STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET, NOBLESVILLE, , 46060

(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 466671, 466624, and 466497. Intake 466671 - State deficiencies related to the allegations are cited at R0052. Intake 466624 - State deficiencies related to the allegations are cited at R0052. Intake 466497 - State deficiencies related to the allegations are cited at R0052. Survey dates: December 15 and 16, 2025 Facility number: 014213 Residential Census: 125 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 30, 2025.	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: (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 protect residents' rights to be free from neglect related to failure to prevent the elopement of cognitively impaired residents from the secured unit for 2 of 3 residents reviewed for elopement risk. This deficient practice resulted in Resident B being unsupervised for over an hour in below freezing temperatures, requiring emergency medical treatment and admission to the hospital Intensive Care Unit. Findings include: 1. Resident B's clinical record was reviewed on 12/15/25 11:07 a.m. Diagnoses included dementia without behavioral disturbance, epilepsy, not intractable, without status	R 0052		01/05/2026

epileptic, heart failure, hypertensive, and anxiety disorder. The resident lived on the secured memory care unit.

Review of a current service plan, dated 9/26/25, indicated Resident B had memory problems, was unable to recall memories and had moderately impaired decision making. The resident required supervision assistance for locomotion, utilized a walker, had an unsteady gait, and balance problems when standing. The resident needed the assistance of another person outside, was at risk of falling inside and outside, had poor gait inside and outside, and may have difficulty getting from room to room based on endurance and stability.

Review of a progress note, dated 12/4/25 at 5:45 a.m. and signed by QMA 2, indicated Resident B was observed on the ground in the courtyard, fully clothed. The resident was found wearing a jacket, jeans, and shoes. The resident was not using her rollator walker and her eyeglasses were not present. QMA 2 notified the on-call nurse that the resident was being sent to the emergency room (ER) for evaluation due to an unwitnessed fall. Resident B was not able to voice what had occurred. QMA 2 was unable to obtain vital signs at this time.

The nurse practitioner, family, and Administrator were notified.

Review of a hospital emergency department progress note, dated 12/4/25 at 6:45 a.m., indicated emergency medical services (EMS) arrived at the assisted living facility to find Resident B near a fireplace, accompanied by staff after being found outside. It was unclear how long she had been outside. EMS began rewarming the resident with a thermal blanket and warming packs, leading her to become slightly more responsive. In the emergency department, Resident B kept wanting to move to her left side into a fetal position and was shivering. A temperature sensing catheter was placed and the resident's initial temperature was 79.16 degrees Fahrenheit (F) and rose to 80.06 degrees F within 10 minutes. Resident B was transferred to the Intensive Care Unit (ICU) for further treatment of hypothermia (low body temperature).

Review of a facility self-reportable incident, dated 12/4/25, indicated during the morning wake up routine, Resident B was not found in their apartment. The resident was found, fully clothed, after an unwitnessed fall in the memory care courtyard. There were no injuries, but the resident was

sent to the emergency department for evaluation.

Review of CNA 1's written statement, dated 12/4/25, indicated she saw Resident B at midnight (12 a.m.) during room rounding, sitting on her bed. At 2:00 a.m., she saw what she thought was the resident lying in bed. She started her morning get-up routine around 4:45 a.m. When she came to Resident B's room, the resident was not present. The CNA checked her other assigned rooms and then notified QMA 2. Resident B was found outside, lying in the garden, on the ground. CNA 1 did not hear any door alarm sound.

Review of QMA 2's written statement, dated 12/4/25, indicated CNA 1 notified her Resident B was not in her apartment at 5:10 a.m. QMA 2 checked the rooms on her assignment, but the resident was not found. The QMA called for assistance and a search was initiated. The resident was found outside, lying face up on the ground. The resident did not respond when staff called out. Staff brought the resident back into the facility, called 911, and notified the nurse on call. Emergency Medical Services (EMS) arrived and were unable to obtain vital signs. QMA 2 asked CNA 1 the last time she had seen the resident, and CNA

1 indicated 2:00 a.m. and 4:00 a.m., when she started the morning get-up routine. QMA 2 did not know when the resident went outside or how long she had been outside. QMA 2 did not hear any door alarm sound.

A 12/11/25 hospital discharge note indicated Resident B was discharged with hospice services after an inpatient stay for hypothermic shock (hypothermia resulting in organ/circulation damage).

Review of a facility developed timeline document, provided by the Administrator on 12/15/25 1:20 p.m., titled "Timeline of Events" written by the Administrator indicated (on 12/4/25) at 5:52 a.m., the ADON notified the Administrator Resident B was found outside, following an unwitnessed fall.

Review of the temperatures for Noblesville for the morning of 12/4/25, obtained from www.timeanddate.com/weather indicated the temperature on 12/4/25 at 12:54 a.m. was 28 degrees Fahrenheit (F). At 3:54 a.m. the temperature was 29 degrees (F) with light snow. At 6:54 a.m. the temperature was 25 degrees (F) with light snow.

During a tour of the memory care unit, on 12/16/25 at 2:48 p.m., the courtyard doors were observed to have locks that

required a key to open the doors and an alarm present.

During an interview on 12/16/25 at 2:00 p.m., the Administrator indicated there were no cameras for the courtyard doors. The Administrator indicated the only way for anyone to exit the secured unit to the courtyard would have been for the door to not be completely closed or it was left unlocked.

During an interview on 12/16/25 at 10:12 a.m., CNA 1 indicated she was assigned to care for Resident B on 12/3/25 through 12/4/25 night shift. CNA 1 indicated she saw the resident around midnight sitting on the bed. The second time (not sure of the time) CNA 1 went to check on the resident; she did not enter the room. The CNA looked through the door and thought she saw the resident in bed. During the 4:00 a.m. room checks, she noticed the resident was not in her room. CNA 1 indicated she checked all of the rooms herself searching for the resident. CNA 1 called QMA 2 and together they searched for the resident. The resident was found outside in the courtyard near the sunroom. The resident was brought back into the facility. Staff called 911 and the resident was sent to the hospital for evaluation.

During an interview on 12/16/25 at 12:33 p.m., CNA 9 indicated the exit door to the courtyard on the secured unit was at times left unlocked so residents could enter the courtyard on their own. CNA 9 indicated the resident was not known for wandering and usually stayed in her room.

During an interview on 12/16/25 at 2:00 p.m., QMA 2 indicated, on the morning of 12/4/25, CNA 1 informed her that Resident B was not in her room. They initiated a head count and were unable to locate the resident in the building. QMA 2 went to the courtyard and found the resident on the ground. When she called out, the resident did not respond. The resident was dressed and was wearing shoes. CNA 1 and QMA 2 were able to bring Resident B back inside the facility. QMA 2 called 911 and the resident was transported to the hospital.

During an interview on 12/17/25 at 2:21 p.m., the Maintenance Director indicated he checked the memory care courtyard doors daily. If someone entered the facility from the courtyard, they did not need a key. It would be possible for the door to not close completely. The Maintenance Director did not know how the resident opened the door to the courtyard unless it was left unlocked.

During an interview on 12/17/25 at 2:30 p.m., the DON indicated it was the expectation of the facility that staff performed safety checks on residents every two hours on all shifts. The facility did not have a written policy for the two-hour safety checks.

During an interview on 12/17/25 at 2:33 p.m., the Administrator indicated the southwest door on the memory care unit was no longer used by staff or visitors. The key code was only known by the Administrator and the Maintenance Director. The Administrator indicated residents were to have safety checks every two hours on all shifts and they were to be documented in the clinical record. The Administrator indicated CNA 1 did not document safety checks during her shift for Resident B.

Review of the task documentation in Resident B's clinical record for December 1 through December 31, 2025 indicated the following task: "Perform safety check. If unable to locate, notify QMA/LPN immediately." The following safety checks were documented: 12/3 at 2:12 p.m. and 12/12 at 10:07 a.m. No other safety checks were documented.

2. Resident C's clinical record

was reviewed on 12/15/25 at 11:00 a.m. Diagnoses included dementia without behavioral disturbance, hypertension, and chronic kidney disease. The resident lived on the memory care unit.

Review of a current service plan, dated 4/26/25, indicated the resident was moderately cognitively impaired and had a history of wandering with exit seeking behaviors.

Review of a progress note, dated 10/14/25, indicated the alarm sounded on the secured unit, the staff approached alarm and was unable to identify why the alarm was sounding. The resident was observed at the Assisted Living entrance (accessible outside of the secured unit and through a hallway and common area) and was redirected back to the secured unit by staff.

Review of a progress note, dated 12/6/25 at 3:00 p.m., indicated staff informed the DON that the door alarm was sounding on the secured unit. The Administrator was notified regarding door alarm sounding. The Administrator reviewed security video. The video showed Resident C exiting through the southwest door. The resident remained on the Assisted Living unit first floor, and circled around to the

service door to the memory care entrance, before returning to the secured unit.

Review of the task documentation in Resident C's clinical record for December 1 through December 31, 2025 indicated the following task: "Perform safety check. If unable to locate, notify QMA/LPN immediately." The following safety checks were documented: 12/6 at 8:57 a.m.,12/8 at 1:41 p.m., 12/9 at 1:48 p.m., 12/10 at 1:59 p.m., and 12/11 at 2:37 p.m. No other safety checks were documented.

A security video, dated 10/14/25 started at 6:01 p.m., was reviewed accompanied Administrator. Resident C was observed walking near the North- East door (service door). At 6:27 p.m. the resident was seen near the South -West door. The resident pushed the panic bar and waited for the door to release, then exited the secured unit and entered the unsecured unit. No staff were present. At 6:29 p.m., the resident was seen exiting the facility through the front entrance. At the same time, staff arrived at the South- West door and were seen attempting to turn off the alarm. Staff exit through the South-West door . At 6:30 p.m., CNA 9 and an unknown staff member were

observed in the walking the resident back into the facility through the front door and returning to the secured unit.

During an interview on 12/16/25 at 11:17 a.m., LPN 10 indicated Resident C had a history of exit seeking behaviors. The resident could be redirected but required closer supervision.

During an interview on 12/16/25 at 2:21 p.m., the DON indicated the facility did not have a written policy for the two -hour safety checks. The topics of elopement and two -hour safety checks were covered in staff meetings.

A copy of the most recent staff meeting agenda was provided by the DON on 12/16/25 at 2:21 p.m. The following information was present: "Check on our Residents MC (Memory Care) QMA-You are responsible for making rounds throughout the unit every two hours. MC CNAs Check on the resident's [sic] on your assignment every two hours. ..."

This citation relates to Intakes 466624, 466497, and 466671.

Based on interview and record review, the facility failed to protect residents' rights to be free from neglect related to failure to prevent the elopement of cognitively impaired residents from the secured unit for 2 of 3 residents reviewed for

elopement risk. This deficient practice resulted in Resident B being unsupervised for over an hour in below freezing temperatures, requiring emergency medical treatment and admission to the hospital Intensive Care Unit.

Findings include:

1. Resident B's clinical record was reviewed on 12/15/25 11:07 a.m. Diagnoses included dementia without behavioral disturbance, epilepsy, not intractable, without status epileptic, heart failure, hypertensive, and anxiety disorder. The resident lived on the secured memory care unit.

Review of a current service plan, dated 9/26/25, indicated Resident B had memory problems, was unable to recall memories and had moderately impaired decision making. The resident required supervision assistance for locomotion, utilized a walker, had an unsteady gait, and balance problems when standing. The resident needed the assistance of another person outside, was at risk of falling inside and outside, had poor gait inside and outside, and may have difficulty getting from room to room based on endurance and stability.

Review of a progress note,

dated 12/4/25 at 5:45 a.m. and signed by QMA 2, indicated Resident B was observed on the ground in the courtyard, fully clothed. The resident was found wearing a jacket, jeans, and shoes. The resident was not using her rollator walker and her eyeglasses were not present. QMA 2 notified the on-call nurse that the resident was being sent to the emergency room (ER) for evaluation due to an unwitnessed fall. Resident B was not able to voice what had occurred. QMA 2 was unable to obtain vital signs at this time. The nurse practitioner, family, and Administrator were notified.

Review of a hospital emergency department progress note, dated 12/4/25 at 6:45 a.m., indicated emergency medical services (EMS) arrived at the assisted living facility to find Resident B near a fireplace, accompanied by staff after being found outside. It was unclear how long she had been outside. EMS began rewarming the resident with a thermal blanket and warming packs, leading her to become slightly more responsive. In the emergency department, Resident B kept wanting to move to her left side into a fetal position and was shivering. A temperature sensing catheter was placed and the resident's initial temperature was 79.16 degrees Fahrenheit (F) and rose

to 80.06 degrees F within 10 minutes. Resident B was transferred to the Intensive Care Unit (ICU) for further treatment of hypothermia (low body temperature).

Review of a facility self-reportable incident, dated 12/4/25, indicated during the morning wake up routine, Resident B was not found in their apartment. The resident was found, fully clothed, after an unwitnessed fall in the memory care courtyard. There were no injuries, but the resident was sent to the emergency department for evaluation.

Review of CNA 1's written statement, dated 12/4/25, indicated she saw Resident B at midnight (12 a.m.) during room rounding, sitting on her bed. At 2:00 a.m., she saw what she thought was the resident lying in bed. She started her morning get-up routine around 4:45 a.m. When she came to Resident B's room, the resident was not present. The CNA checked her other assigned rooms and then notified QMA 2. Resident B was found outside, lying in the garden, on the ground. CNA 1 did not hear any door alarm sound.

Review of QMA 2's written statement, dated 12/4/25, indicated CNA 1 notified her Resident B was not in her

	apartment at 5:10 a.m. QMA 2 checked the rooms on her assignment, but the resident was not found. The QMA called for assistance and a search was initiated. The resident was found outside, lying face up on the ground. The resident did not respond when staff called out. Staff brought the resident back into the facility, called 911, and notified the nurse on call. Emergency Medical Services (EMS) arrived and were unable to obtain vital signs. QMA 2 asked CNA 1 the last time she had seen the resident, and CNA 1 indicated 2:00 a.m. and 4:00 a.m., when she started the morning get-up routine. QMA 2 did not know when the resident went outside or how long she had been outside. QMA 2 did not hear any door alarm sound. A 12/11/25 hospital discharge note indicated Resident B was discharged with hospice services after an inpatient stay for hypothermic shock (hypothermia resulting in organ/circulation damage).			

Review of a facility developed timeline document, provided by the Administrator on 12/15/25 1:20 p.m., titled "Timeline of Events" written by the Administrator indicated (on 12/4/25) at 5:52 a.m., the ADON notified the Administrator Resident B was found outside, following an unwitnessed fall.

Review of the temperatures for Noblesville for the morning of 12/4/25, obtained from www.timeanddate.com/weather indicated the temperature on 12/4/25 at 12:54 a.m. was 28 degrees Fahrenheit (F). At 3:54 a.m. the temperature was 29 degrees (F) with light snow. At 6:54 a.m. the temperature was 25 degrees (F) with light snow.

During a tour of the memory care unit, on 12/16/25 at 2:48 p.m., the courtyard doors were observed to have locks that required a key to open the doors and an alarm present.

During an interview on 12/16/25 at 2:00 p.m., the Administrator indicated there were no cameras for the courtyard doors. The Administrator indicated the only way for anyone to exit the secured unit to the courtyard would have been for the door to not be completely closed or it was left unlocked.

During an interview on 12/16/25

at 10:12 a.m., CNA 1 indicated she was assigned to care for Resident B on 12/3/25 through 12/4/25 night shift. CNA 1 indicated she saw the resident around midnight sitting on the bed. The second time (not sure of the time) CNA 1 went to check on the resident; she did not enter the room. The CNA looked through the door and thought she saw the resident in bed. During the 4:00 a.m. room checks, she noticed the resident was not in her room. CNA 1 indicated she checked all of the rooms herself searching for the resident. CNA 1 called QMA 2 and together they searched for the resident. The resident was found outside in the courtyard near the sunroom. The resident was brought back into the facility. Staff called 911 and the resident was sent to the hospital for evaluation.

During an interview on 12/16/25 at 12:33 p.m., CNA 9 indicated the exit door to the courtyard on the secured unit was at times left unlocked so residents could enter the courtyard on their own. CNA 9 indicated the resident was not known for wandering and usually stayed in her room.

During an interview on 12/16/25 at 2:00 p.m., QMA 2 indicated, on the morning of 12/4/25, CNA 1 informed her that Resident B was not in her room. They initiated a head count and were

unable to locate the resident in the building. QMA 2 went to the courtyard and found the resident on the ground. When she called out, the resident did not respond. The resident was dressed and was wearing shoes. CNA 1 and QMA 2 were able to bring Resident B back inside the facility. QMA 2 called 911 and the resident was transported to the hospital.

During an interview on 12/17/25 at 2:21 p.m., the Maintenance Director indicated he checked the memory care courtyard doors daily. If someone entered the facility from the courtyard, they did not need a key. It would be possible for the door to not close completely. The Maintenance Director did not know how the resident opened the door to the courtyard unless it was left unlocked.

During an interview on 12/17/25 at 2:30 p.m., the DON indicated it was the expectation of the facility that staff performed safety checks on residents every two hours on all shifts. The facility did not have a written policy for the two-hour safety checks.

During an interview on 12/17/25 at 2:33 p.m., the Administrator indicated the southwest door on the memory care unit was no longer used by staff or visitors. The key code was only known

by the Administrator and the Maintenance Director. The Administrator indicated residents were to have safety checks every two hours on all shifts and they were to be documented in the clinical record. The Administrator indicated CNA 1 did not document safety checks during her shift for Resident B.

Review of the task documentation in Resident B's clinical record for December 1 through December 31, 2025 indicated the following task: "Perform safety check. If unable to locate, notify QMA/LPN immediately." The following safety checks were documented: 12/3 at 2:12 p.m. and 12/12 at 10:07 a.m. No other safety checks were documented.

2. Resident C's clinical record was reviewed on 12/15/25 at 11:00 a.m. Diagnoses included dementia without behavioral disturbance, hypertension, and chronic kidney disease. The resident lived on the memory care unit.

Review of a current service plan, dated 4/26/25, indicated the resident was moderately cognitively impaired and had a history of wandering with exit seeking behaviors.

Review of a progress note,

dated 10/14/25, indicated the alarm sounded on the secured unit, the staff approached alarm and was unable to identify why the alarm was sounding. The resident was observed at the Assisted Living entrance (accessible outside of the secured unit and through a hallway and common area) and was redirected back to the secured unit by staff.

Review of a progress note, dated 12/6/25 at 3:00 p.m., indicated staff informed the DON that the door alarm was sounding on the secured unit. The Administrator was notified regarding door alarm sounding. The Administrator reviewed security video. The video showed Resident C exiting through the southwest door. The resident remained on the Assisted Living unit first floor, and circled around to the service door to the memory care entrance, before returning to the secured unit.

Review of the task documentation in Resident C's clinical record for December 1 through December 31, 2025 indicated the following task: "Perform safety check. If unable to locate, notify QMA/LPN immediately." The following safety checks were documented: 12/6 at 8:57 a.m.,12/8 at 1:41 p.m., 12/9 at 1:48 p.m., 12/10 at 1:59 p.m.,

and 12/11 at 2:37 p.m. No other safety checks were documented.

A security video, dated 10/14/25 started at 6:01 p.m., was reviewed accompanied Administrator. Resident C was observed walking near the North- East door (service door). At 6:27 p.m. the resident was seen near the South -West door. The resident pushed the panic bar and waited for the door to release, then exited the secured unit and entered the unsecured unit. No staff were present. At 6:29 p.m., the resident was seen exiting the facility through the front entrance. At the same time, staff arrived at the South- West door and were seen attempting to turn off the alarm. Staff exit through the South-West door . At 6:30 p.m., CNA 9 and an unknown staff member were observed in the walking the resident back into the facility through the front door and returning to the secured unit.

During an interview on 12/16/25 at 11:17 a.m., LPN 10 indicated Resident C had a history of exit seeking behaviors. The resident could be redirected but required closer supervision.

During an interview on 12/16/25 at 2:21 p.m., the DON indicated the facility did not have a written policy for the two -hour safety

	checks. The topics of elopement and two -hour safety checks were covered in staff meetings. A copy of the most recent staff meeting agenda was provided by the DON on 12/16/25 at 2:21 p.m. The following information was present: "Check on our Residents MC (Memory Care) QMA-You are responsible for making rounds throughout the unit every two hours. MC CNAs Check on the resident's [sic] on your assignment every two hours. ..." This citation relates to Intakes 466624, 466497, and 466671.			

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