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	01/08/2024

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/08/24 Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040 At this Emergency Preparedness survey, Garden Villa-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 104. Quality Review completed on 01/10/24	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 filed as evidence of the facility's desire to comply with the regulatory requirements and to continue providing quality care and services to all residents. Acceptance of the Plan of correction (POC) provides the facility's credible evidence of compliance effective no later than January 22nd, 2024. We respectfully request desk review and consideration for paper compliance of substantial compliance of substantial compliance based on the plan of correction (POC) and supporting documentation.	
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: 01/08/24 Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040 At this Life Safety Code survey, Garden	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 filed as evidence of the facility's desire to comply with the regulatory requirements and to continue providing quality care and services to all residents. Acceptance of the Plan of correction (POC) provides the facility's credible evidence of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Warren McCreery	Executive Director	01/19/2024

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	Villa-Bloomington was found not 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 104 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 01/10/24		compliance effective no later than January 22nd, 2024. We respectfully request desk review and consideration for paper compliance of substantial compliance of substantial compliance based on the plan of correction (POC) and supporting documentation.	
K 0331 SS=D Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2			

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	Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 1 senior flex area was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect staff in the senior flex area near therapy. Findings include: Based on observations with the Director of Plant Operations during a tour of the facility from 1:50 p.m. to 3:25 p.m. on 01/08/24, two walls between shower rooms/bathrooms in the former senior flex area had been removed and an approximate four foot by three foot section of drywall was missing on the east wall of the former shower room which exposed the wood studs for the wall. This area of the facility is currently not being used and is closed off to residents and staff. Based on interview at the time of the observations, the Director of Plant Operations stated that corporate had a crew come to the facility in December 2023 and they removed the walls that seperated the shower rooms in the former senior flex area by therapy for a possible conversion to a dialysis area and they have not been back to the facility to continue work. The Director of Plant Operations agreed that wood studs were exposed along the walls and ceiling where the walls had been removed and that wood studs were exposed at the east wall where a section of drywall had been removed. The Director of Plant Operations stated	K 0331	The facility does ensure that there is no exposed wire around wood. In accordance with requirements of 10.2, 19.3.3.1, 19.3.3.2. Corrective actions taken: Area is secured from any residents or staff at this time. Measures in place/system changes. The Director of Maintenance /or designee will ensure that area is fixed and boxed in per code. Photographs will be attached. Monitoring of corrective actions taken. The Quality Assurance and Process Improvement committee will review compliance at the next scheduled QI meeting. If no issues the committee will discontinue any audits.	01/19/2024

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	the flame spread rating of the exposed wood studs was not known. This finding was reviewed with the Executive Director and Director of Plant Operations at the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3,			

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	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 corridor medical records doors and 1 of 1 corridor scheduling office doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 15 residents and staff on station four. Findings include: Based on observation with the Director of Plant Operations on 01/08/24 at 2:20 p.m. during a tour of the facility, the medical records office corridor door was propped open with a rubber door wedge. Additionally, the scheduling office corridor door was also propped open with a door wedge. Based on interview at the time of observation, the Director of Plant Operations agreed the aforementioned corridor doors were propped open impeding the doors from closing and removed the door wedges. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)	K 0363	The facility does ensure that doors remain closed throughout the day. In accordance with requirements of 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485. Corrective actions taken: The facility in-serviced staff who reside in those offices and those doors were immediately closed. Measures in place/system changes. The Director of Maintenance/or designee provided instructions to staff for keeping doors closed. Monitoring of corrective actions taken. The Quality Assurance and Process Improvement committee will review compliance of doors remaining closed weekly for four (4) weeks daily and then monthly for four (4) months at the scheduled QI meetings. Following the combined five (5) monthly audits, if no concerns noted, the committee would file the audits to have been completed. Date of Compliance January 9, 2024.	01/09/2024

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K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life	K 0920	The facility does ensure that power strips for medical devices are not used for personal use. In accordance with requirements of 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5. Corrective actions taken: The cell phone was immediately moved to another acceptable location. Measures in place/system changes. The Director of	01/09/2024

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	safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect one resident in room 321. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility from 1:50 p.m. to 3:25 p.m. on 01/08/24, a nebulizer, a tracheotomy compressor and a cell phone charging cable were plugged into a power strip placed on the floor within two feet of the resident bed in resident sleeping Room 321. The UL listing of the power strip was 1363A. Based on interview at the time of the observation, the Director of Plant Operations agreed a power strip was being used in the patient care vicinity for PCREE and non-PCREE in resident room 321. These findings were reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		Maintenance/or designee provided instructions to the resident and staff about personal devices not being plugged into medical device power strips. Monitoring of corrective actions taken. The Quality Assurance and Process Improvement committee will review compliance of the power strip remaining clear of personal devices for four (4) weeks daily and then monthly for four (4) months at the scheduled QI meetings. Following the combined five (5) monthly audits, if no concerns noted, the committee would file the audits to have been completed. Date of Compliance January 9, 2024	

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