

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2026
NAME OF PROVIDER OR SUPPLIER MORNING VIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 475 NORTH NILES AVENUE, SOUTH BEND, , 46617		
(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 Intakes 471604 and 469045. Intake 471604- State deficiencies related to the allegations are cited at R0052. Survey date: August 26 and 27, 2026 Facility number: 013149 Residential Census: 42 These State Residential Findings are cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-5. Quality Review completed on 8/31/2026	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·	09/25/2026

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FORM APPROVED

OMB NO. 0938-0391

- (1) sexual abuse;
- (2) physical abuse;
- (3) mental abuse;
- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on interview and record review, the facility failed to ensure one of three residents reviewed for elopement (Resident B) was protected from neglect and potential harm when the facility failed to provide adequate supervision and interventions to prevent three separate elopements from a secured unit. This deficient practice resulted in Resident B eloping from the facility with her whereabouts unknown for over 3 hours and being located by law enforcement in a busy metropolitan area. This deficient practice had the potential to affect 30 of 42 residents in the facility who resided on the dementia unit floors. (Resident B)

Finding includes:

Review of the clinical record for Resident B on 8/26/2026 at 10:05 A.M., indicated she was admitted to facility on one of two secured dementia units on

- The resident has returned to facility and has resumed normal daily activities without any further concerns
 - A wander guard has been placed on the resident
2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
 - All current residents have had an updated elopement screen completed with interventions placed as needed per screening
 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- Resident Family and Guest Education:
A mass communication will be distributed to the families/responsible parties of all current residents educating them regarding the risk of elopement, the facility's secured environment, and the importance of maintaining resident

Saturday 8/22/2026 at 10:00 A.M. Her primary diagnosis was Alzheimer's Disease. A Brief Interview for Mental Status (BIMS) assessment, completed on 8/22/2026, indicated the resident had severe cognitive impairment.

A review of Resident B's pre-admission documentation, dated 8/17/2026, indicated the resident had a history of wandering. Included in the pre-admission documentation was an Emergency Room (ER) note for Resident B, dated 7/10/2026, where she was seen for an "altered mental status evaluation." The evaluation indicated the resident's brother had reported that the resident "wanders" and "cannot remember where she lives" and also reported that he frequently received phone calls from her apartment complex regarding her wandering.

A pre-admission note from Resident B's family medicine provider, dated 7/14/2026, indicated the following: "She is accompanied by her brother, who helps to provide some of the history. Over the past several months, she has had worsening forgetfulness and intermittent disorientation with wandering episodes, estimated at 3-4 total. Episodes are most common in the afternoons when

safety.

- Guest Education:
During business hours, all guests will be educated upon arrival and during the check-in process regarding the risk of elopement and the importance of not permitting residents to exit through secured doors without proper authorization and staff involvement.
- After-Hours Guest Notification:
Notices will be posted at the resident sign-in/sign-out binder and check-in kiosk to ensure guests arriving during off-hours are informed of elopement risks and resident safety expectations.
- Staff Education:
An in-service education session regarding elopement prevention, recognition, and response will be conducted at the next all-staff meeting. In addition, all team members will be assigned the following Relias courses, with completion required no later than 9/25/2026:
 1. Recognizing and Responding to Elopement

she wants to leave the house to walk; she typically walks within her apartment complex and often to her caregiver's nearby apartment, which she can navigate. She sometimes needs help to get back home. One recent episode prompted a call to the caregiver at work; she was not found at home and was later found walking within the complex. She denies confusion within the apartment complex itself."

Review of the Resident B's Service Plan indicated it had not been initiated until 8/23/2026 (the day after admission). The Elopement Risk plan and Wander Guard interventions had also not been initiated or implemented until after the resident had eloped. The formal Elopement Risk Assessment was completed on 8/22/2026 only after the resident had eloped, was located and returned by law enforcement.

During an interview on 8/26/2026 at 1:15 P.M., Certified Nursing Assistant (CNA) 3, stated she had worked on the day of Resident B's admission on 8/22/2026. She indicated that Resident B's family had explicitly told CNA 3 at 10:00 A.M. that Resident B had no memory problems. However, after lunch, Resident B had begun wandering the

2. Managing Elopement

- **Wander Guard Policy:**
The facility will finalize, adopt, and implement a comprehensive Wander Guard policy addressing identification of residents at risk for elopement, application and monitoring of Wander Guard devices, staff responsibilities, and response procedures. The adopted policy will be distributed to families/responsible parties of existing residents and incorporated into the admission process for all new residents.
 - **Security Surveillance:**
Reliable surveillance cameras will be installed at all identified access and egress points where monitoring is necessary to assist in the prevention and timely detection of attempted or actual elopement.
1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- DON or designee will

second-floor hallways and had successfully boarded the elevator twice, exited the elevator onto the first floor, and had to be returned to the second floor by staff. CNA 3 confirmed Resident B had not been wearing a Wander Guard at the time, which had allowed the resident unrestricted elevator access. At approximately 4:00 P.M., the resident was noted missing. During an interview on 8/26/2026 at 1:26 P.M., CNA 4 confirmed Resident B had went missing sometime around 4:00 P.M. on 8/22/2026. CNA 4 indicated Resident B had previously managed to ride the elevator down to the first floor twice earlier that day. CNA 4 was unsure how the resident had ultimately exited the building. During an interview with LPN 2 on 8/26/2026 at 1:55 P.M., she indicated she had been at the facility when Resident B was admitted. LPN 2 indicated although it was unusual to get an admission on the weekend, she had been aware of the admission process. LPN 2 indicated she had contacted the Director of Nursing (DON), and was instructed by the DON to complete a skin evaluation and check Resident B's medication orders. LPN 2 indicated the	complete an audit of 5 random residents to ensure their elopement interventions are in place and appropriate • DON or designee will complete an audit of 5 random staff members to ensure their knowledge of elopement interventions and procedures • ED or designee will complete an audit of 5 random visitors to ensure their knowledge of guest education • Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • Any identified concerns will result in immediate re-education and corrective action • The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance 1. By what date the systemic changes will be completed
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resident had not been identified as an elopement risk by the DON as she was told the resident was not an exit seeker . LPN 2 indicated Resident 2 was very confused on admission and had wandered around the building and had gotten onto the first floor via the elevator once before she had eloped from the building. LPN 2 indicated she had wanted to put a Wander Guard (bracelet that causes exit doors to magnetically lock when it comes within a close range of exit doors) on Resident B during the day but she had not been able to locate a new Wander Guard bracelet. LPN 2 indicated that after Resident B had ridden the elevator down to the first floor and had been brought back to the second floor by staff, the DON had been contacted again regarding the wandering risk. LPN 2 indicated she had been instructed by the DON to cut a Wander Guard bracelet off of another resident and place it on Resident B. However, LPN 2 had been uncomfortable with those instructions and had not followed them. Around supertime, at 4:45 P.M., CNA 3 had notified LPN 2 that Resident B could not be located, LPN 2 then notified the DON, Executive Director (ED), Resident B's family and the police. LPN 2 indicated Resident B was returned to the

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facility at 6:57 P.M. by the local police department.

During an interview on 8/26/2026 at 2:00 P.M., the Director of Nursing (DON) indicated that LPN 2 had called her around 10:00 A.M., to report Resident B's arrival. The DON indicated she had explicitly instructed LPN 2 to apply a Wander Guard bracelet to the resident and had informed her of the location of the spare devices, which were in the DON's office. The DON indicated her instructions were not completed by LPN 2.

During an interview on 8/26/2026 at 2:55 P.M., the ED indicated that a review of the front door video surveillance footage had failed to show the resident exiting through the front doors, leaving the exact exit point unknown. He indicated the video footage kept freezing and had gaps of time where footage was not able to be viewed. In addition, the ED indicated the resident had been found at a local eatery in the down town area of the city. He indicated the location was approximately 0.9 miles from the facility. Observation of the terrain between the facility and the eatery indicated there were multiple busy intersections the resident had crossed. The ED indicated after the resident been

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brought back to the facility and he had noted the issues with the cameras, he had ordered new cameras and the facility had implemented a new policy to apply Wanderguard bracelets to all new admissions with dementia for their initial three days until further observations and assessments could be made to determine their elopement risk.

The facility failed utilize pre-admission information noting the resident's confusion and wandering history, failed to execute the DON's instructions timely to apply a Wander Guard device to Resident B, and failed to secure the unit after the resident had successfully bypassed boundaries twice, resulting in an unmonitored exit requiring police intervention to locate and return the resident.

A policy provided by the DON on 8/27/2026 at 9:25 A.M., indicated ..." Wandering and Elopements-The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents"

This citation relates to Intake 471604.

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

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instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREMitchell F. Craven	TITLEAdministrator	(X6) DATE09/11/2026