STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
155019		B. WING		11/04/2024		
			CTDE	EET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				OS CURRY PK		
MA IESTIC CARE OF DI COMINICTONI			OS CORRT PR DOMINGTON, IN 47403			
MAJESTIC CARE OF BLOOMINGTON		BLO	OMINGTON, IN 47403			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
		Recertification and State	F 0000	The filing of this plan of correct		
	1	This visit included the		does not constitute an admiss	I	
	Investigation of Co	omplaint IN00445671.		the alleged deficiencies did in	I	
	G 11 - 13 - 13 - 14	5/71 N. 1 C		exist. This plan of correction		
		5671 - No deficiencies related to		files as evidence of the facility	rs	
	the allegations are	citea.		desire to comply with the		
	Common data a O	ober 29, 30, 31, November 1, and		regulatory requirement and to	I	
	4, 2024	ober 29, 30, 31, November 1, and		continue providing quality care services to all residents.	e and	
	4, 2024					
	Facility number: 00	00007		Acceptance of this plan of		
	Provider number: 1			correction (POC) provides the facility's credible evidence of	;	
	AIM number: 1002			compliance effective Novemb	er 08	
	7 Kilvi number: 1002	2/3040		2024.	ei 00,	
	Census Bed Type:			We respectfully request desk		
	SNF/NF: 99			review and consideration for p	I	
	SNF: 13			compliance of substantial	Aupoi	
	Total: 112			compliance based on the plan	ı of	
				correction (POC) and support	I	
	Census Payor Type	e:		documents submitted.		
	Medicare: 13					
	Medicaid: 62					
	Other: 37					
	Total: 112					
	These deficiencies	reflect State Findings cited in				
	accordance with 41	10 IAC 16.2-3.1.				
	Quality review con	mpleted November 13, 2024.				
E 0605	400.05(:)					
F 0695 SS=D	483.25(i)	a a a tamay Cama a sail				
55=D Bldg. 00	Respiratory/Tract Suctioning	neostomy Care and				
Diag. 00		ion, interview, and record	F 0695	Corrective actions taken:	11/09/2024	
		failed to ensure physician	L 0032	Immediate action(s) taken for	11/08/2024	
	1	red for 1 of 2 residents reviewed		resident #213 were found to h	I	
	for respiratory care			been affected by the alleged	lav c	
	101 respiratory care					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Warren McCreery Executive Director 11/18/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155019	B. WING			11/04/2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER							
MA IESTIC CARE OF BLOOMINICTON				1100 S CURRY PK BLOOMINGTON, IN 47403			
MAJESTIC CARE OF BLOOMINGTON				BLOOK	MINGTON, IN 47403		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
					deficiency include:		
	Finding includes:				Resident #213 was assessed		
					the Director of Nursing Service	es for	
		6 a.m., Resident 213 was			immediate concerns. No		
		g asleep in bed with the			concerns identified at this time) .	
		r level set at 3 L (liters) per			How other residents were		
		(nasal cannula) sitting on her			identified:		
	face and not in the	nostrils.			All residents who have an orde		
					oxygen have the potential to b	е	
		p.m., Resident 213 was			affected. 100% audit of all		
		g asleep in bed with the			residents was completed by th	ie	
		or level set at 3 L per minute			Nursing Management Team		
	_	on her face and not in the			including Assistant Director of		
	nostrils.				Nursing, Unit Managers and/o		
					designee, to ensure that each		
		a.m., Resident 213 was			resident that have orders for		
		g asleep in bed with the			oxygen are following MD orde	rs on	
		or level set at 3 L per minute			11/8/24.		
	and the N/C in her	nostrils.			No further concerns were		
	0 11/1/01 000	D 11			identified.		
		p.m., Resident 213 was			Measures in place/system		
		g asleep in bed with the			changes.		
		or level set at 3 L per minute			QAPI meeting was held with the	ne	
	_	on her face and not in the			Executive Director, Medical		
	nostrils.				Director, Director of Nursing,		
	0 11/4/04 111.04	D 11 . 212			Assistant Director of Nursing,		
		6 a.m., Resident 213 was			Managers one and two, Socia		
		g asleep in bed with the			Services Director, and Memor	-	
		or level set at 3 L per minute			Care Coordinator to review the		
	and the N/C in her	nostriis.			plan and findings. This action	was	
	D 11 (212) 11 1	1 1 1 1			completed by the Executive	0.4	
	Resident 213's clinical record was reviewed on				Director on 11/8/24. On 11/5/24,		
	11/1/24 at 10:00 a.m. The diagnoses included, but were not limited to, anemia, supraventricular			education was initiated and will			
		-		continue until all RN/LPN care			
	tachycardia, and hypertension.				team members have been		
	Dharaining	"Dasidant 212 in dit- J. II			educated on ensuring that oxy	-	
		r Resident 213 indicated, "			levels are followed per MD or		
		minute via nasal cannula every			orders. Nursing Management		
	shift". The start of	iate was 10/11/24.			Team including the Director of		
			1		Nursing Assistant Director of		1

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER					COMPLETE		
		155019	B. WING 11/04/2024				
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
					CURRY PK		
WAJESTI	IC CARE OF BLOO	WIING I ON		BLUUN	MINGTON, IN 47403		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	~	on 11/4/24 at 11:50 a.m., LPN 1 213's oxygen order was for 3 L			Nursing, and Unit Managers. Education completed on 11/5/	24	
		ned the oxygen concentrator			Monitoring of corrective active		
	was set at 3 L per N				taken:		
	•				The Director of Nursing, Assis	tant	
	On 11/4/24 at 4:07	p.m., the Administrator			Director of Nursing, and Unit		
		's policy, "Medication			Managers will randomly audit		
		ted 5/20/22, and indicated it			oxygen orders and following		
		ently being used by the			Physician orders 3X weekly X	3	
	-	f the policy indicated, " ration/Administration d.			months then monthly for 2		
	•	s of medication administration			months, then Quarterly. Audit will be reviewed by the QAPI	s	
	ii. right dose"	s of incuration administration			Committee until such a time		
	II. right dose				consistent substantial complia	nce	
	3.1-47(a)(6)				has been achieved as determi		
					by the committee. Audit resul	ts	
					will be shared with QAPI. QA	PI	
					meeting was held with the		
					Executive Director, MDS, Soci	ial	
					Services, Director of Nursing,		
					Assistant Director of Nursing, Unit managers to review audit		
					education, results, and finding		
					This action was completed by		
					Executive Director on 11/8/24.		
					The next QAPI will be held on		
					12/8/24. Audited records will	be	
					reviewed by the Risk		
					Management/Quality Assuran	ce	
					Committee until such time		
					consistent substantial complia		
					has been achieved as determined by the committee. Audit result		
					will be shared with the Risk		
					Management/Quality Assuran	ce	
					Committee.		
					Date of compliance:		
					November 8, 2024		
			1			1	

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
		155019	B. WI	B. WING 11/04/20			024	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER								
MAJESTIC CARE OF BLOOMINGTON				1100 S CURRY PK BLOOMINGTON, IN 47403				
WINDESTIC OF THE OF BEGOVING TOTAL				DECON	, , , , , , , , , , , , , , , , , , ,			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0732	483.35(g)(1)-(4)							
SS=C	Posted Nurse Sta	affing Information						
Bldg. 00								
		on, interview, and record	F 07	732	Corrective actions taken:		11/08/2024	
	-	failed to ensure the posted			The scheduling system was			
		mation sheet included the			updated to specifically print ou			
		of 5 daily staffing sheets			the entire name (Majestic Car			
	reviewed.				Bloomington). This was identif			
					and fixed companywide while	exit		
	Findings include:				was taking place.			
	0 10/00/04 . 0 0	0 1 1 1 1			How other residents were			
		0 p.m., the daily nurse staffing			identified:			
		was observed posted near the			No residents were identified a	t		
	front entrance door. The staffing information				risk.			
	sheet lacked docum	nentation of the facility name.			Measures in place/system			
		24			changes.			
		the posted staffing sheets,			QAPI meeting was held with the	ne		
		/30/24, 10/31/24, 11/1/24, and			Executive Director, Medical			
		he staffing information sheets			Director, Director of Nursing,	1.124		
	lacked documentar	ion of the facility name.			Assistant Director of Nursing,			
	Duning on internsion	w on 11/4/24 at 3:40 p.m., the			Managers one and two, Socia			
	_	cated the staffing sheet was			Services Director, and Memor	-		
		gh a new company program. He			Care Coordinator to review the			
		ot aware the facility name			plan and findings. This action completed by the Executive	was		
	should be on the re				Director on 11/8/24. On 11/5/	24		
	should be on the re	port.			Majestic Care Corporation	24,		
	During a interview	on 11/4/24 at 3:58 p.m., the			confirmed that all BIPAs would	d he		
		cated the facility did not have a			specific to location and state	1 DC		
		osted daily staffing information.			entire name on daily sheets.			
	poney regulating pe	steed daily starring information.			Monitoring of corrective acti	one		
					taken:	0113		
					The Executive Director, Direct	or of		
					Nursing, Assistant Director of			
					Nursing, and Facility Schedule			
					will randomly audit daily BIPA			
					weekly X3 months then month			
					for 2 months, then Quarterly.	,		
					Audits will be reviewed by the	1		
					QAPI Committee until such a			

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Facility ID: 000007

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES					OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED	
155019			B. W	NG		11/04/	/2024	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF BLOOMINGTON			•	STREET ADDRESS, CITY, STATE, ZIP COD 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DOLUMBRIA N. AV AR AARDEAWAY	-	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	·-	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE	
F 0761 SS=D	483.45(g)(h)(1)(2 Label/Store Drug				consistent substantial complia has been achieved as determing by the committee. Audit results will be shared with QAPI. QAI meeting was held with the Executive Director, MDS, Socia Services, Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, and findings. This activates completed by the Executivates completed by the Executivates completed by the Executivates of 11/8/24. The next QAPI will be held on 12/8/24. Audited records will be review by the Risk Management/Qual Assurance Committee until suffice consistent substantial compliance has been achieved determined by the committee. Audit results will be shared with the Risk Management/Quality Assurance Committee. Date of compliance: November 8, 2024	ned ts PI all and s, ion ve ed lity ch d as		
Bldg. 00	Based on observati review, the facility cart on the 300 uni medication carts of Cart) Findings include:	on, interview, and record failed to ensure a medication t was locked for 1 of 8 oserved. (300 Unit Medication	F 07	761	Corrective actions taken: The cart was immediately lock and secured. Immediate Inserwas done with specific nurse. In-servicing was completed for nurses on 11/5/24. How other residents were identified:	vice r all	11/08/2024	
	On 10/30/24 from	10:18 a.m. until 10:38 a.m., the			No residents identified at risk a	JΣ	ĺ	

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medication cart outside of Room 332 was

observed to be unlocked and unattended by staff.

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this time. 100% audit of all other

carts was completed by the

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155019 B. WING 11/04/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1100 S CURRY PK MAJESTIC CARE OF BLOOMINGTON **BLOOMINGTON, IN 47403** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The medication cart contained medications for **Nursing Management Team** residents on the 300 unit. including the Assistant Director of Nursing, Unit Managers and/or During an interview on 10/30/24 at 10:39 a.m., RN 1 designee, to ensure that each cart indicated she had been at the other end of the was locked on 11/5/24. hallway providing care to residents from another No further concerns were medication cart, and the medication cart was to be identified. locked if it was unattended by staff. Measures in place/system changes. On 11/4/24 at 4:00 p.m., the Director of Nursing QAPI meeting was held with the provided the Facility Drug Product Storage Executive Director, Medical Requirements, revised 2/22/22, and indicated this Director, Director of Nursing, was the policy currently used by the facility. A Assistant Director of Nursing, Unit review of the policy indicated, "...all drug storage Managers one and two, Social areas shall be kept secure from unauthorized entry Services Director, and Memory and shall be limited to authorized personnel..." Care Coordinator to review the plan and findings. This action was 3.1-25(m)completed by the Executive Director on 11/8/24. On 11/5/24, education was initiated and will continue until all RN/LPN care team members have been educated on ensuring that carts are always locked when not in sight are being followed. Nursing Management Team including the Director of Nursing, Assistant Director of Nursing, and Unit Managers. Education completed on 11/5/24. Monitoring of corrective actions taken: The Director of Nursing, Assistant Director of Nursing, and Unit Managers will randomly audit carts to be locked 3X weekly X3 months then monthly for 2 months, then Quarterly. Audits

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will be reviewed by the QAPI Committee until such a time

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/04/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP COD 1100 S CURRY PK BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) consistent substantial complia has been achieved as determi by the committee. Audit result will be shared with QAPI. QAI meeting was held with the Executive Director, MDS, Soci Services, Director of Nursing, Assistant Director of Nursing, Unit managers to review audit education, results, and finding This action was completed by Executive Director on 11/8/24. The next QAPI will be held on 12/8/24. Audited records will I reviewed by the Risk Management/Quality Assurance	nce ined ts PI and s, s. the	(X5) COMPLETION DATE	
					Committee until such time consistent substantial complia has been achieved as determi by the committee. Audit result will be shared with the Risk Management/Quality Assurant Committee. Date of compliance: November 08, 2024	nce ined ts		

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