STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARMEL	301 EXECUTIVE DR, CARMEL, , 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake IN00464948. Intake IN00464948-State deficiencies related to the allegations are cited at R44. Survey date: October 9, 2025 Facility number: 010416 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 9, 2025.	R 0000		
R 0044	Residents' Right - Deficiency 410 IAC 16.2-5-1.2(r)(1-5) (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge "	R 0044	**What corrective actions will be taken for residents identified as affected by the deficient**	11/30/2025

	means the movement of a resident to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate. (5) When the facility proposes to transfer or discharge a resident		**practice?** The Health and Wellness Director (HWD) and Health and Wellness Coordinator (HWC) will receive reeducation and in-service training by the Executive Director (ED) or designee, on the relevant policies and regulatory guidelines pertaining to resident discharges. **How the facility will identify other residents who may be affected by the same deficient practice and what corrective actions will be taken:** The Health and Wellness Director (HWD), Health and Wellness Coordinator (HWC), Nurse Practitioner (NP) ,physician, Medical Director, Executive Director (ED), or designee will review all residents with behavioral-based changes in	

under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following:

(A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B).

(B) Any physician when transfer or discharge is necessary under subdivision (4)(D).

Based on interview and record review, the facility failed to ensure documentation by the physician was completed to indicate a discharge was necessary for 1 of 3 residents reviewed for admission, transfer, and discharge. (Resident B)

Findings include:

An email to the Indiana Department of Health, dated 9/20/25 at 10:17 a.m., indicated Resident B was sent to the hospital for a psychiatric evaluation. The doctor at the hospital spoke with Resident B's family and indicated Resident B was not a danger to himself or to others. The facility where Resident B lived would not allow him to return!

The clinical record for Resident B was reviewed on 10/9/25 at 1:30 p.m. The diagnoses included, but were not limited to

condition and or any involuntary discharges for
compliance

What measures or systemic changes will be implemented to prevent the recurrence of the deficient practice:

The Executive (ED) or designee will conduct
quality assurance reviews in collaboration with the Health and Wellness
Director (HWD), Health and Wellness Coordinator (HWC), or Nurse Practitioner
(NP), as applicable. They will review risk audits, the written Physician orders or advisement, policies, and state
regulations monthly for two (2) months, then quarterly for two (2) quarters identifying trends to ensure compliance

How the corrective action(s) will be monitored to ensure the deficient practice will not

	vascular dementia, atherosclerotic heart disease (plaque buildup in the heart), and hyperlipidemia (high fat levels in the blood). A nursing progress note, dated 9/13/25 at 2:37 p.m., indicated Resident B was observed in his room with superficial cuts to his hands. A disposable razor was found. The resident was asked what he was doing, and he responded he was trying to kill himself. The resident was sent out to the hospital. The clinical record did not include documentation by the physician to indicate a discharge was necessary. During an interview, on 10/9/25 at 9:50 a.m., the Assistant Director of Nursing indicated Resident B was sent out to behavioral health for attempting to harm himself with a razor blade. He would use razors to shave. He had taken the razor apart and used the blades to cut the tops of his hands. The resident indicated he was trying to harm himself, he did not want to be here anymore and could not live like this anymore. He had no prior suicidal ideations or attempts. The facility thought Resident B would later be readmitted to the facility, but when the Assistant Director of Nursing went to assess Resident B at the hospital he		**recur, i.e., what quality assurance program will be put into place;** The ED, HWD, HWC or designee will conduct risk-based audit each month.Then review all residents at risk with NP. All results and trends will be reviewed and discussed monthly in the quality assurance meeting.	

was still stating he did not want to live anymore and still had suicidal thoughts.

During an interview, on 10/9/25 at 10:10 a.m., the Assistant Director of Nursing indicated the facility made the determination Resident B could not be readmitted due Resident B still had suicidal thoughts and for his safety. Resident B was initially discharged from the facility on 9/13/25 and the follow up assessment at the hospital was completed on 9/21/25.

During an interview, on 10/9/25 at 1:50 p.m., the District Director of Operations indicated at the time of the follow-up assessment, on 9/21/25, the resident was still at risk to himself, so they would not admit a resident who was at risk.

During an interview, on 10/9/25 at 1:57 p.m., the Assistant Director of Nursing indicated the physician did not document why the discharge was necessary.

During an interview, on 10/9/25 at 1:58 p.m., the District Director of Operations indicated the physicians did not typically make notes in the resident's medical record, but they would look.

During an interview, on 10/9/25 at 2:15 p.m., the District Director of Operations indicated the facility followed all state

requirements and regulations.

During an interview, on 10/9/25 at 3:04 p.m., the District Director of Operations indicated they did not have a policy for the physician documenting why the discharge was necessary.

This citation relates to Intake IN00464948.

Based on interview and record review, the facility failed to ensure documentation by the physician was completed to indicate a discharge was necessary for 1 of 3 residents reviewed for admission, transfer, and discharge. (Resident B)

Findings include:

An email to the Indiana Department of Health, dated 9/20/25 at 10:17 a.m., indicated Resident B was sent to the hospital for a psychiatric evaluation. The doctor at the hospital spoke with Resident B's family and indicated Resident B was not a danger to himself or to others. The facility where Resident B lived would not allow him to return!

The clinical record for Resident B was reviewed on 10/9/25 at 1:30 p.m. The diagnoses included, but were not limited to vascular dementia, atherosclerotic heart disease (plaque buildup in the heart),

	and hyperlipidemia (high fat levels in the blood). A nursing progress note, dated 9/13/25 at 2:37 p.m., indicated Resident B was observed in his room with superficial cuts to his hands. A disposable razor was found. The resident was asked what he was doing, and he responded he was trying to kill himself. The resident was sent out to the hospital. The clinical record did not include documentation by the physician to indicate a discharge was necessary.			

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREEvelyn Laws	TITLEAdministrator	(X6) DATE10/29/2025