STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155100	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Bedford	2111 Norton LN Bedford, IN 47421

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure residents were provided the informed consent prior to an increase or a start of a psychotropic medications for 2 of 5 residents reviewed for unnecessary medications. (Resident 13 and 23)Findings include: 1. On 5/13/26 at 11:55 a.m., Resident 13's clinical record was reviewed. The diagnoses included, but were not limited to, dementia with psychotic behaviors and anxiety. The care plan, dated 10/30/25, indicated Resident 13 received psychotropic medication. The intervention was to educate the resident's family about the risks, the benefits and the potential adverse side effects of the prescribed medication, and to obtain the consent as indicated. The Physician Order indicated Rexulti (antipsychotic) 1 milligram (mg) was initiated one time a day for dementia with agitation, on 12/11/25. The December 2025 Medication Administration Record (MAR) indicated Rexulti 1 mg administration was started on 12/12/25. The Psychoactive Medication Consent and Management Agreement, dated 12/14/25, lacked documentation from resident's representative giving consent for the initiation of the new psychotropic medication. 2. On 5/13/26 at 11:50 a.m., Resident 23's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's Disease, major depressive disorder, psychotic disorder, and anxiety. The care plan, dated 4/3/26, indicated Resident 23 received psychotropic medication. The intervention was to educate the resident's family about the risks, the benefits and the potential adverse side effects of the prescribed medication, and to obtain the consent as indicated. The Physician Order indicated Vraylar (antipsychotic) was increased from 1.5 mg to 3 mg one time a day for aggression, on 4/25/26. The April 2026 MAR indicated Vraylar 3 mg started administration on 4/26/26. The Psychoactive Medication Consent and Management Agreement, dated 4/28/26, indicated Resident 23's representative gave telephone consent to increase Vraylar on 4/28/26. During an interview on 5/13/26 1:03 p.m., the Director of Nurses (DON) indicated Psychoactive Medication Consent and Management Agreement would be completed prior to an initiation or increase of a new psychotropic medication. During an interview on 5/13/26 at 1:23 p.m., the DON indicated Resident 13's clinical record lacked documentation of informed consent prior to the start of the Rexulti. Resident 23's clinical record lacked documentation of informed consent prior to the increase of the Vraylar. On 3/14/25 at 1:25 p.m., the DON provided the facility policy, Psychotropic Medication Use, dated 8/1/25 and indicated it was the policy currently being used by the facility. A review of the policy indicated, .E. Informed consent must be obtained and documented prior to initiation or an increase in dosage of a psychotropic medication, including a discussion of risks, benefits, and alternatives . 410 IAC (Indiana Administrative Code) 16.2-3.1- 3(n)(2)

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, the facility failed to ensure the Discharge MDS (Minimum Data Set) assessment was completed within allotted timeframe for 1 of 1 residents reviewed for resident assessment. (Resident 108)Finding includes:On 5/12/26 at 10:18 a.m., Resident 108's clinical record was reviewed. The diagnoses included, but were not limited to, alcohol abuse, anxiety and major depressive disorder. A progress note, dated 12/18/25 at 12:50 a.m., indicated Resident 108 was transferred to the emergency room. A progress note, dated 12/18/25 at 11:38 a.m., indicated the resident would be transferred to another Long Term Care facility upon discharge from the hospital.A review of Resident 108's MDS assessments indicated there was no Discharge MDS assessment completed.A review of the Resident Assessment Instrument (RAI), 3.0 User's Manual, Version 1.20.1, October 2025, on 5/12/26 11:00 a.m., indicated the Discharge MDS assessment must be completed within 14 calendar days after the discharge date and must be submitted within 14 days after the MDS completion date.During an interview with the MDS coordinator on 5/13/26 at 12:15 p.m., she indicated the discharge MDS was not completed on discharge of the resident and should have been completed within 14 calendar days of the discharge date . She indicated the facility did not have a resident assessment policy and they use the RAI tool criteria for timeframe of completion.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected a resident's status for 1 of 32 residents reviewed for MDS accuracy. (Resident 23)Findings include:On 5/13/26 at 11:50 a.m., Resident 23's clinical record was reviewed. The diagnoses included, but were not limited to Alzheimer's disease and major depressive disorder. A review of the resident's April 2026, MAR (Medication Administration Record) indicated on 4/2/26, the resident was prescribed mirtazapine (an antidepressant medication) at bedtime for insomnia. A 4/9/26 admission MDS assessment failed to document an antidepressant prescription for the resident.During an interview on 5/13/26 at 12:08 p.m., the MDS coordinator indicated the 4/9/26 MDS assessment was incorrect and should have included the antidepressant medication.410 IAC (Indiana Administrative Code) 16.2-3.1-31(d)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure a physician's order was current for a resident receiving oxygen via a nasal cannula for 1 of 2 residents reviewed for respiratory care. (Resident 3)On the following dates and times, Resident 3 was observed in her room receiving oxygen from a humidifying oxygen delivery machine via a nasal cannula: 5/8/26 at 1:54 p.m.5/12/26 at 10:10 a.m. and 12:13 p.m.5/13/26 at 10:35 a.m. During an interview on 5/8/26 at 1:55 p.m., Resident 3 indicated after her last hospitalization she was told to use the oxygen for another 30 days. It was past 30 days, and she was still wearing the nasal cannula and receiving oxygen, because staff told her she needed it. The nasal cannula bothered her, and she did not want to wear it if it was not necessary. On 5/11/26 at 11:05 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited to, atrial fibrillation and anxiety. A review of current physician's orders indicated no oxygen was prescribed. The last physician's order for oxygen had a start date of 2/2/26 and a discontinued date of 2/23/26. During an interview on 5/13/26 at 11:35 a.m., the Director of Nursing Services indicated there was no current physician's order for oxygen for the resident. 410 IAC (Indiana Administrative Code) 16.2-3.1- 47(a)(6)