel- goes to [NAME] wound clinic. Interventions included but not limited to, assess and document skin condition, notify MD of signs of infection, assess for pain and treat as indicated, assist with bed mobility to turn and reposition routinely, pressure reducing/redistributing cushion in chair, pressure reducing/redistributing mattress on bed, prevalon boot to right foot at all times as tolerated, supplements as ordered, and wound treatment as ordered. During an observation of the room of resident 96 on 11/22/2025 at 11:55 A.M., there was no sign or personal protective equipment to identify that resident was on enhanced barrier precautions. During an interview conducted on 1/22/2025 at 11:53 A.M., RN 10 indicated that resident 96 had a stage three pressure ulcer to her right heel. She indicated that because of the pressure ulcer, the resident should have been on enhanced barrier precautions. 7. A record review for Resident 314 was completed on 1/22/2025 at 10:09 A.M. Diagnosis included but were not limited to lymphedema, hypertension, and COPD. A current care plan dated 1/15/2025 indicated that Resident 314 has impaired skin integrity: pressure ulcer on left buttocks stage 2, Venous ulcer - right great toe, right 2nd toe, left great toe, left 2nd toe, and left 3rd toe. Interventions included but were not limited to: assess and document skin condition, notify MD of signs of infection (redness, drainage, pain, fever), assess for pain and treat as indicated, assist with bed mobility to turn and reposition routinely, notify MD of worsening or not improvement in wound, pressure reducing/redistributing mattress on bed, wound treatment as ordered. During an interview on 1/22/2025 at 2:18 P.M., LPN 16 indicated that Resident 314 has wounds that were treated by the wound center and also had wounds on his toes that were treated by the facility. She indicated that with the wounds the resident should have been on enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/22/2025 at 2:20 P.M., Resident 314 was sitting in his wheelchair with wraps on his bilateral lower extremities. There was no sign or personal protective equipment to identify that resident was on enhanced barrier precautions. 49994 8. The record for Resident H was reviewed on 1/17/2025 at 10:04 A.M. Diagnoses included, but were not limited to: malignant neoplasm of prostate and colon and obstructive and reflex uropathy. During an observation of catheter care on 1/21/2025 at 3:29 P.M., CNA 3 put on a gown and a pair of gloves prior to entering Resident H's room. CNA 3 removed the resident's pants and brief. CNA 3 then changed her gloves began cleaning the resident's catheter tubing. CNA 3 grabbed a clean brief from the bedside table and removed the resident's soiled brief, proceeded to provide perineal care with a soapy rag, placed the clean brief on the resident with the same gloves that had been used to provide perineal care. CNA 3 then pulled the residents pants up and covered the resident with his blankets. CNA 3 removed her gloves and performed hand hygiene. During an interview on 1/21/2025 at 3:43 P.M., CNA 3 indicated she had not changed her gloves after providing perineal care and should have. During an interview on 1/16/2025 at 11:44 A.M., the DON indicated when she was notified of nausea, vomiting and diarrhea in multiple residents on the 200 unit, she notified the Nurse Practitioner and the local Health Department. A review of the facilities monthly infection surveillance report for the month of January indicated 20 residents experienced nausea, vomiting and diarrhea that began on 1/3/2025. A record review was completed for all residents that resided on the 200 hall and indicated an additional six residents, who were not documented on the monthly infection surveillance report for the month of January also experienced nausea, vomiting and diarrhea on 1/3/2025. During an interview on 1/16/2025 at 2:16 P.M., the ADON indicated the cases were not reported to the state and should have been. A policy was provided, on 1/23/2025 at 12:16 P.M., by the Director of Nursing. The policy titled, Nephrostomy-Cystostomy Care, indicated, .Residents with nephrostomy or cystostomy tubes will receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences .2. The care and maintenance of nephrostomy/cystostomy tubes shall be in accordance with physician orders. The orders shall specify the type and frequency of dressing changes and emptying of collection bags along with special instructions. 3. Nephrostomy/cystostomy tubes shall be managed by licensed nurses. Nurse aides may handle the collection bags in accordance with facility procedures for handling urinary drainage bags A policy for urinary drainage bags was requested, on 11/23/2025 at 11:42A.M. The Executive Director indicated a policy was not available for maintenance of a urinary drainage bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/2025 at 2:33 P.M., the ADON provided the policy titled, Reportable Infections, dated 1/2/2024 and indicated it was the policy currently being used by the facility. The policy indicated, Policy: It is the policy of this facility to report possible incidents of communicable disease or infections to appropriate personnel or authorities. 9. The Infection Preventionist will review lab reports. Any infection or communicable disease that is a reportable disease will be reported to public health authorities On 1/21/2025 at 9:22 A.M., the Administrator provided the policy titled, Medication Administration, dated 12/12/2023, and indicated the policy was the one currently used by the facility. The policy indicated .13, Remove medication from source, taking care not to touch medication with bare hand A current policy was provided by the ADON on 1/22/2025 at 10:23 A.M., titled, Enhanced Barrier Precautions, indicated an order for enhanced barrier precautions would be obtained for residents with the following: Wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers and/or indwelling medical devices even if the resident is not know to be infected or colonized with a MDRO A policy was requested regarding catheter care but one was not provided prior to the survey exit. This citation relates to complaint IN00451678. 3.1-18(a) 3.1-18(b)(2)