

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 09/10/2026	
NAME OF PROVIDER OR SUPPLIER HARMONY AT ELKHART		STREET ADDRESS, CITY, STATE, ZIP CODE 1129 PARKWAY AVENUE, ELKHART, , 46516					
(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 471727 & 471661 Intake 471727 - State deficiencies related to the allegations are cited at R0052 Intake 471661 - State deficiencies related to the allegations are cited at R0052 Survey date: 9/9/2026-9/10/2026 Facility number: 014916 Residential Census: 104 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality Review completed o 9/15/2026	R 0000					
R 0052	Residents' Rights - Offense	R 0052	The alleged deficiency had the				

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410 IAC 16.2-5-1.2(v)(1-6)

(v) Residents have the right to be free from:

(1) sexual abuse;

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on observation, interview, and record review the facility failed to ensure pre-admission evaluations, including elopement risk were completed and adequate supervision was provided to prevent repeated elopements from the secured memory care unit for 1 of 3 residents reviewed for supervision. (Resident B) This deficient practice resulted in the resident eloping from the secured Memory Care unit twice and being located, both times, at two different family addresses, over 4 miles from the facility after having obtained rides from unknown persons. This deficient practice had the potential to affect 36 residents on the secured dementia unit.

Findings include:

A review of the facility reported

potential to effect 29 of 29 residents in memory care.

HCD or designee will audit charts for residents in memory care to ensure each resident has a complete and accurate assessment which includes an elopement risk assessment.

HCD completed staff in-service on elopement on 9/25/2026. HCD or designee will ensure all current and incoming residents will have a SLUMS and Elopement risk performed as part of their assessment prior to admission to identify residents at risk for elopement. At risk residents will have interventions added to their service plan to ensure safety. Maintenance Director changes door codes on 9/25/2026 to ensure only employees had the code. Door codes will be changed routinely to ensure integrity of the code.

HCD or designee will audit resident charts for SLUMS and Elopement risk assessment weekly for 4 weeks, then monthly for 5 months.

Maintenance Director will change all Harmony Square door codes monthly for a minimum of 6 months.

Systemic changes will be completed by 10-22-2026.

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OMB NO. 0938-0391

Incident 69 reported to the State Agency on 8/25/2026, indicated on 8/24/2026 that Resident B had been noted by staff in the facility at 2:00 P.M. However, at 5:20 P.M. the resident could not be located in the facility and was thought to have been out of the facility with his family. The local Police department returned the resident to facility per the family's request. The incident report indicated, after the resident had been returned, on 8/25/2026 new door codes to the secured memory care unit were initiated, the visitor policy was reviewed with staff regarding how to sign visitors in and out. A follow up note, dated 9/3/2026, indicated a new cognitive test was completed for Resident B and he had scored within the normal, typical cognitive function range.

A review of the facility's investigation regarding Incident 69 indicated Resident B had been located, on 8/24/2026 at 5:20 P.M., by Resident B's spouse at their home address, which was 4.1 miles from the facility. The investigative findings indicated the facility believed the resident had walked out with a visitor and had gotten to his sister's new apartment and his sister had taken Resident B to his wife's home. There was no evidence that the resident had left with his

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family members from the secured dementia unit.

Review of a Nursing Progress Note, dated 8/24/2026 at 7:14 P.M., incicated: "Resident last observed by staff at approximately 1400 in Harmony Square by the nurses station. Resident noted to be absent at approximately 5:20 P.M., when went to escort to meal staff initiated search of building and grounds. Resident's spouse contacted facility at approximately 5:20 P.M. reporting resident was at her residence. Resident returned to facility at 6:47 P.M. via law enforcement per family request."

Resident B's clinical record was reviewed on 9/9/2026 at 10:05 A.M. Diagnoses included, but were not limited to, mild cognitive impairment, unspecified psychosis, alcohol abuse, and nicotine dependence.

The resident's initial "In Health and Service Evaluation Results and Service Plan," dated 8/6/2026, indicated the following: " (Resdient's name) to reside in the facility's safe and secure environment due to serious cognitive impairment...

The resident may be unable to recognize dangers and required supervision and oversight for

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safety. Resident's physician ordered a secure unit... Resident has occasional disorientation to person, place, time or situation that does not interfere with functioning in familiar surroundings. Requires some direction and reminding from others... Resident wanders within the residence... Occasional poor judgment issued. Resident has occasional inappropriate judgment. Resident may resist care at times. Needs protection and supervision because resident may make unsafe or inappropriate decisions... Resident occasionally has hallucinations/delusions." There was no documentation of a pre-admission evaluation or initial Service Plan for Resident B prior to 8/6/2026. There were no specific interventions noted on the service plan reagrding the resident's cognitive impairment and potential to need supervision an oversight for safety besides having the resident reside on the secured dementia unit,providing some direction and reminders, and providing "protection and supervision." A review of Incident 70 reported to the State Agency on			
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8/28/2026, indicated on 8/27/2026 at 5:09 P.M., Resident B had last been seen on his unit at 3:30 P.M. but at 5:09 P.M. staff notified management they were unable to locate Resident B. Elopement procedure were initiated, at which point, staff noted a window in the southwest side of the unit, next to the exit door, had been broken and the screen was missing. Resident B was located at his wife's home. Resident B's wife had called law enforcement to have him returned to the facility. Resident B was returned to the facility by law enforcement at 5:45 P.M. The Physician was updated regarding concerns and was in agreement that the resident could not safely remain in the current setting at this time as he required further evaluation. The facility contacted 911 to have the resident transported to the local hospital for further evaluation. Upon arrival to the facility, EMS (Emergency Medical Services) personnel evaluated Resident B and advised staff that they were unable to transport the resident against his will at that time. EMS reported that the resident was able to appropriately answer their cognitive questions. EMS personnel advised staff to contact law enforcement for further assistance. Staff contacted law enforcement, and

law enforcement came to the facility. Following law enforcement's assessment and interventions, they instructed the EMS staff to transport the resident to the hospital. The incident report concluded that by 8/28/2026, an elopement procedure had been initiated, and the resident had been transported to the hospital for further evaluation. The broken window had been secured for safety and all windows on the unit were checked for safety concerns, faults or damage.

A review of there facility's investigation of Incident 70, dated 8/28/2026, indicated preventative measures were the facility was to continue coordination with the hospital, resident's physician, and his family to develop a safe and appropriate discharge or return plan based on the resident's current needs and safety risks. The resident's physician was notified of concerns and an urgent appointment with the the resident's neuro-cognitive provider was made. Increased supervision and additional safety procedures were to have been implemented should the resident return. A follow up note, on 9/3/2026, indcated the resident had been found to be cognitively intact with new cognitive testing. A meeting with Resident B's family had

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occurred and his family had decided to take the resident home. The resident had been discharged from the facility on 8/31/2026.

A Nursing Progress Note, dated 8/27/2026 at 8:17 P.M., indicated at approximately 5:09 P.M., the writer had been notified by staff that Resident B could not be located within the community. Staff had reported having last seen Resident B in the community at approximately 3:30 PM. Upon notification that the resident could not be located, the community's "elopement/missing resident" procedure was initiated and an immediate search of the community and surrounding areas was conducted. During the search, a window, located on the southwest side of the unit near an exit door was observed to have been broken and the window screen had been removed. The facility was unable to confirm that this window was the location of the resident's exit. Resident had been located at his former home where his wife resides. The resident's wife reported Resident B had been attempting to "break into" the home through a window. Resident B's wife reported that she was fearful and had contacted local law enforcement for assistance. Law enforcement had responded

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and had escorted the resident back to the community at approximately 5:45 PM.

During an interview with Resident B's wife on 9/9/2026 at 10:55 A.M., she indicated Resident B had been admitted to the facility on 7/20/2026, and on 8/24/25 at 5:20 P.M. she notified the facility that her husband had arrived at his sister's house and his sister had brought him to their home. She indicated at the time of her call, the facility had not been aware that Resident B was missing. Resident B's wife indicated the resident indicated he had "got a ride "to his sister's house. Resident B's wife indicated she had called police to have him returned to the facility. On 8/27/2026 around 5:30 P.M. his wife indicated Resident B was again at her house trying to break a window to get into the home. She contacted the facility and had called the police to have him returned to the facility.

During an interview with QMA #1 on 9/9/2026 at 1:21 P.M., she indicated Resident B had always been trying to get out of unit. He had been seen, on multiple occasions, trying to open windows and follow people out of the door.

During an interview with the Executive Director on 9/11/2026 at 10:05 A.M. she

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acknowledged Resident B's pre-assessment evaluation had not been completed until 8/6/2026. There was no documentation located by the Executive Director that a pre-assessment evaluation had been completed prior to Resident B's admission to the secured deentia unit. She indicated the former Healthcare Director should have completed the assessment but was no longer employed at the facility.. When the Executive Director realized no pre-assessment had been completed she had completed an assessment on 8/6/2026. She acknowledged the assessment was completed after the resident had been in the facility for 17 days.

The Executive Director provided a facility policy, titled Resident Assessment Policy, dated 4/2026, and indicated this was the current policy used by the facility. A review of the policy indicated..."Residents should be assessed to determine the level of care and services needed...An initial service plan should be developed by a Healthcare Director or Nurse upon admission and no more than 14 days prior to resident's move into the community...A final resident assessment should be completed by a licensed nurse or registered nurse a. at move-in, b. 30 days

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after move-in..."

The Healthcare Director provided a facility policy, titled Elopement Policy, dated 4/2026, and indicated this was the current policy used by the facility. A review of the policy indicated..."Procedure: 1. Assessment: a licensed nurse completes an elopement risk upon move-in, bi-annually and upon change in condition. The resident's risk for elopement is determined using the Saint Louis University Mental Status Examinant (SLUMS) in combination with Harmony's Elopement Risk Assessment in Yardi (electronic health record system). Residents who answer "yes" to to any question on the Elopement Risk Assessment form are considered at risk for elopement...after the resident if found, Step 1-The licensed nurse reviews and updates the resident's individualized service plan and ensures the resident is safe in the community. Step 3-The Healthcare Director an Executive Director collaboratively complete a detailed review of event by completing a Missing Resident Checklist.

During an interview with the Executive Director on 9/11/2026 at 10:08 A.M., the Executive Director indicated Resident B's Service Plan had not been

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updated and the Missing Resident Checklist had not been completed after the elopement events on 8/24/2026 & 8/27/2026.

A document titled, Elopement Risk Assessment dated 8/25/2025 was provided by the Healthcare Director on 9/10/2026 at 12:44 P.M., indicated Resident B had answered yes to 4 questions on the assessment and was determined to have a moderate risk for elopement. A second Elopement Risk Assessment document dated 8/28/2026 indicated Resident B had answered yes to 7 questions on the assessment and was determined to have a high risk for elopement.

This citation relates to Intake 471661 and 471727

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
SIGNATURETara Carney

TITLEExecutive Director

(X6) DATE10/02/2026