STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING **01** B. WING _____	**05/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF BLOOMINGTON	**1100 S CURRY PK** **BLOOMINGTON, IN 47403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Pre Occupancy Survey for the following rooms will now each have two beds: rooms 205-212 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/06/25 Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040 At this Pre Occupancy survey, Majestic Care of Bloomington was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in resident sleeping rooms 101 through 126, 201 through 216 and 301 through 339. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms on Station 4, 5, and 6. The facility has a capacity of 224 and had a census of 108 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two	K 000		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING **01** B. WING _____	**05/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF BLOOMINGTON	**1100 S CURRY PK** **BLOOMINGTON, IN 47403**

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K 000	Continued From page 1 detached storage buildings. Quality Review completed on 05/09/25	K 000		