STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00457398 and IN00458551. Complaint IN00457398 - State deficiencies related to the allegations are cited at R0041 and R0052. Complaint IN00458551 - State deficiencies related to the allegations are cited at R0041 and R0052. Survey dates: April 29 & 30 and May 1, 2025 Facility number: 016149 Residential Census: 16 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 5/12/2025	R 0000	Initial Comments.	
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency Based on observation, interview and record review, the facility failed to implement their policies related to the following events: failure to report a fall with major injury to the State Agency, failure to investigate and report an elopement to the State Agency in a timely manor, and failure to report two allegations of abuse to the State Agency in a timely manor, for 3 of 3 residents reviewed for abuse and neglect, (Residents B, C, and D). Findings include: 1. The clinical record for Resident B was reviewed	R 0041	Plan of Correction Chapters South Bend Survey Event ID: 21VV11 Date Systematic Changes will be completed: 6/30/25 1 Corrective Actions taken for Residents affected. The facility will implement an Elopement Policy for Chapters. The facility hosted training for De-escalation for those with Dementia/Alzheimer's in response to an abuse incident that could have been prevented with	07/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Sieplinga	CEO	07/01/2025

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	on 4/30/25 at 3:39 P.M. Diagnoses included Alzheimer's Disease. Resident B's nursing progress note, dated 2/26/25 at 7:00 P.M., indicated the resident was seated in the dinner room after dinner and had refused to get up. Staff had allowed the resident to remain in the dinner room. Resident B fell asleep in the chair and had fallen in the dining room onto his right side. The resident had experienced pain, had been assisted by staff up off of the floor back into the dining chair without any nursing assessment of potential injuries and had been sent to the local Emergency Room by ambulance on 2/26/2025 at 7:17 P.M., when he continued to scream out in pain and could not bear weight to his right leg. A progress note dated 2/27/25 at 8:59 P.M., indicated the local ER reported Resident B had sustained a fractured femur and required surgical intervention for the fracture. During an interview on 4/29/25 at 12:00 P.M., the Administrator indicated Resident B was in the dining room when he stood up from his chair, slipped, and fell. He sustained a hip fracture that required surgery, and was released from the hospital following surgery to a local rehabilitation facility. Resident B returned to this facility on 3/14/25, when he was placed on hospice care and had expired on 3/16/25. The Administrator indicated staff had not completed a physical assessment on the resident at any time following the fall and the resident should not have been moved until a complete assessment was done. The Administrator indicated she had not reported the fall to the State Agency because she had not realized she was required to report falls with injuries.		proper de-escalation practices. The facility will review the Abuse/Neglect Policy will all staff. All reporting procedures will be reviewed with staff, clinical staff, and leadership. 2 We are looking into other options for the front door system, whilst we are navigating this, we will have someone at the front door from 10-6p. 3 All Resident Care Plans and assessments are up to date. Those with Elopement Risks are on every 2-hour checks, and Wander Risk Sheets have been placed in an elopement binder in the nurses' station. 4 Staffing has been addressed; we are currently staffing 3:3:2. We currently have 16 residents on site. This gives us 1 clinical staff member per 5 residents. 5 We have daily checklists in place for 2-hour checks on all residents. These sheets require clinical staff to state the time and place of the resident they are checking on. 6 All items will be monitored per policy and procedures in place for Chapters Living of South Bend, as well as checklists in place for clinical staff. 7 Corporate Nursing will assist with Fall Reviews, which will be monitored monthly for the next 6 months by the DON at the building. 8 The administrator has	

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	2. The clinical record for Resident C was reviewed on 5/1/25 at 9:10 A.M. Diagnoses included dementia. State Health Department report, Incident Number 4, submitted by the facility on 4/8/25, indicated on 4/6/25 at about 8:38 A.M., Qualified Medication Aide (QMA) 12, notified the Administrator that Resident C's responsible party notified her of an incident she witnessed on her personal video camera. The Administrator had met with Resident C's responsible party on 4/6/25 at 10:30 A.M. and viewed footage from the personal video camera from the night of 4/5/25 at approximately 11:00 P.M. In the footage, it was observed that QMA 11 was being unpleasant, forceful with care, had sworn at Resident C, disregarded her requests and had left her on the bedside after placing a pillow behind her back so she could not turn out of bed, among other observations. The Administrator indicated in the report that QMA 11 had been suspended pending an investigation and Resident C had sustained no injuries. During an interview on 4/29/25 at 12:00 P.M., the Administrator indicated she immediately reported the incident to the Corporate office, and attempted to reach QMA 11 unsuccessfully. The Administrator indicated QMA 11 was placed on immediate administrative leave pending investigation and then terminated when abuse was substantiated. The Administrator indicated she had submitted the incident report on 4/8/2025 and she was not aware that she was required to report allegations of abuse to the State Agency within 24 hours. 3. The clinical record for Resident D was reviewed		reviewed the fall and elopement policies with Corporate Nursing and the VP of Operations. The administrator has also reviewed reportable policies and will immediately implement moving forward to ensure proper documentation and reportable timelines. 9 All residents involved service plans have been reevaluated. No increase in service plans resulted as part of the evaluation. They have been indicated as elopement and or fall risks. **Please see attached Updated policies for Chapters Living of South Bend and De-escalation Training that took place, which was set up before the State entered and occurred whilst the State was in the building. This measure was put in place as a corrective action prior to the state visit**	

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	on 5/1/25 at 2:06 P.M. Diagnoses included neurocognitive disorder with Lewy bodies. State Health Department report, Incident Number 3, submitted by the facility on 3/4/25, indicated on 3/1/25 at 6:34 P.M., Resident D was using the community phone to try and contact his family. QMA 6 called the Director of Nursing and reported an incident involving a resident to staff altercation. The Director of Nursing contacted the Administrator who arrived at the facility with the Director of Marketing at 7:15 P.M., where they observed Resident D on the floor in the North Living area. The Administrator indicated the resident complained of shoulder pain and advised QMA 6 to call 911 immediately. Emergency Medical Services arrived at the facility around 7:30 P.M., assessed the resident and transported to the local ER. Resident D returned to the facility on 3/5/25 around 12:30 A.M. Resident D sustained a dislocated left shoulder. On 3/3/25, the Administrator placed QMA 6, QMA 9, and CNA 10 on administrative leave, pending internal investigation. After the Administrator had completed the investigation, on 3/5/2025, it was determined QMA 6 and 9 had antagonized Resident D inappropriately and he had fallen as a result of his frustrations. A Follow up report, dated 3/14/25, indicated the internal investigation was completed and on 3/5/25 QMA 6 and QMA 9 were terminated for their conduct in the incident and their actions were unjustified. CNA 10 was allowed to return to work on 3/6/25. The incident was not reported to the State Health Department until 3/4/2025, three days after the incident had occurred and a follow up report was not completed until 3/14/2025. State Health Department report, Incident Number 5, submitted by the facility on 4/30/25, indicated			

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	on 4/27/25 at 4:01 P.M., Resident D was let out of the facility by a visitor. Resident D was then seen by another visitor sitting in the grass on the north side of the facility by the employee entrance at around 4:40 P.M. The Director of Nursing who was on site at the time and at 4:42 P.M., re-entered the building escorted by the Director of Nursing. At 6:00 P.M. during an interview with the Administrator, Resident D indicated he went outside to help his dad clip the pigs and was sitting in the grass enjoying the sunshine. There were no associated injuries. Preventive measures on 4/30/25 were to check and lock all doors, and visitor education. The incident was not reported to the State Health Department until 4/30/2025, three days after the elopement had occurred. On 4/30/25 at 11:26 A.M., the Administrator provided a policy titled, "Chapters Living Fall Policy," dated 4/29/25, indicating it was the current facility policy. The policy indicated, "Responsibilities Administrator or Director of Nursing *Ensure policy implementation and regular review. *Oversee fall incident reporting...Immediately report any fall or near-miss incident. On 4/30/25 at 11:26 A.M., The Administrator provided a policy titled, "Chapters Living Abuse and Neglect Policy," dated 4/29/25, indicating it was the current facility policy. The policy indicated, "...A preliminary internal investigation will be initiated within 24 hours. The incident will be documented and reported to the Indiana Department of Health witching mandated timelines." On 4/30/25 at 1:30 P.M., The Administrator			

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	provided a policy titled, "Chapters Living 'Resident Elopement Policy," dated 4/29/25, indicating it was the current facility policy. The policy indicated, "...Elopement: An incident in which a resident leaves a safe, supervised area without staff awareness or contrary to their car plan, placing them at risk of harm...Submit incident report to the Indiana Department of Health and other authorities as required..." This citation relates to Complaints IN00457398 and IN00458551.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview, and record review, the facility failed to ensure resident's rights were honored for 3 of 3 residents reviewed for resident rights, abuse, and neglect. The deficient practice included the following results: two residents who fell and sustained injuries were not assessed for injuries before moving them (Resident B and Resident D), a resident with cognitive impairment that required supervision was not supervised, resulting in a fall with injury (Resident B), a resident with cognitive impairment and known exit seeking behaviors was not supervised, resulting in an elopement (Resident D), and 2 residents with cognitive impairment were subjected to physical abuse and/or involuntary seclusion, (Resident C and Resident D). Findings include: 1. The clinical record for Resident B was reviewed on 4/30/25 at 3:39 P.M. Diagnoses included Alzheimer's Disease.	R 0052	Plan of Correction Chapters South Bend Survey Event ID: 21VV11 Date Systematic Changes will be completed: 6/30/25 1 Corrective Actions taken for Residents affected. The facility will implement an Elopement Policy for Chapters. The facility hosted training for De-escalation for those with Dementia/Alzheimer's in response to an abuse incident that could have been prevented with proper de-escalation practices. The facility will review the Abuse/Neglect Policy will all staff. All reporting procedures will be reviewed with staff, clinical staff, and leadership. 2 We are looking into other options for the front door system, whilst we are navigating this, we will have someone at the front door	07/31/2025

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	Resident B's Service Plan dated 2/24/25, indicated the resident's communication ability was severely impaired as the resident was unable to communicate or receive information and had difficulty following instructions. In addition, the resident was frequently disoriented and required frequent supervision and oversight. Resident B required supervision due to an inability to discern and avoid situations in which he may be abused, neglected, or exploited, and had occasional judgment issues which resulted in him resisting care at time and needing protection and supervision due to making unsafe or inappropriate decisions. Resident B's progress note dated 2/26/25 at 7:00 P.M., indicated the resident was seated in the dinner room after dinner refusing to get up. Staff had allowed the resident to remain in the dinner room, unsupervised. Resident B had fallen asleep in the dining chair and fell from the chair onto his right side. Staff heard the resident fall and immediately went to check on him, obtained vitals and asked the resident if he was "okay." The resident was screaming out in pain. However staff assisted the resident up from the floo but he immediately pulled his right foot up and refused to walk or bear ay weight on it and began reaching for a chair, while he continued to scream out in pain. Staff assisted the resident to sit in the chair and notified the Director of Nursing. The Director of Nursing instructed the staff to call the resident's responsible party to see if they wanted the resident sent to the hospital for an evaluation. Resident B's responsible party requested he be sent to the Emergency Room (ER). The resident was sent to local ER by ambulance at 7:17 P.M. A progress note, dated 2/27/25 at 8:59 P.M., indicated the local ER reported Resident B had		from 10-6p. 3 All Resident Care Plans and assessments are up to date. Those with Elopement Risks are on every 2-hour checks, and Wander Risk Sheets have been placed in an elopement binder in the nurses' station. 4 Staffing has been addressed; we are currently staffing 3:3:2. We currently have 16 residents on site. This gives us 1 clinical staff member per 5 residents. 5 We have daily checklists in place for 2-hour checks on all residents. These sheets require clinical staff to state the time and place of the resident they are checking on. 6 All items will be monitored per policy and procedures in place for Chapters Living of South Bend, as well as checklists in place for clinical staff. 7 Corporate Nursing will assist with Fall Reviews, which will be monitored monthly for the next 6 months by the DON at the building. 8 The administrator has reviewed the fall and elopement policies with Corporate Nursing and the VP of Operations. The administrator has also reviewed reportable policies and will immediately implement moving forward to ensure proper documentation and reportable timelines. 9 All residents involved service	

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	sustained a fractured femur as a result of the fall and required surgical intervention for correction of the injury. Review of a facility video, provided by the Administrator on 4/29/25 at 2:53 P.M., dated 2/26/25 around 7:00 P.M., indicated Resident B was observed seated in a chair at the counter in the dining area. There were no nursing staff in the area and a dietary aid was seen in the kitchen. Resident B was observed to have stood up from the chair by himself, had stumbled and fallen to the floor. Nursing staff were observed to have arrived and attended to the resident quickly, and had assisted the resident back into the chair in a seated position. There was no assessment observed to have been completed while the resident was on the floor before staff had moved him back into the dining chair. During an interview on 4/29/25 at 12:00 P.M., the Administrator indicated Resident B was in the dining room when he stood up from his chair, slipped, and fell. He sustained a hip fracture that required surgery, and was released from the hospital following surgery to a local rehabilitation facility. Resident B returned to this facility on 3/14/25, when he was placed on hospice care and had expired on 3/16/25. The Administrator indicated staff had not completed a physical assessment on the resident at any time following the fall and the resident should not have been moved until a complete assessment was done. 2. The clinical record for Resident C was reviewed on 5/1/25 at 9:10 A.M. Diagnoses included dementia. A State Health of Department report for Incident Number 4, submitted by the facility on 4/8/25,		plans have been reevaluated. No increase in service plans resulted as part of the evaluation. They have been indicated as elopement and or fall risks. **Please see attached Updated policies for Chapters Living of South Bend and De-escalation Training that took place, which was set up before the State entered and occurred whilst the State was in the building. This measure was put in place as a corrective action prior to the state visit**	

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	indicated on 4/6/25 at about 8:38 A.M., Qualified Medication Aide (QMA) 12 notified the Administrator that Resident C's responsible party notified her of an incident she had witnessed on her personal video camera. The Administrator met with Resident C's responsible party on 4/6/25 at 10:30 A.M. and viewed footage from the camera from care given on the night of 4/5/25 at approximately 11:00 P.M. In the footage, it was observed that QMA 11 was being unpleasant, forceful and had sworn at Resident C, disregarded the resident's request and had left her in bed after she had placed a pillow behind her back so she could not turn or get out of bed by herself, among other observations. The Administrator indicated in the report that QMA 11 was suspended pending an investigation and Resident C had sustained no injuries as a result of the interaction. Resident C's Service Plan dated 4/16/25, indicated the resident was able to communicate effectively and make her needs known, was oriented to person, place, time, and situation. The resident had displayed frequent anxiety issues that required redirection from staff and had occasional disruptive, aggressive, or socially inappropriate behavior that required special tolerance or staff training. The resident utilized a walker and wheelchair for locomotion and required moderate assistance with transfers and was potentially at risk for falls. Review of the personal camera video, provided by the Administrator on 5/1/25 at 1:46 P.M., indicated on 4/5/25 at 11:30 P.M., Resident C had called out for her responsible party when QMA 11 entered the room and asked what the resident needed. Resident C indicated she wanted out of bed. QMA 11 refused to allow the resident to get out			

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	of bed. In addition, QMA 11 had shoved the resident to her side, while in the bed, and had placed a pillow behind her to keep her from getting out of the bed and placed her legs back in the bed under the blankets multiple times. QMA 11 had exited the room while ignoring the calls from the resident. QMA 11 was not seen entering the room again until 4/6/25 at 5:21 A.M. Resident C was again calling out for her responsible party and sitting up at the side of the bed when QMA 11 entered the room. QMA 11 went to the resident, said "here," forcefully pushed medication from a spoon into the resident's mouth two times. The resident indicated she wanted to talk to QMA 11 and QMA indicated she did not want to talk to the resident and left the room. During an interview on 4/29/25 at 12:00 P.M the Administrator indicated she had received a phone call from QMA 11 on 4/5/25 around 11:30 P.M. and QMA 11 had reported that Resident C was being difficult and was not redirectable. The Administrator indicated she had gone to the facility and had spoken with Resident C in her room. The Administrator indicated she found the resident to be calm and had instructed QMA 11 to notify her with any further concerns. The Administrator indicated QMA 11 had not called with any further concerns and in the morning on 4/6/25, QMA 12 notified her that Resident C's responsible party had called with concerns regarding something she had seen in the personal camera footage of the resident's room. The Administrator indicated she had met with the responsible party on 4/6/25 at about 11:00 A.M. and was shown a recording of QMA 11 behaving inappropriately with the resident, being rough in the way she had spoken to and handled the resident. The Administrator indicated she immediately reported the incident to the Corporate			

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	office and had attempted to reach QMA 11, unsuccessfully. The Administrator indicated QMA 11 was placed on immediate administrative leave pending an investigation and was then terminated when abuse was substantiated 3. The clinical record for Resident D was reviewed on 5/1/25 at 2:06 P.M. Diagnoses included neurocognitive disorder with Lewy bodies. A State Health Department report, Incident Number 3, submitted by the facility on 3/4/25, indicated on 3/1/25 at 6:34 P.M., Resident D had been using the community phone to try and contact his family. QMA 6 called the Director of Nursing and reported an incident involving a resident to staff altercation. The Director of Nursing contacted the Administrator who arrived at the facility with the Director of Marketing at 7:15 P.M., where they observed Resident D on the floor in the North Living area. The Administrator indicated the resident complained of shoulder pain and staff member, QMA 6, was instructed to call 911 immediately. Emergency Medical Services arrived at the facility around 7:30 P.M., assessed the resident and transported him to the local ER. Resident D returned to the facility, on 3/5/25 around 12:30 A.M. ,and had been diagnosed and treated for a dislocated left shoulder. On 3/3/25, the Administrator had placed QMA 6, QMA 9, and CNA 10 on administrative leave, pending an internal investigation. A Follow up report, dated 3/14/25, indicated the internal investigation had been completed and on 3/5/25 QMA 6 and QMA 9 were terminated for their conduct in the incident as their actions were "unjustified." CNA 10 was allowed to return to work on 3/6/25.			

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	Nursing Progress notes, dated 3/1/25 at 7:00 P.M., indicated Resident D had asked staff to use the phone. Staff gave the resident the phone and observed the resident making multiple phone calls with no one answering. Staff asked the resident for the phone and told the resident that he could try again in a few minutes. The resident stated he was told he could use the phone for however long he wanted to do so. The Resident stated he was not going to give staff the phone.. A staff member had then reached for the phone and the resident had grabbed the staff member's hand and bent their fingers back. The Resident had then attempted to body slam QMA 9 , causing both the resident and the staff member to fall on the floor. The Resident had then complained that his shoulder hurt. The Administrator was notified and arrived at the facility and had directed staff to call the police to have them transport Resident D to the Emergency Room (ER) for an evaluation. A local ambulance service had transported the resident to the ER. Review of the facility Incident Investigation, completed on 3/3/25, indicated the Administrator had viewed video camera footage and investigated the incident, which had occurred on 3/1/25, and had observed QMA 6 inciting Resident D and repeatedly antagonizing and pushing at the resident until he responded as he aggressively. QMA 6 stated she asked QMA 9 for help, which was observed in the video review. The investigation concluded that both QMA 6 and QMA 9 were involved in an incident with the resident that could have and should have been prevented. CNA 10 had appeared and had tried to de-escalate the situation and get the resident's attention to distract him and remove him from the situation. After the fall occurred, QMA 6 and			

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		A. BUILDING 00 B. WING	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	QMA 9 indicated they tried to help the resident up off the floor, however video evidence showed this had not occurred and the resident was not assessed for any injuries nor had vital signs been assessed.. On 3/4/25 QMA 6, QMA 9, and CNA 10 were placed on Administrative leave. On 3/5/25, QMA 6 and QMA 9 were terminated for their conduct in the incident as their actions were found "unjustified" and they had "failed to follow the company rules/handbook." A State Health Department report, Incident Number 5, submitted by the facility on 4/30/25, indicated on 4/27/25 at 4:01 P.M., Resident D was let out of the facility by a visitor. Resident D was then seen by another visitor sitting in the grass on the north side of the facility by the employee entrance at around 4:40 P.M. The Director of Nursing, who was on site at the time, escorted Resident D back into the building at 4:42 P.M. At 6:00 P.M. during an interview with the Administrator, Resident D indicated he went outside to help his dad clip the pigs and the resident had stated he was sitting in the grass outside, enjoying the sunshine. There were no associated injuries. Preventive measures, implemented on 4/30/25, were to check and lock all doors and visitor education. Resident D's Service Plan dated 10/11/24, indicated Resident D as able to communicate effectively and make his needs known, had mild impairment to orientation but was sometimes disoriented to person, place, time, or situation requiring some direction and reminders. Resident D had a history of wandering and could wander outside ,putting his heath or safety at jeopardy. The resident had a history of occasional disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper			

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	required special tolerance or staff training. Resident D displayed occasional judgement issues needing protection and supervision because he made unsafe or inappropriate decisions. On 4/30/25 at 11:26 A.M., the Administrator provided a policy titled, "Chapters Living Abuse and Neglect Policy," dated 4/29/25. The policy indicated, "...Abuse: Intentional or reckless infliction of injury, confinement, intimidation...Neglect: Failure to provide goods or services necessary to avoid physical harm, mental anguish, or emotional distress. This citation relates to Complaints IN00457398 and IN00458551.			