STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF SOUTH BEND	955 N HICKORY ROAD, SOUTH BEND, , 46615

(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 Complaints IN00466891, IN00466897, IN00467619, and IN00468205. Complaint IN00466891 - No deficiencies related to the allegations are cited. Complaint IN00466897 - No deficiencies related to the allegations are cited. Complaint IN00467619 - No deficiencies related to the allegations are cited. Complaint IN00468205 - State deficiencies related to the allegations are cited at R0052. Survey date: February 25 & 26, 2026 and March 2, 2026. Facility number: 016149 Residential Census: 26 This State Residential Finding is cited in accordance with 410	R 0000		

	IAC 16.2-5. Quality Review completed on 3/4/2026			
R 0052	Residents' Rights - Offense 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 emsure supervision of a cognitively impaired resident with a history of roaming tendencies and known exit seeking behaviors for 1 of 3 residents reviewed for neglect, (Resident B). This facility failure resulted in an resident elopement lasting over 2 hours with the facility unaware of the elopement until the police contacted the Resident's family regarding the missing resident and the family contacted the facility.	R 0052	· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Executive Director spoke with Resident A POA and explained exactly what occurred. Deep apologies were given and POA ensured an investigation will take place. · 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? Every resident could have been affected by the deficient. Resident B's POA was informed of the deficient and educated on the importance of watching all surroundings. Family memebers still have access code's however, the greeter must have a visual of guest and give guest a yellow visitor pass. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? There will be a greeter at the door at all times. Guest MUST check in with greeter and	03/09/2026

	Findings include:		get a green/yellow name badge. · 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; and · By what date the systemic changes will be completed? Executive Director or designee will check sign in book once a week for 4 weeks and thereon randomly. The Executive Director will review camera footage every other day starting 3/25/26 to ensure policy is being followed. Monitoring will go on for 6 months, thereon randomly. The changes were made on 3/5/26. Each guest MUST wear a visitor badge, even if they work for a different agency.	

	On 2/25/26 at 10:45 A.M., the Executive Director provided facility two videos dated 2/19/26 from 3:05 P.M., to 3:19 P.M., showing both the entrance to the common area and the front entrance of the facility looking outward and westward toward the sidewalk. At 3:05 P.M., Resident B was seen walking through the entrance common area from the north hall, stopping to pick up a pillow from the sofa and continued to walk south inside the building and then out of camera range. No staff were seen in the area. At 3:10, another resident's family member entered the building carrying a large container. At that time, Resident B was again seen in the entrance of the common area at the door. The other resident's family member allowed Resident B to exit the building by keeping the door open. No staff were seen in the area. Resident B was viewed at 3:10 P.M. on the outside camera where she walked out the main entrance doors, turned right and walked south on the sidewalk until she was out of the camera's visual area. Resident B was noted to be wearing shoes, blue slacks, and a short sleeved blue T-shirt. The resident did not have a jacket and had not carried anything in her hands. During an interview on 2/26/26			

at 9:45 A.M., Resident B's POA indicated the resident had been at the facility for a short respite and was to discharge on 2/20/26. The POA indicated on 2/19/26 at about 5:00 P.M., he had received a call from the local police who reported they had Resident B and he was to meet them at a local school parking lot to pick her up. The POA indicated the police reported Resident B was found at a local address, 5.5 miles from the facility. The POA indicated the resident had lived at the address with her parents ,53 years earlier, and he had no idea how she had gotten to her childhood home. The POA indicated the police had likely identified who had lived at the home and through obituaries, were able to identify the resident and then contact her family. Resident B's POA indicated he had met the police and took the resident to their private home. Resident B's POA indicated he then telephoned the facility on 2/19/26 at about 5:15 P.M. to report the elopement and to inquire about the incident.

During an interview on 2/25/25 at 10:45 A.M., the Executive Director indicated on 2/19/26 at about 5:15 P.M., she had received a call from Resident B's POA who indicated he had received a call from the police department saying that they had

found his wife at a local residence and he had met the police and had picked her up. The Executive Director indicated the facility was unaware that Resident B was missing from the building and the call from the resident's POA was her first notification of the elopement. The Executive Director indicated she immediately viewed the facility's camera footage at the front entry and had seen a family member of a new resident bringing in personal items, open the door, and allow Resident B to exit the building. The Executive Director indicated Resident B's POA had picked her up from the local police where she had been found at her childhood home. The Executive Director indicated she was unaware of how the resident had traveled from the facility to her childhood home, which was over five miles from the facility.

The Executive Director indicated resident family members were provided with their own personal door code to get in and out of the building. The Executive Director indicated the Business Office was on one side of the facility entrance area and the Director of Nurses' office was on the other side of the entry area. The Executive Director indicated both offices had large windows to view the entrance area but

were too high off the ground for a clear view of the entrance area unless the staff members were standing. The Executive Director indicated there was not a manned reception area and on 2/19/26, during the elopement, staff had not been in the area of the front entry due to attending a mandatory training in another area of the facility. The Executive Director indicated staff were supposed to check on all residents every hour and document their locations, but staff had not documented hourly checks on 2/19/26. The Executive Director indicated the facility followed the Indiana Department of Health's policy regarding elopement.

A review of Google Maps indicated the facility was 5.3 miles away, through a congested city area to the home address where Resident B had been found.

A review of the "Time and Date," past weather in South Bend, Indiana indicated the outside temperature on 2/19/26 from 3:00 P.M. to 6:00 P.M., was between 52 and 55 degrees Fahrenheit with cloudy skies.

The clinical record for Resident B was reviewed on 2/27/25 at 3:39 P.M. Diagnoses included but were not limited to Alzheimer's Dementia. The

residents' Nursing and Services Evaluation, dated 2/13/26, indicated Resident B had severe cognitive impairment, wandering tendencies, exit-seeking behavior, and a history of elopement from home. The resident was documented as often requesting to go home and searching for her home. The residents' wandering included intrusive wandering and she had been noted to push on or try to open exit doors. Resident B required safety checks twelve times daily and was determined to be a fall risk, due to confusion and disorientation.

A facility reported incident. Incident Number 14, reported to the Indiana State Department of Health on 2/20/26, indicated on 2/19/26 at 5:15 P.M., the facility became aware that Resident B had followed another residents' family member out of the facility and Resident B's POA contacted the facility to notify them that the local police department had found his wife. The report indicated the POA took the resident to their private home after collecting her from the local police and that there were no injuries reported. The preventive measures implemented in regards to Incident Number 14 indicated the Executive Director had ordered visitor passes and all

family members and outside vendors were to wear name tags while at the facility. The report follow-up, dated 2/26/26 , indicated the Executive Director had reviewed the camera footage and found another resident's family member had let Resident B out of the building and that the family was educated on being aware of surroundings and paying attention to the people around her. The Executive Director had contacted Resident B's POA to explain how the elopement had occurred and that going forward every visitor was to wear a visitor pass on their person.

On 3/2/26 at 12:27 P.M., the Executive Director provided a policy titled, "Resident Rights," dated 2/1/23, and indicated it was the current facility policy. The policy indicated, "Residents have the right to be safe in their home and functions as independently as possible ...Associates protect, advocate for and support residents ..."

Review of Indiana Department of Health Long-Term Care Abuse and Incident Reporting Policy, dated 12/6/22, indicated, "Definitions...Elopement occurs when a resident without decision making capacity leaves the premises or a safe area without authorization ...or any necessary supervision to do so

	...Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect means: a. An act or omission that places a resident in a situation that may endanger thr resident's life or health ..." This citation relates to Complaint IN00468205.			

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 SIGNATUREjasmine wynnne	TITLEExecutive Director	(X6) DATE03/25/2026