

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 07/14/2026
NAME OF PROVIDER OR SUPPLIER HERITAGE WOODS OF GREENBRIAR		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR, INDIANAPOLIS, , 46219			
(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 469228 and 407123 Intake 469228 - No deficiencies related to the allegations are cited. Intake 470123 -- State deficiency related to the allegations is cited at R0052. Survey dates: July 13 and 14, 2026 Facility number: 011799 Residential Census: 92 This State Residential Finding is cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on July 17, 2026.	R 0000			
R 0052	Residents' Rights - Offense	R 0052		08/13/2026	

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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 a resident was free from neglect when a resident with dementia was not provided adequate supervision to prevent the resident from eloping (unsupervised wandering that leads to a resident leaving the facility which could lead to the resident experiencing significant injury or death) from the secured memory care unit and exiting the facility, walking 2.8-3.0 miles (roundtrip) without knowledge of the resident's location for 1 of 3 residents reviewed for elopement. (Resident B)

Finding include:

On 6-8-26, the facility sent a report to the Indiana Department of Health's Long Term Care Division which indicated the power of attorney

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(POA) of Resident B had called the facility on 6-7-26, to report Resident B had phoned the POA and was on a nearby street, at least 0.1 miles from the facility. It indicated the facility was unaware of her being off the premises and immediately began searching for the resident. The report indicated Resident B returned to the facility "on her own accord." The report did not indicate when the resident left the facility or what time she returned. A physical assessment of Resident B was completed upon return to the facility and the resident had no apparent injuries.

The clinical record of Resident B was reviewed on 7-13-26 at 11:00 a.m. It indicated she was admitted to the facility over 4 years ago. Her diagnoses included, but were not limited to chronic cognitive impairment, dementia and major cognitive disorder with unspecified behavioral disturbances.

The most recent nursing assessment for Resident B, dated 1-20-26, indicated she was moderately cognitively impaired, requiring "frequent help due to disorientation, memory loss, and difficulty completing tasks. The resident had no observable safety awareness deficits," was alert to

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person, time and place, was able to tell time and follow instructions, was independently ambulatory without the use of any devices, resided on a secured memory care unit, had no history of wandering or elopement and had no "behavioral challenges." The interventions included, but were not limited to, reside on the secured memory care unit and staff to conduct safety checks every two hours.

The nursing progress notes, dated 6-7-26 at 5:56 p.m., indicated Resident B left the facility. The resident indicated she had to meet a friend who was giving her some yarn. The writer asked resident why she didn't tell staff that she needed to leave facility and resident indicated she was excited to get some yarn. Resident B indicated she got the yarn and came back to the facility. The family and physician were notified.

A nursing progress note dated 6-8-26 at 2:37 p.m., indicated Resident B walked to a local store on a nearby street. Resident B was able to share the name of the store. Based on this information, Google Maps was able to specify the store was located 1.5 miles, one-way, from the facility.

An observation of the direction of travel from the front entrance

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of the facility to the short street, Spoon Drive, to the next main street was less than 0.1 miles. Spoon Drive was observed to have sidewalks only on the north side of the street, with the south side of the street having a retention pond a short distance from the street and surrounded by a metal fence. At the intersection of Spoon Drive with Post Road, the direction of travel would have been south on Post Road, towards Washington Street. From this intersection towards Washington Street, the sidewalks were located only on the east side of the street. Post Road and Washington Street were both moderately to heavily traveled roads, with each having 4 travel lanes, plus a center turn lane. There was not a traffic signal at Spoon Drive and Post Road. The distance from this intersection to Washington Street is 0.8 miles. At the intersection of Post Road and Washington Street, the direction of travel would have been eastbound. There was a traffic signal at this intersection, with sidewalks on both sides of this street. The distance from this intersection to the mentioned store is 0.6 miles, for a total of 1.4 miles, one-way or round trip distance of 2.8 miles.

The facility sent a follow-up report to the Indiana

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Department of Health's Long Term Care Division on 6-12-26, which indicated the facility's investigation indicated the camera footage showed Resident B had exited the secured memory care unit and the facility by following a peer's family out the secured door of the unit and to the outside at the front entry. The facility's interviews with the resident indicated she had left the premises to obtain yarn for a project she wished to complete. A receipt for the purchase of yarn was located in a bag from the same store she had mentioned. The report did not address the time at which she exited the facility nor the time of return, or the estimated distance she had walked during this elopement. The report specified Resident B "was able to recall all events leading up to, during and after her departure from the community. Resident B was placed on 30 minute checks for 72 hours and had no other exit seeking behaviors. During the interview Resident B, she indicated she thought was allowed to the community by herself.

During an interview with LPN 3 on 7-13-26 at 10:14 a.m., he indicated he was familiar with Resident B and described her as a "higher functioning" person with dementia, able to provide

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most of her own personal care and did not have a prior history of exit-seeking. He indicated on the day shift of 6-7-26, he had worked on the memory care unit and had seen Resident B on the unit prior to him leaving for the day.

During an interview with the Memory Care Director on 7-13-26 at 1:03 p.m., she indicated Resident B had resided on the secured memory care unit for approximately one year. She added Resident B "had never displayed any behaviors of elopement."

During an interview with Resident B on 7-13-26 at 2:35 p.m., she was unable to recall any details of 6-7-26. She indicated she was able to leave the facility as she desired, but preferred to have someone drive her instead of walking to shopping areas.

On 7-13-26 at 11:16 a.m., the Corporate Nurse provided a copy of a policy entitled, "Elopement Risk and Missing Resident Policy," with a revision date of 11/2023. This policy indicated, "As a community the goal was to provide a safe environment for all residents."

This Residential tag relates to Intake 470123.

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2.5-1.2(v)(5)

2.5-1.2(v)(2)

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
SIGNATURE

TITLE

(X6) DATE