STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING -- B. WING	12/03/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/03/24 Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040 At this Emergency Preparedness survey, Majestic Care of Bloomington was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 224 certified beds. At the time of the survey, the census was 114. Quality Review completed on 12/04/24	E 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is files as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this plan of correction (POC) provides the facility's credible evidence of compliance. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the plan of correction (POC) and supporting documents submitted.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/03/24 Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040 At this Life Safety Code survey, Majestic Care of Bloomington was found not in compliance with	K 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is files as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this plan of correction (POC) provides the facility's credible evidence of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Warren McCreery	Executive Director	12/12/2024

Any defiencystatement 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 disclo 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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	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 114 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 detached storage buildings. Quality Review completed on 12/04/24		We respectfully request desk review and consideration for paper compliance of substantial compliance based on the plan of correction (POC) and supporting documents submitted.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are	K 0353	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Geyer Fire Protection was notified and came out to fix the accelerators and order new hydraulic name plates. How other residents were identified?	12/12/2024

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	found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of "Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems" Quarterly/Semiannual documentation dated 11/13/24 during record review with the Director of Plant Operations at 11:42 a.m. on 12/03/24, the following was noted: a) Part II number 1 under quarterly inspections of Wet System #1 was marked 'No' for hydraulic nameplate securely attached to riser and legible b) Part II number 1 under quarterly inspections of Dry System #2 was marked 'No' for hydraulic nameplate securely attached to riser and legible c) Part II number 1 under quarterly inspections of Dry System #3 was marked 'No' for hydraulic nameplate securely attached to riser and legible and Part III number 4 was marked 'No' for Quick opening device passed test with comment 'Accelerator shut off' d) Part II number 1 under quarterly inspections of Dry System #4 was marked 'No' for hydraulic nameplate securely attached to riser and legible and Part III number 4 was marked 'No' for Quick opening device passed test with comment 'Accelerator shut off' Based on interview at the time of record review, the Director of Plant Operations stated he was unaware of the noted issues on the		No residents were identified at risk. Measures in place/system changes. QAPI meeting was held with the Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Services and Maintenance Director to review the plan and findings. This action was completed by the Executive Director on 12/6/2024. On 12/11/2024, the accelerators were replaced and on 12/12/2024 the name plates were placed. Monitoring of corrective actions taken. The Director of Maintenance and Executive Director have ensured that the accelerators were replaced (noted in pictures). The system was then put back into service and working to full capacity. Name plates were then ordered and put up on 12/12/24. The remedies were brought to QAPI and will be followed by the group for the next three quarters to ensure compliance. The committee will audit the quarterly records from Geyer Fire Protection to ensure these are being routinely checked along with being added to the Quarterly reviews for the Director of Maintenance. These will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance	

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	Quarterly/Semiannual sprinkler inspection from 11/13/24 for the three Dry and one Wet sprinkler systems. This finding was reviewed with the Executive Director, Director of Plant Operations and Maintenance Assistant, at the exit conference. 3.1-19(b)		has been achieved as determined by the committee. Date of Compliance. 12/11/2024 Accelerators 12/12/2024 Name Plates	